Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

FLORIDA MEDICAID

MEMBER HANDBOOK

Children's Medical Services (CMS) Health Plan

1-866-799-5321
TTY 1-800-955-8770
March 2025

SunshineHealth.com/CMS
CMS_9633

If you do not speak English, call us at **1-866-799-5321**. We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language.

Spanish: **Si usted no habla inglés,** llámenos al **1-866-799-5321**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: **Si vous ne parlez pas anglais**, appelez-nous au **1-866-799-5321**. Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole: **Si ou pa pale lang Anglè**, rele nou nan **1-866-799-5321**. Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a.

Italian: **Se non parli inglese** chiamaci al **1-866-799-5321**. Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua.

Russian: **Если вы не разговариваете по-английски,** позвоните нам по номеру **1-866-799-5321**. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке.

Vietnamese: **Nếu bạn không nói được tiếng Anh**, hãy gọi cho chúng tôi theo số **1-866-799-5321**. Chúng tôi có dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của quý vị bằng ngôn ngữ của quý vị. Chúng tôi cũng có thể giúp quý vị tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với quý vị bằng ngôn ngữ của quý vị.

Important Contact Information

Member Services Help Line	**1-866-799-5321**	Available 24 hours
Member Services Help Line TTY	**1-800-955-8770**	Available 24 hours
Website	**SunshineHealth.com/CMS**	
Address	P.O. Box 459089 Fort Lauderdale, FL 3345-9089	
Transportation services: non-emergency	**Medical Transportation Management (MTM)** Phone: 1-844-399-9469 (TTY: 711)	
Dental ***Benefits are offered through your Medicaid Dental Plan**	Contact your Case Manager directly or at 1-866-799-5321 for help with arranging these services	
Vision	**1-866-799-5321** (TTY: 1-800-955-8770)	
Hearing/Audiology	**HearUSA** Phone: **1-855-242-4935** (TTY: 711)	

Important Contact Information

To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	**1-800-96-ABUSE (1-800-962-2873)** TTY: **711** or **1-800-955-8771** **https://www.myflfamilies.com/service-programs/abuse-hotline/**
For Medicaid Eligibility	**1-866-762-2237** (TTY: **711** or **1-800-955-8771**) **https://www.myflfamilies.com/service-programs/access/medicaid/**
To report Medicaid Fraud and/or Abuse	**1-888-419-3456** **https://apps.ahca.myflorida.com/mpi-complaintform/**
To file a complaint about a health care facility	**1-888-419-3456** **https://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml**
To request a Medicaid Fair Hearing	**1-877-254-1055** 1-239-338-2642 (fax) **https://ahca.myflorida.com/medicaid/complaints/fair_hrng.shtml**
To file a complaint about Medicaid services	**1-877-254-1055** (TTY: **1-866-467-4970**) **https://ahca.myflorida.com/Medicaid/complaints/**

To find out information about domestic violence	**1-800-799-7233** (TTY: **1-800-787-3224**) **http://www.thehotline.org/**
To find information about health facilities in Florida	**http://www.floridahealthfinder.gov/index.html**
To find information about urgent care	Visit **FindAProvider.SunshineHealth.com** to find the urgent care center closest to you. Or call our 24-Hour Nurse Advice Line at **1-866-799-5321** (TTY: 1-800-955-8770) or our 24-Hour Behavioral Health Crisis Line at **1-866-799-5321** (TTY: 1-800-955-8770).
For an emergency	**9-1-1** Or go to the nearest emergency room
For a Behavioral Health emergency	**988**

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Welcome to Children's Medical Services Health Plan's Statewide Medicaid Managed Care Plan

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

There are many types of Medicaid services you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care from a **Managed Medical Assistance (MMA)** plan. If you are age 18 or older with a disability, you can apply to receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like AIDS, you can receive care that is designed to meet your needs in a **Specialty** plan.

This handbook will be your guide for all healthcare services available to you. You can ask us any questions or get help making appointments. If you need to speak with us, just call us at 1-866-799-5321.

Section 1: Your Plan Identification Card (ID card)

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

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

Your ID card will look like this:

(Front)

(Back)

Section 2: Your Privacy

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

If you have any questions, call Member Services. Our Sunshine Health Privacy Practices describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

For help to translate or understand this, please call 1-866-799-5321. Hearing impaired TTY 1-800-955-8770.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-866-799-5321. (TTY 1-800-955-8770).

Interpreter services are provided free of charge to you.

Covered Member Privacy Practices:

At Children's Medical Services Health Plan, your privacy is important to us. We will do all we can to protect your health records. By law, we must protect these health records.

Our Privacy Practices policy tells you how we use your health records. It describes when we can share your records with others. It explains your rights about the use of your health records. It also tells you how to use those rights and who can see your health records. This does not apply to health records that do not identify you. If one of the below reasons does not apply, we must get your written consent.

Children's Medical Services Health Plan, Operated by Sunshine Health, can change our Privacy Practices. Any changes in our Privacy Practices will apply to all the health records we keep. If we make changes, we will send you a new notice.

Please note: You will also receive a Privacy Practice Notice from Medicaid outlining its rules for your health records. Other health plans and health care providers may have other rules when using or sharing your health records. We ask that you obtain a copy of their Privacy Practices Notices and read them carefully.

How We Use or Share Your Health Records:

Below is a list of how we may use or share your health records without your consent:

- **Treatment.** We may use or share your health records with doctors or other health care providers providing medical care to you and to help manage your care. For example, if you are in the hospital, we may give the hospital your records sent to us by your doctor.
- **Payment.** We may use and disclose your Personal Health Information (PHI) to make benefit payments for the health care services provided to you. We may release your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes.
- **Health Care Operations.** We may use and share your health records to: perform our health care operations; help resolve any appeals or grievances filed by you or a health care provider with Sunshine Health or the State of Florida; or help assist others who help us provide your health services. We will not share your records with these groups unless they agree to protect your records.
- **Appointment Reminders/Treatment Alternatives.** We may use and release your health records to remind you of dates and times for treatment and medical care with us. We may also use or release it to give you information about treatment options. We may also use or release it for other health-related benefits and services. For instance, information on how to stop smoking or lose weight.

- **As Required by Law.** We may use or share your health records without your consent if any law office requires them. The request will be met when the request complies with the law. If there are any legal conflicts, we will comply with the law that better protects you and your health records.
- **Public Health Activities.** We may release your health records to a public health authority to prevent or control disease, injury or disability. We may release your health records to the Food and Drug Administration (FDA). We can do this to ensure the quality, safety or effectiveness of products or services under the control of the FDA.
- **Victims of Abuse and Neglect.** We may release your health records to a local, state or federal government authority. This includes social services or a protective services agency authorized by law to have these reports. We will do this if we have reason to believe there is a case of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings.** We may release your health records in judicial and administrative proceedings, as well as in response to an order of a court, administrative tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.
- **Law Enforcement.** We may release your health records to law enforcement, when required. For instance, a court order, court-ordered warrant, subpoena or summons issued by a judicial officer, or a grand jury subpoena. We may also release your health records to find or locate a suspect, fugitive or missing person.
- **Coroners, Medical Examiners and Funeral Directors.** We may release your health records to a coroner or medical examiner. This may be needed, for example, to decide a cause of death. We may also release your health records to funeral directors, as needed, to carry out their duties.
- **Organ, Eye and Tissue Donation.** We may release your health records to organ procurement organizations or entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissues.
- **Threats to Health and Safety.** We may use or release your health records if we believe, in good faith, that it is needed to prevent or lessen a serious or looming threat. This includes threats to the health or safety of a person or the public.
- **Specialized Government Functions.** If you are a member of U.S. Armed Forces, we may release your health records as required by military command authorities. We may also release your health records to:
    - authorized federal officials for national security
    - intelligence activities
    - the Department of State for medical suitability determinations
    - protective services of the President or other authorized persons

- **Workers' Compensation.** We may release your health records to comply with laws relating to workers' compensation or other like programs, established by law. These are programs that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations.** We may release your health records in an emergency situation, or if you are unable to respond or are not present. This includes to a family member, close personal friend, authorized disaster relief agency, or any other person you told us about. We will use professional judgment and experience to decide if the release is in your best interest. If it is in your best interest, we will release only your health records that are directly relevant to the person's involvement in your care.
- **Inmates.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official where such information is necessary for the institution to provide you with health care, to protect your health or safety, or the health or safety of others, or for the safety and security of the correctional institution.
- **Research.** In some cases, we may release your health records to researchers when their clinical research study has been approved. They must have safeguards in place to ensure the privacy and protection of your health records.

Uses and Releases of Your Health Records That Require Your Written Consent:

We are required to get your written consent to use or release your health records, with few exceptions, for the reasons below.

- **Sale of Health Records.** We will request your written consent before we make any release of your health records for which payment may be made to us.
- **Marketing.** We will request your written consent to use or release your health records for marketing purposes with limited exceptions. For instance, we don't need your consent when we have a face-to-face event with you or when we give you promotional gifts of modest value.
- **Psychotherapy Notes.** We will request your written consent to use or share any of your psychotherapy notes that we have on file with limited exception. For instance, for certain treatment, payment or health care operation functions.

All other uses and releases of your health records not described will be made only with your written consent. You may cancel consent at any time. The request to cancel consent must be in writing. Your request to cancel consent will take effect as soon as you request it except in two cases. The first case is when we have already taken actions based on past consent. The second case is before we received your written request to stop.

Member Rights:

Below are your rights with regard to your health records. If you would like to use any of the rights, please contact us using the information provided at the end of this notice.

- **Right to Revoke.** You may revoke your consent to have your PHI released at any time. It must be in writing. It must be signed by you or on your behalf. It must be sent to the address at the end of this notice. You may submit your letter either by mail or in person. It will be effective when we actually received it. The revoked consent will not be effective if we or others have already acted on the signed form.
- **Request Restrictions.** You have the right to ask for limits on the use and release of your PHI for treatment, payment or health care operations as well as releases to persons involved in your care or payment of your care. This includes family members or close friends. Your request should be detailed and exact. It should also say to whom the limit applies. We are not required to agree to this request. If we agree, we will comply with your limit request. We will not comply if the information is needed to provide you with emergency treatment. However, we will limit the use or release of health records for payment or health care operations to a health plan when you have paid for the service or item out-of-pocket in full.
- **Right to Request Confidential Communications.** You have the right to ask that we communicate with you about your health records in other ways or locations. This right only applies if the information could harm you if it is not communicated in other ways or locations. You do not have to explain the reason for your request. You must state how you could be harmed if the change is not made. We must work with your request if it is reasonable and states the other way or place where your health records should be sent.
- **Right to Access and Receive a Copy of your Health Records.** You have the right, with certain limits, to look at or get copies of your health records contained in a record set. You may ask that we give copies in a format other than photocopies. If it is possible, we will use the format of your choice. You must ask in writing to get access to your health records. If we deny your request, we will provide you a written reason. We will tell you if the reasons for the denial can be reviewed. We will also let you know how to ask for a review, or if the denial cannot be reviewed.
- **Right to Change your Health Records.** You have the right to ask us to make changes to correct health records we keep about you. These changes are known as amendments. Any request for an amendment must be in writing. You need to give a reason for your change request. We will contact you in writing no later than 60 days after we get your request. If we need more time, we may take up to another 30 days. We will let you know of any delays and the date when we will get back to you.

If we make the changes, we will let you know they were made. We will also give your changes to others who we know have your health records and to other persons you name. If we choose not to make your changes, we will let you know why in writing. You have a right to dispute the denied change request in writing.

- **Right to Receive an Accounting of Disclosures.** You have the right to receive a list of instances within the last six (6) years in which we or our business associates released your PHI. This does not apply to the release for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other events. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more details on our fees at the time of your request.
- **Right to File a Complaint.** If you feel your privacy rights have been violated, or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone. Use the contact information at the end of this notice. You will not be retaliated against for filing a complaint.

  You can also file a complaint with the Secretary of the U.S. Department of Health and Human services Office for Civil Rights by sending a letter to 200 Independence Ave. SW, Washington, D.C. 20201, or calling 1-800-368-1019, (TTY 1-866-788-4989), or visiting http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

  WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.
- **Right to Receive a Copy of our Privacy Practice.** You may ask for a copy at any time. Use the contact information listed below. If you get our Privacy Practice on our website or by email, you can request a paper copy of the notice.

Contact Information:

If you have any questions about our Privacy Practices related to your health records, or how to use your rights, you can contact us in writing. You can also contact us by phone. Use the contact information listed below.

Sunshine Health
Attn: Privacy Official
P.O. Box 459089
Fort Lauderdale, FL 33345-9089

TEL: 1-866-799-5321
TTY: 1-800-955-8770

Section 3: Getting Help from Member Services

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

Contacting Member Services

You may call us at 1-866-799-5321, or 1-800-955-8770, Monday to Friday, 8 a.m. to 8 p.m. Eastern, but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our 24-Hour Nurse Advice Line at **1-866-799-5321**. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

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

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

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call **1-800-955-8770** and give them our Member Services phone number. It is 1-866-799-5321. They will connect you to us.
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

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

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

Section 6: Your Eligibility

You must be covered by Medicaid and enrolled in our plan for Children's Medical Services Health 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 Member Services at 1-866-799-5321 (TTY 1-800-955-8770). We can help you check on your coverage.

If you Lose your Medicaid Eligibility

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

If you have Medicare

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

If you are having a baby

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

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

Section 7: 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 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. Your open **enrollment period** is based upon where you live in Florida. The State's Enrollment Broker will send you a letter to tell you when your open enrollment period is.

Region	Counties	Open Enrollment Period	Effective Date
9-11	(Broward, Indian River, Martin, Miami-Dade, Monroe, Okeechobee, Palm Beach, St. Lucie,)	Oct. 1 – Nov. 30	Dec. 1
5-8	(Brevard, Charlotte, Collier, DeSoto, Glades, Hardee, Hendry, Highlands, Hillsborough, Lee, Manatee, Orange, Osceola, Pasco, Pinellas, Polk, Sarasota, Seminole)	Nov. 1 – Dec. 31	Jan. 1
1-4	(Bay, Calhoun, Escambia, Franklin, Gadsden, Gulf, Holmes, Jackson, Jefferson, Leon, Liberty, Madison, Okaloosa, Santa Rosa, Taylor, Wakulla, Walton, Washington)	Dec. 1 – Jan. 31	Feb. 1

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

Enrollment in the SMMC Long-Term Care Program

The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to individuals 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.

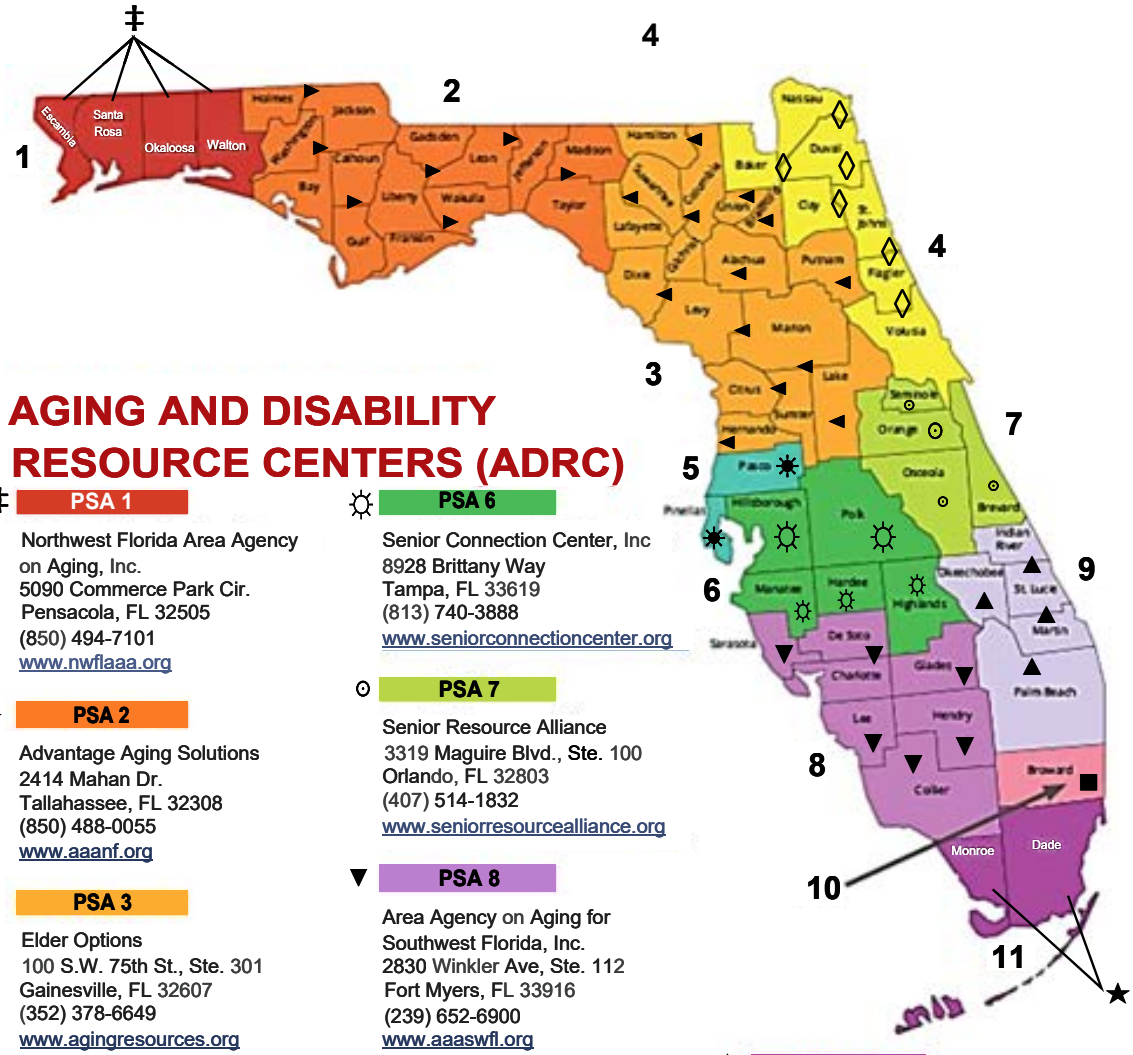
We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

The LTC program 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. Once the screening is complete, the Agency and Disability Resource Centers (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. Some enrollees do not have to complete the screening or wait list process if they meet all other LTC program eligibility requirements. For more information on Screening Exceptions in the LTC Program, visit the Agency's web page at https://ahca.myflorida.com/Medicaid/statewide_mc/ltc_scrn.shtml. 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 Sunshine Health 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 8: Leaving Our Plan (Disenrollment)

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

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

- We do not cover a service for moral or religious reasons

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

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

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

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

[2]To learn how to ask for an appeal, please turn to Section 13, Member Satisfaction, on Page 71.

Removal from Our Plan (Involuntary Disenrollment)

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

- You lose your Medicaid
- You move outside of where we operate, or outside the State of Florida
- You lose your Children's Medical Services clinical screening eligibility or you turn 21 years old
- 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
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]

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

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

Section 9: Managing Your Care

We will match you with a care manager. Your care 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 care manager will work with your providers to manage your healthcare.

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

Care Coordination Support from CMS Health Plan Trained Staff

Our Care Managers are trained to understand the unique challenges that our Specialty members face. They offer the highest quality of care.

Members also get support through our Care Coordination Outreach Program. At least once per quarter, we check on our members to see if they need help with services like:

- Behavioral, medical, or pharmacy
- Social services like housing, food, etc.

Access to Dedicated Children's Medical Services Health Plan at School Specialist

Members and their families have access to our "CMS Health Plan at School" Specialist. This person knows how to work with the schools to help our members get the services they need to improve school success.

Access to Children's Medical Services Health Plan Early Steps Specialist

Members and their families have access to our "CMS Health Plan Early Steps" Specialist. This individual will work with families to make a smooth transition from Early Steps in- home services as the child is turning three years of age and will move to new providers.

Transition Aged Youth Program (TAY)

We help members get ready to become adults. Our trained care managers are here to guide members and families on things like:

- Provider choice
- Employment
- Housing
- Transportation

Our program includes screening, coaching and education. We help members and families figure out what services and skills they need help with and create a plan to reach their goals.

Access to Transitions Specialist

Members and their families have access to our "CMS Health Plan Transitions" specialist. This specialist helps families and youth in transition from a Skilled Nursing Facility, Assisted Living Facility or hospital-like setting to live with their family or in a group home. This specialist works closely with a family to evaluate options and to create a plan to move the member if a change is in their best interest.

Changing Care Managers

If you want to choose a different care manager, call Member Services. There may be times when we will have to change your care 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 Care Manager

If something changes in your life or you don't like a service or provider, let your care manager know. You should tell your care 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 10: Accessing Services

Before you get a service or go to a healthcare 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 healthcare 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 healthcare providers that are in our provider network. Our **provider network** is the group of doctors, therapists, hospitals, facilities, and other healthcare 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 healthcare provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call **1-866-799-5321** to get a copy or visit our website at **SunshineHealth.com/CMS**. We can tell you more about your providers' schooling, residency and qualifications.

Providers Not in Our Plan

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

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

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

Telemedicine

Children's Medical Services Health Plan uses this service to expand healthcare access to all members.

That includes:

- Members living in rural areas
- Members living in medically underserved communities
- Members who prefer the convenience and privacy of telemedicine
- Members who have complex conditions or schedules

We cover visits through this service just like in-person visits.

It doesn't matter if the location is remote. But the physician must conduct the visits in the scope of his or her practice.

How can you find a doctor who uses the service? That's easy!

You have a few options:

- Look in the Children's Medical Services Health Plan Provider Directory
- Visit our online provider search tool
- Call Member Services.

Once you find a provider, you can get care via telemedicine from your home! All you have to do is use your cellphone, tablet or computer.

Don't have those? That's OK, too!

Here are more options:

- We can refer you to the Safelink cellphone program, which offers free mobile phones and a free monthly allotment of minutes, text messages, and data that you can use for telemedicine
- You can visit one of our Welcome Rooms, which are equipped with computers, Wi-Fi, and private meeting spaces for a telemedicine visit
- Our CMS Care Managers' laptops can be made available for telemedicine appointments

Dental Services

Your dental plan will cover most of your dental services, but some dental services may be covered by your medical plan. The table below will help you to understand which plan pays for a service.

Type of Service(s)	Dental Plan	Medical Plan
Dental Services	Covered when you see your dentist or dental hygienist	Covered when you see your doctor or nurse
Scheduled dental services in a hospital or surgery center	Covered for dental services by your dentist	Covered for doctors, nurses, hospitals, and surgery centers
Hospital visit for a dental problem	*Not covered.*	Covered.
Prescription drugs for a dental visit or program	*Not covered.*	Covered.
Transportation to your dental service or appointment	*Not covered.*	Covered.

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 of the services listed in this handbook are covered services. Remember, just because a service is covered does not mean you will need it. You may have to pay for services if we did not approve it first.

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

Services for Children[4]

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

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

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

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

Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Children's Medical Services Health Plan

The Medicaid fee-for-service program is responsible for covering the following services, instead of Children's Medical Services Health Plan covering these services:

- Behavior Analysis (BA)
- 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.shtml**.

Moral or Religious Objections

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

Section 11: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

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

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

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

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

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

Members are more likely to have multiple health issues like asthma, diabetes, cardiovascular disease, cerebral palsy, sickle cell disease and other health conditions. We can help our members find a provider who is part of a Medical or Behavioral Health Home or Patient-Centered Medical Home.

Specialist Care and Referrals

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

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

Second Opinions

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

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

Urgent Care

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

If you need Urgent Care after office hours and you cannot reach your PCP, call our hour Nurse Advice Line. Speak with a nurse toll-free at **1-866-799-5321**. He or she will try to help you over the phone. You may also call our 24-Hour Behavioral Health Crisis Line at **1-866-799-5321**. You may be told to go to an urgent care center for help. Urgent care centers do not require a prior approval.

You may also find the closest Urgent Care center to you by calling Member Services at **1-866-799-5321** or visiting our website at **SunshineHealth.com/CMS** and clicking "Find a Provider."

Hospital Care

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

Your care manager will work with you and your provider to put services in place when you go home from the hospital.

Emergency Care

You have a medical emergency when you are so sick or hurt that your life or health is in danger if you do not get medical help right away.

Some examples are:

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

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

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

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

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

Provider Standards for PCP and Specialist Appointment Scheduling

PCP Appointment Type	Access Standard
Urgent Care	Within 48 hours for service that does not require prior authorization and within 96 hours for services that do require prior authorization
Regular and Routine Well Exam	Within 30 days
After Hours Care	Primary Care Providers must have a call receiving service that connects members with a provider. Most primary care providers also offer after hours appointment availability to Medicaid members.
Specialist Appointment Type	**Access Standard**
New Patient Appointment	Within 60 days of request with appropriate referral
Routine Prenatal Exams	Within four weeks until week 32, every two weeks until week 36 and every week thereafter until delivery
Oncology: New Patient Appointment	Within 30 days of request
Follow Up After Physical Health Admission	Within seven days of discharge from the hospital
Behavioral Health Appointment Type	**Access Standard**
Non-life Threatening Emergency	Within six hours
Urgent Access	Within 48 hours
Initial Visit for Routine Care	Within 10 business days
Follow Up for Routine Care	Within 30 calendar days
Follow Up After Behavioral Health Hospital Admission	Within seven calendar days
After Hours	Your Behavioral Health (BH) provider must have a call receiving service that is answered by a live person.

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 SunshineHealth.com/CMS 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 pharmacies fill prescriptions for specialty drugs. These types of drugs may be injected, infused or swallowed. You usually can't get these drugs at a store. Sunshine Health partners with AcariaHealth to provide specialty drugs. These are drugs that treat complex conditions. They require extra support to make sure they are used correctly. You will be offered the option to select a different specialty pharmacy by mail, after your initial specialty medication is filled. If you want a different specialty pharmacy, complete the Specialty Pharmacy Change Request Form provided, and we will review and let you know if it is approved.

If you have questions about any of the pharmacy services or need help with this form, call Member Services at 1-866-799-5321.

Behavioral Health Services

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

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

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

- Calling **1-866-799-5321** (TTY 1-800-955-8770)
- Looking at our provider directory
- Going to our website **SunshineHealth.com/CMS**

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

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

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

Member Reward Programs

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

Focus Area	Activity Criteria	Incentive Value
Tobacco Cessation Health Coaching Sessions	Age 10 years old and up. Must submit a consent form signed by member's parent/guardian, verbally pledge to stop tobacco use within 30 days and complete all four sessions within six months of the first session. $5 reward after each completed session.	Up to $20
Weight Loss Health Coaching Sessions	Age 10 years old and up. Must submit a consent form signed by member's parent/guardian, verbally pledge to lose weight within 30 days and complete six sessions within six months.	$20
Substance Use Health Coaching	Age 12 years old and up. Complete three coaching sessions with a Care Manager in three months. Signed consent form by member's parent/guardian is required.	$10
Comprehensive Diabetes Care	Age 13-20 years. Complete both HbA1c test and dilated eye exam once in the calendar year.	$25

Focus Area	Activity Criteria	Incentive Value
Post-Behavioral Health Admission Follow up Visit	Complete an outpatient follow up appointment with a behavioral health provider within seven days after discharge from an inpatient facility	$20
Annual Well Child Visit: Age 0-30 months	One visit per calendar year with a PCP.	$10
Annual Well Child Visit: Age 3-21 years	One visit per calendar year with a PCP.	$20
Childhood Immunization Status (Combo 3)	Age 2 years. Complete vaccine series by 2nd birthday: 4 doses diphtheria, tetanus, and pertussis (DTaP); 3 doses inactivated poliovirus (IPV); 1 dose measles, mumps, and rubella (MMR); 3 doses haemophilus influenza type B (HiB); 3 doses hepatitis B; 1 dose varicella-zoster virus (chicken pox or VZV); and 4 doses pneumococcal conjugate vaccinations (PCV).	$20
Immunizations for Adolescents (Combo 2)	Age 10-13 years. Complete vaccine series by 13th birthday: 1 dose meningococcal, 1 dose tetanus, diphtheria, pertussis (Tdap), and 2-3 doses human papillomavirus (HPV).	$20
HPV Vaccine Series	Age 13-26 years. Complete 2-3 doses human papillomavirus (HPV) vaccine	$20

Lead Screening in Children	Age 2 years. Complete annual blood test for lead poisoning screening.	$20
Health Risk Assessment (HRA) Completion for New Members	Completion of HRA for new members within 60 days of enrollment.	$20
Notification of Pregnancy Form (First trimester)	Age 12-20 years. Complete and sign a Notification of Pregnancy form within first trimester	$20
Prenatal Care	Complete three prenatal visits.	$50
Postpartum Care	Complete one postpartum follow up visit between 7-84 days after delivery.	$20
TDAP for Pregnant Women	Complete one dose tetanus, diphtheria, pertussis (Tdap) vaccine during pregnancy.	$20

How it works: Earning rewards is easy! When you make certain healthy choices, reward dollars will automatically be put on your rewards card. The rewards are added after we receive the claim from your provider for the healthy behavior you've completed. If it's your first reward, a card will be mailed to you.

Please remember that rewards cannot be transferred. If you leave our plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us at **1-866-799-5321**, or visit **SunshineHealth.com/CMS-rewards**.

Disease Management Programs

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

Cancer Program: Offers education about diagnosis and treatment helps manage symptoms and side effects, helps with finding healthcare services, and emotional support for members and their families during this difficult time

Diabetes Program: Helps people with diabetes learn more about diabetes and health risks, healthy lifestyle choices (like diet, smoking, exercise and controlling blood sugar levels), staying on track with the plan of care and medication schedule

Asthma Program: Guides those with asthma to learn more about the condition, health risks, how to reduce triggers (like dust, mold, cold air, cigarette smoke), and staying on track with the plan of care and medication schedule

High Blood Pressure (Hypertension) Program: Helps those with high blood pressure to address and improve lifestyle habits like smoking, exercise, low fat diet, following the medication schedule, new ways to manage stress, and learning the early signs of a heart attack

Behavioral Health Program: Helps members find a provider, counselor or other care, offers guidance on health, wellness and healthy support systems, following the plan of care and medication schedule, changing unhealthy behaviors and learning healthy coping skills

Substance Use Disorder Program: Offers guidance on health, wellness, and positive support systems, referrals to Narcotics Anonymous (NA) and Alcoholics Anonymous (AA), encouragement and support for the treatment plan and self-care

End-of-Life Issues including information on Advance Directives: Care management supports members with life-threatening illness. Care Managers will discuss treatment plan options, quality-of-life decisions and Advance Directives including:

- Living Will
- Health Care Surrogate Designation
- Organ Donation
- Program of All-Inclusive Care for Children (PACC)/Partners in Care –Together for Families (PIC-TFK)

Get these forms from your Care Manager or from the following website:
http://floridahealthfinder.gov/reports-guides/advance-directives.aspx

Quality Enhancement Programs

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

- Children's Programs
- Domestic Violence
- Pregnancy Prevention
- Pregnancy Related Programs
- Healthy Start Services
- Nutritional Assessment/Counseling
- Behavioral Health Programs
- Telemedicine
- Telemonitoring

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

To get more information about our quality enhancement program or to give us your ideas, call Member Services at 1-866-799-5321 (TTY 1-800-955-8770).

Section 12: 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 child's PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary for us to pay for them[6].

There may be some services we do not cover but might still be covered by Medicaid. To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call Medical Transportation Management (MTM) **1-844-399-9469** to schedule a ride.

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

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

NOTE: Services highlighted are behavioral health in lieu of services. This means they are optional services you can choose over more traditional services based on your individual needs.

[6] You can find the definition for Medical Necessity at http://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf

Service	Description	Coverage/ Limitations	Prior Authorization
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots	No
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary	Prior Authorization Required for Non Emergent Ambulance Transportation
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary	Prior Authorization Required depending on services provided
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary	Prior Authorization may be Required

Service	Description	Coverage/ Limitations	Prior Authorization
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year, as medically necessary	Prior Authorization may be Required
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover, as medically necessary: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0-18 years old) enrolled in a DCF program	Covered as medically necessary	Prior Authorization Required

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	Prior Authorization Required depending on services provided
Child Health Services Targeted Case Management	Services provided to children (ages 0–3 years old) to help them get healthcare and other services OR Services provided to children (ages 0 – 20 years old) 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
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover, as medically necessary: • 24 established patient visits per year, per member • X-rays	No
Clinic Services	Healthcare services provided in a county health department, federally qualified health center, or a rural health clinic	Medically necessary services must be provided in a county health department, federally qualified health center or a rural health clinic.	No

Service	Description	Coverage/ Limitations	Prior Authorization
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	Covered as medically necessary and recommended by us	Prior Authorization Required
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No prior authorization required for the first three days of involuntary behavioral health inpatient admission. After the first three days, prior authorization required. Prior authorization is required for voluntary admissions.
Detoxification or Addictions Receiving Facility Services	Emergency substance abuse services that are performed in a facility that is not a regular hospital.	All ages. Up to a total of 15 days per month.	No prior authorization required for the first three days of involuntary behavioral health inpatient admission. After the first three days, prior authorization required. Prior authorization is required for voluntary admissions.

Service	Description	Coverage/ Limitations	Prior Authorization
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor, when medically necessary: • Hemodialysis treatments • Peritoneal dialysis treatments	No
Drop-In Center Services	A social club offering peer support and a flexible schedule of activities.	Covered as medically necessary.	No
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 us toll-free at 1-866-799-5321 to learn more.	Prior Authorization is Required for custom and power wheelchairs, hospital beds, and scooters

Service	Description	Coverage/ Limitations	Prior Authorization
Early Intervention Services	Services to children ages 0–36 months 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

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 (checkup) per year • Well child visits (child health check-ups) are provided based on age and developmental needs • One visit per month for people living in nursing facilities • Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover, as medically necessary: • Up to 26 hours per year	No

Service	Description	Coverage/ Limitations	Prior Authorization
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	Covered as medically necessary and recommended by us	No
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	Covered as medically necessary	Prior Authorization Required depending on services provided
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	Covered as medically necessary	Prior Authorization required depending on services provided
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
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: • Cochlear implants • One new hearing aid per ear, once every 3 years • Repairs	Prior Authorization is required for cochlear implants

Service	Description	Coverage/ Limitations	Prior Authorization
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 • Up to 3 visits per day for all other recipients	Prior Authorization Required
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	Prior Authorization Required depending on services provided
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	Up to 26 hours per year, as medically necessary	No

Service	Description	Coverage/ Limitations	Prior Authorization
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	Covered as medically necessary and recommended by us	No
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	Prior Authorization Required
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	Covered as medically necessary	Prior Authorization Required depending on services provided
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary	Prior Authorization Required for Genetic Testing
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	No

Service	Description	Coverage/ Limitations	Prior Authorization
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	Covered as medically necessary	No
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary	No
Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	Covered as medically necessary and recommended by us	Prior Authorization Required
Mental Health Targeted Case Management	Services to help get medical and behavioral healthcare for people with mental illnesses	Covered as medically necessary	No
Mobile Crisis Assessment and Intervention Services	A team of healthcare professionals who provide emergency mental health services, usually in people's homes	Covered as medically necessary and recommended by us	No

Service	Description	Coverage/ Limitations	Prior Authorization
Multi-Systemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	Covered as medically necessary and recommended by us	Prior Authorization Required
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary	Prior Authorization Required depending on services provided
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary	No

Service	Description	Coverage/ Limitations	Prior Authorization
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	Prior Authorization Required
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 years old and for adults under the $1,500 outpatient services cap, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: • Follow-up wheelchair evaluations, one at delivery and one 6-months later	Prior Authorization Required
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	Prior Authorization Required depending on services provided

Service	Description	Coverage/ Limitations	Prior Authorization
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	Prior Authorization Required depending on services provided
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 and non-emergency services are covered as medically necessary	Prior Authorization Required depending on services provided
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	Covered as medically necessary; some service limits may apply	Prior Authorization Required

Service	Description	Coverage/ Limitations	Prior Authorization
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	Covered as medically necessary and recommended by us	Prior Authorization Required
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, as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation every 5 years • Follow-up wheelchair evaluations, one at delivery and one 6 months later	Prior Authorization Required

Service	Description	Coverage/ Limitations	Prior Authorization
Podiatry Services	Medical care and other treatments for the feet	We cover, as medically necessary: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging for the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg	Prior Authorization Required depending on services provided
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other healthcare provider	We cover, as medically necessary: • Up to a 34-day supply of drugs, per prescription • Refills, as prescribed	Prior Authorization is Required for select drugs
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 years old who need constant care	We cover, as medically necessary: • Up to 24 hours per day	Prior Authorization Required

Service	Description	Coverage/ Limitations	Prior Authorization
Program of All-inclusive Care for Children (PACC) 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 PACC services by their primary care provider or specialty physician. PACC services are currently available in most counties in Florida. Please contact member services to see if services are available in your county.	Participation in PACC is voluntary. Children receiving PACC services can choose to enroll in another MMA plan; however, if they do so, they will relinquish their PACC services. PACC services include: • Support Counseling; • Expressive Therapies; • Respite Support; • Hospice Nursing Services; • Personal Care; • Pain and Symptom Management; • Bereavement Services; and • Volunteer Services. To participate in PACC, the enrollee must receive at least two (2) different PACC services during each three (3) month period.	Must be referred for PACC services by the child's primary care physician or specialty physician as specified in s. 409.912(11), F.S. Enrollees receiving PACC must be reauthorized annually as medically eligible for the PACC program.

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	All ages. Up to a total of 15 days per month. (IMD facilities)	No prior authorization required for the first three days of involuntary behavioral health inpatient admission. After the first three days, prior authorization required. Prior authorization is required for voluntary admissions.
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover, as medically necessary: • 10 hours of psychological testing per year	Prior Authorization Required once member exceeds plan limits/units, except for H2019.
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	No

Service	Description	Coverage/ Limitations	Prior Authorization
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	Prior Authorization Required depending on services provided
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	No
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover medically necessary family planning. 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 approval to get these services. They are free. It is your choice and confidential, even if you are under 18 years old.	No

Service	Description	Coverage/ Limitations	Prior Authorization
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover medically necessary: • Respiratory testing • Respiratory surgical procedures • Respiratory device management	Prior Authorization Required depending on services provided
Respiratory Therapy Services	Services for recipients ages 0–20 years old to help you breathe better while being treated for a respiratory condition, illness or disease	We cover medically necessary: • One initial evaluation per year • One therapy re-evaluation every 6 months • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Prior Authorization Required depending on services provided
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 years old with mental illnesses or substance use disorders	We cover the following medically necessary services: • Assessments • Foster care services • Group home services	Prior Authorization Required

Service	Description	Coverage/ Limitations	Prior Authorization
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover, as medically necessary: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year	Prior Authorization Required
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0–20 years old	Prior Authorization Required
Substance Abuse Intensive Outpatient Program Services	Substance abuse treatment of detoxification services provided in an outpatient setting.	Covered as medically necessary and recommended by us	Prior Authorization Required
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	Prior Authorization Required

Service	Description	Coverage/ Limitations	Prior Authorization
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	Covered as medically necessary and recommended by us	Prior Authorization Required
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0–20 years old 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	No
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Prior Authorization Required
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following medically necessary services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0–20 years old • Contact lenses • Prosthetic eyes	Prior Authorization Required for eyeglasses and contact lenses only

Service	Description	Coverage/ Limitations	Prior Authorization
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	Covered as medically necessary	Prior Authorization Required depending on services provided

Your Plan Benefits: Expanded Benefits

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

Service	Description	Coverage/ Limitations	Prior Authorization
Biometric Equipment	Digital blood pressure cuff and weight scale	One (1) digital blood pressure cuff every three (3) years; One (1) weight scale every three (3) years	No
Caregiver Behavioral Health Services for Non-Medicaid Caregivers	This benefit covers caregiver counseling provided in an individual or group setting for non-Medicaid caregivers of members to help address any needs he or she may have (e.g. burnout, depression, high stress levels) to help caregivers to continue caring for the member(s)	Must be a non-Medicaid caregiver of a member	No
Carpet Cleaning	Preventing allergen build up in home carpets is a vital measure to help alleviate symptoms. Provide carpet-cleaning service for qualified members with asthma. Benefit allowed by household and based on diagnosis.	For qualified members with asthma 2 carpet cleanings per year	Contact your care manager to determine eligibility.

Cellphone Program	Having access to a smartphone is an affordable and convenient way for individuals to have safe, reliable access to telephonic and web-based services. Members will receive free cellphone via Safelink/ TracFone. The phone includes 350 minutes for talk and unlimited text.	Phone includes 350 monthly minutes for talk and unlimited text messaging	No

Service	Description	Coverage/ Limitations	Prior Authorization
Computerized Cognitive Behavioral Analysis for Non-Medicaid Caregivers	Including, but not limited to the following: health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, health and behavioral interviews (individual, group, family (with or without the patient)	Must be a non-Medicaid caregiver of a member; unlimited with prior authorization	Prior Authorization Required
Doula Services	Doula services for members with a goal of improved birth outcomes, reduced pre-term births, and improved prenatal care. Using a doula during pregnancy, birth, and postpartum has been shown to be an effective best practice that can enhance the birthing experience, reduce complications, and improve outcomes for women and infants.	For members ages 13 to 20 years old	No
Flu Prevention Kit	1 Flu Prevention kit; 3 ply face masks – 10 piece; oral digital thermometer; hand sanitizer	Eligible for the first 1,000 members who have received their flu vaccine	No

HEPA Filter Vacuum Cleaner	Provide qualified members with asthma with a vacuum cleaner with HEPA filter. Using HEPA filters can trap these pollutants and may help bring allergy relief. HEPA stands for high-efficiency particulate air.	For qualified members with asthma Limit of 1 per lifetime	Contact your care manager to determine eligibility.
Home Delivered Meals (General)	Members may be eligible to receive 10 meals for nutritional support	10 meals per authorized request	Prior Authorization Required

Service	Description	Coverage/ Limitations	Prior Authorization
Home Delivered Meals - Disaster Preparedness/ Relief	Access to healthy food during an emergency, such as a natural disaster, can be difficult. One (1) emergency meal kit annually	1 kit per member annually	Prior Authorization Required
Home Delivered Meals - Post-Facility Discharge (Hospital or Nursing Facility)	Access to healthy food during an emergency, such as health-related, can be difficult. Members discharged within two weeks from an inpatient facility (Hospital, Skilled Nursing Facility or inpatient Rehabilitation) may be eligible to receive 10 meals per authorized request	10 meals per authorized request	Prior Authorization Required
Housing Assistance	Members can receive up to $250 per year for housing assistance and $75 limit per quarter to purchase healthy food items	$250 per year plus $75 per quarter for health food items	Contact your care manager to determine eligibility.
Hypoallergenic Bedding	Eligible members with asthma can get an allowance to buy hypoallergenic bedding	For qualified members with asthma	Contact your care manager to determine eligibility.
Individual Therapy Sessions for Caregivers	Provide individual therapy sessions to address behavioral health needs for caregivers of members	For caregivers of a member; unlimited visits with prior authorization	No

Service	Description	Coverage/ Limitations	Prior Authorization
Legal Guardianship	Legal guardianship can help protect an individual who is no longer able to make decisions for themselves that are in the best interest of their health and well-being. This is available for members who are in a SNF or PDN setting and parent is obtaining guardianship to protect individuals who are unable to care for their own well-being.	For members ages 17 through 18.5 years old. Maximum of five hundred dollars ($500) per eligible enrollee per lifetime.	Contact your care manager to determine eligibility.
Meals - Non-emergency Transportation Day-Trips	To support enrollees of all ages who need to travel long distance for medical appointments, meal stipend (available for long distance medical appointment day-trips).	Up to twenty dollars ($20) per meal up to 3 meals per day, up to two hundred dollars ($200.00) per day up to one thousand dollars ($1,000.00) per year for trips greater than one hundred (100) miles.	Prior Authorization Required
Newborn Circumcisions	Male circumcision is a common procedure typically performed in the first month after birth. Provide circumcision coverage for children with prescribed limits	For members ages 0 through 28 days. Limit of 1 per lifetime.	No
Non-medical Transportation	Provide transportation services for non-medical appointments. Limited to trips within the member's home county/local area.	Not for member in a SNF/nursing home setting; up to 2 trips per month	No

Nutritional Counseling	A healthy diet can promote weight loss, lower blood pressure and cholesterol and has additional health benefits such as reducing depression and improving sleep. Assessment, hands-on care, education, and guidance to caregivers and members about nutrition	None	No
Over-the-Counter (OTC)	Coverage for cold, cough, allergy, vitamins, supplements, ophthalmic/otic preparations, pain relievers, gastrointestinal products, first aid care, hygiene products, insect repellant, oral hygiene products and skin care	Monthly household limits do not carry over from month to month. Limited to items listed in the OTC catalog All ages. Up to $25 per household, per month.	No

Service	Description	Coverage/ Limitations	Prior Authorization
Swimming Lessons (Drowning Prevention)	Children under age 21 can receive group swim sessions which include up to 8 lessons from a local YMCA.	One group session, up to 8 lessons from local YMCA. In areas where a YMCA does not exist, members may use a local swim vendor.	No
Transition From SNF/Statewide Inpatient Psychiatric Program Services to Private Home Setting	This benefit provides up to $2,500, per lifetime for the child's private home setting if they are in a skilled nursing facility or statewide inpatient psychiatric program and transitioning to a private home setting within the community	Up to $2,500 per member per lifetime The benefit is available up to 90 days post transition	Contact your care manager to determine eligibility.

Your Plan Benefits: Special Programs

Service	Description	Coverage/ Limitations	Prior Authorization
Adaptive Devices	Receive items to help members move around the home	1 item per plan year.	No
Benefit Counseling	Receive benefit counseling services	Three (3) sessions per plan year.	No
Community Connections Help Line	FREE Community Connections Help Line to connect you to community services such as utility assistance, food banks and transportation in your community	None	No
Education/ Supports for Wellness	Help members access wellness education/ supports in their community	Up to $200 per member per year	No
Financial Counseling	Receive financial counseling services	Six (6) sessions per plan year	No
Health/Wellness Coaches	Access to a health/wellness coach to provide education and guidance to caregivers and members to make healthy choices	None	No
Healthy Behaviors Program	Members receive rewards who complete specific preventive health, wellness, and engagement milestones	None, Additional information can be found on pages 36-37	No
Pest Control	Receive pest control services	Up to $500 annual per member's household	Contact your care manager to determine eligibility.

Service	Description	Coverage/ Limitations	Prior Authorization
Respite Care	Provides caregivers a temporary rest from caregiving.	200 hours of in home respite care, 10 days of out of home respite care. Must not receive respite services through Model and/or Developmental Disability Waiver.	No
Steps2Success	Reading Scholarships: FREE reading scholarships for qualified members who are in Pre-Kindergarten to 12th grade who want to improve their reading skills General Educational Development® (GED®) Exam: You can take the GED® test for FREE if you're age 16 or older and don't have your high school diploma	Reading Scholarship: Space is limited GED: 1 voucher per year per member (covers 4 tests)	No
Tutoring Services	Receive 12 tutoring sessions to aid in removing educational barriers	Up to 2 hours of tutoring time per session; maximum of 12 tutoring sessions annually	Contact your care manager to determine eligibility.

Section 13: Member Satisfaction

Complaints, Grievances, and Plan Appeals

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

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. 1-866-799-5321 (TTY 1-800-955-8770)	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. You can contact us at: Sunshine Health P.O. Box 459087 Fort Lauderdale, FL 33345-9087 Fax: 1-866-534-5972 Sunshine_Appeals @centene.com	We will: • Send you a letter within 5 business days to tell you we received your grievance. • Review your grievance and send you a letter with our decision within 90 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.

	What You Can Do:	What We Will Do:
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. • If you call in your appeal, you may follow up in writing within 10 business days of the day you called. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. You can contact us at: Sunshine Health P.O. Box 459087 Fort Lauderdale, FL 33345-9087 1-866-799-5321 Fax: 1-866-534-5972 Sunshine_Appeals @centene.com	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you. If we need more time to solve your appeal, we will: • Send you a letter with our reason and tell you about your rights if you disagree

	What You Can Do:	What We Will Do:
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	• Write us or call us within 60 days of our decision about your services. You can contact us at: Sunshine Health P.O. Box 459087 Fort Lauderdale, FL 33345-9087 1-866-799-5321	• 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**	• Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ***You must finish the appeal process before you can have a Medicaid Fair Hearing.*	• Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. • Upon your request, provide you a copy of your appeal file any time during and/or after the completion of the appeal review free of charge • 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
Phone: 1-877-254-1055 (toll-free)
Fax: 1-239-338-2642
MedicaidFairHearingUnit@ahca.myflorida.com

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

- Your child's name
- Your child's member number
- Your child's Medicaid ID number
- A phone number where you or your child's 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 your child needs
- 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.

Continuation of Benefits for Medicaid Members

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

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

To have your services continue during your appeal or fair hearing, you must file your appeal and ask to continue services within this time frame, 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 14: 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 healthcare
- 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 (advance 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
- Request and receive a copy of your medical records and ask that they be amended or corrected

Section 15: 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 healthcare provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow healthcare facility conduct rules and regulations
- Treat healthcare staff and case manager with respect
- Tell us if you have problems with any healthcare 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

Section 16: 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 care manager. The Florida Division of Emergency Management can also help you with your plan. You can call them at **1-850-413-9969** or visit their website at **www.floridadisaster.org**.

Tips on How to Prevent Medicaid Fraud and Abuse:

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

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at **1-888-419-3456** or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/mpi-complaintform

You can also report fraud and abuse to us directly by contacting Sunshine Health's anonymous and confidential hotline at 1-866-685-8664, or by contacting the Compliance Officer at 1-866-799-5321. You may also send an email to Compliancefl@centene.com.

Abuse/Neglect/Exploitation of People

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

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

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

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

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

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

Advance Directives

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

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

You can download an advance directive form from this website:

http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx.

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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at **1-866-799-5321** or the Agency by calling **1-888-419-3456**.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your child's care manager about what kinds of information you can receive for free.

Some examples are:

- Your member record
- A description of how we operate
- Notice of Privacy Practices
- Your Member Handbook
- Your Provider Directory
- Information about our providers, services and your rights and responsibilities
- How new technology is evaluated to be included as a covered benefit
- Qualified Sign Language interpreters
- Information in other formats (language line assistance, large print, audio, Braille, accessible electronic formats)

Mobile App

Plan members can download our free mobile app, CMS Health Plan. 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 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 Child's Healthcare: Access to 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 child's health records on your mobile device. That helps you manage your child's health and get services.

Imagine:

- 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 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 SunshineHealth.com/login.

Section 17: Additional Resources

Floridahealthfinder.gov

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

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

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit http://www.floridahealthfinder.gov/HealthPlans/search.aspx. You may choose to view the information by each Plan or all Plans at once.

To view Children's Medical Services Health Plan HEDIS results and compare the performance of plans, visit http://www.floridahealthfinder.gov/HealthPlans/Default.aspxand choose Quality of Care Indicators.

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.

Services Beyond Healthcare

Through Community Connections, you can connect to a wide range of services that help you live a healthier life.

Community Connections is Here 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 Community Connections Help Line can match you with services. It is available for both Children's Medical Services Health Plan members and non-members. Our Peer Coaches will listen to your needs. They can refer you to more than 1.2 million resources – available across the nation or in your local area.

Call for the help you need. Our number is 1-866-775-2192.

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

Section 18: Forms

Member Information Update Form

It's important that we have your child's current contact information. That way we can get in touch with you when needed. Please use this form to update your child's address and phone number. You can also update it on our website. Simply go to SunshineHealth.com/CMS.

Sometimes we may need to release your child's medical records. Please read the Notice of Privacy Practices attached. It explains why. Then sign the statement below and mail to: **ATTN: Children's Medical Services Health Plan, P.O. Box 459089, Fort Lauderdale, FL 33345-9089.**

Member ID Number: _____

Member Name: _____

First Middle Last

Home Address: _____

Street City ZIP

Mailing Address: _____

Street City ZIP

Phone: _____

County You Live In: _____

I allow Children's Medical Services Health Plan to release my child's medical records as needed. I have read the Notice of Privacy Practices. I understand:

- How this information may be used
- When this information may be released
- How I can get this information

_____ _____

Signature (or signature of parent or guardian if member is under age 21) Date

P.O. Box 459089
Fort Lauderdale, FL 33345-9089

Authorization to Use and Disclose Health Information

Notice to Member:

- Completing this form will allow Children's Medical Services (CMS) Health Plan, operated by Sunshine Health, to (i) use your health information for a particular purpose, and/or (ii) share your health information with the individual or entity that you identify on this form.
- You do not have to give permission to use or share your health information. Your services and benefits with CMS Health Plan will not change if you do not submit this form.
- If you want to cancel this authorization form, send us a written request to revoke it at the address on the bottom of this page. A revocation form can be provided to you by calling Member Services at the phone number on the back of your member ID card.
- CMS Health Plan cannot promise that the person or group you allow us to share your health information with will not share it with someone else.
- Keep a copy of all completed forms that you send to us. We can send you copies if you need them.
- If you need help, contact Member Services at the phone number on the back of your member ID card.
- Fill in all the information on this form. When finished, mail the form and any supporting documentation to:

CMS Health Plan
Attn: Compliance Department
P.O. Box 459089 Fort Lauderdale, FL 33345-9089

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

PLEASE READ THE INSTRUCTIONS CAREFULLY AND COMPLETE THE FORM BELOW. INCOMPLETE FORMS CANNOT BE ACCEPTED.

1 MEMBER INFORMATION:

Member Name *(print)*: _____

Member Date of Birth: _____ Member ID Number: _____

2 I GIVE CMS HEALTH PLAN PERMISSION TO USE MY HEALTH INFORMATION FOR THE PURPOSE IDENTIFIED OR TO SHARE MY HEALTH INFORMATION WITH THE PERSON OR GROUP NAMED BELOW. THE PURPOSE OF THE AUTHORIZATION IS *(check one option below)***:**

□ to allow CMS Health Plan to help me with my benefits and services, **OR**

□ to permit CMS Health Plan to use or share my health information for _____

3 PERSON OR GROUP TO RECEIVE INFORMATION *(add more Persons or Groups on next page)***:**

Name (person or group): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

4 I AUTHORIZE CMS HEALTH PLAN TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION

(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information. ***Both CANNOT be selected.****)*

□ **All of my health information INCLUDING:**

Genetic information, services or test results; HIV/AIDS data and records; mental health data and records (but not psychotherapy notes); prescription drug/medication data and records; and drug and alcohol data and records (please specify any substance use disorder information that may be disclosed);

OR

□ **All of my health information EXCEPT** *(check only the boxes below that apply)***:**

□ Genetic information, services or tests
□ AIDS or HIV data and records
□ Drug and alcohol data and records
□ Mental health data and records (but not psychotherapy notes)
□ Prescription drug/medication data and records
□ Other:

_____

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:

5 _____

Date this authorization ends unless canceled. If this field is blank, the authorization expires one year from the date of the signature below.

- -

6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:**

_____

DATE:_____

IF LEGAL REPRESENTATIVE - Relationship to Member:

_____

If you are the Member's legal or personal representative, ***you must send us copies of relevant forms****, such as power of attorney or order of guardianship.*

MAIL COMPLETED AUTHORIZATION FORM AND ANY SUPPORTING DOCUMENTATION TO:
CMS Health Plan, Attn: Compliance Department
P.O. Box 459089-Fort Lauderdale, FL 33345- 9089

ADDITIONAL INDIVIDUAL PERSON(S) OR GROUP(S) TO RECEIVE INFORMATION:

NOTE: If you are consenting to disclose any substance use disorder records to a recipient that is neither a third party payor nor a health care provider, facility, or program where you receive services from a treating provider, such as a health insurance exchange or a research institution (hereafter, "recipient entity"), you must specify the name of an individual with whom or the entity at which you receive services from a treating provider at that re cipient entity, or simply state that your substance use disorder records may be disclosed to your current and future treating providers at that recipient entity.

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

City: ____ State: ____ Zip: ____ Phone: ____

Name (individual or entity): ____

Address: ____

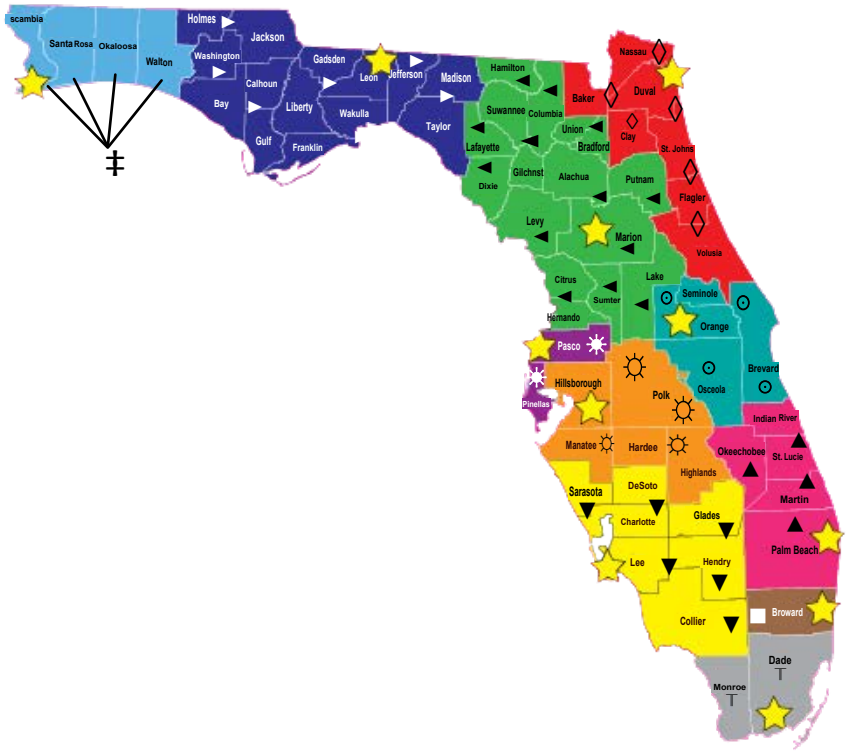
City: ____ State: ____ Zip: ____ Phone: ____

Section 19: Welcome Rooms

Children's Medical Services Health Plan members can visit our Welcome Rooms in Florida. Members, caregivers and families can get help and support at our Welcome Rooms. You can also go to health and education events there. These are ways you can use our Welcome Rooms:

- Talk to us about your health plan.
- Meet with a Children's Medical Services Health Plan Care Manager about your Plan of Care
- Go to events like:
  - Children and adult reading classes.
  - Baby showers.
  - Special needs resources.
- Get information about things like:
  - Transportation.
  - Food.
  - Housing.
  - Financial help.

★ Here is a list of the Welcome Rooms across Florida



REGION 1

Pensacola - Escambia County
2620 Creighton Road
Suite 401
Pensacola, FL 32504
1-850-473-2801

REGION 2

Tallahassee - Leon County
2525 S. Monroe St.
Unit 1
Tallahassee, FL 32301
1-850-523-4301

REGION 3

Ocala - Marion County
2724 NE 14th St.
Ocala, FL 34470
1-352-840-1102

REGION 4

Jacksonville - Duval County
5115 Normandy Blvd., Unit 1
Jacksonville, FL 32205
1-904-348-5267

REGION 5

New Port Richey - Pasco County
5035 US Hwy. 19
New Port Richey, FL 34652
1-727- 834-2301

REGION 6

Tampa - Hillsborough County
200 West Waters Ave.
Tampa, FL 33604
1-813-470-5651

REGION 7

Orlando - Orange County
6801 - W. Colonial Drive Suite E
Orlando, FL 32818
1-407-253-7602

REGION 8

Ft Myers - Lee County
4901 Palm Beach Blvd.
Suite 80
Ft Myers, FL 33905
1-239-690-5722

REGION 9

West Palm Beach - Palm Beach County
4278 Okeechobee Blvd.
West Palm Beach, FL 33409
1-561-337-3564

REGION 10

Lauderhill - Broward County
1299C NW 40th Ave. #12C
Lauderhill, FL 33313
1-954-400-6451

REGION 11

Palmetto Bay - Dade County
9552 SW 160th St.
Miami, FL 33157
1-786-573-7801

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

The Children's Medical Services Health Plan has partnered with Sunshine Health to provide managed care services to our members. Sunshine Health is a licensed Florida health plan.

Children's Medical Services Health Plan provides free aids and services to people with disabilities, such as qualified sign language interpreters, written information in other formats (large print, audio, accessible electronic and other formats), and free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

This information is available for free in other languages. Please contact Member Services at 1-866-799-5321, TTY 1-800-955-8770 Monday through Friday, 8 a.m. to 8 p.m. Eastern.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con nuestro número de servicio al cliente al 1-866-799-5321, TTY 1-800-955-8770 de lunes a viernes, de 8 a.m. a 8 p.m. del este.

Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Children's Medical Services Health Plan, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-866-799-5321 (TTY 1-800-955-8770).

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Children's Medical Services Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-799-5321 (TTY 1-800-955-8770).

Notice of Non-Discrimination

Children's Medical Services Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Children's Medical Services Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.
Children's Medical Services Health Plan:

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

If you need these services, contact Children's Medical Services Health Plan at 1-866-799-5321 (TTY 1-800-955-8770). If you believe that Children's Medical Services Health Plan 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: Grievance/Appeals Unit Children's Medical Services Health Plan, PO Box 459087 Fort Lauderdale, FL 33345-9087, 1-866-799-5321 (TTY 1-800-955-8770), Fax, 1-866-534-5972. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Children's Medical Services Health Plan is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY).

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