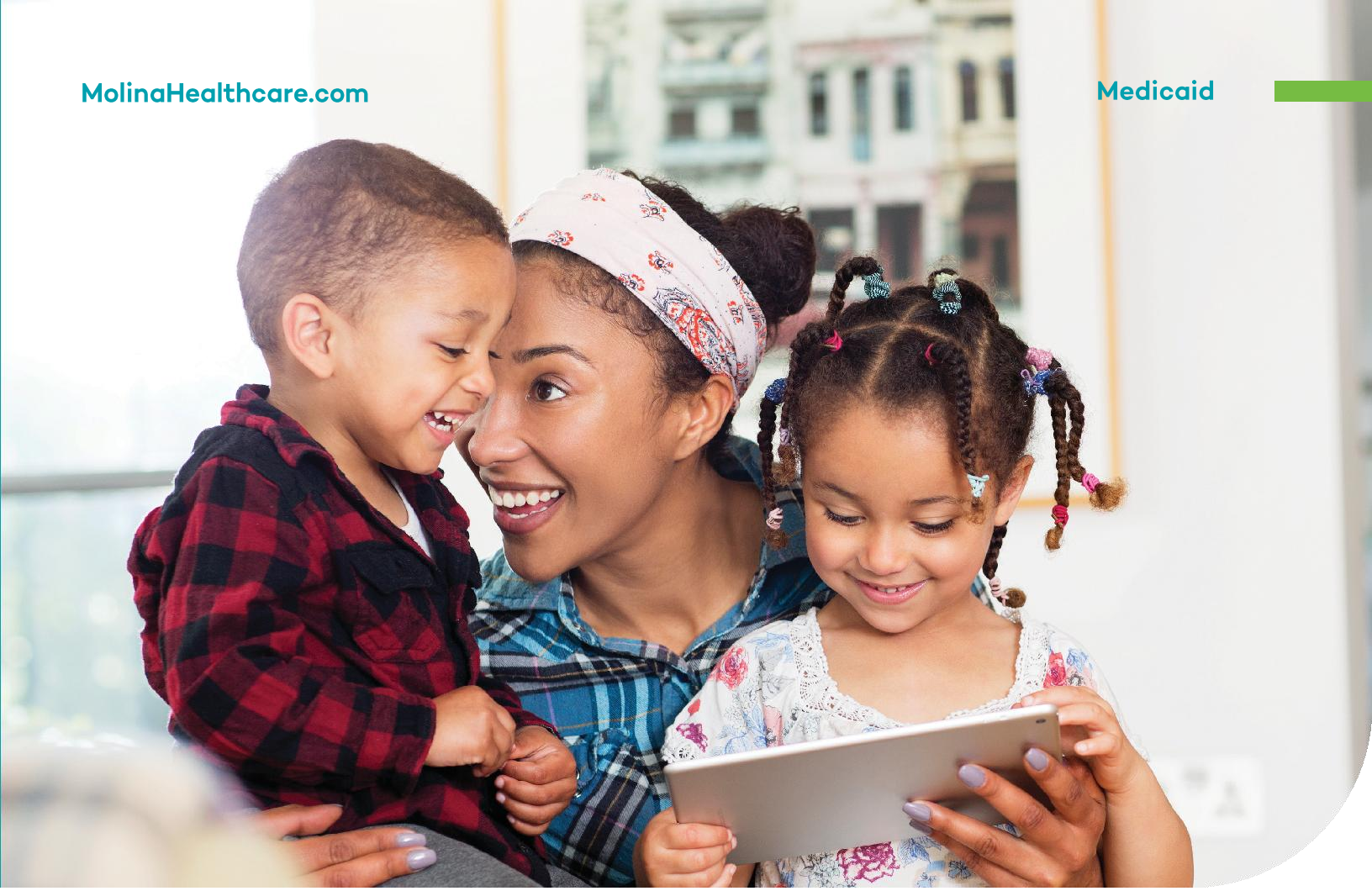


Children's Medical Services (CMS) Plan operated by Molina Healthcare Member Handbook

CMS – Medicaid Title 19

Children's Medical Services Plan
BY MOLINA HEALTHCARE

Questions? Call Member Services at (800) 262-0750 or TTY at 711

If you do not speak English, call us at (800) 262-0750 (TTY: 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.

Si usted no habla inglés, llámenos al (800) 262-0750 (TTY: 711). Ofrecemos servicios de interpretación y podemos ayudarle a re- sponder preguntas en su idioma.También podemos ayudarle a encontrarun proveedor de salud que pueda comunicarse con usted en su idioma.

Si vous ne parlez pas anglais, appelez-nous au (800) 262-0750 (TTY: 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 communiqueravec vous dans votre langue.

Si ou pa pale lang Anglè, rele nou nan (800) 262-0750 (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 yonpwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a.

Se non parli inglese chiamaci al (800) 262-0750 (TTY: 711). Disponiamo di servizi di interpretariato esiamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti atrovare un fornitore di servizi sanitari che parli la tua lingua.

Если вы не разговариваете по-английски, позвоните нам по номеру (800) 262-0750 (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

Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi theo số (800) 262-0750 (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	(888) 275-8750 Nurse Advice Line (800) 262-0750 Member Services	Available 24 hours Monday to Friday 8:00 a.m.–7:00 p.m. local time
Member Services Help Line TTY	(866) 735-2922 Nurse Advice Line 711 Member Services	Available 24 hours Monday to Friday 8:00 a.m.–7:00 p.m. local time
Website	**www.MolinaHealthcare.com/Members/CMS**	
Address	Children's Medical Services (CMS) Plan by Molina Healthcare Westside Plaza I, Ste 120A, 8400 NW 33rd St Doral, FL. 33122	

Service	Contact Information
Transportation Services: Non-Emergency	MTM Health (844) 399-9469 (TTY: 711) Available 24 hours
Dental (Benefits are offered through your Medicaid Dental Plan)	Contact your Care Manager directly or at (800) 262-0750 (TTY: 711) for help arranging these services
Vision	iCare (800) 262-0750
Laboratory	Quest Diagnostics To find locations near you, call (866) 697-8378
Over-the-Counter	OTC Health Solutions (888) 628-2770, TTY: (877) 672-2688

Service	Contact Information
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	(800) 96-ABUSE (800-962-2873) TTY: 711 or (800) 955-8771 **https://www.yflfamilies.com/services/abuse/abuse-hotline/how-report-abuse**
For Medicaid Eligibility	(866) 762-2237 TTY: (800) 955-8771 **https://www.myflfamilies.com/medicaid#ME**
To report Medicaid Fraud and/or Abuse	(888) 419-3456 **https://apps.ahca.myflorida.com/mpi-complaintform/**
To file a complaint about a health care facility	(888) 419-3456 **http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml**
To request a Medicaid Fair Hearing	(877) 254-1055 (239) 338-2642 (fax) **MedicaidHearingUnit@ahca.myflorida.com**
To file a complaint about Medicaid services	(877) 254-1055 TDD: (866) 467-4970 **http://ahca.myflorida.com/Medicaid/complaints/**
To find out information about domestic violence	(800) 799 SAFE ((800) 799-7233) TTY: (800) 787-3224 **http://thehotline.org/**
To find information about health facilities in Florida	**https://quality.healthfinder.fl.gov/**
To find information about urgent care	Nurse Advice Line (888) 275-8750 Available 24 hours or locate your nearest Urgent Care Center at **https://molina.sapphirethreesixtyfive.com/?ci=fl-medicaid&locale=en_us**
For an emergency	9-1-1 Or go to the nearest emergency room
For a Behavioral Health emergency	988

Table of Contents

Welcome to Children's Medical Services (CMS) Plan by Molina Healthcare

Children's Medical Services (CMS) Plan by Molina Healthcare 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 (or your child) are enrolled in our SMMC plan. This means we will offer you (or your child) Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services you (or your child) 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 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.

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 (800) 262-0750 (TTY: 711), Monday – Friday, 8:00 a.m. – 7:00 p.m. local time.

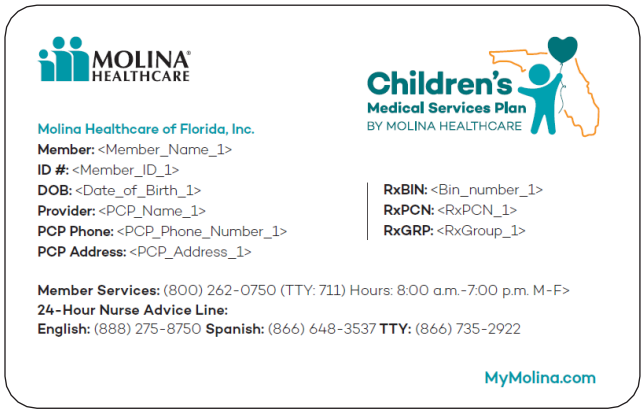
Section 1: Your Plan Identification Card (ID Card)

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

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

The ID card will look like this:

FRONT



BACK

Section 2: Your Privacy

Your privacy is important to us. You have rights when it comes to protecting your (or your child's) 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 (or your child) that is not allowed by law.

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

Your Protected Health information

PHI means protected health information. PHI is health information that includes your name, member number or other identifiers, and is used or shared by CMS Plan.

Why does CMS Plan use or share our Members' PHI?

- To provide for your (or your child's) treatment
- To pay for health care
- To review the quality of the care you get
- To tell you about your choices for care
- To run our health plan
- To use or share PHI for other purposes as required or permitted by law.

When does CMS plan need your written authorization (approval) to use or share your PHI?

The CMS Plan needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

- To look at your (or your child's) PHI
- To get a copy of your PHI
- To amend your PHI
- To ask us to not use or share your PHI in certain ways
- To get a list of certain people or places we have given your PHI

How does the CMS Plan protect your PHI?

The CMS Plan uses many ways to protect PHI across our health plan. This includes PHI in written word, spoken word, or in a computer. Below are some ways the CMS Plan protects PHI:

- The CMS Plan has policies and rules to protect PHI.
- The CMS Plan limits who may see PHI. Only the CMS Plan staff with a need-to-know PHI may use it.
- The CMS Plan staff is trained on how to protect and secure PHI.
- The CMS Plan staff must agree in writing to follow the rules and policies that protect and secure PHI.
- The CMS Plan secures PHI in our computers. PHI in our computers is kept private by using firewalls and passwords.

What must the CMS Plan do by law?

- Keep your PHI private.
- Give you written information, such as this on our duties and privacy practices about your PHI.
- Follow the terms of our Notice of Privacy Practices.

Call or write the CMS Plan and complain.

- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way. The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. It is on our web site at: **MolinaHealthcare.com/members/CMS**. You may also get a copy of our Notice of Privacy Practices by calling our Member Services Department at (800) 262-0750 (TTY: 711), Monday – Friday, 8:00 a.m. – 7:00 p.m. local time.

Release of Information on Sensitive Conditions

Release of information about protected and sensitive conditions and services, including psychotherapeutic services, requires your permission before we can share it with other providers. By filling out the CMS Plan Authorization to Use and Disclose Protected Health Information (AUD) form you can give us your permission. This form can be found at **MolinaHealthcare.com/members/CMS** or you can receive a copy by calling the CMS Plan Member Services Department at (800) 262-0750 (TTY: 711), Monday – Friday, 8:00 a.m. – 7:00 p.m. local time.

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all your questions. We can help you choose or change your (or your child's) 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 (800) 262-0757 or TTY 711, Monday to Friday, 8:00 a.m. to 7:00 p.m. local time, 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 the CMS Plan Member Services.)

Contacting the CMS Plan Member Services after Hours

If you call when we are closed, you may call our 24-Hour Nurse Advice Line at: (888) 275-8750 for English, (866) 648-3537 for assistance in other languages and TTY (866) 735-2922. 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 (or your child) 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 CMS Plan Member Services phone number. It is (800) 262-0750. 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 (or your child's) 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 (or your child's) name, address, county, or telephone number changes as well. Call DCF toll free at (866) 762-2237 (TTY (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 (800) 772-1213 (TTY

(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 (your child) as an enrollee, it is the plan's responsibility to inform you at least 30 days before the intended effective date of change.

Section 7: Your Medicaid Eligibility

You (or your child) must be covered by Medicaid and enrolled in our plan for Children's Medical Services (CMS) Plan 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 health plan coverage 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 coverage has changed or if you have any questions about your child's coverage, call CMS Plan Member Services at (800) 262-0750 (TTY: 711). We can help you check on your coverage.

If you Lose your Medicaid Eligibility

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

If you have Medicare

If you (or your child) 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.

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 State's Enrollment Broker at (877) 711-3662, (TDD (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 the requirements for the program each year.

For example:

1. Are you 18, 19 or 20 years old?
2. Do you have a chronic debilitating disease or condition of one or more physiological or organ systems
3. Do you need 24-hour-per-day medical, nursing or health supervision or intervention?

If you said "yes" to all three questions, you may contact CMS Plan to request an assessment for the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

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

AGING AND DISABILITY RESOURCE CENTERS (ADRC)

PSA 1

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

PSA 2

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

PSA 3

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

PSA 4

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

PSA 5

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

PSA 6

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

PSA 7

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

PSA 8

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

PSA 9

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

PSA 10

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

PSA 11

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

Section 9: Leaving Our Plan

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 (or your child) are locked- in, call the State's Enrollment Broker to see if you would be allowed to change plans.

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

- You (or your child) receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You (or your child) 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 CMS Plan Member Services at (800) 262-0750 (TTY: 711) or the State's Enrollment Broker at (877) 711-3662 (TDD (866) 467-4970).

Removal from Our Plan (Involuntary Disenrollment)

The Agency can remove you (or your child) 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

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

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[1] For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: **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 76.

Section 10: Managing Your Care

We will assign you a Case Manager. Your Case Manager is your go-to person. He or She is responsible for coordinating your care. This means they are the person who will help you figure out what services you need and how to get them. The Case Manager will work with your providers to manage your health care.

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.

Care Coordination Support from CMS Plan Trained Staff

Our Case Managers are trained to understand the unique challenges that our CMS Plan Members face. They offer the highest quality of care. Members also get support through our team of specialists including Family Support Specialists, Education Liaisons, Early Steps Specialist, Transition Coaches, Care Coordinators, and Health Educators.

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

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 (or your child) 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 (800) 262-0750 (TTY: 711) to get a copy or visit our website at **MolinaProviderDirectory.com/FL**.

Your Case Manager can help you choose a service provider who is in our network for each of your services. Once you choose a service provider, they can contact them to begin your services. Your Case Manager will work with you, your family, your caregivers, your doctors and other providers to make sure that you (or your child's) Medicaid 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 CMS Plan 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 your CMS Plan. Contact Member Services at (800) 262-0750 (TTY: 711) for help in 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 (or your child) 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 CMS Plan Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[3]

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 CMS Plan

The Medicaid fee-for-service program is responsible for covering the following services, instead of Children's Medical Services (CMS) Plan 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

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.sh tml 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 (877) 711-3662 (TDD (866) 467-4970). The State's Enrollment Broker will help you find a provider for these services.

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

Section 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

If you (or your child) 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 (or your child) 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 (or your child) 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 CMS Plan Member Services.

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.

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

You do not need a referral for well child visits with in-network providers. Also, there is no charge for well child visits.

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.

Access to Integrated Care through Patient-Centered Medical Homes / Behavioral Health Homes

If you (or your child) have multiple health issues like asthma, diabetes, cardiovascular disease, cerebral palsy, sickle cell disease, you may benefit from having a provider that offers comprehensive care. Centered Medical Hom or a health home clinic offered by a children's hospital. Talk with your CMS Plan Case Manager to learn more.

Specialist Care and Referrals

Sometimes, you may need to see a provider other than your (or your child's) 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.

Make sure you tell your care manager about your **referrals**. The care manager will work with the specialist to get your child care.

Second Opinions

You have the right to get a **second opinion** about your (or your child's) 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 (or your child's) PCP, care manager or CMS Plan 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 (or your child's) 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 (or your child) need Urgent Care after office hours and you cannot reach your PCP, call our 24-hour Nurse Advice Line at (888) 275-8750 for English, (866) 648-3537 for assistance in other languages and (866) 735-2922 for TTY. Our nurses are available to help you 24 hours a day, seven days a week.

You may also find the closest Urgent Care center to you by contacting Member Services or visiting our website: **MolinaProviderDirectory.com/FL**.

Hospital Care

If you (or your child) 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 care manager, they will work with you and your provider to put services in place when you (or your child) go home from the hospital.

Emergency Care

You have an **emergency** medical condition when you (or your child) 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 (or your child's) 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 CMS Plan 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 website at **https://ahca.myflorida.com/medicaid/prescribed-drugs/medicaid-pharmaceutical-therapeutics-committee/florida-medicaid-preferred-drug-list-pdl** 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

Specialty drugs are used to treat complex conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often need special care. Certain drugs may not be available at every pharmacy. They are only available through a specialty pharmacy. Molina's contracted specialty pharmacies are CVS Caremark Specialty and Publix Specialty Pharmacy. If you do not want to use the assigned specialty pharmacy or if you have any questions, please call CMS Plan Member Services at (800) 262-0750 (TTY: 711), Monday – Friday, 8:00 a.m. – 7:00 p.m. local time.

Behavioral Health Services

There are times when you (or your child) 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 (or your child) 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 (or your child) may be facing. You can call a behavioral health provider for an appointment. You can get help finding a behavioral health provider by:

- Talking with your CMS Plan Case Manager
- Calling CMS Plan Member Services
- Looking at our provider directory
- Going to our website: **MolinaProviderDirectory.com/FL**

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

You do not need a referral from your (or your child's) PCP for behavioral health services.

If you (or your child) are thinking about hurting yourself or someone else, call 9-8-8 or 9-1-1. 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 (or your child's) PCP if you can. Follow up with your (or your child's) provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you (or your child's) to a hospital or provider that is in our plan's network once you (or your child's) 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:

CMS Plan Healthy Behavior Program	Incentive/Reward
Child Well Visit	• **$20 gift card** for completion of a well care child/adolescent visit by December 31. *(once per calendar year)*
Diabetes Program	• **$20 gift card** for completing HbA1c blood test and receiving a result under 7.5% and completing of a Diabetic Retinal Eye Exam by December 31 *(for members 18 years of age and older; one per calendar year and **both** services must be completed)*
Depression and Suicide Prevention Program	• **$25 gift card** for completion of initial 12-week program; and another **$25 gift card** for completion of a follow-up appointment with a behavioral health provider within 30 days of a positive PHQ-A depression screen.
Healthy Beginnings Maternity Program Incentive	• **$20 gift card** after attending a prenatal visit in 1st trimester or within 42 days of enrollment; and completing another prenatal visit during the 2nd trimester. • **$20 gift card** for attending a postpartum visit 7-84 days after delivery.

CMS Plan Healthy Behavior Program	Incentive/Reward
	• **$10 gift card** after attending a prenatal dental cleaning visit.
Healthy Weight Program	• **$25 gift card** for completion of initial 12-week program; and another **$25 gift card** if enrollee achieves a clinically meaningful weight goal during the 12-week program.
Substance Abuse Program	• **$25 gift card** for completion of initial 12-week milestone; and another **$25 gift card** for completion of a 24-week milestone.
Tobacco Prevention and Cessation Program	• **$25 gift card** for completion of initial 12-week program; and another **$25 gift card** after 6 months of confirmed tobacco/vaping abstinence.

Please remember that rewards cannot be transferred. If you (or your child) 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 talk to your CMS Plan Case Manager or call us at (800) 262-0750 (TTY: 711).

Chronic Disease Management Programs

We have special programs available that will help you (or your child). These programs support healthy growth and development through specialized education and care coordination. We offer programs for the following:

- Asthma
- Behavioral health (including depression, mental illness, and substance use)
- Cancer
- Cardiovascular Disease
- Celia Disease
- Diabetes
- End of life issues including palliative care
- Gene Therapy
- Hemophilia
- HIV
- Irritable Bowel Disease
- Kidney Disease
- Obesity
- Sickle Cell
- Transplants

Please talk with your CMS Plan Case Manager or call (800) 262-0750 (TTY: 711) for more information.

Quality Enhancement Programs

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

- Children's Program
- Domestic Violence Program
- Pregnancy Prevention Program
- Prenatal/Postpartum Program
- Behavioral Health Programs
- Smoking Cessation Program (including vaping and chewing tobacco)
- Substance Abuse Program

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 CMS Plan 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[4].

There may be some services we do not cover but might still 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 (877) 254-1055. If you need a ride to any of these services, we can help you. You can call MTM Health at (844) 399-9469 (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 CMS Plan Member Services.

Covered Medical Services

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

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

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots	Yes
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	Yes, for transport between facilities
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	• As medically necessary and recommended by us • 3 hours per day for up to 30 days	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary	Yes
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary	No
Assistive Care Services	Services provided to adults (ages 18 and older) to help with activities of daily living and taking medication	We cover 365/366 days of service per year as medically necessary	Yes
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors	We cover recipients under the age of 21 years requiring medically necessary services	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Behavioral Health Assessment Services	Services used to detect or diagnose mental illness and behavioral health disorders	We cover as medically necessary: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0-18) enrolled in a DCF program	We cover 365/366 days of services per year as medically necessary, including therapy, support services and aftercare planning	Yes
Behavioral Health Therapy Services	Individual and group therapy for persons with a mental health condition by a mental health professional	Up to 104 units of individual therapy per year and 156 units of group therapy	No
Brief Strategic Family Therapy	Target is families with children under 18 years of age who display or are at risk for developing problem behaviors including: drug use and dependency, antisocial peer associations, bullying, or truancy	12-16 weekly sessions	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
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	No, in office setting
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	No
Child-Parent Psychotherapy	Designed to strengthen the relationship between a young child (0-5 years of age) and their parent or primary caregiver while addressing emotional, behavioral, and developmental difficulties related to trauma, attachment disruptions, or other adverse experiences	52 sessions	No
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: • Up to 24 visits per year, per member • X-rays	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Clinic Services	Health care services provided in a county health department, federally qualified heath center, or a rural health clinic	We cover as medically necessary	No
Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	• As medically necessary and recommended by us • Per diem, 8-10 hours of treatment per week for 2 – 4 months	Yes
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No, but if a continued stay then Yes
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 treatment • Peritoneal dialysis treatments	No
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	Yes

Covered Medical Services

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 Member Services for more information	Yes
Early Intervention Services	Services to children ages 0-3 who have developmental delays and other conditions	We cover as medically necessary: • One initial evaluation per lifetime, completed by a team • Up to 3 screenings per year • Up to 3 follow-up evaluations per year • Up to 2 training or support sessions per week	No
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover as medically necessary: • One adult health screening (check-up) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facility • Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover as medically necessary: • Up to 26 hours per year	No
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	Yes
First Episode Psychosis	First Episode Psychosis (FEP) early intervention services are coordinated recovery-oriented behavioral health services designed to identify, assess, and treat adolescents and you adults experiencing a first episode of psychosis	8-10 hours per week for 2 to 4 months	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Functional Family Therapy	Family intervention program for at-risk youth and their families; Target is children 11-18 years with behavioral or emotional challenges	Sessions last approximately 3 to 6 months	Yes
Gastrointestinal Services	Services to treat conditions, illnesses or diseases of the stomach or digestion system	We cover as medically necessary	No
Genitourinary Services	Services to treat conditions, illnesses or diseases of the genitals or urinary system	We cover as medically necessary	No
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover as medically necessary: • Up to 39 hours per year	No
Healthy Families	Promotes healthy parent-child interaction and attachment, increasing knowledge of child development, improving access to and use of services, and reducing social isolation. Target is parents of children under 5 years of age	Approximately 2 to 3 years of services	Yes
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 aids per ear, once every three years • Repairs	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
HomeBuilders	This program is a home and community-based intensive family preservation services treatment program designed to avoid unnecessary placement of children and youth into foster care, group care, psychiatric hospitals, or juvenile justice facilities; Target is families with children under 18 years of age	Approximately 40 hours	Yes
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover when medically necessary: • Up to 4 visits per day for pregnant recipients and recipients ages 0-20 • Up to 3 visits per day for all other recipients	Yes
Hospice Services	Medical care, treatment and emotional support services for people with terminal illnesses or who are 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 • Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility or in a nursing facility	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Housing Assistance		1 unit = 15 minutes; H0043 limited to 30 days over 180-day period; H2015 344 units per month or 48 units per day	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover as medically necessary: • Up to 26 hours per year	No
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us	Yes
Inpatient Detoxification Hospital Care	Room and board – semi-private two beds	365 days for under 21 and 45 days for over 21, not inclusive of emergency days or days under the Marchman Act	Yes
Inpatient Hospital Services	Medical care that you get while you are in the hospital; this can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation when medically necessary: • Up to 365/366 days for recipients ages 0-20	Yes
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or disease	Covered as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary	No
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	No
Medication Assisted Treatment Services	Services to help people who are struggling with drug addiction	Covered as medically necessary	Yes
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary	No
Mental Health Intensive Outpatient Program (IOP)	Intensive outpatient treatment, 3 hours per day, 3 times days per week	As medically necessary and recommended by us	Yes
Mental Health Partial Hospitalization Program Services	Treatment provided in a hospital for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us	Yes
Mental Health Targeting Case Management	Services to get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	Covered as medically necessary and recommended by us	No

Covered Medical Services

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	Yes
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	overed as medically necessary	No
Non-Emergency Transportation Services	Transportation to and from all 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	Yes, with exceptions; contact MTM Health for more info
Nurse Family Partnership	Promotes women's health, pregnancy outcomes, early childhood development, and parenting capacity; Target is first-time mothers who are pregnant or have a child under 2 years of age	Weekly services	Yes
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	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
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 the 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 five years We cover for people of all ages as medically necessary: • Follow-up wheelchair evaluations; one at delivery and one 6-months later	Yes
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary	Yes
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	No, in office settings

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
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	Yes
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	Covered as medically necessary	No
Parents as Teachers	Teaches parents skills intended to promote positive child development and prevent child maltreatment; Target is expectant parents and parents with children up to 5 years of age that are in high-risk environments such as teen parents	1 to 2 monthly sessions	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Parent-Child Interaction Therapy	Focuses on decreasing child behavior problems (e.g., defiance, aggression), increasing child social skills and cooperation and improving the parent-child attachment relationship; Teaches parents traditional play-therapy skills to use as social reinforcement of positive child behavior and traditional behavior management skills to decrease negative child behavior; Target is families with children ages 2-7 years of age	Up to 52 weekly sessions	No
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: • 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 evaluation; one at delivery and one 6-months later	Yes
Podiatry Services	Medical Care and other treatments for the feet	We cover as medically necessary: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging of the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
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 34-day supply of drugs per prescription • Refills as prescribed	Yes
Private Duty Nurse Services	Nursing services provided in the home to people ages 0-20 who need constant care	We cover as medically necessary: • Up to 24 hours per day	Yes
Partners in Care: Together for Kids (PIC:TFK) program	Pediatric palliative care support services for a set number of children who have been diagnosed with potentially life-limiting conditions and have been referred for PIC:TFK services by their primary care provider or specialty physician. Participation in PIC:TFK is voluntary. Children receiving PIC:TFK services can choose to enroll in another MMA plan; however, if they do so, they will relinquish their PIC:TFK services Please talk with your Case Manager to see if services are available in your county.	PIC:TFK services include: • Support Counseling • Expressive Therapies • Respite Support • Hospice Nursing Services • Personal Care • Pain and Symptom Management • Bereavement Services • Volunteer Services To participate in PIC:TFK, you (or your child) must receive at least two (2) different PIC:TFK services during each three (3) month period.	Must be referred for PIC:TFK services by the child's primary care physician or specialty physician as specified in s. 409.912(11), F.S. Enrollees receiving PIC:TFK must be reauthorized annually as medically eligible for the PIC:TFK program

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Psychological Testing Services	Test used to detect or diagnose problems with memory, IQ or other areas	We cover as medically necessary: • 10 hours of psychological testing per year	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life; they include help with basic activities such as cooking, managing money and performing household chores	We cover as medically necessary: • Up to 480 hours per year	Yes
Qualified Residential Treatment Program Services	Services for children to provide community-based, residential, and behavioral health treatment	We cover as medically necessary for members under the age of 18	Yes
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans; they also include portable x-rays	Covered as medically necessary	Yes
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospital that have special care centers to handle serious conditions	Covered as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
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 as 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.	No
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover as medically necessary: • Respiratory testing • Respiratory surgical procedures • Respiratory device management	No

Covered Medical Services

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 as medically necessary: • One initial evaluation per year • One Therapy re-evaluation per six months • Up to 210 minutes of therapy treatment per week (maximum of 60 minutes per day)	Yes
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	No
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance abuse disorders	We cover as medically necessary: • Assessments • Foster care services • Group home services	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Speech-Language Pathology Services	Services that include tests and treatments to help you talk or swallow better	We cover the following services as medically necessary 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 services as medically necessary for adults: • One communication evaluation per 5 years	Yes
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	Yes
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance abuse	As medically necessary and as recommended by us	Yes
Substance Abuse Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance abuse	Covered as medically necessary and recommended by us	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Substance Abuse Short-Term Residential Treatment Services	Treatment for people who are recovering from substance abuse disorders	As medically necessary and as recommended by us	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover as medically necessary • Up to 9 hours per month	Yes
Transplant Services	Services that include all surgery and pre- and post-surgical	Covered as medically necessary	Yes
Trauma-Focused Cognitive Behavioral Therapy	Behavioral health treatment designed to address trauma-related emotional and behavioral difficulties in children and adolescents 3 to 18 years of age	12 to 18 weeks	No
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following 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 21 and older • Contact lenses • Prosthetic eyes	No
Visual Care Services	Services that test and treat conditions, illnesses and disease of the eyes	overed as medically necessary	No

Your Plan Benefits: Expanded Benefits

Expanded benefits are extra goods or services we provide to you (your child), free of charge. Talk to your Case Manager or call Member Services to ask about getting expanded benefits.

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Adaptive / Safety Devices	Items to help members move around the home	As medically necessary for services in excess of Medicaid coverage	Yes
Bed Hold Days	Bed hold days refer to the duration for a member's nursing facility bed is held during their absence due to hospitalization	For residential setting: Maximum of fourteen (14) days per hospitalization; enrollee must return to the facility / setting; enrollee must reside in the facility for a minimum of thirty (30) days between episodes.	Yes
Biometric Equipment	Devices to monitor blood pressure or weight	We cover: • One digital blood pressure cuff every three years OR • One weight scale every three years	Yes
Cellular Phone Program	Service coverage for SafeLink phone	Unlimited text mes saging, data, and calls	No

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Clothing/ Equipment Allowance	Clothing, equipment, and/or tools to facilitate employment or further education (interview, required uniform/footwear, required tools or equipment), or participation in organized sporting activities (uniform, equipment, footwear).	Up to $50 per member (lifetime maximum). Services must not be subsidized or reimbursable through another source.	Yes
Collaborative Care	Covers your PCP providing active collaborative care management with your behavioral health providers	Unlimited	No
Diapers for New Moms	After live-delivery, diapers for new moms. Must sign up for this benefit through Case Management within 30 days of becoming pregnant, or becoming a member, whichever is later	One case per month for up to six months following baby's birth	Yes
Doula Services	Prenatal, postpartum and assessments and/or education in your home along with labor support visit	We cover: • Up to eight classes/education sessions per pregnancy • One labor support during delivery per pregnancy	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Durable Medical Equipment and Supplies - sensory toys, items, or calming aids	Choice of sensory toys, items, or calming aids	Up to $250 per member (lifetime maximum) towards choice of sensory toys, items, or calming aids for members on the iBudget Waiver or Waitlist, or diagnosed with Autism Spectrum Disorder	Yes
Durable Medical Equipment and Supplies - Wigs, medical makeup, and adaptive clothing	For members who have hair loss due to a medical condition or treatment, have visible scarring which limits their engagement or participation in activities, or require adaptive clothing due to mobility restrictions or aids to improve independence or quality of life	Limited to one package per year, per member based on qualifying condition	Yes
Fitness Benefit	Access to fitness facilities	Up to $60 per month, per household. Services must not be subsidized or reimbursable through another source.	Yes
Home Care - Carpet Cleaning	Carpet cleaning service	Up to 2 carpet cleanings per household, per household for members diagnosed with asthma or those receiving private duty nursing services	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Home Care - High Efficiency Particulate Air (HEPA) Air Filter	HEPA air filter to remove pollutants from member's bedroom	One HEPA air filter every five years and one replacement filter every three months for members who are diagnosed with asthma or those receiving private duty nursing services	Yes
Home Care - HEPA Filter Vacuum Cleaner	Vacuum cleaner with a HEPA filter to remove pollutants	One vacuum cleaner for primary residence every five years for members diagnosed with asthma or those receiving private duty nursing services	Yes
Home Care - Hypoallergenic Bedding	Hypoallergenic sheets and pillowcases	Up to two sets for members diagnosed with asthma or those receiving private duty nursing services	Yes
Home Care - Pest Control	Pest control services	Up to $500 per household per year for members who are diagnosed with asthma or those receiving private duty nursing services	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Home Delivered Meals – Disaster Preparedness / Relief	Shelf-stable meals delivered to member's hom e during state of emergency	One delivery annually of two meals per day for 14 days (28 meals total)	Yes
Home Delivered Meals – Change in Condition	Home-delivered meals when there is a change in member's condition or housing or caregiver disruption	Up to three meals per day for 8 weeks	Yes
Home Delivered meals – Post-Facility Discharge	Home-delivered meals when leaving the hospital or nursing facility	Up to three meals per day for 30 days	Yes
Hospital-grade Breast Pumps	Rented hospital-grade breast pump	One pre pregnancy	Yes
Meals - Non-emergency Transportation Day-Trips	Meal allowance for long-distance medical-related trips	• Up to $20 per meal. up to 3 meals per day • Up to $200.00 per day • Up to $1,000.00 per year for trips greater than 100 miles.	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Medically Tailored and Culturally appropriate meals	Home-delivered meals for members who are pregnant	We cover: • Up to three meals per day for up to eight weeks per calendar year and pregnancy for members with high-risk pregnancy • Up to three meals per day for up to four weeks per calendar year and pregnancy for members not at high risk • Up to three meals per day for the duration of the pregnancy and for three months post-partum for members who have transitioned out of the child welfare system and are living independently	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Medication Safety Kit	Provides controlled access to critical medications	One kit per member when member is prescribed ongoing medication that may present a hazard to minors in the home if the medication were accessible	Yes
Mother and Baby Items -Baby Essentials	Provides non-medical infant essentials that support newborn care and safe sleep, including baby bottles, bassinet covers and sheets, diaper bags, baby carrier, basic baby clothing, baby toiletries and other individualized needs upon review	Up to $500 per member, per baby born while enrolled with the Plan	Yes
Newborn Circumcision	Circumcision Neonate	• One per lifetime (maximum age is 31 days)	No

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Over-the-counter (OTC) benefit	Pharmacy over-the- counter medicines and health-related products	We cover: • Up to $65 per household, per month for non-pregnant members • Up to $70 per household, per month for pregnant members • Up to $65 per member, per month for members who receive private duty nursing or are in child welfare living in a foster home • Up to $65 per member, per month for members who have aged out of foster care and are living independently Limited to approved list of products from a Plan-approved vendor	No

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Respite Care Services	This service lets your caregivers take a short break/ you can use this service in your home, on assisted living facility or in a nursing facility	We cover: • 200 hours of in-home respite • 10 days of out-of-home respite Must not receive respite services through a Florida Medicaid covered service/waiver	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Service / Therapy Animal Benefit	Financial help for service animals	Up to $5,000 total per member aged 6-20 yrs old (lifetime maximum) which may be paid over multiple years to active members. Limited to members diagnosed with a clinical condition that limits safe mobility or independence (e.g., blindness, seizure disorders) for training or maintenance of an animal that performs specific tasks and is trained and certified through a service animal training organization. Excludes emotional support animals.	Yes
Swimming Lessons (Drowning Prevention)	Basic swimming or water safety lessons specifically for drowning prevention	Up to eight lessons	Yes

Medical and Behavioral Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Vision Flex Card and Visual Aid	Provides assistance with frames and lenses	$50 per member who receives eyeglasses as a covered service Coverage limited to the purchase of non-covered frames or accessories when eyeglasses are being dispensed as a covered service. Limit two polycarbonate lenses per year.	Yes

Caregiver Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Caregiver Education	Provides educational resources for member's caregiver	Online access for one caregiver or family access for multiple caregivers	Yes
Caregiver Support	Provides access to programs to address behavioral health needs of member's caregivers	Access to Molina support applications for social isolation, BH support, peer support such as BeMe and Pyx for each family member who serves as a caregiver	Yes

Caregiver Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Legal Guardianship	Legal guardianship can help protect individuals who are unable to make decisions for themselves that are in the best interest of their health and well-being	Up to $500 per member (lifetime maximum) must be between 17 and 20 years old	Yes
Non-Medical Transportation for a Caregiver	Transportation for Plan-defined covered trip reasons, such as job interviews, volunteering, or attending support groups	Up to ten one-way trips for non-medical purposes, per month, per enrollee, for Plan-defied covered trip reasons Benefit is not applicable if family has access to a vehicle	Yes
Therapy Sessions for Caregivers	Individual therapy sessions for member's primary caregiver	As needed	Yes

Special Programs

Service	Description	Coverage / Limitations	Prior Authorization
Fuel Subsidy for Family Home Health Aides	Funding assistance to encourage family members who do not live in the same household as a member receiving private duty nursing services to perform Home Health Aide services.	One-time $250 gas subsidy	Yes

PDN - Community Support Toolkit	Incentives to promote and facilitate member's timely discharge from a nursing facility and maintain the member in the community with medically necessary private duty nursing services	We cover: • Up to $75,000 to help a member transition from a nursing facility to home. Examples include home adaptations, transportation needs, homewares, housing stability, and non-covered items to facilitate transition and maintain the member in the home environment. • Up to $25,000 to help a member stay in the home setting. Examples include home adaptations, transportation needs, homewares, housing stability, family stability, and non-covered items to maintain the member in the home environment. • Up to $500 per year to support times of transition or intense needs to help maintain the member in the home for convenience and entertainment services. Examples include meal delivery, cleaning service, streaming services, snacks/treats for minor children, books or games for minor children. • One full house cleaning service per month. • Up to five hours per month to help with household chores and interim cleaning when the member's needs exceed family abilities	Yes

Special Programs

Service	Description	Coverage / Limitations	Prior Authorization
		This benefit may not duplicate any other assistance benefit received	
SIPP Community Support Toolkit	Incentives to promote and facilitate member's timely discharge from a SIPP facility and maintain the member in the community	We cover: • Up to $500 per year to support the family during times of transition or intense needs to help maintain the member in the home for convenience and entertainment services. Examples include meal delivery, cleaning service, streaming services, snacks/treats for minor children, books or games for minor children. • Up to $5,000 per member (lifetime maximum) to help a member transition home from a SIPP. Examples include home adaptations, transportation needs, homewares, housing stability, family stability, and non-covered items required to transition the member to the home environment.	Yes

Your Plan Benefits: Pathways to Prosperity

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

Pathway to Prosperity Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Criminal Expungement Support	Criminal Expungement Support	Up to $75 per member (lifetime maximum) for criminal expungement fees	Yes
Disaster Relief Benefits - Housing Assistance Post-disaster	Financial assistance post-disaster event to cover things such as meals or groceries, cleaning supplies, storage or moving supplies, emergency clothing, emergency fuel, emergency hotel or boarding	Up to $500 when member is or may be displaced from the primary residence post disaster. Funding amount will be determined based on need when alternate relief options are not available.	Yes
Emergency Preparedness Kit	Emergency supplies	We cover: • One emergency kit per household • One damage resistant/proof storage receptacle for household per lifetime	Yes

Pathway to Prosperity Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Family Support Services – Child Care Assistance	Assistance with childcare for members who have given birth so them may attend job interviews, education/training opportunities, or activities that will help the member obtain or maintain independence/ prosperity to benefit their household.	Up to $2,000 per member (lifetime maximum) who has given birth and is the custodial parent for the child when they do not have access to childcare	Yes
Food Assistance	Funding to purchase healthy food at the grocery store when the member does not have adequate access to food supplies to maintain a healthy lifestyle	We cover: • Up to $250 per household (lifetime maximum) for emergency food support • Up to $1,000 (lifetime maximum) per member who has aged out of the child welfare system and who is living independently	Yes
GED Preparation	GED preparation course reimbursement	Up to $10 for online prep classes per member (lifetime maximum)	Yes

Pathway to Prosperity Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Housing Assistance – Child Welfare	Financial help to support members aging out of the child welfare system	We cover: • Up to $2,500 per member (lifetime maximum). Excludes members receiving private duty nursing who are eligible for the PDN Community Support Toolkit • Up to $2,500 per member (lifetime maximum) who is transitioning or has transitioned to living independently in their own primary residence having aged out of the child welfare system • Up to an additional $3,000 to help maintain housing stability when member experiences housing insecurity	Yes
Internet Access	Home internet for members who are aging out of the child welfare system so they can continue their education or maintain employment	Monthly internet service for members who are aging out of the Child Welfare system and are living independently in their own home. Member must be actively enrolled in school, higher education, training course, or seeking or maintaining employment.	Yes

Pathway to Prosperity Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Life Skills Development	For children or adolescents with a diagnosed development disability to provide life skills development that help the child or adolescent keep, learn or improve skills and functioning for daily living	Up to 160 hours per calendar year. These services will be provided in the home or outpatient setting.	Yes
Non-Medical Transportation	Transportation for Plan-defined covered trip reasons, such as grocery shopping, family leisure activity, child sports/ activities	We cover: • Up to ten round trips per month, per household • Up to 20 round trips per month, per household when member is receiving private duty nursing services and personal transportation is not available Transportation provided by rideshare unless member is present and requires special transportation	Yes
School Supply Assistance – School Supply Stipend	Choice of up to four school supply items per school year	Limit one kit per member per school year	Yes

Pathway to Prosperity Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Tutoring Educational Supports, Vocational Training and/or Job Readiness – Education Prep Tools	Access to study guides to support educational goals	We cover: • One self-paced study guide for Reading, English, Science, and Math for grades 1-12 • One SAT study guide Limited to one age-appropriate tool kit per member. May not duplicate materials received through tutoring benefit.	Yes
Tutoring Educational Supports, Vocational Training and/or Job Readiness – Tutoring Services	Tutoring assistance to help members obtain educational goals	We cover: • One online self-paced tutoring course for members who require assistance to obtain or maintain their educational goals OR • Up to 16 personal tutoring session (online) when the member cannot participate in self-paced tutoring	Yes
Tutoring Educational Supports, Vocational Training and/or Job Readiness – Tutoring for Higher Education	Tutoring assistance to help members obtain educational goals	We cover: • Tutoring assistances to prepare for advanced or vocational education • One self-paced online tutoring/standardized test preparation course to prepare for college or vocational school acceptance	Yes

Pathway to Prosperity Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Tutoring Educational Supports, Vocational Training and/or Job Readiness	Funds to pay non-subsidized costs associated with post-secondary education and training such as books, computer, parking or other expenses	Up to $500 per member (lifetime maximum for members enrolled in a degree or qualification conferring higher education course where no other forms of subsidy are available for the requested expense)	Yes

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: CMS Plan Helpful Information

Starting Services

It is important that we learn about you (or your child) 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 CMS Plan. She or he will also ask questions about:

- You (your child's) health
- How you take care of yourself (your child)
- Who helps take care of you (your child)
- Other things

These questions make up your initial assessment. The initial assessment helps us learn about what you need. It also helps us decide what services will help you (or your child) the most.

Developing a Plan of Care

To help you (or your child) get services under CMS Plan, you have a person and family-centered plan of care (plan of care). Your Case Manager make your (or your child's) plan of care with you. Your plan of care is the document that tells you all about the services you (or your child) can get from CMS Plan. Your Case Manager will talk to you and any family members or caregivers you want to include to decide what services will help. They will use the initial assessment and other information to make a plan that is just for you (or your child). Your (or your child's) plan of care will tell you:

- What services you (or your child) are getting
- Who is providing services (your service providers)
- 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 (or your child) need help with school, your plan of care will tell you that our School Liaison and tutoring benefits can help meet educational goals.
- How your CMS Plan services work with other services you (or your child) get from outside our Plan, such as from Medicare, your church or other programs.

Your Personal Goals

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

- Managing conditions like asthma
- Participating in school activities
- Transitioning from pediatric providers to adult care providers
- Moving from a nursing facility

Your Case Manager will send your PCP a copy of your (or your child's) plan of care. They will also share it with your other health care providers.

Updating your Plan of Care

Your Case Manager will call you to see how services are going and how you (or your child) are doing. If any changes are made, she or he will update your plan of care and get you a new copy. Remember, you can call your Case Manager any time to talk about problems you (or your child) have, changes in your (or your child's) life, or other things. Your Case Manager or a health plan representative is available to you when you need them.

Section 16: 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. (800) 262-0750 (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. Children's Medical Services (CMS) Plan Appeal and Grievance Unit PO Box 36030 Louisville, KY 40233-6030 (800) 262-0750 (TTY: 711) (877) 508-5748 (Fax) or **MFLGrievanceandAppeals Department@molinahealthcare.com** (Email)	We will: • Review your grievance and send you a letter with our decision within 30 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Children's Medical Services (CMS) Plan Appeal and Grievance Unit PO Box 36030 Louisville, KY 40233-6030 (800) 262-0750 (TTY: 711) (877) 508-5748 (Fax) or **MFLGrievanceandAppeals Department@molinahealthcare.com** (Email)	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.

	What You Can Do:	What We Will Do:
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. Children's Medical Services (CMS) Plan Appeal and Grievance Unit PO Box 36030 Louisville, KY 40233-6030 (800) 262-0750 (TTY: 711) (877) 508-5748 (Fax) or **MFLGrievanceandAppeals Department@molinahealthcare.com** (Email)	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 decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ***You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal

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

Medicaid Fair Hearings (for Medicaid Members)

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

Agency for Health Care Administration Medicaid Fair Hearing Unit
P.O. Box 7237
Tallahassee, FL 32314-7237
(877) 254-1055 (toll-free)
(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 (21) 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
(877) 254-1055 (toll free)
(239) 338-2642 (fax)
MedicaidHearingUnit@ahca.myfloriday.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 (or your child) are now getting a service that is going to be reduced, suspended or terminated, you (or your child) 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 17: 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))

Section 18: 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 care 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
- Agree to and participate in face-to-face assessments, face-to-face visits and routine telephone contact with your Case Manager.

Section 19: Other Important Information

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 (850) 413- 9969 or visit their website at **https://www.floridadisaster.org/**.

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 (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 Molina Healthcare AlertLine, which can be reached tollfree at (866) 606-3889 or you may use the service's website to make a report at any time at **http://www.molinahealthcare.com/**.

You may also report cases of fraud, waste or abuse to us by contacting Molina Healthcare of Florida's Compliance Department. You have the right to have your concerns reported anonymously without fear of retaliation.

Children's Medical Services (CMS) Plan
Attn: Compliance Department
Westside Plaza I, Ste 120A,
8400 NW 33rd St
Doral, FL 33122

Remember to include the following information when reporting:

- Nature of complaint
- The names of individuals and/or entity involved in suspected fraud and/or abuse including address, phone number, Medicaid ID number and any other identifying information.

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 (800) 96-ABUSE (800-962-2873) or for TTY/TDD at (800) 955-8771 if you are

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 tollfree at (800) 799-7233 (TTY (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.

- A Living Will
- Health Care Surrogate Designation
- 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 (800) 262-0750 (TTY: 711), or the Agency by calling (888) 419-3456.

Getting More Information

You have a right to ask for information. Call CMS Plan 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
- A free copy of the rules we used to make our decision
- Information about provider incentives

Mobile App

Plan members can download the free Molina Healthcare mobile app. It includes many helpful and educational resources including:

- Our online provider directory and "Find a Provider" tool for locating in-network doctors, hospitals, facilities, and more
- Reminders from the plan about making appointments for checkups and other medical services that will help your child stay healthy
- Your child's online Member ID card so you always have it handy for medical appointments
- Access to our 24-hour Nurse Advice Line is one touch away on our mobile app
- About Us/Contact information

You can use our mobile app anytime and anywhere. It is available for Apple and Android smartphone and tablets. Talk with your (or your child's) Care Manager for help with

downloading and using it.

Evaluation of New Technology

We study new technology each year. Plus, we look at the ways we use the technology we have now. We do this for a few reasons. They are to:

- Make sure we're aware of changes in the industry
- See how new improvements can be used with the services we provide to our members
- Make sure that our members have fair access to safe and effective care

We do this review in the following areas:

- Behavioral health procedures
- Medical devices
- Medical procedures
- Pharmaceuticals

Connecting Your (Your Child's) Healthcare: Access Your Child's Digital Health Records

The federal Interoperability and Patient Access Rule (CMS 9115 F) makes it easier for members to get their health records. You now have full access to your (your child's) health records on your mobile device. That helps you manage your (your child's) health and get services.

Imagine:

- Your (or your child) goes to a new doctor because they don't feel well. The new doctor can pull up your child's health history from the past five years.
- You use a current provider list to find a doctor or specialist.
- That doctor or specialist can use your child's health history to find out what is wrong.
- You go to your computer to see if a claim is paid, denied or still being processed.
- If you want, you take your (your child's) health history with you as you switch health plans.

The rule applies to information for dates of service on or after Jan. 1, 2016. It makes it easy to find information on your child's claims, pharmacy drug coverage, health information and providers. For more info, visit your child's Secure Member Portal account at **member.molinahealthcare.com**.

Section 20: Additional Resources

http://floridahealthfinder.gov/

The Agency is committed to its mission of providing "Better Health Care for All Floridians". The Agency has created a website **http://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**.

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.

Pathways Program is Her for You

Everyone deserves to live their best life possible. Yet a lot of things can affect your ability to do that. A phone call to our Pathways Program can match you with services. It is available for CMS Plan members and their families.

Through the Pathways Program, you can connect to a wide range of services that help you (your child) live a healthier life. Program services vary depending on where you are in your life and what your needs are, but can include:

- Financial assistance (utilities, rent)
- Medication assistance
- Housing services
- Transportation
- Food assistance
- Affordable childcare
- Job/education assistance
- Family Supplies – diapers, formula, cribs and more

CMS Plan members who disenroll due to aging out of the plan and who do not remain in another SMMC Medicaid plan are eligible to receive an additional year of access to the Pathways Program for additional supports and linkage to community-based organizations to resolve health-related social needs.

Call for the help you need at (800) 262-0750 (TTY: 711).

Section 21: Forms

1. Authorization for the Use and Disclosure of Protected Health Information
2. Appointment of Representative (AOR) Form

Authorization for the Use and Disclosure of Protected Health Information

Name of Member:_____ Member ID#: _____

Member Address:_____ Date of Birth: _____

City/State/Zip: _____ Telephone #: _____

I hereby authorize the use or disclosure of my protected health information (PHI) as described below.

1. Persons or organizations authorized to use or disclose the protected health information:

_____

_____

_____

2. Name(s) and address(es) of persons or organizations authorized to receive or use the protected health information: (please print)

_____

_____

_____

3. Specific description of the protected health information that may be used or disclosed:

_____

_____

_____

4. **Release Requiring Specific Approval:** I know my records may contain PHI about testing, diagnosis or treatment for HIV/AIDS, for any other Sexually Transmitted Diseases (STDs), for Alcohol and Drug Abuse, for Chemical Dependency, and/or for Mental Health. I will allow Molina Healthcare to disclose and/or re- disclose any and all such information, except for the information I initial below.

I don't want my health care information about testing, diagnosis or treatment for the following shared:

___ HIV/AIDS;_____Other STDs;_____Alcohol & Drug Abuse/Chemical Dependency;_____Mental Health

5. The protected health information will be used or disclosed for:

_____

_____

_____

6. I understand the following:
    a. I may revoke this authorization at any time. I can do this by telling Molina Healthcare in writing or verbally. This right does not apply to actions already taken by Molina Healthcare because of this authorization.

b. I know this authorization is voluntary and I may refuse to sign. If I refuse to sign this, it will not affect my Treatment Payment or Enrollment or eligibility for my benefits

c. I know the PHI I authorize a person or entity to receive may be re-disclosed. I know that state and federal law may no longer protect this PHI. Please see "Notice of Recipients of Alcohol and Drug Abuse Information" below.

d. I have a right to receive a copy of this authorization.

7. This authorization expires 90 days from the date of your signature unless otherwise specified below.

This authorization expires [on/upon] _____

_____ _____

Signature of Member or Member's Personal Representative

Date

_____ _____

Personal Representative's Name, if applicable (please print): _____

Relationship to Member: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney *

☐ Other Please Describe: _____

Description of Personal Representative's authority to act for the member (please print):

* Please attach legal documentation if you are the legal guardian or Holder of Power of Attorney for Healthcare Decisions.

A copy of this signed form will be provided to the Member if the authorization was sought by Molina Healthcare.

NOTICE TO RECIPIENTS OF ALCOHOL OR DRUG ABUSE INFORMATION

This information has been disclosed to you from records protected by the Federal confidentiality rules (42 CFR Part 2). The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Appointment of Representative (AOR) Form

Children's Medical Services Plan BY MOLINA HEALTHCARE

Member Name

Molina Member ID Number

Appointment of Representative

I agree to name _____

(Name and address) to be my representative with a grievance or an appeal for

_____(specific issue).

I approve this person to make or give any request or notice; present or evidence; to obtain information, including, without limitation, the release of past, present or future: HIV test results, alcohol and drug abuse treatment, psychological/psychiatric testing and evaluation information, and any other information regarding medical diagnosis, treatments and/or conditions; and to receive any notice in relation with my pending grievance/appeal.

Signature (member)

Address

Telephone Number (with Area Code)

Date

Acceptance of Appointment

I, _____ , hereby agree to the above appointment. I certify that I have not been suspected or prohibited from practice before the Social Security Administration; that I am not as a current or former officer or employee of the United States, disqualified as acting as the claimant's representative; that I will not charge or receive any fee for the representation unless it has been authorized in accordance with the laws and regulations.

I am a/an

(Attorney, union representative, relative, etc.)

Signature (member)

Address

Telephone Number (with Area Code)

Date

MOLINA® HEALTHCARE

Nondiscrimination of Healthcare Service Delivery

Molina complies with the guidance set forth in the final rule for Section 1557 of the Affordable Care Act, which includes notification of nondiscrimination and instructions for accessing language services in all significant Member materials, physical locations that serve our Members, and all Molina MMA website home pages. All Providers who join the Molina Provider network must also comply with the provisions and guidance set forth by the Department of Health and Human Services (HHS) and the Office for Civil Rights (OCR). Molina requires Providers to deliver services to Molina Members without regard to race, color, national origin, age, disability or sex. This includes gender identity, sexual orientation, pregnancy and sex stereotyping. Providers must post a non-discrimination notification in a conspicuous location of their office along with translated non-English taglines in the top fifteen (15) languages spoken in the state to ensure Molina Members understand their rights, how to access language services, and the process to file a complaint if they believe discrimination has occurred.

Additionally, Participating Providers or contracted medical groups/IPAs may not limit their practices because of a Member's medical (physical or mental) condition or the expectation for the need of frequent or high cost-care. Providers must not discriminate against members based on their payment status and cannot refuse to serve Members because they receive assistance from a State Medicaid Program

Section 1557 Investigations

Contact us at (800) 424-4518 (TTY: 711) if you need any of these services.
All Molina Providers shall disclose all investigations conducted pursuant to Section 1557 of your Protection and Affordable Care Act to Molina's Civil Rights Coordinator at:

Molina Healthcare
Civil Rights Coordinator
200 Oceangate, Suite 100
Long Beach, CA 90802
Toll Free: (866) 606-3889
TTY/TDD: 711
Online: https://molinahealthcare.AlertLine.com
Email: civil.rights@molinahealthcare.com

Please note: If you have a disability and need more help, we can help you. If you need someone that speaks your language, we can also help. You may call our Member Services Department at (800) 262-0750 for more help from 8:00 am to 7:00 pm local time. If you are blind or have trouble hearing or communicating, please call 711 for TTY/TTD services. We can help you get the information you need in large print, audio (sound), and braille. We provide you with these services for free.

Tenga en cuenta lo siguiente: si tiene una discapacidad y necesita más ayuda, podemos ayudarlo. También podemos ayudarlo si necesita a alguien que hable en su idioma. Para obtener más ayuda, puede llamar a nuestro Departamento de Servicios para Miembros al (800) 262-0750, de 8:00 a. m. a 7:00 p. m. Si es ciego o tiene problemas de audición o comunicación, llame al 711 para acceder a servicios de TTY/TDD. Podemos ayudarlo a obtener la información que necesita en letra de molde grande, audio (sonido) y en sistema Braille. Estos servicios son gratuitos.

Remake: Si ou gen yon andikap epi ou bezwen plis èd, nou kapab ede w. Si ou bezwen yon moun ki pale lang ou an, nou kapab ede w tou. Ou gendwa rele Depatman Sèvis Manm nou an nan (800) 262-0750 pou jwenn plis èd soti 8è:00 a.m. rive 7è:00 p.m. Si ou avèg oswa ou gen difikilte pou tande oswa pou kominike, tanpri rele 711 pou sèvis TTY/TTD yo. Nou kapab ede w jwenn enfòmasyon oubezwen an gwo karaktè, odyo (son) ak an Bray. N ap ba w sèvis sa yo pou gratis.

Xin lưu ý: Nếu quý vị là người khuyết tật và cần thêm trợ giúp, chúng tôi có thể giúp quý vị. Nếu quý vị cần người có thể nói ngôn ngữ của quý vị, chúng tôi cũng có thể giúp. Quý vị có thể gọi cho Bộ phận Dịch vụ thành viên của chúng tôi theo số (800) 262-0750 để được trợ giúp thêm từ 8:00 am đến 7:00 pm. Nếu quý vị bị mù hoặc có vấn đề về thính giác hoặc giao tiếp, vui lòng gọi 711 cho dịch vụ TTY/TTD. Chúng tôi có thể giúp quý vị nhận thông tin quý vị cần bằng bảng chữ in lớn, âm thanh và chữ nổi Braille. Chúng tôi cung cấp miễn phí các dịch vụ này cho quý vị.

Non-Discrimination Notification

Children's Medical Services (CMS) Plan by Molina Healthcare

Discrimination is against the law. The Children's Medical Services (CMS) Plan operated by Molina Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

CMS Plan:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact CMS Plan Member Services at (800) 262-0750 (TTY: 711).

If you believe that Molina has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
200 Oceangate, Ste 100
Long Beach, CA 90802
Phone: (866) 606-3889 (TTY: 711)
Fax: (877) 508-5738
Email: **civil.rights@molinahealthcare.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Molina Member Services is available to help you. You may obtain our grievance procedure by visiting our website at: **https://www.molinahealthcare.com/members/common/en-US/Notice-of-Nondiscrimination.aspx**.

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

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

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

Non-Discrimination Tag Line – Section 1557

Children's Medical Services (CMS) Plan by Molina Healthcare

English	ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call (800) 262-0750 (TTY: 711).
Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 262-0750 (TTY: 711).
French Creole (Haitian Creole)	ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele (800) 262-0750 (TTY: 711).
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 262-0750 (TTY: 711).
Portuguese	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para (800) 262-0750 (TTY: 711).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (866) 472-4585（TTY：711）。
French	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 262-0750 (TTY : 711).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 262-0750 (TTY: 711).
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 262-0750 (телетайп: 711).
Arabic	ةظوملحة: اذإ تكن ركذا ثدحتت غةللا، نإف تامدخ ةدعاسملا ةيوغللا رفاوتت نماجملاب لكل لتصا مقرب (866) 472-4585 (مقر فتاه مصلا مكبلاو: 711).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero (800) 262-0750 (TTY: 711).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 262-0750 (TTY: 711).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 262-0750 (TTY: 711) 번으로 전화해 주십시오.
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer (800) 262-0750 (TTY: 711).
Gujarati	**ધ્યાન: જો તમે ગુજરાતી બોલતા હો, તો ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** (800) 262-0750 (TTY: 711).
Thai	เรียน: ถาคุณพูดภาษาไทยคุณสามารถใชบริการชวยเหลือทางภาษาไดฟร โทร (800) 262-0750 (TTY: 711).

Children's
Medical Services Plan
BY MOLINA HEALTHCARE

Children's
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BY MOLINA HEALTHCARE