CHA
Health Plan

Clear Health Alliance's Florida Medicaid Member Handbook

844-406-2398 (TTY 711)
clearhealthalliance.com/member

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CLEAR HEALTH ALLIANCE'S
FLORIDA MEDICAID MEMBER HANDBOOK

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“If you do not speak English, call us at 844-406-2398 or TTY at 711. 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 844-406-2398 (TTY 711). 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 844-406-2398 (ATS 711). 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 844-406-2398 (TTY 711) pou LTC, oswa TTY 711. 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 844-406-2398 (TTY 711). 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 844-406-2398 (TTY 711). 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 844-406-2398 (TTY 711). 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	1-844-406-2398	Available 24 hours
Member Services Help Line TTY	711	Available 24 hours
Website	https://www.clearhealthalliance.com/member	
Address	11430 NW 20th Street, STE 300 Miami, FL 33172	

Transportation Services: Non-Emergency	1-877-671-6671
Pharmacy benefits/prescription drugs	1-833-235-2028 (TTY 711)
Specialty pharmacy benefits/prescription drugs	CarelonRx Specialty Pharmacy 1-833-255-0646 (TTY 711)
Eye care	iCare Health Solutions 1-855-418-1627
Behavioral health services	1-844-280-9633
Chronic health condition management	CHA Case and Disease Management/ Care Coordination 1-855-459-1566
<Dental care>	Contact your case manager directly or at 1-844-406-2398 (TTY 711) for help with arranging these services.
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	Go to https://www.clearhealthalliance.com/member and use our **Find A Doctor** tool to search for a network urgent care center near you. If you're not sure if you need urgent care, call your PCP. They will tell you what to do. Or you can call a nurse for advice anytime, day or night, at 1-844-406-2396.
For an emergency	9-1-1 Or go to the nearest emergency room

Table of Contents

Welcome to Clear Health Alliance's Statewide Medicaid Managed Care Plan
Clear Health Alliance 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. [See Addendum A.]

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 1-844-406-2398 (TTY 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.

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:

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

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown in the footer of this notice.

Please read this notice carefully. This tells you:

- **Who can see your protected health information (PHI).**
- **When we have to ask for your OK before we share your PHI.**

- **When we can share your PHI without your OK.**
- **What rights you have to see and change your PHI.**

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you are a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that is told to us, in writing, or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files.
  - Destroy paper with health information so others cannot get it.
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in.
  - Use special programs to watch our systems.
- Used or shared by people who work for us, doctors, or the state, we:
  - Make rules for keeping information safe (called policies and procedures).
  - Teach people who work for us to follow the rules.

When it is OK for us to use and share your PHI

We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it is OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals, and others get you the care you need
- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we will pay for healthcare or services before you get them (called prior authorization or preapproval)
  - To find ways to make our programs better, as well as support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you do not want this,

please visit https://www.clearhealthalliance.com/florida/privacy-policy.html for more information.

- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it is OK
  - With someone who helps with or pays for your healthcare, if you cannot speak for yourself and it is best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We cannot take back what we used or shared when we had your OK. But we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we are asked
- To answer legal documents
- To give information to health oversight agencies for things such as audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to worker's compensation if you get sick or hurt at work

Your rights

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We do not have your

whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**

- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we do not have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we shared your PHI with someone else. This will not list the times we shared it because of healthcare, payment, everyday healthcare business, or some other reasons we did not list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What we have to do

- The law says we must keep your PHI private except as we said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we will do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you are in danger.
- We must tell you if we have to share your PHI after you asked us not to.
- If state laws say we have to do more than what we said here, we will follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you

We, along with our affiliates and vendors, may call or text you using an automatic telephone dialing system and an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we will not contact you in this way anymore. Or you may call 844-203-3796 to add your phone number to our Do Not Call list.

What to do if you have questions

If you have questions about our privacy rules or want to use your rights, please call Member Services at 1-**844-406-2398 (TTY 711)**.

What to do if you have a complaint

We are here to help. If you feel your PHI has not been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

You may write to or call the Department of Health and Human Services:

Office for Civil Rights

U.S. Department of Health and Human Services

Sam Nunn Atlanta Federal Center, Ste. 16T70

61 Forsyth St. SW

Atlanta, GA 30303-8909

Phone: 800-368-1019

TDD: 800-537-7697

Fax: 404-562-7881

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we will tell you about the changes in a letter. We also will post them on the web at https://www.clearhealthalliance.com/florida/privacy-policy.html.

Race, ethnicity, and language

We get race, ethnicity, and language information about you from the state Medicaid agency. We protect this information as described in this notice.

We use this information to:

- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:

- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information

We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It is often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health.
  - Habits.
  - Hobbies.
- We may get PI about you from other people or groups such as:
  - Doctors.
  - Hospitals.
  - Other insurance companies.
- We may share PI with people or groups outside of our company without your OK in some cases.
- We will let you know before we do anything where we have to give you a chance to say no.
- We will tell you how to let us know if you do not want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact Member Services at 844-406-2396 (TTY 711) for Florida Medicaid or 877-440-3738 (TTY 711) for Long-Term Care Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

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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 1-844-406-2398, or TTY 711, Monday to Friday, 8 a.m. to 7 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 24-hour Nurse HelpLine at 844-406-2398 (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 1-844-406-2398. 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 CHA 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).

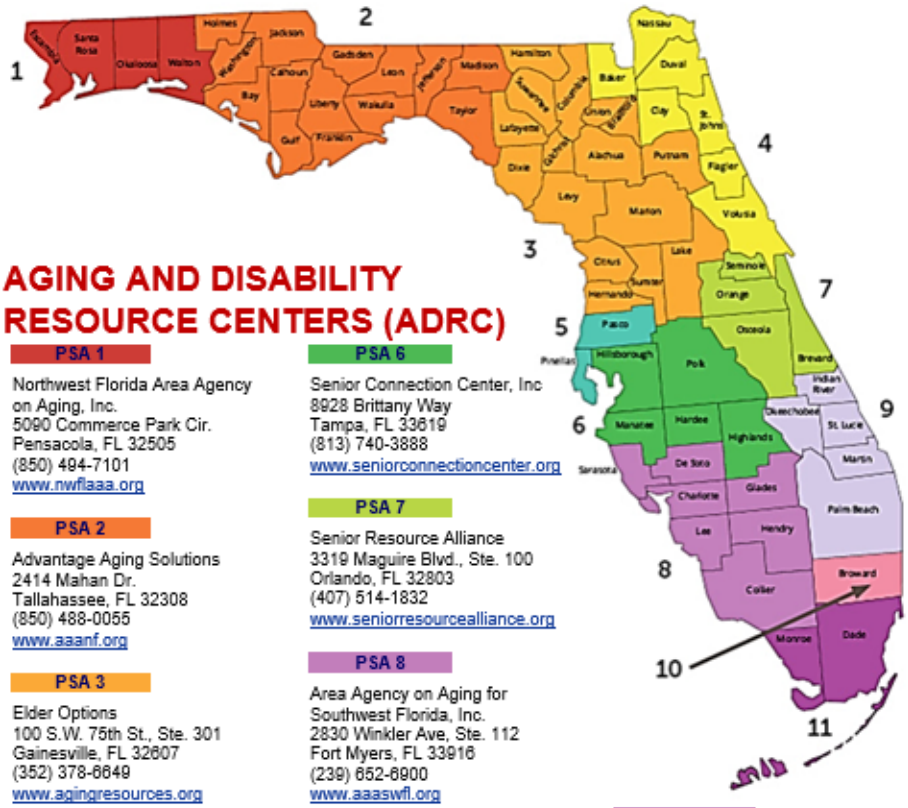
Enrollment in the SMMC Long-Term Care Program

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.



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 at 1-844-406-2398, or TTY 711 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
- You or your caregivers behave in a way that makes it hard for us to provide you with care

[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 17, Member Satisfaction, on page 71.

- 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 1-844-406-2398, or TTY 711 to get a copy or visit our website at https://www.clearhealthalliance.com/member.

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 CHA. Contact Member Services at 1-844-406-2398, or TTY 711 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 CHA

The Medicaid fee-for-service program is responsible for covering the following services, instead of CHA 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]

[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).

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 24-hour Nurse HelpLine at 844-406-2398 (TTY 711). Nurses are available to answer your health questions anytime, day or night.

You may also find the closest Urgent Care center to you by calling us.
We can help you find a center near you. Or view the provider directory online at https://www.clearhealthalliance.com/member. Click on Find A Doctor and search for urgent care centers.

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 https://www.clearhealthalliance.com/member 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
Some specialty medications require special handling, and local drugstores may not have them in stock. CHA partners with CarelonRx Specialty Pharmacy as the preferred

pharmacy to provide your specialty medications to you. CarelonRx Specialty Pharmacy has the experience to handle your specialty drug(s), plus:

- Pharmacists and nurses to answer your questions.
- Safe, on-time, and free delivery directly to your home Monday to Friday at a time that works for you.
- Other delivery options, such as to your office, provider's office, or to a local CVS Pharmacy.
- Special temperature-controlled packaging if required for your drugs.
- Reminder calls when it's time to refill your drugs.
- The ability for you to refill your medications online. Just log in to your account on https://www.clearhealthalliance.com/member, or call Pharmacy Member Services 24/7 at 833-235-2028 for help.
- Needles and syringes automatically sent if you need them to take your drugs.
- Help tracking information about the drugs you take to make sure they're all safe to take together.

You or your provider can call CarelonRx Specialty Pharmacy at 833-255-0646 (TTY 711). Your provider can also fax your prescription to 833-263-2871 or send prescriptions electronically.

CarelonRx Specialty Pharmacy is our preferred specialty pharmacy. You do not have to use CarelonRx Specialty Pharmacy. You can go to any CHA network pharmacy to get your specialty medications. Find a pharmacy online at https://www.clearhealthalliance.com/member. Go to the Find A Doctor page and view the provider directory or choose "Search now" to search for a local pharmacy. Or you can call Member Services. We'll help you find one near you.

Mail Order Pharmacy information

CHA partners with CarelonRx Mail Order Pharmacy to provide you free, safe home delivery of your maintenance prescription medications that you might fill at a local retail pharmacy.

Your provider can send your prescription to CarelonRx Mail Order Pharmacy in one of these ways:

- By fax to 800-378-0323.
- By phone call to 833-203-1742.
- By sending it electronically.

You can request refills of your mail order medications by calling Pharmacy Member Services 24/7 at 833-214-3607, logging in to your account at https://www.clearhealthalliance.com/member, or using the refill form on the website.

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 CHA Member Services at 1-844-406-2398 or calling Behavioral Health Services at 1-844-375-7215.
- Looking at our provider directory
- Going to our website at https://www.clearhealthalliance.com/member.

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:

Healthy Rewards Healthy Behaviors programs

<We will support and reward you for taking steps to get and stay healthy through our Healthy Rewards Healthy Behaviors programs. We offer these programs to our members who want to stop smoking, manage their weight, address any abuse problems, have a baby, or keep their children healthy.

We can help members plan and set goals for these topics:

- Alcohol and substance abuse – help and support through telehealth and/or

- in-person visits
- Smoking cessation – help and support through coaching and being part of community groups
- Weight management – help and support from your provider to make good exercise and food choices
- Maternity – help and support from your doctor and case manager to have a healthy pregnancy and a healthy baby
- Well-child visits – help and support from the child's doctors to maintain good health.
- Asthma - help and support to remain adherent to treatment and manage children's asthma.
- HIV - help and support to adhere to treatment and achieve viral load suppression.

There are separate programs under each topic you can join with different goals to meet. Through each program, you'll get tips, help, and support from your provider and case manager. When you join and meet a program's goals within 12 months, you will get a gift card reward.

Your doctor or a case manager can refer you to one or more of these programs. You can also refer yourself. To join a program, you need to complete the enrollment form for each program for which you are interested in joining. You can find full descriptions of each Healthy Rewards Healthy Behaviors program, along with enrollment and program forms, on the member website, https://www.clearhealthalliance.com/member. You may also enroll by logging into your Benefit Reward Hub at https://www.clearhealthalliance.com/member. From here, you can visit the Healthy Rewards Healthy Behaviors portal.

If you would like to learn more, email HealthyBehaviors@elevancehealth.com or call Member Services.>

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 at 1-844-406-2398.

Chronic Disease Management Programs
We have special programs available that will help you if you have one of these conditions.

Cancer and Cancer Prevention

Diabetes and Diabetes Prevention

Depression and Depression Prevention (including suicide prevention)

Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome

(AIDS), and HIV prevention

Hypertension

End-Stage Renal Disease>

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:

CARES program

The CHA CARES program is a field-based behavioral health case management program for members with behavioral health and substance abuse disorders. We want to make sure you're getting the care and support you need if we can't reach you by phone. In this program, you get in-person help from a case manager with things like making sure you're taking your medications and getting follow-up care. This ensures you get the treatment, wellness, and recovery services you need to support your care plan. For questions about the program, talk to your behavioral health case manager or call Member Services.

Rising Star program

Some days are better than others when you have a behavioral health condition. As a member in the Rising Star program, you can get customized care from a team of people who knows you and your history and can help you. This team includes a home hospital, psychiatrist, and a CHA behavioral health case manager. Your case manager works with you, your home hospital, psychiatrist, and pharmacist on a plan for you to get and stay healthy. If you qualify, you can choose to be in the program; it is not required.

For questions about the program, talk to your behavioral health case manager or call Member Services.

Children's programs

We offer programs to help you get the care you need for your child. School-based clinics are open in select locations to make it easier to get healthcare services for your child. Children 5 years and younger are referred to the Florida Women, Infants, and Children (WIC) program for help with meeting their nutritional needs.

If your child is behind on well-child visits and immunizations, you may get a phone call or a letter to remind you to schedule a visit. If you need help making a visit or getting a ride to the visit, call Member Services. We can help.

Domestic violence

Domestic violence is abuse. Abuse is not healthy or safe. It is never OK for someone to hurt you or make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect you and your family. If you feel you are a victim of abuse, tell your doctor or case manager. We can help you. We also offer home visits through the Healthy Start program for pregnant mothers who may be fearful of being at home or are facing domestic violence.

Safety tips for your protection:

- If you're hurt, call your PCP. Call 911 or go to the nearest hospital if you need emergency care.
- Have a plan on how you can get to a safe place, like a women's shelter or a friend's or relative's home.
- Pack a small bag and give it to a friend to keep for you until you need it.

If you have questions or need help, please call:

- Member Services toll free at 1-844-406-2398, or TTY at 711; follow the prompts to the 24-hour Nurse HelpLine.
- National Domestic Violence Hotline at 800-799-7233 (TTY 800-787-3224).
- Abuse hotline at 800-96-ABUSE.

Pregnancy prevention

CHA provides various tools to help members take important steps to stay healthy. This is whether you're thinking of having a baby, trying to have a baby, or not yet ready to have a baby. You have access to many reproductive health and wellness materials that talk about contraceptive methods and family planning. If you would like information on family planning, please talk to your doctor, visit your county health department, or call Member Services.

Pregnancy-related programs

If you're pregnant or trying to get pregnant, CHA provides information on how to prepare and how to stay healthy through your pregnancy. You can get information about preconception health, the importance of prenatal care, postpartum care, birth spacing, and critical health topics. If you're pregnant, you will get a call that asks you important questions about your health and your pregnancy. It's important for you to answer these questions so CHA can help you and tailor a program just for you. You will get calls telling you what to expect at each stage of your pregnancy. You will also get reminders about prenatal visits, postpartum visits, well-child visits, and more. CHA has case managers that specialize in pregnancy and are available for you.

Taking Care of Baby and Me® program

Our program for all pregnant members is called Taking Care of Baby and Me. It is very important to see your primary care provider (PCP) or obstetrician or gynecologist

(OB-GYN) for care when you are pregnant. This kind of care is called prenatal care. It can help you to have a healthy baby. Prenatal care is important each time you are pregnant. With our program, members have access to health information and may receive incentives for going to their appointments. With our program, members get health information and incentives for getting prenatal and postpartum (after birth) care. Our program also helps pregnant members with complex healthcare needs. Nurse case managers work closely with these members to give:

- Education
- Emotional support
- Help in following their doctor's care plan

Information on services and resources in your community, such as Women, Infants, and Children (WIC) Program; breastfeeding; and counseling.

Our nurses also work with doctors and help with other services members may need. The goal is to promote better health for members and the delivery of healthy babies.

Doula services

Pregnant members and new mothers can benefit from physical, emotional, and educational support from a doula before, during, and after giving birth. A doula, also called a birth coach, birth companion, or post-birth supporter, can help pregnant members and members who are new moms:

Connect with community resources like:

- WIC
- Healthy Start
- Diaper banks
- Food pantries
- Feel heard by listening to them and their needs.
- Make informed choices through education.
- Create their birth plan.
- Support their birth experience.
- Decrease their:
- Chance of a Cesarean (C-section) birth.
- Length of labor.
- Need for pain medications.
- Odds of a preterm birth.
- Improve their success with breastfeeding.
- Have an easier shift into parenthood.

My Advocate® — quality care for you and your baby

At CHA, we want to give you the very best care during your pregnancy. That's why we invite you to enroll in My Advocate, which is part of our Taking Care of Baby and Me program. My Advocate gives you the information and support you need to stay healthy during your pregnancy. My Advocate delivers maternal health education by phone, web, and smartphone app that is helpful and fun. If you choose the phone version, you will get to know Mary Beth, My Advocate's automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- Education you can use.

- Communication with your case manager based on My Advocate messaging if you should have questions or issues.
- An easy communication schedule.
- No cost to you.

With My Advocate, your information is kept secure and private. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn, and answer a question or two. If you tell us you have a problem, you'll get a call back from a case manager in 1–2 business days.

- My Advocate topics include:
- Pregnancy
- Postpartum care
- Well-child care

If you think you are pregnant:

Call your PCP or OB-GYN provider right away. If you don't have an OB-GYN, we can help you find one in the CHA network. You don't need a referral from your PCP to see an OB-GYN. Your OB-GYN should see you within two weeks.

When you find out you are pregnant:

Call Member Services and your Department of Children and Families (DCF) caseworker.

This will help your baby get CHA healthcare benefits when they are born. You will need to choose a PCP for your baby in your last trimester. If you don't choose one during this time, we'll choose one for you.

Visit our Pregnancy and Women's Health page at https://www.clearhealthalliance.com/member for information and resources on how to keep you and your baby healthy. If you would like to receive pregnancy information by mail, please call Member Services.

While you're pregnant:

You need to take good care of your health. You may be able to get healthy food from the WIC program if you qualify for Medicaid. Call Member Services for the WIC program close to you.

You must visit your PCP or OB-GYN often. Your PCP or OB-GYN and your pregnancy education package will tell you how often.

When you have a new baby:

You and your baby may stay in the hospital at least 48 hours after a vaginal delivery or 72 hours after a Cesarean section (C-section). You may stay in the hospital less time if your PCP or OB-GYN and the baby's provider see you and your baby are doing well. If

you and your baby leave the hospital early, your PCP or OB-GYN may ask you to have an office or in-home nurse visit within 48 hours.

CHA pays for elective circumcisions for newborn members up to 28 days of age. Circumcision will be a one-time, lifetime benefit.

After you have your baby:

You must call CHA Member Services to let your care manager know you had your baby. We will need to get details about your baby. We can help you pick a PCP for your baby if you have not already picked one before they were born.

You must call your DCF caseworker. If you do not wish for the baby to become a member, you must call an Enrollment Broker toll free at 877-711-3662

(TTY 866-467-4970) to pick a different health plan for them.

You will still get health promotion calls while enrolled in the program for up to 12 weeks if you enrolled in My Advocate during your pregnancy.

Set up a visit with your PCP or OB-GYN for your postpartum checkup. This is very important to ensure you're healing well. This visit should be done between 7 to 84 days after you deliver.

If you delivered by C-section, your PCP or OB-GYN may ask you to come back for a two-week post-surgery checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 7 to 84 days after your delivery for your postpartum checkup.

If you need help making your appointments for your prenatal or postpartum visits or have any questions, call Member Services. We can help.

Healthy Start services

CHA partners with the Healthy Start Coalition to make sure you have a healthy pregnancy and healthy baby. Healthy Start offers classes on:

- How to have a healthy pregnancy
- Eating well while you are pregnant
- How to stop smoking
- Breastfeeding
- How to care for your baby
- Family planning
- Childbirth
- Parenting

To find Healthy Start services near you, call Member Services or visit healthystartflorida.com/about-us/coalition-map.

Nutritional assessment and counseling

Members who are pregnant, breastfeeding, or postpartum and children from birth to 5 years of age can get a nutritional assessment, counseling, and referrals to the Florida WIC program. Your doctor will assess your eating habits, educate on breast milk alternatives, and give custom diet counseling and a nutrition care plan. You should get a copy of the WIC referrals your doctor makes.

CHA also provides a Gestational Diabetes program for women who have been diagnosed with gestational diabetes and may need more support to eat right.

Your case manager can help you with these services. You can also call Member Services for health education materials on these topics.

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. 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.

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 1-844-406-2398 (TTY 711) 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.

[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
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	<Required>
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	Not required
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.	Required for nonemergent transportation services
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	As medically necessary and recommended by us	<Required>
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	May be required
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.	Required
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to	We cover recipients under the age of 21 years requiring medically necessary services.	Not required

Service	Description	Coverage/Limitations	Prior Authorization
	decrease maladaptive behaviors and increase or reinforce 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)	Not required
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	Required
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program	As medically necessary and recommended by us	<Not required>
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 for cardiac testing and surgical procedures
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	Required

Service	Description	Coverage/Limitations	Prior Authorization
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover, as medically necessary: - 24 patient visits per year, per member - X-rays	Not required
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic		Not required
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	<Required>
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	<Not required>
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	Not required
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	<Required>

Service	Description	Coverage/Limitations	Prior Authorization
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 includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	As medically necessary, some service and age limits apply. Call 1-844-406-2396 (TTY 711) for more information.	Required
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	Not required
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.	Required for air ambulances
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	Not required

Service	Description	Coverage/Limitations	Prior Authorization
		- One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	
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	Not required
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	<Required>
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary	May be required for diagnostic tests and procedures
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary	May be required for diagnostic tests and procedures
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 -	Not required
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	We cover, when medically necessary:	Required

Service	Description	Coverage/Limitations	Prior Authorization
	assistance provided in your home to help you manage or recover from a medical condition, illness or injury	- Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients	
Hospice Services	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	- Covered as medically necessary	Not required
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	Not required
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	Required
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

Service	Description	Coverage/Limitations	Prior Authorization
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	- Covered as medically necessary -	Requires a referral from your PCP
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 problems who live in foster care homes	Must be in the custody of the Department of Children and Families	Required
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	- Covered as medically necessary	Not required
Medication Management Services	Services to help people understand and make the best choices for taking medication	- Covered as medically necessary	Not required
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	Required
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Required
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	Required

Service	Description	Coverage/Limitations	Prior Authorization
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	<Required>
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 for diagnostic tests and procedures
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	PA required for out-of-state travel and transfers between hospitals or facilities
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	Required
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:	Required

Service	Description	Coverage/Limitations	Prior Authorization
		- Follow-up wheelchair evaluations, one at delivery and one 6-months later	
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	May be required
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	- Covered as medically necessary	May be required for diagnostic tests and procedures
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 for some non-emergent services
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	Required
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	<Required>
Physical Therapy Services	Physical therapy includes exercises , stretching and other treatments to help	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary:	Required

Service	Description	Coverage/Limitations	Prior Authorization
	your body get stronger and feel better after an injury, illness or because of a medical condition	- 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	
Podiatry Services	Medical care and other treatments for the feet	We cover, as medically necessary: - Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the foot, ankle and lower leg - Surgery on the foot, ankle or lower leg	Not required
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	Required for some drugs. Call Member Services for more information.
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	Required
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	<Not required>
Psychological Testing Services	Tests used to detect or diagnose problems with	We cover, as medically necessary: - 10 hours of psychological testing per year	Required

Service	Description	Coverage/Limitations	Prior Authorization
	memory, IQ or other areas		
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	Required
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 special care centers to handle serious conditions	Covered as medically necessary	Not required
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.	Not 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	May be required for diagnostic tests and procedures

Service	Description	Coverage/Limitations	Prior Authorization
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)	Not required
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	<Not required>
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	Required
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	Required
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Required
Substance Abuse Intensive Outpatient	Treatment provided for more than 3 hours per day,	As medically necessary and recommended by us	<Required>

Service	Description	Coverage/Limitations	Prior Authorization
Program Services	several days per week, for people who are recovering from substance use disorders		
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	<Required>
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	Required
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Required
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	May be required for prosthetic devices
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	- Covered as medically necessary	May be required for procedures and some tests

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 and Coverage / Limitations	Prior Authorization
Acupuncture	Members, age 21+, can receive acupuncture as an alternative to pain management therapy to ease physical, mental, and emotional conditions. We offer unlimited acupuncture visits based on medical necessity.	Required
Adult additional primary care services	Members, age 21+, can receive unlimited primary care visits.	Required
Adult Vision (visual aid services)	Members, age 21+, can receive an eye exam and glasses or a 6-month supply of prescription contact lenses annually.	Not required
Alzheimer's Reading Support	Members, age 60+, diagnosed with Alzheimer's can receive a $50 gift card to purchase activity and engagement books to reduce cognitive decline.	Required
Assisted Living Facility Bed Hold	Members can receive an in-network Assisted Living Facility/Adult Family Care Home bed hold for up to 31 days.; members, age 18+, must reside in the facility for a minimum of 30 days between episodes and intend to return to the facility. Members and providers must notify the Managed Care Plan within 48 hours of leaving the facility.	Not required

Service	Description and Coverage / Limitations	Prior Authorization
Assisted Living Facility (ALF) Transition Catalog	Members can select one item from a catalog of bed and bath items to assist with their transition to an assisted living facility (ALF). For members ages 21+ currently living in an ALF or members transitioning into an ALF.	Required
Asthma & COPD Relief Catalog	Members diagnosed with asthma or COPD can select one relief product from a catalog, such as: inhaler vaporizer kits, travel nebulizer compressor systems, hypoallergenic bedding, pillow and mattress covers, HEPA air filters, and asthma monitoring devices.	Required
Behavioral Health Services	Members, age 21+, can receive the following extras with prior authorization: **Assessment Services** Members can receive unlimited assessment services, psychiatric evaluations, brief behavioral health status exams, psychological testing, and more, based on medical necessity. **Drug Screening** Members can receive eight (8) additional drug, alcohol, and other screenings, based on medical necessity. **Medication Management** Members can receive eight (8) additional medication	Required

Service	Description and Coverage / Limitations	Prior Authorization
	management services, based on medical necessity.	
Caregiver Support	Members, age 18+, can receive the following support for their caregivers: **Caregiver Respite:** up to four (4) hours per month, up to 48 hours per year, to help reduce stress, anxiety, and prevent caregiver burnout. **Individual Therapy Sessions:** up to one hour of therapy per day for 12 days per year. **NEMT Caregiver Transportation:** up to 4 one-way rides per month, within 25 miles, to visit a member who resides in an assisted living facility, adult family care home, or nursing home.	Required
Carpet Cleaning	Members diagnosed with asthma or COPD can receive a $100 gift card, twice a year, to apply toward carpet cleaning services.	Required
Chiropractic Care	Members, age 21+, can receive chiropractic treatments to realign the spine, for pain relief, as an alternate to pain management therapy.	Required

Service	Description and Coverage / Limitations	Prior Authorization
Community Reintegration Support	Members, ages 18+, transitioning out of a nursing facility can receive up to $6,000 per lifetime to help pay for moving costs, security and utility deposits, and household furnishings.	Required
Disaster Relief Benefit	**Grocery and Cleaning Supply Card** Members can receive a $100 gift card per disaster to purchase groceries and cleaning supplies after a Governor declared state of emergency disaster. Member must live in a Governor declared state of emergency area up to 4 weeks after a CAT 2 or higher storm. **Home Delivered Meals** Members can receive one package of five shelf-stable meals delivered directly to their homes per disaster. Members must live in a Governor declared state of emergency area up to 4 weeks after a CAT 2 or higher storm.	Not required
Doula services	Pregnant members, age 13-54, can receive home visits for prenatal and postnatal monitoring, assessment, and follow-up care, including newborn care and screening. Unlimited visits per pregnancy and up to 3 months after delivery.	Not required

Service	Description and Coverage / Limitations	Prior Authorization
Durable medical Equipment: Blood Pressure Monitor	Members, age 18+, diagnosed with hypertension or obesity can receive a digital blood pressure monitor every 3 years.	Required
Educational Support	Members, age 5-19, can receive the following extra benefits: **Academic Achievement Award** A $25 gift card for achieving a GPA of 2.5 or higher. **Online Enrichment Classes** A $50 gift card to enroll in various online classes including but not limited to nutrition, cooking, and fitness related courses. **School Supply Assistance** A $50 voucher to purchase school supplies. **Tutoring Services** Up to 2 hours per week of virtual tutoring services in language arts, math, science, social studies, and foreign language for members at-risk of failing.	Required
Emergency Preparedness Kit	Members can receive an Emergency Preparedness Kit after completing a disaster plan. The kit includes items such as; a multi-function tool, light stick, flashlight, mini first aid kit, emergency survival	Not required

Service	Description and Coverage / Limitations	Prior Authorization
	blanket, waterproof poncho, hand warmers, matches, tissues, towelettes, hand sanitizer, emergency whistle with carabiner, and dust mask. Kits will be offered one per household per lifetime.	
Family Night Package	Members, ages 5-17, can select one of the following packages per household to help promote family togetherness: • **Family Game Night** - includes a card game, jumbo playing dice, jigsaw puzzle and a classic board game along with a $50 restaurant gift card. • **Family Movie Night** - includes a $50 Fandango gift card and a $50 restaurant gift card.	Not required
Fresh Food Connect	Members, age 17+, can choose one of the following items annually: • $150 Healthy Grocery Card • Annual Sam's Club membership • Annual Costco membership • Three boxes of Produce Delivery	Not required
Healthy Lifestyle Aids	Members can select two items from a custom catalog of lifestyle aids options.	Not required

Service	Description and Coverage / Limitations	Prior Authorization
Hearing services for adults	Members, age 21+, can receive hearing service benefits one evaluation and screening, one hearing aid per ear, one hearing aid fitting/check, and one hearing aid dispensing service fee every two years.	Not required
Home Delivered Meals - Post Facility Discharge	Members, age 5+, can receive up to 14 home delivered meals to enhance recuperation post discharge from a minimum 3-day inpatient hospital stay or nursing facility. Members must meet minimum hospital stay requirements and request service from discharge coordinator or CM.	Not required
Home Delivered Meals - Pregnant Moms	At-risk pregnant members, age 13+, can receive up to 100 home-delivered meals to allow them to focus on a healthy pregnancy.	Not required
Home Health Nursing/Aide Services	Members, age 21+, can receive one additional visit per day of home health nursing and/or personal care services.	Not required
Home Visit by a Clinical Social Worker	Members can receive up to 48 visits per year by a clinical social worker.	Required
Housing Assistance	Members, age 18+, who are experiencing homelessness or housing insecurity can receive up to $500 to use toward any of the following	Required

Service	Description and Coverage / Limitations	Prior Authorization
	housing services: application fees, deposits, housing related documentation, utility hook ups, rental and utility arrears, and essential furniture and/or household goods.	
Massage Therapy	Members, age 21+, can receive unlimited massage therapy services as an alternative for pain management to help with pain relief, relaxing muscles, tendons and joints, and relieving stress.	Required
Medicine Safety Kit	Members can receive our Medicine Safety Kit, which includes a lockable medicine box, Rx destroyer gel, childproof prescription caps, and pill case covers that reset when opened.	Not required
Mom & Baby Essentials	Pregnant and newly postpartum Members, age 13-54, can receive a $200 gift card to purchase items that support a healthy pregnancy and healthy environment for baby.	Not required
NEMT Day Trip Meals	Members can receive up to $200 per day toward the cost of food during medical visits more than 100 miles from home. Limited to once every 30 days.	Required
NEMT Services - Non-Medical Purposes	Members may need additional transportation beyond the medical transportation. Members can go to community events, health and wellness activities, local	Not required

Service	Description and Coverage / Limitations	Prior Authorization
	dental clinics, places of worship, libraries, social and group activities, support groups, job coaching, and GED prep courses. Eight (8) one-way rides per month up to 25 miles per one-way trip.	
Newborn circumcision	Newborn male Members, up to 28 days old, can receive one circumcision.	Not required
Nursing Support	Pregnant Members, age 13-54, can choose one of the following items to help support healthy breastfeeding: • Boppy pillow • Microwave sterilizer. • Breast pump accessory kit (disposable nursing pads, extra milk storage bags, and bottles). • Breastfeeding support kit (infant support nursing pillow, washable nursing pads, and nursing cover).	Not required
Nutritional Counseling	Members, age 21+, can receive unlimited nutritional counseling sessions. This expanded benefit will assist to reduce the risk or slow the progression of chronic diseases like diabetes, hypertension, obesity, and coronary artery disease.	Required
Occupational therapy for adults	Members, ages 21 and older, can receive an annual evaluation and re-evaluation and up to seven therapy sessions per week.	Not required

Service	Description and Coverage / Limitations	Prior Authorization
Opioid Use Disorder (OUD) Recovery Program	This recovery program can help members age 18+, with an opioid addiction, overcome opioid addiction through medicine, counseling, therapy, and community support. Recovery care is convenient and available virtually or local group meetings.	Not required
Over-the-Counter (OTC) medications and supplies	Members can receive $65 per month per household to purchase over the counter products.	Not required
Pest Control	Members diagnosed with asthma can receive a $125 gift card, quarterly, to help pay for pest control treatments in the home.	Required
Physical therapy for adults	Members ages 21 and older can receive an annual evaluation, a re-evaluation, and up to seven therapy sessions per week to promote healthy outcomes.	Not required
Post-Secondary Education Card	Members, ages 17-21, pursuing a post-secondary education within the next year can receive up to $200 per lifetime to use toward the following: • SAT/ACT study guides • college application fees • textbooks • dorm room items	Not required

Service	Description and Coverage / Limitations	Prior Authorization
Prenatal Services	Pregnant Members, age 13-54, can receive 14 prenatal visits or 18 prenatal visits for high-risk pregnancy members and three postpartum visits within 90 days of delivery.	Required
Respiratory Supplies	Members, age 21+, can receive various respiratory relief supplies to help improve their breathing.	Required
Sensory Solutions	Members can receive a $75 gift card to purchase sensory products such as Compression Garments, Weighted Lap Blankets, Texture Fidgets, Sensory Books, per eligible member per year.	Not required
Speech Therapy/Speech Language Pathology	Members, age 21+, can receive additional Speech Therapy benefits based on medical necessity: • One evaluation and re-evaluation per year. • One evaluation of oral and pharyngeal swallowing function per year. • Up to seven therapy sessions per week. • One initial Augmentative and Alternative Communication (AAC) evaluation per year. • One AAC re-evaluation per year. • Up to four 30-minute sessions for AAC fitting, adjustment, and training sessions per year.	Not required

Service	Description and Coverage / Limitations	Prior Authorization
STEM Puzzle Set	Members, ages 6-18, can receive a STEM puzzle set of four puzzles representing Science, Technology, Engineering, and Mathematics once per lifetime.	Not required
Summer Reading Program	During summer months (June, July, and August): • Members, age 6-10, can receive a $100 gift card to purchase books. • Members, age 11-18, can select one of the following options: • a $100 gift card to purchase books, or • an eReader with a $30 digital library card per lifetime	Not required
Therapy (Individual/Family)	Members enrolled the behavioral case management can receive up to an additional 10 visits per year for individual/family therapy with prior authorization.	Required
Transportation Essentials	Pregnant members, age 18+, can select a $100 gift card for one of the following transportation options: • Ride Share Gift Card • Gas Card • Public Transportation	Not required
Waived Copayments	Members can receive no copayments for certain services.	Not required

Service	Description and Coverage / Limitations	Prior Authorization
Water Safety Benefit	Members, age 1-4, can receive a $160 gift card to help cover the cost for swim lessons once per lifetime.	Not required

Additional eligibility requirements may apply.

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.

Service	Description and Coverage / Limitations	Prior Authorization
Food Assistance	Members can receive food assistance with up to 100 meals annually for the first 1,000 MMA pregnant members and first 50 HIV/AIDS specialty product members who are current on their prenatal visits. Must have CM approval.	Required
Housing Assistance	Our Housing Program can live independently in the setting of their choice. Expanded benefit units, amount, and frequency are determined on a case-by-case basis by Housing Specialist based on the situation and the needs of the member.	Required
Housing Assistance	Members can use the Eviction Prevention Program. Total Expanded Benefit units, amount, and frequency are determined on a case-by-case basis by Housing Specialist based on the situation and the needs of the member.	Required
Housing Assistance	Our Housing Benefit provides financial support to helps members with housing related needs. We will provide up to $500 for members. SMI may have greater challenges in securing and maintaining stable housing, we will provide up to $2,500 for members in the SMI specialty product.	Required

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.	Required
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.	Required
Assistive Care Services	These are 24-hour services if you live in an adult family care home.	Required
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.	Required
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	Required

[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
Behavioral Management	Services for mental health or substance abuse needs	Required
Caregiver Training	Training and counseling for the people who help take care of you	Required
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.	Not required
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.	Required
Home Delivered Meals	This service delivers healthy meals to your home.	Required
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores.	Required
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	Required

Service	Description	Prior Authorization
	available for family members or caregivers.	
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Required
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, 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.	Required
Medication Administration	Help taking medications if you can't take medication by yourself	Required
Medication Management	A review of all the prescription and over-the-counter medications you are taking	Required
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	Required
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy,	Required

Service	Description	Prior Authorization
	occupational therapy, and speech-language pathology	
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Required
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Required
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.	Required
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.	Required
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.	Required
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	Required
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	Required

Service	Description	Prior Authorization
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.	Not required

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 and Coverage / Limitations	Prior Authorization
Assisted Living Facility Transition Catalog	Members living in an ALF and new enrollees transitioning/moving into an ALF can select up to $50 worth of items. One benefit per lifetime, requires CM referral.	Not required
Community Reintegration Support	Members who reside in a nursing home that want to return to the community can receive benefit of maximum of $6000.00 allowance per member, per lifetime. Selected items must be necessary to return to the community and be approved. Benefit must be used within 90 days of transition.	Required
Pathways to Purpose	Pathways to Purpose Transportation provides four one-way rides per month for volunteering and mentoring. Benefit is 48 one-way rides annually	Not required

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. Call 1-844-406-2398, or TTY 711.	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. CHA Grievance & Appeals Coordinator P.O. Box 62429 Virginia Beach, VA 23466	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.

	What You Can Do:	What We Will Do:
	Phone: 877-372-7603 (TTY 711) Fax: 866-216-3482 Email: flmedicaidgrievances@simplyhealthcareplans.com	
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. CHA Grievance & Appeals Coordinator P.O. Box 62429 Virginia Beach, VA 23466 Phone: 877-372-7603 (TTY 711) Fax: 866-216-3482 Email: flmedicaidgrievances@simplyhealthcareplans.com	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 danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. CHA Grievance & Appeals Coordinator P.O. Box 62429 Virginia Beach, VA 23466 Phone: 877-372-7603 (TTY 711) Fax: 866-216-3482 Email: flmedicaidgrievances@simplyhealthcareplans.com	We will: • Give you an answer within 48 hours after we receive your request. • 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	You can:	We will:

	What You Can Do:	What We Will Do:
decision, you can ask for a **Medicaid Fair Hearing****	• 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.*	• 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
P.O. Box 7237
Tallahassee, FL 32314-7237
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
P.O. Box 7237
Tallahassee, FL 32314-7237
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 the Special Investigations Unit. Call 844-406-2398 (TTY 711). When you call, ask to speak to the Special Investigations Unit. Please give as many details as possible.

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 1-844-406-2398 (TTY 711) 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
- FloridaHealthFinder.gov, where you can learn about CHA quality performance ratings and more. See the next section for more information.

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

<Call Member Services at 844-406-2398 or TTY at 711 to request auxiliary aids and services. in accordance with 42 CFR 438.10(d) in 18 point font and in top 4 Languages (English, Spanish, Haitian Creole, and Vietnamese)>

Non-Discrimination Notice
CHA Healthcare Plans, Inc. follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- National origin
- Disability
- Color
- Age
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 877-372-7603 (TTY 711).

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax or phone:

CHA Grievance Coordinator

P.O. Box 62429

Virginia Beach, VA 23466

Phone: 877-372-7603 (TTY 711)

Fax: 866-216-3482

Email: flmedicaidgrievances@simplyhealthcareplans.com

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services

200 Independence Ave. SW

Room 509F, HHH Building

Washington, DC 20201

- **By phone:** 800-368-1019 (TTY/TDD 800-537-7697)

For a complaint form, visit www.hhs.gov/ocr/file/index.html.