Florida community care

Florida Medicaid Member Handbook

FCChealthplan.com | 1-833-FCC-PLAN
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“If you do not speak English, call us at 1-833-FCC-PLAN (1-833-322-7526). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language."

Spanish: Si usted no habla inglés, llámenos al 1-833-FCC-PLAN (1-833-322-7526). . Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: **Si vous ne parlez pas anglais**, appelez-nous au 1-833-FCC-PLAN (1-833-322-7526). . Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole: **Si ou pa pale lang Anglè**, rele nou nan 1-833-FCC-PLAN (1-833-322-7526). . Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian: **"Se non parli inglese** chiamaci al 1-833-FCC-PLAN (1-833-322-7526). . Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua."

Russian: **«Если вы не разговариваете по-английски,** позвоните нам по номеру 1-833-FCC-PLAN (1-833-322-7526). У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Vietnamese: “**Nếu bạn không nói được tiếng Anh**, hãy gọi cho chúng tôi theo số <1-833-FCC-PLAN (1-833-322-7526). >. Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn."

Important Contact Information

Member Services Help Line	1-833-FCC-PLAN(1-833-322-7526)	Available 24 hours
Member Services Help Line TTY	711	Available 24 hours
Website	www.fcchealthplan.com	
Address	Florida Community Care 4601 NW 77th Ave Miami, FL 33166	

Transportation Services: Non-Emergency	Contact Member Services at 1-833-FCC-PLAN (1-833-322-7526). for help with transportation to and from your medical appoints and other program services.
Prescriptions/Pharmacy	If you have prescription drug coverage with FCC: CVS Contact your local CVS pharmacy or for questions about your pharmacy benefit call 1-877-888-8347
Vision	iCare 1-888-234-6408
Dental	Contact your Medicaid Dental Plan. If you need help finding their contact information call Member Services at 1-833-FCC-PLAN (1-833-322-7526).
Hearing	HearUSA 1-844-339-1726
Care Manager	Contact your care manager directly or Member Services at 1-833-FCC-PLAN (1-833-322-7526) if you need help reaching them.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-800-96-ABUSE (1-800-962-2873) TTY: 711 or 1-800-955-8771 https://www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse
For Medicaid Eligibility	1-866-762-2237 TTY: 711 or 1-800-955-8771 https://www.myflfamilies.com/medicaid#ME

To report Medicaid Fraud and/or Abuse	1-888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	1-888-419-3456 http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml
To request a Medicaid Fair Hearing	1-877-254-1055 1-239-338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com
To file a complaint about Medicaid services	1-877-254-1055 TDD: 1-866-467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	1-800-96-ELDER (1-800-963-5337) http://www.elderaffairs.org/doea/arc.php
To find out information about domestic violence	1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224 http://www.thehotline.org/
To find information about health facilities in Florida	https://quality.healthfinder.fl.gov/
To find information about urgent care	First, contact your PCP. If you cannot reach your PCP, call Member Services at 1-833-FCC-PLAN (1-833-322-7526). You may also check the Florida Community Care online directory at www.fcchealthplan.com.
For an emergency	9-1-1 Or go to the nearest emergency room

Table of Contents

Welcome to Florida Community Care's Statewide Medicaid Managed Care Plan

Florida Community Care has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the **Statewide Medicaid Managed Care (SMMC) Program**. You are enrolled in our SMMC plan. This means we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

If your child is enrolled in the Florida KidCare **MediKids** program, most of the information in this handbook applies to you. We will let you know if something does not apply.

If you are a participant in the Intellectual Developmentally Disabled (IDD) Pilot Program, most of the information in this handbook applies to you. We will let you know if something does not apply or if there is information that applies to IDD enrollees.

This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at 1-833-FCC-PLAN (1-833-322-7526) of TTY at 711.

Section 1: Your Plan Identification Card (ID card)

You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

Always carry your ID card and show it each time you go to a health care appointment or the hospital. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

For Members with Medicare Coverage, your ID card will look like this:

For Members without Medicare Coverage, your ID card will look like this:

Section 2: Your Privacy

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, Plan identification number, race, ethnicity, and other things that identify you. We will not share any health information about you that is not allowed by law.

If you have any questions, call Member Services. Our privacy policies and protections are:

Our Responsibilities

Florida Community Care, LLC. by law must keep your health information safe and private. We must tell you about our legal duties and privacy practices related to your health information. We must follow the terms of this notice.

Here are some examples of how we will use your information without your permission:

- For treatment — *Example: to arrange for referrals with a specialist*
- To run our operations — *Example: to develop better services for you*
- For payment — *Example: to pay your doctor*
- If required or allowed by law for these reasons:
  - for help with public health and safety issues. Example: to report suspected abuse, neglect, or domestic violence
  - to send you appointment reminders, or about treatment alternatives, or health-related benefits and services that may be of interest to you if you have not opted out
  - research purposes
  - to respond to an organ donation request
  - to work with a medical examiner or funeral director.
  - to address worker's compensation claims
  - law enforcement, and other government requests.
  - to respond to lawsuits, court orders and legal actions.
  - when a business associate performs certain functions on your behalf, such as payment.
  - to any person involved in your care. Example: a family member in an emergency. If you cannot object, we may decide if giving the information is in your best interests.

We may also use and share your health information with you or your authorized representative's written permission when:

- using or sharing psychotherapy notes as allowed by law, or
- in the release to third parties, or
- for certain marketing communications.

Please note that you may take away our permission at any time in writing, except if we have already acted.

What are your Rights?

You have the right:

- **To ask for a copy of your health and claim records.**
  We may charge a reasonable fee. You can name someone else to receive your records.

- **To inspect and correct health and claims records.**
  If they are incorrect or incomplete. We may deny your request and will explain in writing.

- **To request confidential communications.**
  For example: to receive mail at a different address. We will accept valid requests. Tell us if you fear that contacts about your health information where you are now would put you in danger.

- **To limit what we use or share for treatment, payment, or our operations or to others.**
  We may deny your request.

- **To a list of those with whom we have shared your information for six years prior to the date you ask except for:**
  - treatment, payment, and health care operations;
  - prior disclosures;
  - sharing done with your agreement;
  - uses for disclosures authorized or required by law.

  We will charge a reasonable fee if you ask for a list more than once in a period of 12 months. You need to make this request in writing.

- **To choose someone to act for you to exercise your rights and make choices**
  By a medical power of attorney or legal guardian. We will verify this authority before we take any action.

- **To be notified of any breach of unsecured medical information**
  Unless we determine that there is a low probability that your medical information has been compromised.

Exercising your Rights

- **Contacting FCC**

  If you have any questions, or if you believe that your privacy rights have been violated, you may contact us at:

  Florida Community Care, LLC
  Privacy Officer
  4601 NW 77th Avenue
  Miami, FL 33166
  Tel: 1 (833) 322-7526
  Compliance@fcchealthplan.com

You may also submit a complaint to the Office of Civil Rights, call us to provide you with the information of the Office of Civil Rights in your region.

You will not be retaliated against for filing a complaint.

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all of your questions. We can help you

choose or change your Primary Care Provider (PCP for short), find out if a service is covered, get referrals, find a provider, replace a lost ID card, report the birth of a new baby, and explain any changes that might affect you or your family's benefits.

Contacting Member Services

You may call us at 1-833-FCC-PLAN (1-833-322-7526).or TTY: 711, Monday to Friday, 8 a.m. to 8 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. **(**If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our After-Hours Hotline at 1-833-FCC-PLAN (1-833-322-7526)., or TTY: 711. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

If you do not speak English, we can help. We have people who help us talk to you in your language. We provide this help for free.

For people with disabilities: If you use a wheelchair, or are blind, or have trouble hearing or understanding, call us if you need extra help. We can tell you if a provider's office is wheelchair accessible or has devices for communication. Also, we have services like:

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 1-833-FCC-PLAN (1-833-322-7526). They will connect you to us
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at 1-866-762-2237 (TTY 1-800-955-8771) Monday through Friday from 8 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (MyACCESS) account at https://myaccess.myflfamilies.com/. If you receive Supplemental Security Income (SSI), you must also contact the Social Security Administration (SSA) to report changes. Call SSA toll free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 8 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your Social Security account at https://secure.ssa.gov/RIL/SiView.do.

Section 6: Changes to your Health Plan

If your health plan experiences a significant change that affects you as an enrollee, it is the plan's responsibility to inform you (the enrollee) at least 30 days before the intended effective date of the change.

Section 7: Your Medicaid Eligibility

You must be covered by Medicaid and enrolled in our plan for Florida Community Care to pay for your health care services and health care appointments. This is called having **Medicaid eligibility**. If you receive SSI, you qualify for Medicaid. If you do not receive SSI, you must apply for Medicaid with DCF.

Sometimes things in your life might change, and these changes can affect whether you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services. We can help you check on your coverage.

If you Lose your Medicaid Eligibility

If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare

If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a baby

If you have a baby, he or she will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived, and we will help make sure your baby is covered and has Medicaid right away.

It is helpful if you let us know you are pregnant **before** your baby is born to make sure your baby has Medicaid. Call DCF toll free at 1-866-762-2237 while you are pregnant. If you need help talking to DCF, call us. DCF will make sure your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Section 8: Enrollment in Our Plan

Initial Enrollment

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in the same region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open Enrollment Period

Each year, you will have 60 days when you can change your plan if you want. This is called your **open enrollment period**. The State's Enrollment Broker will send you a letter to tell you when your open enrollment period is.

You do not have to change plans during your open enrollment period. If you do choose to leave our plan and enroll in a new one, you will start with your new plan at the end of your open enrollment period. Once you are enrolled in the new plan, you are locked-in until your next open enrollment period. You can call the Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Enrollment in the SMMC Long-Term Care Program

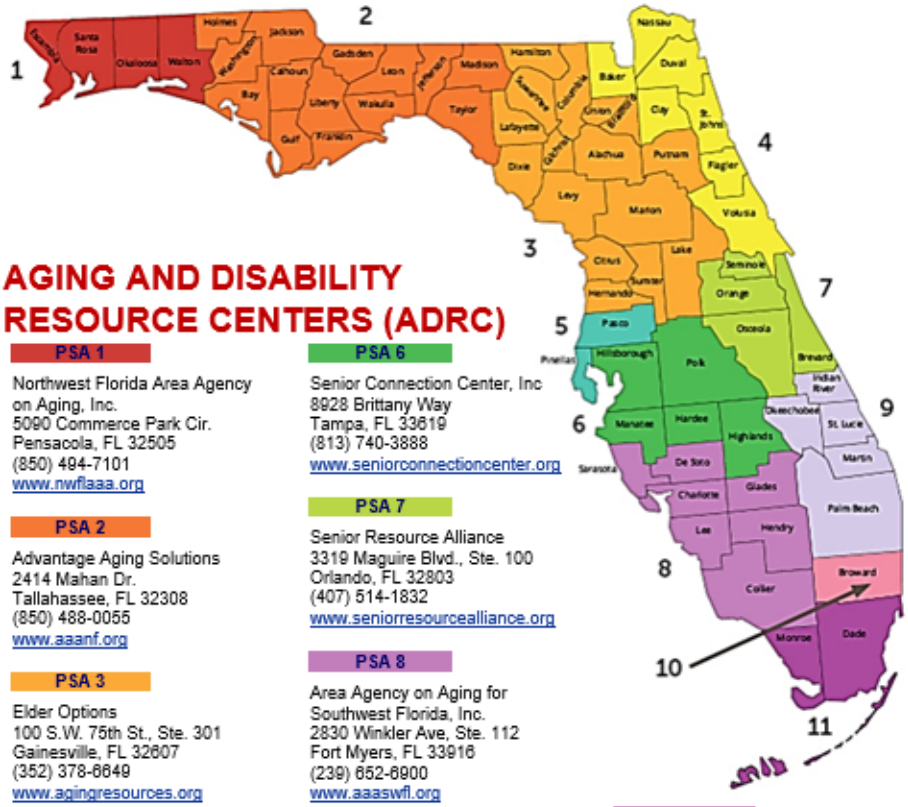
The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help with chores; help with shopping; or supervision.

We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list

and a space becomes available for you in the LTC program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

You can find the phone number for your local ADRC using the following map. They can also help answer any other questions that you have about the LTC program. Visit https://ahca.myflorida.com/Medicaid/statewide_mc/smmc_ltc.shtml for more information.



AGING AND DISABILITY RESOURCE CENTERS (ADRC)

PSA 1

Northwest Florida Area Agency on Aging, Inc.
5090 Commerce Park Cir.
Pensacola, FL 32505
(850) 494-7101
www.nwflaaa.org

PSA 2

Advantage Aging Solutions
2414 Mahan Dr.
Tallahassee, FL 32308
(850) 488-0055
www.aaanf.org

PSA 3

Elder Options
100 S.W. 75th St., Ste. 301
Gainesville, FL 32607
(352) 378-6649
www.agingresources.org

PSA 4

Elder Source, The Area Agency on Aging of Northeast Florida
10688 Old St. Augustine Rd.
Jacksonville, FL 32257
(904) 391-6600
www.myeldersource.org

PSA 5

Area Agency on Aging of Pasco-Pinellas, Inc.
9549 Koger Blvd., Gadsden Bldg., Ste. 100
St. Petersburg, FL 33702
(727) 570-9696
www.agingcarefl.org

PSA 6

Senior Connection Center, Inc
8928 Brittany Way
Tampa, FL 33619
(813) 740-3888
www.seniorconnectioncenter.org

PSA 7

Senior Resource Alliance
3319 Maguire Blvd., Ste. 100
Orlando, FL 32803
(407) 514-1832
www.seniorresourcealliance.org

PSA 8

Area Agency on Aging for Southwest Florida, Inc.
2830 Winkler Ave, Ste. 112
Fort Myers, FL 33916
(239) 652-6900
www.aaaswfl.org

PSA 9

Area Agency on Aging of Palm Beach/Treasure Coast, Inc.
4400 N. Congress Ave.
West Palm Beach, FL 33407
(561) 684-5885
www.youragingresourcecenter.org

PSA 10

Aging and Disability Resource Center of Broward County, Inc.
5300 Hiatus Rd.
Sunrise, FL 33351
(954) 745-9567
www.adrcbroward.org

PSA 11

Alliance for Aging, Inc.
760 N.W. 107th Ave., Ste. 214,
2nd Floor
Miami, FL 33172
(305) 670-6500
www.allianceforaging.org

Section 9: Leaving Our Plan (Disenrollment)

Leaving a plan is called **disenrolling.** By law, people cannot leave or change plans while they are locked-in except for specific reasons. If you want to leave our plan while you are locked-in, call the State's Enrollment Broker to see if you would be allowed to change plans.

You can leave our plan at any time for the following reasons (also known as **For Cause Disenrollment** reasons[1]):

- We do not cover a service for moral or religious reasons
- You live in and get your Long-Term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[2]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason

If you have any questions about whether you can change plans, call Member Services 1-833-FCC-PLAN (1-833-322-7526)or the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Removal from Our Plan (Involuntary Disenrollment)

The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called **involuntary disenrollment**. These reasons include:

- You lose your Medicaid eligibility
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions

[1] For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: https://www.flrules.org/gateway/RuleNo.asp?title=MANAGED CARE&ID=59G-8.600

[2] To learn how to ask for an appeal, please turn to Section 15, Member Satisfaction, on page 52.

- You or your caregivers behave in a way that makes it hard for us to provide you with care
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]

If the Agency removes you from our plan because you broke the law or for your behavior, you cannot come back to the SMMC program.

Section 10: Managing Your Care

If you have a medical condition or illness that requires extra support and coordination, we may assign a case manager to work with you. Your case manager will help you get the services you need. The case manager will work with your other providers to manage your health care. If we provide you with a case manager and you do not want one, call Member Services to let us know.

If you are in the LTC program, we will assign you a case manager. You must have a case manager if you are in the LTC program. Your case manager is your go-to person and is responsible for **coordinating your care**. This means they are the person who will help you figure out what LTC services you need and how to get them.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing Case Managers

If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter to let you know and we may give you a call.

Important Things to Tell Your Case Manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service
- You have concerns about a service provider
- Your services aren't right
- You get new health insurance
- You go to the hospital or emergency room
- Your caregiver can't help you anymore
- Your living situation changes
- Your name, telephone number, address, or county changes

[3] This is for Long-Term Care program enrollees only. If you have questions about your facility's compliance with this federal requirement, please call Member Services or your case manager.

Request to Put Your Services on Hold

If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a Consent for Voluntary Suspension Form to put your service(s) on hold.

Section 11: Accessing Services

Before you get a service or go to a health care appointment, we have to make sure you need the service and that it is medically right for you. This is called **prior authorization.** To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in Our Plan

For the most part, you must use doctors, hospitals, and other health care providers that are in our **provider network**. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your **freedom of choice**. If you use a health care provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call 1-833-FCC-PLAN (1-833-322-7526)to get a copy or visit our website at www.fcchealthplan.com.

If you are in the LTC program, your case manager is the person who will help you choose a service provider who is in our network for each of your services. Once you choose a service provider, they will contact them to begin your services. This is how services are **approved** in the LTC program. Your case manager will work with you, your family, your caregivers, your doctors and other providers to make sure that your LTC services work with your medical care and other parts of your life.

Providers Not in Our Plan

There are some services that you may be able to get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before

you use a provider that is not in our provider network. If you have questions, call Member Services.

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Florida Community Care. Contact Member Services at 1-833-FCC-PLAN (1-833-322-7526)for help with arranging these services.

What Do I Have To Pay For?

You may have to pay for appointments or services that are not covered**.** A **covered service** is a service we must provide in the Medicaid program. All the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[4]

We must provide all medically necessary services for our members who are ages 0 – 20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

No dollar limits; or
No time limits, like hourly or daily limits

Your provider may need to ask us for approval before giving your child the service. Call Member Services if you want to know how to ask for these services.

Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Florida Community Care.

The Medicaid fee-for-service program is responsible for covering the following services, instead of Florida Community Care covering these services:

County Health Department (CHD) Certified Match Program
Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver
Familial Dysautonomia (FD) Home and Community-Based Services Waiver
Hemophilia Factor-related Drugs
Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)
Medicaid Certified School Match (MCSM) Program
Model Home and Community-Based Services Waiver
Newborn Hearing Services
Prescribed Pediatric Extended Care
Substance Abuse County Match Program

[4] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements.

This Agency webpage provides details about each of the services listed above and how to access these services: http://ahca.myflorida.com/Medicaid/Policy_and_Quality/Policy/Covered_Services_HCBS_Waivers.shtml.

Moral or Religious Objections

If we do not cover a service because of a religious or moral reason, we will tell you that the service is not covered. In these cases, you must call the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970). The Enrollment Broker will help you find a provider for these services.

Section 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

If you have Medicare, please contact the number on your Medicare ID card for information about your PCP.

One of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will contact your PCP to make an appointment for services such as regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PCP by calling Member Services.

You can choose a different PCP for each family member or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family.

You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for Your Child

You can pick a PCP for your baby before your baby is born. We can help you with this by calling Member Services. If you do not pick a PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and

how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.[5]

You can take your child to a pediatrician, family practice provider, or other health care provider.

You do not need a referral for well child visits. Also, there is no charge for well child visits.

Specialist Care and Referrals

Sometimes, you may need to see a provider other than your PCP for medical problems like special conditions, injuries, or illnesses. Talk to your PCP first. Your PCP will refer you to a **specialist**. A specialist is a provider who works in one health care area.

If you have a case manager, make sure you tell your case manager about your **referrals**. The case manager will work with the specialist to get you care.

Second Opinions

You have the right to get a **second opinion** about your care. This means talking to a different provider to see what they have to say about your care. The second provider will give you their point of view. This may help you decide if certain services or treatments are best for you. There is no cost to you to get a second opinion.

Your PCP, case manager or Member Services can help find a provider to give you a second opinion. You can pick any of our providers. If you are unable to find a provider with us, we will help you find a provider that is not in our provider network. If you need to see a provider that is not in our provider network for the second opinion, we must approve it before you see them.

Urgent Care

Urgent Care is not Emergency Care. Urgent Care is needed when you have an injury or illness that must be treated within 48 hours. Your health or life are not usually in danger, but you cannot wait to see your PCP or it is after your PCP's office has closed.

If you need Urgent Care after office hours and you cannot reach your PCP, call Member Services at 1-833-FCC-PLAN (1-833-322-7526) or TTY at 711.

You may also find the closest Urgent Care center to you by checking the Florida Community Care online directory at www.fcchealthplan.com.

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[5] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care – Periodicity Schedule" at Periodicity Schedule (aap.org).

Hospital Care

If you need to go to the hospital for an appointment, surgery or overnight stay, your PCP will set it up. We must approve services in the hospital before you go, except for emergencies. We will not pay for hospital services unless we approve them ahead of time or it is an emergency.

If you have a case manager, they will work with you and your provider to put services in place when you go home from the hospital.

Emergency Care

You have an **emergency** medical condition when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. You can find this list on our Web site at www.fcchealthplan.com or by calling Member Services.

We cover **brand name** and **generic** drugs. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. Sometimes, we may need to approve using a brand name drug before your prescription is filled.

We have pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Specialty Pharmacy Information

You can fill your first prescription at any specialty pharmacy that is in our provider network. The pharmacy will arrange to have refills delivered to your place of residence. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time, but we will let you know if anything changes.

Behavioral Health Services

There are times when you may need to speak to a therapist or counselor, for example, if you are having any of the following feelings or problems:

- Always feeling sad
- Not wanting to do the things that you used to enjoy
- Feeling worthless
- Having trouble sleeping
- Not feeling like eating
- Alcohol or drug abuse
- Trouble in your marriage
- Parenting concerns

We cover many different types of behavioral health services that can help with issues you may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Calling 1-833-FCC-PLAN (1-833-322-7526)
- Looking at our provider directory
- Going to our website www.fcchealthplan.com

Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is out of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member Reward Programs

We offer programs to help keep you healthy and to help you live a healthier life (like losing weight or quitting smoking). We call these **healthy behavior programs**. You can earn rewards while participating in these programs. Our plan offers the following programs:

Substance Use

The Substance Use Program helps you with treatment options. You can get access to psychiatrists, substance abuse professionals, alcohol and substance use programs, and local community resources.

What you have to do	What you get (Rewards)	Limits on purchase
Be in the program and complete the Health Risk Assessment (HRA) yearly. This will be available via FCC's website and/or telephonically.	A $10.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Be in the program and attend AA/NA programs. OR Complete an initial Psychiatrist visit, and two (2) follow up visits with the psychiatrist within 90 days of initial visit.	A $40.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling

Smoking Cessation

The Smoking Cessation Program includes counseling and medicines that do not have nicotine to help reach your goals. You can get help to stop smoking.

What you have to do	What you get (Rewards)	Limits on purchase
Be in the program and complete the Health Risk Assessment (HRA) yearly. This will be available via FCC's website and/or telephonically.	A $10.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Be in the program and show proof of completion of the Smoking Cessation Program from Area Health Education Centers (AHEC)	A $40.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling

Tobacco Cessation Counselor/Instructor.		

Weight Management

The Weight Management Program includes nutrition counseling over the phone and a diet plan. Florida Community Care's team will help you reach your goals. We will also work with your doctors to help you manage your weight.

What you have to do	What you get (Rewards)	Limits on purchase
Be in the program and complete the Health Risk Assessment (HRA) yearly. This will be available via FCC's website and/or telephonically.	A $10.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Be in the program and have visited your primary doctor two (2) times in six (6) months.	A $20.00 pre-paid gift card	The card cannot be used for alcohol, tobacco, drugs, and gambling
Be in the program and attend four (4) counseling sessions with a nutritionist via phone in six (6) months.	$5 pre paid gift card for each counseling session for a total of $20	The card cannot be used for alcohol, tobacco, drugs, and gambling

Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us 1-833-FCC-PLAN (1-833-322-7526) or TTY at 711.

Chronic Disease Management Programs

We have special programs available that will help you if you have one of these conditions.

Cancer and Cancer Prevention

Cancer is a disease in which cells grow and divide with little or no control. There are many types of cancer, they normally are named for the organ or cell where the cancer begins. If you have cancer, we can help you based on your needs.

If you have cancer or are in remission, this program helps to bring together you and your family and caregivers. It helps you deal with frustration, fatigue, pain, isolation, poor sleep, and living with the unknown.

The FCC staff will also work closely with your doctors to help you manage the disease and its symptoms.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information

Diabetes and Diabetes Prevention

Diabetes is a chronic disease where your body does not make enough insulin or the insulin in your body does not work the way it is supposed to work. This will cause high levels of sugar in your blood. Diabetes worsens with age and with other health conditions that may be present.

Florida Community Care's Diabetes Program has staff that know how to help people with diabetes.

This includes:

• Education that may help you manage your diabetes and other things to look for
• Reviewing your medicines with your doctors
• Teaching you how important it is to check your blood sugar levels and how to keep track of them
• Support for you and your caregivers
• Diet education and possible referral to a registered dietitian

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Mental Health and Depression and Depression Prevention (including suicide prevention)

Mental Health is a state of mental well being that helps you cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community. Two (2) types of mental health concerns are depression and bipolar disorder.

Depression is a feeling of sadness or a loss of interest and pleasure in most usual activities that may affect your ability to function.

Bipolar Disorder also known as manic-depressive illness. This disorder is a brain disorder that causes unusual shifts in a person's mood, energy, and ability to function.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome

HIV is a virus that attacks the body's immune system. Without treatment, it can lead to AIDS. HIV treatment involves taking medicine as prescribed by a doctor. You should start HIV treatment as soon as possible after diagnosis. The treatment lowers the amount of HIV in the blood to a point that it will not be detected; lowering the risk of transmitting it to others.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Attention deficit/hyperactivity disorder (ADHD)

Attention-deficit/hyperactivity disorder or ADHD is a common behavioral condition that can have an impact on your life. There is also added stress on your family members and caregivers. It mostly affects your ability to concentrate, affecting school, work, relationships, and other parts of your life.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Asthma and Chronic Obstructive Pulmonary Disease (COPD) Asthma is a lung disease that causes the inside of the airways to get swollen and the muscles to get tight. This may cause you to have trouble breathing. You may also get shortness of breath and feel weak.

COPD can also be known as chronic bronchitis and/or emphysema. Bronchitis is swelling of the airways in the lungs. Emphysema is damage to the air sacs in the lungs.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Cardiovascular Disease and Hypertension

Cardiovascular disease affects the blood flow to the heart. Decreased blood flow can cause a heart attack. There are ways to decrease the risk of cardiovascular disease.

Hypertension or High Blood pressure is when the force of your blood in your arteries is always high. This can cause damage to the walls of your arteries. Hypertension or high blood pressure is a condition that cannot be cured BUT CAN be managed.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD)

Chronic kidney disease means the kidneys are damaged and they cannot filter your blood well enough to remove waste products and extra water from your body , help control blood pressure, help make red blood cells, and help keep bones healthy.

End-stage renal disease (ESRD), also known as Kidney Failure, is when kidney function is no longer adequate for long-term survival without kidney transplantation or dialysis.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Dementia

Dementia is loss of mental function that will affect the ability to carry our everyday tasks. Dementia affects memory, ability to do everyday tasks, and ability to communicate.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Osteoporosis

Osteoporosis causes bones to become weak and fragile, so that they break easily- even because of a minor fall, a bump, a sneeze, or a sudden movement. Fractures caused by osteoporosis can be life threatening and a major cause of pain and long term disability.

The overall risk of osteoporosis is influenced by age, gender and ethnicity. Generally, the older you get, the greater your risk of osteoporosis. Women are more susceptible to bone loss than men.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Parkinson's Disease

Parkinson's Diseases is a brain disorder that causes unintended or uncontrollable movements, such as shaking, stiffness, and difficulty with balance and coordination. Symptoms usually begin gradually and worsen over time.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Blood Disorders

There are several types of blood disorders. Two of the most common are Hemophilia and Sickle Cell Disorder.

Hemophilia is a bleeding disorder you are born with in which the blood does not clot properly. People with hemophilia A or B have low levels of either factor VIII (8) or factor IX (9). It can lead to spontaneous bleeding (bleeding that occurs for no known reason) as well as bleeding following injuries or surgery. Some symptoms of hemophilia are:

- Bleeding into the joints. This can cause swelling and pain or tightness in the joints
- Bleeding into the skin (which is bruising) or muscle and soft tissue causing a build-up of blood in the area (called a hematoma).

Sickle Cell Disorder (SCD) is a group of inherited red blood cell disorders. With SCD the red blood cells become hard, sticky, and look like a C-shaped farm tool called sickle, due to the hemoglobin (a protein that carries oxygen) being abnormal.

Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Quality Enhancement Programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

Falls Prevention Program

We know many times a visit to the emergency room is because of a fall. We provide special help to prevent falling. This may include any safety issues at home. Your care manager will talk with you about reasons why. The care manager will talk with you about ways to prevent a fall. Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Domestic Violence

If you are afraid of someone in your house, please tell your care manager. We can help you based on information you give us. We can help you get services that you need to keep you safe and from being afraid. Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Pregnancy Prevention

If you want to keep from getting pregnant, please tell your care manager. We can help you learn more about how to prevent pregnancies. We can give you information about programs that might be right for you. If you would like to know more about how to prevent pregnancies, please contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Pregnancy-Related Programs

If you are pregnant or have just given birth, there may be programs helpful to you. We can refer you to those programs. Your care manager will learn more about your situation when they contact you to see how you are doing. If it will help, we can have weekly or monthly phone calls.

Healthy Start Services

If you are pregnant there are programs that will help you to be sure that you have a healthy baby. Your Care Manager can learn more about what you may need when they talk with you. We can help you connect with the Healthy Start program in your area. This will help you to make sure you have just the right care so that you and your baby stay healthy. Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Nutritional Assessment/Counseling

If you are pregnant, we can help you with your nutritional needs. We will make sure that you get the information you need based on what you tell your Care Manager. We can help you get services such as the Women, Infants and Children Nutrition Program

(WIC), with Healthy Start or other social services. Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

Housing Assistance

We can help you if you are homeless. We can also help you if you are at risk of losing housing, or in the criminal justice system. We will ask questions to help understand any other problems you may be facing. We can connect you to community resources available to you. Contact your care manager or Member Services at 1-833-FCC-PLAN (1-833-322-7526) for more information.

You also have a right to tell us about changes you think we should make.

To get more information about our quality enhancement program or to give us your ideas, call Member Services at 1-833-FCC-PLAN (1-833-322-7526.

Section 13: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary for us to pay for them[6].

There may be some services we do not cover but might be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called "In Lieu of Services (ILOS)." To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call 1-833-FCC-PLAN (1-833-322-7526) to schedule a ride.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the date the change takes place.

If you have questions about any of the covered medical services, please call Member Services.

Service	Description	Coverage/Limitations	Prior Authorization *
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	Yes

[6] You can find the definition for Medical Necessity in the Definitions Policy at https://ahca.myflorida.com/medicaid/rules/adopted-rules-general-policies

Service	Description	Coverage/Limitations	Prior Authorization *
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots	No
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary.	No
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	As medically necessary and recommended by us	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	Yes
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	May be required
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year, as medically necessary.	Yes
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce	We cover recipients under the age of 21 years requiring medically necessary services.	Yes

Service	Description	Coverage/Limitations	Prior Authorization *
	appropriate behaviors.		
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover, as medically necessary: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning	Yes
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program	As medically necessary and recommended by us	Yes
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor, when medically necessary: - Cardiac testing - Cardiac surgical procedures - Cardiac devices -	May be required
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services OR Services provided to children (ages 0 – 20) who use medical foster care services	Your child must be enrolled in the DOH Early Steps program OR Your child must be receiving medical foster care services	Yes
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause	We cover, as medically necessary: - 24 patient visits per year, per member - X-rays	No

Service	Description	Coverage/Limitations	Prior Authorization *
	other disorders by affecting the nerves, muscles, and organs		
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic		No
Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	As medically necessary and recommended by us	No
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor, when medically necessary: - Hemodialysis treatments - Peritoneal dialysis treatments	Yes
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	Yes
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and	As medically necessary, some service and age limits apply. Call 1-833-FCC-PLAN for more information.	Yes

Service	Description	Coverage/Limitations	Prior Authorization *
	includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away		
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover medically necessary: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week	No
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	No
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover medically necessary: - One adult health screening (check-up) per year - Well child visits are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover medically necessary: - Up to 26 hours per year	No

Service	Description	Coverage/Limitations	Prior Authorization *
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	Yes
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary	May be required
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary	May be required
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover medically necessary: - Up to 39 hours per year	No
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	Required for cochlear implants and bone anchored hearing aids
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover, when medically necessary: - Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients	Yes
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are	- Covered as medically necessary - See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether	No

Service	Description	Coverage/Limitations	Prior Authorization *
	at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	living at home, in a facility, or in a nursing facility	
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover medically necessary: - Up to 26 hours per year	No
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us	Yes
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation, when medically necessary: - Up to 365/366 days for recipients ages 0-20 - Up to 45 days for all other recipients (extra days are covered for emergencies)	Required for elective inpatient admissions
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	- Covered as medically necessary	Yes
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	- Covered as medically necessary	Required for genetic testing
Medical Foster Care Services	Services that help children with health	Must be in the custody of the Department of Children and Families	Yes

Service	Description	Coverage/Limitations	Prior Authorization *
	problems who live in foster care homes		
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	- Covered as medically necessary	No
Medication Management Services	Services to help people understand and make the best choices for taking medication	- Covered as medically necessary	No
Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us	Yes
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us	No
MultiSystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	As medically necessary and recommended by us	No
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	- Covered as medically necessary	May be required

Service	Description	Coverage/Limitations	Prior Authorization *
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary	No
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	- We cover 365/366 days of services in nursing facilities as medically necessary	No
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	- Covered as medically necessary	No

Service	Description	Coverage/Limitations	Prior Authorization *
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	- Covered as medically necessary	Yes
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	- Emergency services are covered as medically necessary - Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	May be required
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	- Covered as medically necessary. Some service limits may apply -	Yes
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	Yes
Physical Therapy Services	Physical therapy includes exercises , stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Podiatry Services	Medical care and other treatments for the feet	We cover, as medically necessary: - Up to 24 office visits per year	No

Service	Description	Coverage/Limitations	Prior Authorization *
		- Foot and nail care - X-rays and other imaging for the foot, ankle and lower leg - Surgery on the foot, ankle or lower leg	
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover, as medically necessary: - Up to a 34-day supply of drugs, per prescription - Refills, as prescribed	May be required
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover, as medically necessary: - Up to 24 hours per day	Yes
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover, as medically necessary: - 10 hours of psychological testing per year	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover, as medically necessary: - Up to 480 hours per year	Yes
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	- Covered as medically necessary	May be required
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have	Covered as medically necessary	No

Service	Description	Coverage/Limitations	Prior Authorization *
	special care centers to handle serious conditions		
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	May be required
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover medically necessary: - Respiratory testing - Respiratory surgical procedures - Respiratory device management	No
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover medically necessary: - One initial evaluation per year - One therapy re-evaluation per 6 months - Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Yes
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	Yes
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders	We cover the following medically necessary: - Assessments - Foster care services - Group home services	Yes

Service	Description	Coverage/Limitations	Prior Authorization *
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following medically necessary services for children ages 0-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following medically necessary services for adults: - One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric Program Services (SIPP)	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Yes
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover medically necessary services: - Up to 9 hours per month	Yes
Transplant Services	Services that include all surgery	Covered as medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization *
	and pre and post-surgical care		
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following medically necessary services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 0-20 - One frame every two years and two lenses every 365 days for adults ages 21 and older - Contact lenses - Prosthetic eyes	Please contact iCare Health Solutions Ph (855) 373-7627
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	- Covered as medically necessary	Please contact iCare Health Solutions Ph (855) 373-7627

Your Plan Benefits: Expanded Benefits

Expanded benefits are extra goods or services we provide to you, free of charge. Call Member Services to ask about getting expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization
Adult Visual Aid Services	Aids to assist with vision needs	For enrollees 21 years of age and older: • Contact lenses – 6-month supply without needing to prove medical necessity (as required by Medicaid) • Frames – one per year, instead of one every two years (as covered by Medicaid)	No
Additional Primary Care Services	Well or sick visits to see your PCP	Medicaid covers this service for enrollees 21 years and older with a limit of two visits per month per specialty. This benefit allows for unlimited office visits to	No

Service	Description	Coverage/Limitations	Prior Authorization
		your PCP for enrollees 21 years and older.	
Prenatal Services	Prenatal and after birth care including breast pumps, visits to see doctor during pregnancy, and after.	For pregnant enrollees: • Hospital type breast pump (one rental per year) • Standard breast pump (one rental every two years) • 14 visits for low-risk pregnancies (vs. 10 covered by Medicaid) • 18 visits for high-risk pregnancies (vs. 14 covered by Medicaid) • Three visits within 90 days following delivery (vs. two covered by Medicaid)	No
Durable Medical Equipment (DME) services and supplies	Automatic Blood Pressure Monitor	For enrollees residing at home or in an ALF with history of HBP, as outlined in the enrollees' care plan	No
Physical Therapy for Adults	Services to help with pain or to assist enrollee with regaining physical function and movement.	For enrollees 21 years of age and older, in addition to the Medicaid covered wheelchair evaluation services, FCC will provide: • One evaluation per year • One reevaluation per year • Up to three therapy visits per week (maximum of four units per day)	Yes
Newborn Circumcision	The surgical removal of the skin covering the tip of the penis on newborn boys.	One per lifetime for newborn males up to 28 days old	No, if completed before hospital discharge
Hearing Services for adults	Services to help with hearing loss	For enrollees 21 years of age and older once every two years (vs. every three years, as covered by Medicaid)	No

Service	Description	Coverage/Limitations	Prior Authorization
		• One hearing aid assessment to determine candidacy and most appropriate hearing aid • One hearing evaluation • One hearing aid fitting/checking • One hearing aid per ear • One hearing aid dispensing fee	
Occupational therapy for adults	Services to help with pain or to assist enrollee with regaining physical function and movement.	For enrollees 21 years of age and older, in addition to the Medicaid covered wheelchair evaluation services, FCC will provide: • One evaluation per year • One reevaluation per year • Up to 3 therapy visits per week (maximum of 4 units per day)	Yes
Over-the-Counter (OTC) medications and supplies	• Cough, cold, and allergy medications • Vitamins and supplements • Ophthalmic/Optic preparations (Medicines for the eyes) • Pain relievers • Gastrointestinal products (Products for the stomach and bowel) • First aid care • Hygiene products • Insect repellant (Mosquito spray) • Oral hygiene products (Mouth and teeth cleansing	Sixty five dollars ($65) per household.	No

Service	Description	Coverage/Limitations	Prior Authorization
	products) • Skin care • Smoking cessation products • Antifungals		
Doula Services	Birth coach who helps women during pregnancy	All enrollees who have opted into our Care Management program; As Outlined in Enrollee's Plan of Care	Yes
Expanded Benefits for Pregnant Women	Intensive outpatient services with therapy and treatment to help with alcohol and/or drug abuse	Pregnant members ages 21 and older for up to 8 weeks. This includes services for: ~3 hours a day ~3 days a week	No
Stress Relief Support	Up to $25 one-time purchase per year for educational/emotionally supportive toys/games to develop awareness of emotions and coping mechanisms.	Up to $25 one-time annual purchase. As Outlined in Enrollee's Plan of Care	Yes
Weighted Blanket	Weighted blanket to reduce anxiety and improve sleep.	1 per year	No
Tcare Assist and Tcare Connect (MMA Enrollees – Pathways to Possibility)	Care Management Solution for Caregivers that evaluates likelihood of burnout and develops interventions that include social determinants supports.	As Outlined in Enrollee's Plan of Care	Yes
Waived Copayments	Members will not need to pay any copayment charges	No benefit will have a co-payment	N/A

Service	Description	Coverage/Limitations	Prior Authorization
Housing Support	Supported housing	Housing Supports – Families of children in a nursing facility preparing to transition their child home may receive up to $75,000 per lifetime for home readiness projects, such as physical adaptations to their home or vehicle.	Yes
Housing Assistance	Housing support allowance for enrollees needing assistance with housing costs	All enrollees who are homeless or at risk of homelessness. Up to $300 per year.	Yes
Acupuncture	Acupuncture is a form of alternative medicine in which thin needles are used	A professional certified in Acupuncture can provide up to 48 units (15 minutes per unit) per year	Yes
Assessment/Evaluation Services - Behavioral	Services used to detect or diagnose mental illnesses and behavioral health disorders	Unlimited	No
Behavioral Health Medical Services (Drug Screening)	Behavioral health related medical services: alcohol and drug screening, behavioral health medical screenings for mental health and substance abuse	Unlimited	Yes
Behavioral Health Medical Services (Verbal Interaction)	Behavioral health related medical services: verbal interactions, substance abuse	Unlimited for verbal interaction, medication management, and drug screening	Yes
Behavioral Health Screening Services	Behavioral health related medical services verbal interaction and mental health	Unlimited for verbal interaction	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Cellular Phone Services	1 cell phone; 350 minutes; unlimited text messages; 16 GB data	All enrollees eligible (under 18 requires parent/guardian approval) If enrollee has no current cell phone. Also, if there is only limited service.	No
Chiropractic Services	Diagnosis and manipulative treatment of the joints, especially the spine	Up to 28 more visits	Yes
Home Delivered Meals – Post-Facility Discharge (Hospital or Nursing Facility)	Meals delivered to the home as needed	Up to 10 meals per event	Yes
Home Delivered Meals – Disaster Preparedness/Relief	One shelf-stable meal package (10 meals) per disaster	For all enrollees in an affected area with Governor declared state of emergency.	Yes
Home Delivered Meals (General)	Meals delivered to the home as needed	For the first 1,000 pregnant women in compliance with prenatal visits	Yes
Home Health Nursing/Aid Services	Home based care as needed in the enrollee's plan of care.	Unlimited as deemed medically necessary	Yes
Home Visit by a Clinical Social Worker	Clinical Social worker visit as needed in the enrollee's plan of care	Up to 48 hours per year, as deemed medically necessary	Yes
Massage Therapy	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking,	Unlimited as deemed medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization
	compression, percussion)		
Meals – Non-Emergency Transportation Day-Trips	Allowance to cover the cost of food for long distance trip.	Up to $20 per meal, up to 3 meals per day, up to $120 per day, up to $1000 per year for trips over 100 miles	Yes
Non-Medical Transportation	Transportation for non-medical trips	One round trip per month, up to 30 miles	No, call Member Services to schedule
Nutritional Counseling	Nutritional Counseling as needed in the enrollee's plan of care	For MMA-only enrollees Unlimited as authorized on enrollee's Unlimited as deemed medically necessary of care	Yes
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	Unlimited as deemed medically necessary for certain services	Yes
Respiratory Therapy	Services to treat problems with the lungs	For enrollees 21 years of age and older • One initial therapy evaluation per year, per enrollee • One respiratory therapy visit, one per day	Yes
Speech Therapy	Services to help with the voice and to talk and swallow	For enrollees 21 years of age and older • Evaluation/ reevaluation, one per year • Evaluation of swallowing, one per year • Speech therapy visit, up to 7 therapy treatment units per week • Augmentative Alternative Communication (AAC) initial evaluation, one per year •	Yes

Service	Description	Coverage/Limitations	Prior Authorization
		AAC reevaluation, one per year • AAC fitting, adjustment, and training visit, up to four 30-minute sessions per year	
Swimming Lessons (Drowning Prevention)	Help with swimming for children	$200 per year for the first 1,000 members (children 3–16 years old)	Yes
Therapy - Art	Art therapy such as music, dance, art or play therapy, not for recreation related to care or treatment of patients mental health problems.	Unlimited as deemed medically necessary. Must be delivered by a behavioral health clinician with art therapy certification.	Yes
Therapy/Psychotherapy (Group)	Services for a group of people to have therapy sessions with a mental health professional	Unlimited	Yes
Therapy/Psychotherapy (Individual/Family)	Services for people to have either one-to-one or family therapy sessions with a mental health professional	Unlimited	Yes
Voucher for GED Exam Fees	Assistance with paying GED Test Fees and assistance with locating free study resources to help you prepare.	One time $128 voucher. Enrollees 21 years and older who submit a request for a voucher. No more than 500 enrollees per year.	Yes

Your Plan Benefits: Pathways to Prosperity

The Plan shall assess members who may be experiencing barriers to employment, economic self-sufficiency, and independence gain access to care coordination/case management services and health-related social needs, such as housing assistance, food sustainability, vocational training, and educational support services.

Section 14: Cost Sharing for Services

Cost sharing means the portion of costs for certain covered services that is your responsibility to pay. Cost sharing can include coinsurance, copayments, and deductibles. If you have questions about your cost sharing requirements, please contact Member Services.

Section 15: Long-Term Care (LTC) Program Helpful Information

(Read this section if you are in the LTC program. If you are not in the LTC program, skip to Section 17)

Starting Services

It is important that we learn about you so we can make sure you get the care that you need. Your case manager will set up a time to come to your home or nursing facility to meet you.

At this first visit, your case manager will tell you about the LTC program and our Plan. She or he will also ask you questions about:

- Your health.;
- How you take care of yourself.;
- How you spend your time.;
- Who helps takes care of you; and
- Other things.

These questions make up your **initial assessment.** The initial assessment helps us learn about what you need to live safely in your home. It also helps us decide what services will help you the most.

Developing a Plan of Care

Before you can begin to get services under the LTC program, you must have a **person-centered plan of care (plan of care)**. Your case manager makes your plan of care with you. Your plan of care is the document that tells you all about the services you get from our LTC program. Your case manager will talk to you and any family members or caregivers you want to include to decide what LTC services will help. They will use the initial assessment and other information to make a plan that is just for you. Your plan of care will tell you:

- What services you are getting
- Who is providing your service (your service providers)
- How often you get a service
- When a service starts and when it ends (if it has an end date)
- What your services are trying to help you do. For example, if you need help doing light housekeeping tasks around your house, your plan of care will tell you that an adult companion care provider comes 2 days a week to help with your light housekeeping tasks.

- How your LTC services work with other services you get from outside our Plan, such as from Medicare, your church or other federal programs
- Your **personal goals**

  We don't just want to make sure that you are living safely. We also want to make sure that you are happy and feel connected to your community and other people. When your case manager is making your plan of care, they will ask you about any **personal goals** you might have. These can be anything, really, but we want to make sure that your LTC services help you accomplish your goals. Some examples of personal goals include:

  - Walking for 10 minutes every day
  - Calling a loved one once a week
  - Going to the senior center once a week
  - Moving from a nursing facility to an assisted living facility

You or your **authorized representative** (someone you trust who is allowed to talk to us about your care) must sign your plan of care. This is how you show you agree with the **services** on **your plan of care**.

Your case manager will send your PCP a copy of your plan of care. They will also share it with your other health care providers.

Updating your Plan of Care

Every month your case manager will call you to see how your services are going and how you are doing. If any changes are made, she or he will update your plan of care and get you a new copy.

Your case manager will come to see you in person to review your plan of care every 90 days (or about 3 months). This is a good time to talk to them about your services, what is working and isn't working for you, and how your goals are going. They will update your plan of care with any changes. Every time your plan of care changes, you or your authorized representative must sign it.

Remember, you can call your case manager any time to talk about problems you have, changes in your life, or other things. Your case manager or a health plan representative is available to you when you need them.

Your Back-Up Plan

Your case manager will help you make a **back-up plan**. A back-up plan tells you what to do if a service provider does not show up to give a service. For example, your home health aide did not come to give you a bath.

Remember, if you have any problems getting your services, call your case manager.

Section 16: Your Plan Benefits: Long-Term Care Services

The table below lists the Long-Term care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them[7].

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

If you have any questions about any of the covered Long-Term care services, please call your case manager or Member Services.

Service	**Description**	**Prior Authorization ***
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping.	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home.	Yes
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Yes
Behavioral Management	Services for mental health or substance abuse needs	Yes

[7] You can find a copy of the Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy at https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies.

Service	Description	Prior Authorization *
Caregiver Training	Training and counseling for the people who help take care of you	Yes
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	No
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to your home.	Yes
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores.	Yes
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	No
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness,	Yes

Service	Description	Prior Authorization *
	or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	
Medication Administration	Help taking medications if you can't take medication by yourself	Yes
Medication Management	A review of all the prescription and over-the-counter medications you are taking	Yes
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Yes

Service	Description	Prior Authorization *
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Facility.	Yes
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	Yes
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition.	Yes
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	Yes
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	Yes
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility	We may offer the choice to use this service instead of nursing facility services.
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	No

Long-Term Care Participant Direction Option (PDO)*

You may be offered the Participant Direction Option (PDO). You can use PDO if you use any of these services and live in your home:

- Attendant care services
- Homemaker services
- Personal Care services
- Adult companion care services
- Intermittent and skilled nursing care services

PDO lets you **self-direct** your services. This means you get to choose your service provider and how and when you get your service. You have to hire, train, and supervise the people who work for you (your direct service workers).

You can hire family members, neighbors, or friends. You will work with a case manager who can help you with PDO.

If you are interested in PDO, ask your case manager for more details. You can also ask for a copy of the PDO Guidelines to read and help you decide if this option is the right choice for you.

**PDO is not an available option for Intellectual and Developmental Disabilities Waiver program participants. See Exhibit C*

Your Plan Benefits: LTC Expanded Benefits

Expanded benefits are extra services we provide to you at no cost. Talk to your case manager about getting expanded benefits.

Service	Description	Coverage/Limitations	Prior Authorization
ALF/AFDH – Bed Hold Days	Bed will be held while away sick at a hospital or rehab	LTC enrollees that are in ALF or AFCH Up to 31 days per month	No
Caregiver Transportation	For LTC eligible caregivers who need transportation to see loved ones that reside in an ALF or SNF	Four one-way trips or two round trips a month up to 40 miles per month	No, Call Member Services to schedule
Transition Assistance – Nursing Facility to Community Setting	Pays for certain expenses if an enrollee moves from a nursing home to the community (ALF or Home).	Up to $5,000 per transition	Yes
Transportation Services to a vaccination site for covered vaccine	Transportation to a vaccination site for administration of a plan covered vaccine.	Two round trips per year up to 20 miles each round trip	No, Call Member Services to schedule
Tcare Assist and Tcare Connect (LTC enrollee)	Care Management Solution for Caregivers that evaluate likelihood of burnout and develops interventions that include social determinants supports	As Outlined in Enrollee's Plan of Care	Yes

Joy for All	"Companion" Robotic Pets: • Stimulate conversation and communication in withdrawn seniors. • Calm anxiety and soothe those that are agitated • Increase quality of life for those with dementia or who are socially isolated • Can improve behavior without the use of drugs	As Outlined in Enrollee's Plan of Care	Yes

Over-the-Counter (OTC) medications and supplies	• Cough, cold, and allergy medications • Vitamins and supplements • Ophthalmic/Otic preparations (Medicines for the eyes) • Pain relievers • Gastrointestinal products (Products for the stomach and bowel) • First aid care • Hygiene products • Insect repellant (Mosquito spray) • Oral hygiene products (Mouth and teeth cleansing products) • Skin care • Smoking cessation products • Antifungals	Sixty-Five dollars ($65) per household.	No
Pathways to Purpose-PURPOSEful Connections	For LTC enrollees that live at home and are screened as at risk for feelings of isolation. Includes a starter kit with hand-written letter, games, social activities available in their community, pens, paper and prepaid envelopes to send letters back to the plan and create a personal pen-pal relationship.	1 per year for eligible Enrollees as outlined in the Enrollee's Plan of Care	Yes

Section 17: Member Satisfaction

Complaints, Grievances, and Plan Appeals

We want you to be happy with us and the care you receive from our providers. Let us know right away if at any time you are not happy with anything about us or our providers. This includes if you do not agree with a decision we have made.

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. 1-833-FCC-PLAN (1-833-322-7526)	We will: • Try to solve your issue within 1 business day.
If you are not happy with us or our providers, you can file a **Grievance**	You can: Write us or call us at any time. Call us to ask for more time to solve your grievance if you think more time will help. Florida Community Care Attn: Grievances and Appeals 4601 NW 77th Avenue Miami, FL 33166 1-833-FCC-PLAN (1-833-322-7526)	We will: • Review your grievance and send you a letter with our decision within 30 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Florida Community Care Attn: Grievances and Appeals 4601 NW 77th Avenue Miami, FL 33166 1-833-FCC-PLAN (1-833-322-7526)	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.
If you think waiting for 30 days will put your health in	You can: • Write us or call us within 60 days of our decision about your services.	We will: • Give you an answer within 48 hours after we receive your request.

	What You Can Do:	What We Will Do:
danger, you can ask for an **Expedited or "Fast" Appeal**	Florida Community Care Attn: Grievances and Appeals 4601 NW 77th Avenue Miami, FL 33166 1-833-FCC-PLAN (1-833-322-7526)	• Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. **********You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal

If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid Members)

You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:

Agency for Health Care Administration
Medicaid Fair Hearing Unit
PO Box 7237
Tallahassee, FL 32314-723
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:

- Your name

- Your member number
- Your Medicaid ID number
- A phone number where you or your representative can be reached

You may also include the following information, if you have it:

- Why you think the decision should be changed
- The service(s) you think you need
- Any medical information to support the request
- Who you would like to help with your fair hearing

After getting your fair hearing request, the Agency will tell you in writing that they got your fair hearing request. A hearing officer who works for the State will review the decision we made.

If you are a Title XXI MediKids member, you are not allowed to have a Medicaid Fair Hearing.

Review by the State (for MediKids Members)

When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 30 days after you get the notice. **You must finish your appeal process first.**

You may ask for a review by the State by calling or writing to:

Agency for Health Care Administration
PO Box 7237
Tallahassee, FL 32314-723
1-877 254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

After getting your request, the Agency will tell you in writing that they got your request.

Continuation of Benefits for Medicaid Members

If you are now getting a service that is going to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal or Medicaid fair hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued, and our decision is not in your favor, we may ask you to pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

- 10 days after you receive a Notice of Adverse Benefits Determination (NABD), or
- On or before the first day that your services will be reduced, suspended or terminated

Section 18: Your Member Rights

As a recipient of Medicaid and a member in a Plan, you also have certain rights. You have the right to:

- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation
- Receive information on beneficiary and plan information

- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS)

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive services in a home-like environment regardless where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the services you need
- To be able to take part in decisions about your health care
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

Section 19: Your Member Responsibilities

As a recipient of Medicaid and a member in a Plan, you also have certain responsibilities. You have the responsibility to:

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions for care, and ask questions
- Keep your appointments, and notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff and case manager with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-Term Care program
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Section 20: Other Important Information

Patient Responsibility for Long-Term Care (LTC) or Hospice Services

If you receive LTC or hospice services, you may have to pay a "share *in* cost" for your services each month. This share *in* cost is called "patient responsibility." The Department of Children and Families (DCF) will mail you a letter when you become eligible (or to tell you about changes) for Medicaid LTC or hospice services. This letter is called a "Notice of Case Action" or "NOCA." The NOCA letter will tell you your dates of eligibility and how much you must pay the facility where you live, if you live in a facility, towards your share in the cost of your LTC or hospice services.

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling 1-866-762-2237 toll-free, or visit the DCF Web page at https://www.myflfamilies.com/medicaid (scroll down, review the links on the left side of the webpage and select the document entitled 'SSI-Related Medicaid Program Fact Sheet').

Indian Health Care Provider (IHCP) Protection

Indians are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services.

Emergency Disaster Plan

Disasters can happen at any time. To protect yourself and your family, it is important to be prepared. There are three steps to preparing for a disaster: 1) Be informed; 2) Make a Plan; and 3) Get a Kit. For help with your emergency disaster plan, call Member Services or your case manager. The Florida Division of Emergency Management can also help you with your plan. You can call them at 1-850-413-9969 or visit their website at www.floridadisaster.org.

For LTC members, your case manager will assist you in creating a disaster plan.

Tips on How to Prevent Medicaid Fraud and Abuse:

- DO NOT share personal information, including your Medicaid number, with anyone other than your trusted providers.
- Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information.
- Be careful with door-to-door visits or calls you did not ask for.
- Be careful with links included in texts or emails you did not ask for, or on social media platforms.

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

You can also report fraud and abuse to us directly by contacting:

- Hotline: 1 (866) 409-8031. The Hotline is a telephone line and voice mailbox that can be used 24 hours a day, 7 days a week. This number is confidential and has no caller ID. Please give as much information as possible. Please include the first and last names of anyone involved. This could include employees, providers, and subcontractors involved.

- In Writing: A report may be made in writing by filling out the Compliance Referral Form. It is located on our website at www.fcchealthplan.com. The Compliance Referral Form may be mailed or faxed.

  Florida Community Care Attn: Compliance Department
  4601 NW 77th Avenue
  Miami, FL 33166
  Fax: 1-305-675-5934

- E-mail: A report may be made by sending an email to Florida Community Care. Compliance@fcchealthplan.com

Abuse/Neglect/Exploitation of People

You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at 1-800-96-ABUSE (1-800-962-2873) or for TTY/TDD at 1- 800-955-8771.

You can also call the hotline if you know of someone else that is being mistreated.

Domestic Violence is also abuse. Here are some safety tips:

- If you are hurt, call your PCP
- If you need emergency care, call 911 or go to the nearest hospital. For more information, see the section called EMERGENCY CARE
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

If you have questions or need help, please call the National Domestic Violence Hotline toll free at 1-800-799-7233 (TTY 1-800-787-3224).

Advance Directives

An **advance directive** is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

1. A Living Will
2. Health Care Surrogate Designation
3. An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website: https://quality.healthfinder.fl.gov/report-guides/advance-directives.

Make sure that someone, like your PCP, lawyer, family member, or case manager knows that you have an advance directive and where it is located.

If there are any changes in the law about advance directives, we will let you know within 90 days. You don't have to have an advance directive if you do not want one.

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-833-FCC-PLAN (1-833-322-7526)or the Agency by calling 1-888-419-3456.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member record
- A description of how we operate
- Florida Community Care's HEDIS Results, as available
- Member educational materials
- Hard-copy member handbook
- Hard-copy provider directory
- The criteria used in making any adverse benefit determinations

Section 21: Additional Resources

Floridahealthfinder.gov

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website www.FloridaHealthFinder.gov where you can view information about Florida home health agencies, nursing facilities, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures
- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing facilities at https://elderaffairs.org/programs-services/housing-options/ as well as links to additional Federal and State resources.

MediKids Information

For information on MediKids coverage please visit: http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ICSP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit https://elderaffairs.org/programs-services/medicaid-long-term-care-services/statewide-medicaid-managed-care-long-term-care-program/.

Section 22: Forms

Living Will

Designation of Health Care Surrogate

Donor Form (Anatomical Donation)

Advance Directive Wallet Card

This information is available for free in other languages and formats. Please contact our Member Services number at 1-833-322-7526 (TTY: 711), Monday – Friday, 8 a.m. to 8 p.m.

Spanish

Esta información está disponible gratuitamente en otros idiomas y formatos. Comuníquese con nuestro Servicio al Miembros al 1-833-322-7526 (TTY: 711) de lunes a Viernes, de 8 a.m. a 8 p.m.

Haitian Creole

Enfòmasyon sa a disponib gratis nan lòt lang ak fòma. Tanpri kontakte nimewo Sèvis Manm nou an nan 1-833-322-7526 (TTY: 711), lendi rive vandredi, 8 a.m. a 8 p.m.

Notice of Nondiscrimination

Florida Community Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Florida Community Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Florida Community Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact Member Services.

If you believe that Florida Community Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Member Services, 833-FCC-PLAN (833-322-7526) or 711 for TTY.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Written or Oral Translation Services

English: ATTENTION: If you do not speak English, written translation or oral interpretation services, free of charge, are available to you. Call 1-833-322-7526 (TTY: 711).

Español (Spanish): ATENCIÓN: Si no habla inglés, tiene a su disposición servicios de traducción escrita o interpretación oral, gratuitos. Llame al 1-833-322-7526 (TTY: 711).

Kreyòl Ayisyen (Haitian Creole): ATANSYON: Si ou pa pale Anglè, gen sèvis entèpretasyon alekri oswa aloral ki disponib gratis pou ou. Rele 1-833-322-7526 (TTY: 711).

Tiếng Việt (Vietnamese): LƯU Ý: Nếu bạn không nói tiếng Anh, chúng tôi sẽ cung cấp miễn phí cho bạn dịch vụ dịch thuật bằng văn bản hoặc phiên dịch lời nói. Gọi 1-833-322-7526 (TTY: 711).

Português (Portuguese): ATENÇÃO: Se você não fala inglês, há serviços gratuitos de tradução escrita ou interpretação oral à sua disposição. Ligue para 1-833-322-7526 (TTY: 711).

中文 (Chinese)：**注意**：**如果您不会**讲英文，我们为您提供免费的笔译或口译服务。

请致电 1-833-322-7526 (TTY: 711)。

Zhōngwén (Chinese): Zhùyì: Rúguǒ nín bùhùi jiǎng yīngwén, wǒmen wèi nín tígōng miǎnfèi de bǐyì huò kǒuyì fúwù. Qǐng zhìdiàn 1-833-322-7526 (TTY: 711).

Français (French): ATTENTION : Si vous ne parlez pas l’anglais, des services gratuits de traduction écrite ou d'interprétation orale sont à votre disposition. Appelez le 1-833-322-7526 (ATS : 711).

Tagalog (Tagalog): Tawag-pansin: Kung hindi ka nagsasalita ng Ingles, available sa iyo ang nakasulat na pagsasalin o oral interpretation services nang walang bayad. Tawagan ang 1-833-322-7526 (TTY: 711).

Русский (Russian): ВНИМАНИЕ: Если вы не говорите по-английски, то вам доступны бесплатные услуги письменного и устного перевода. Звоните 1-833-322-7526 (TTY: 711)

العربية (Arabic): تنبيه: إذا كنت لا تتحدث الإنجليزية، فستتوفر لك خدمات الترجمة التحريرية أو الشفهية مجانًا. اتصل هاتفيًا بالرقم 1-833-322-7526 (TTY: 711).

Italiano (Italian): ATTENZIONE: Se non parla inglese, sono disponibili servizi gratuiti di traduzione scritta o interpretariato orale. Chiamare 1-833-322-7526 (TTY: 711)

Deutsch (German): ACHTUNG! Wenn Sie die englische Sprache nicht beherrschen, stehen Ihnen schriftliche Übersetzungen oder mündliche Dolmetscherdienste kostenlos zur Verfügung.
Rufen Sie 1-833-322-7526 (TTY: 711) an.

한국어(Korean): 주의: 영어를 구사하지 못하시면 서면 번역이나 구두 통역 서비스를 무료로 이용하실 수 있습니다. 1-833-322-7526 (TTY: 711)번으로 연락해 주십시오.

Polski (Polish): UWAGA: Jeżeli nie mówisz po angielsku, możesz skorzystać z bezpłatnych pisemnych i ustnych usług tłumaczeniowych. Zadzwoń 1-833-322-7526 (TTY: 711).

ગુજરાતી (Gujarati): ધ્યાન: જો તમે અંગ્રેજી ન બોલતા હો, તો લેખિત અનુવાદ અથવા મૌખિક અર્થઘટન સેવાઓ, વિના મૂલ્યે, તમને ઉપલબ્ધ છે. 1-833-322-7526ને કૉલ કરો (TTY: 711).

ภาษาไทย (Thai): โปรดทราบ: หากท่านพูดภาษาอังกฤษไม่ได้ ท่านสามารถใช้บริการแปลเอกสารหรือล่ามแปลภาษาฟรีได้ที่ โทร 1-833-322-7526 (TTY:711)

If you are unable to read this in a smaller font, this information is available to you in other formats or by oral interpretation, free of charge. Call 1-833-322-7526 (TTY: 711).