Molina Healthcare of Florida Medicaid Member Handbook

MOLINA HEALTHCARE

Questions? Call Member Services at (866) 472-4585 or TTY at 711

If you do not speak English, call us at (866) 472-4585 (TTY: 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language.

Si usted no habla inglés, llámenos al (866) 472-4585 (TTY: 711). Ofrecemos servicios de interpretación y podemos ayudarle a re- sponder preguntas en su idioma.También podemos ayudarle a encontrarun proveedor de salud que pueda comunicarse con usted en su idioma.

Si vous ne parlez pas anglais, appelez-nous au (866) 472-4585 (TTY: 711). Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiqueravec vous dans votre langue.

Si ou pa pale lang Anglè, rele nou nan (866) 472-4585 (TTY: 711). Nou ka jwenn sèvis entèprèt pou ou,epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yonpwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a.

Se non parli inglese chiamaci al (866) 472-4585 (TTY: 711). Disponiamo di servizi di interpretariato esiamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti atrovare un fornitore di servizi sanitari che parli la tua lingua.

Если вы не разговариваете по-английски, позвоните нам по номеру (866) 472-4585 (TTY: 711). У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке

Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi theo số (866) 472-4585 (TTY: 711). Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn

Important Contact Information

Member Services Help Line	(888) 275-8750 Nurse Advice Line (866) 472-4585 Member Services	Available 24 hours Monday to Friday 8:00 a.m.–7:00 p.m. ET
Member Services Help Line TTY	(866) 735-2922 Nurse Advice Line 711 Member Services	Available 24 hours Monday to Friday 8:00 a.m.–7:00 p.m. ET
Website	www.MolinaHealthcare.com	
Address	Molina Healthcare Westside Plaza I, Ste 120A, 8400 NW 33rd St Doral, FL. 33122	

Service	Contact Information
Transportation Services: Non-Emergency	MTM Health (888) 298-4781 Available 24 hours
Dental	Contact your case manager directly or at (866) 472-4585 for help with arranging these services.
Vision	iCare (866) 472-4585
Laboratory	Quest Diagnostics To find locations near you, call (866) 697-8378
Over-the-Counter	OTC Health Solutions (888) 628-2770, TTY: (877) 672-2688
Long-Term Care PDO	Consumer Direct (866) 472-4585

Service	Contact Information
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	(800) 96-ABUSE (800-962-2873) TTY: 711 or (800) 955-8771 https://www.yflfamilies.com/services/abuse/abuse-hotline/how-report-abuse
For Medicaid Eligibility	(866) 762-2237 TTY: 711 or (800) 955-8771 https://www.myflfamilies.com/medicaid#ME
To report Medicaid Fraud and/or Abuse	(888) 419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	(888) 419-3456 http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml
To request a Medicaid Fair Hearing	(877) 254-1055 (239) 338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com
To file a complaint about Medicaid services	(877) 254-1055 TDD: (866) 467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	(800) 96-ELDER (800-963-5337) http://elderaffairs.state.fl.us/doea/arc.php
To find out information about domestic violence	(800) 799 SAFE ((800) 799-7233) TTY: (800) 787-3224 http://thehotline.org/
To find information about health facilities in Florida	https://quality.healthfinder.fl.gov/
To find information about urgent care	Nurse Advice Line (888) 275-8750 Available 24 hours or locate your nearest Urgent Care Center at https://molina.sapphirethreesixtyfive.com/?ci=fl-medicaid&locale=en_us
For an emergency	9-1-1 Or go to the nearest emergency room

Table of Contents

Welcome to Molina Healthcare of Florida's Statewide Medicaid Managed Care Plan

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

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

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

This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at (866) 472-4585 (TTY: 711), Monday to Friday, 8:00 a.m. – 7:00 p.m. ET.

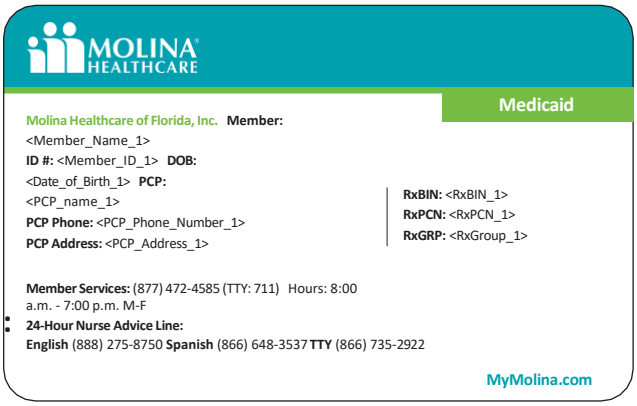
Section 1: Your Plan Identification Card (ID card)

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

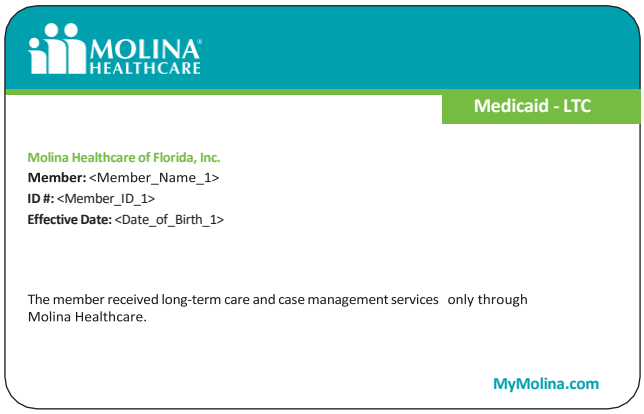
Always carry your ID card and show it each time you go to a health care appointment or the hospital. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

Your ID card will look like this:

MMA/SPECIALTY:



LTC:



Section 2: Your Privacy

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

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

Your Protected Health information

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

Why does Molina use or share our Members' PHI?

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

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

Molina needs your written approval to use or share your PHI for purposes not listed above.

What are your privacy rights?

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

How does Molina protect your PHI?

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

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

What must Molina do by law?

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

What can you do if you feel your privacy rights have not been protected?

- Call or write Molina and complain.
- Complain to the Department of Health and Human Services.

We will not hold anything against you. Your action would not change your care in any way. The above is only a summary. Our Notice of Privacy Practices has more information about how we use and share our Members' PHI. It is on our web site at: www.MolinaHealthcare.com. You may also get a copy of our Notice of Privacy Practices by calling our Member Services Department at (866) 472-4585 (TTY: 711), Monday to Friday, 8:00 a.m. – 7:00 p.m. ET.

Release of Information on Sensitive Conditions

Release of information about protected and sensitive conditions and services, including psychotherapeutic services, requires your permission before we can share it with other providers. By filling out the Molina Authorization to Use and Disclose Protected Health Information (AUD) form you can give us your permission. This form can be found at www.MolinaHealthcare.com or you can receive a copy by calling Member Services Department at (866) 472-4585 (TTY: 711), Monday to Friday, 8:00 a.m. – 7:00 p.m. ET.

Section 3: Getting Help from Our Member Services

Our Member Services Department can answer all your questions. We can help you choose or change your 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 (866) 472-4585 or TTY 711, Monday to Friday, 8:00 a.m. to 7:00 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, you may call our 24-Hour Nurse Advice Line at: (888) 275-8750 for English, (866) 648-3537 for assistance in other languages and TTY (866) 735-2922. Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

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

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

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is (866) 472- 4585. They will connect you to us.

- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability All of these services are provided free to you.

Section 5: When Your Information Changes

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

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

Section 6: Changes to your Health Plan

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

Section 7: Your Medicaid Eligibility

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

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

If you Lose your Medicaid Eligibility

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

If you have Medicare

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

If you are having a baby

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

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

Section 8: Enrollment in Our Plan

Initial Enrollment

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

Open Enrollment Period

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

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

Enrollment in the SMMC Long-Term Care Program

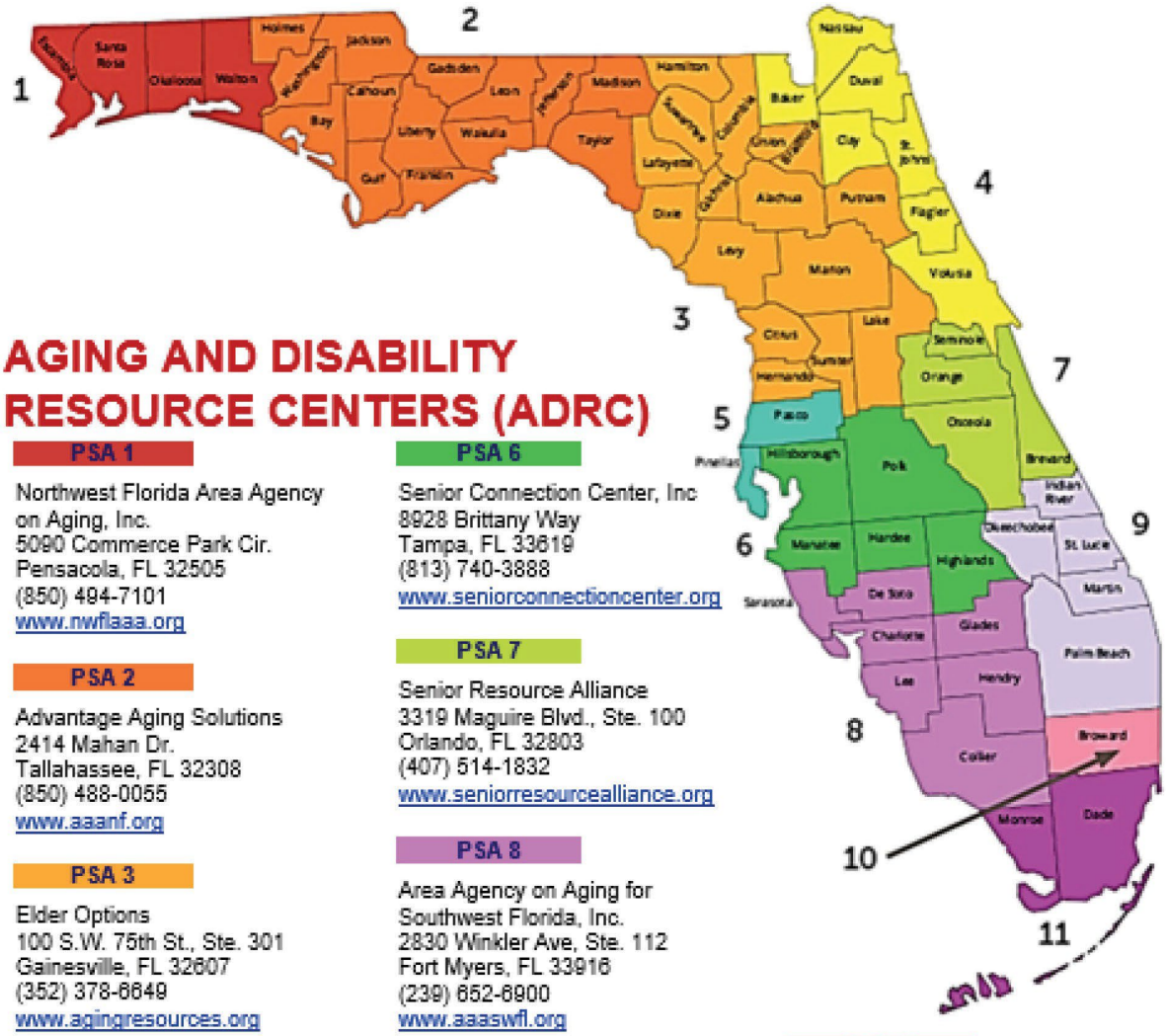
The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help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

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

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these

screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list and a space becomes available for you in the LTC program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet the requirements for the program each year.

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



AGING AND DISABILITY RESOURCE CENTERS (ADRC)

PSA 1

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

PSA 2

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

PSA 3

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

PSA 4

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

PSA 5

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

PSA 6

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

PSA 7

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

PSA 8

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

PSA 9

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

PSA 10

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

PSA 11

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

Section 9: Leaving Our Plan (Disenrollment)

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

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

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

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

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason
- If you have any questions about whether you can change plans, call Member Services at (866) 472-4585 (TTY: 711) or the State's Enrollment Broker at (877) 711-3662 (TDD (866) 467-4970).

Removal from Our Plan (Involuntary Disenrollment)

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

- You lose your Medicaid eligibility
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions
- You or your caregivers behave in a way that makes it hard for us to provide you with care
- 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-like3

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.

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

[2] To learn how to ask for an appeal, please turn to Section 17, Member Satisfaction, on page 59.

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

Section 10: Managing Your Care

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

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

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

We will ask you to complete a Health Risk Assessment when you enroll. A Health Risk Assessment (HRA) will help us understand your healthcare needs and how we can help you get the services you need. It only takes a few minutes to complete. We can call, text, or email you with the information on how to complete the Health Risk Assessment. Please call (866) 472-4585 (TTY: 711), or email MFLCommunityConnectors@molinahealthcare.com for more information.

Changing Case Managers

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

Important Things to Tell Your Case Manager

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

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

Request to Put Your Services on Hold

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

Section 11: Accessing Services

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

Providers in Our Plan

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

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call (866) 472-4585 (TTY: 711) to get a copy or visit our website at MolinaProviderDirectory.com/FL.

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

Providers Not in Our Plan

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

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

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

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Molina Healthcare. Contact Member Services at (866) 472-4585 (TTY: 711) for help in arranging these services.

Type of Dental Service(s):	Dental Plan Covers:	Medical Plan Covers:
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	Covered	Covered
Prescription drugs for a dental visit or problem	*Not covered*	Covered
Transportation to your dental service or appointment	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 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 Molina Healthcare of Florida

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

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

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

Moral or Religious Objections

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

Section 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

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

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

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

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

Choosing a PCP for Your Child

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

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy[5].

You can take your child to a pediatrician, family practice provider, or other health care provider. You do not need a referral for well child visits. Also, there is no charge for well child visits.

Specialist Care and Referrals

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

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

Second Opinions

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

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

Urgent Care

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

If you need Urgent Care after office hours and you cannot reach your PCP, call our 24-hour Nurse Advice Line at (888) 275-8750 for English, (866) 648-3537 for assistance in other languages and (866) 735-2922 for TTY. Our nurses are available to help you 24 hours a day, seven days a week.

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

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

Hospital Care

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

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

Emergency Care

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

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

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

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

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

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

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. You can find this list on our Web site at https://ahca.myflorida.com/medicaid/prescribed-drugs/medicaid-pharmaceutical-therapeutics-committee/florida-medicaid-preferred-drug-list-pdl or by calling Member Services.

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

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

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

Specialty Pharmacy Information

Specialty drugs are used to treat complex conditions like cancer, rheumatoid arthritis and multiple sclerosis. Specialty drugs often need special care. Certain drugs may not be available at every pharmacy. They are only available through a specialty pharmacy. Molina's contracted specialty pharmacies are CVS Caremark Specialty and Publix Specialty Pharmacy. If you do not want to use the assigned specialty pharmacy or if you have any questions, please call Member Services at (866) 472-4585 (TTY: 711), Monday – Friday, 8:00 a.m. – 7:00 p.m., ET.

Behavioral Health Services

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

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

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

- Calling Member Services
- Looking at our provider directory
- Going to our website: **MolinaProviderDirectory.com/FL**

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

You do not need a referral from your 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. You may also access 24/7 Telehealth Crisis Support services by calling Impower at 1-689-688- 9875. You will speak with a clinician who will give you a link to a virtual session. 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:

- Smoking Cessation Program
- Adult and Pediatric Preventive Care
- Weight Loss Programs
- Alcohol or Substance Abuse Program
- Pregnancy Rewards Program

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 (866) 472-4585.

Chronic Disease Management Programs

We have special programs available that will help you if you have one of these conditions. Please visit **Florida Medicaid Disease Management Programs** or call (866) 472-4585 for more information.

- Cancer and Cancer Prevention to help you prevent, better understand and cope with a cancer diagnosis.
- Diabetes and Diabetes Prevention to help you prevent and managed diabetes.
- Depression and Depression prevention (including suicide prevention) to help you through care coordination.
- Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and HIV prevention is available to help prevent and manage HIV/AIDS.
- Asthma program to help you best manage you or your child's asthma.
- Chronic Obstructive Pulmonary Disease (COPD) program to help you manage and coordinate needed care.
- High Blood Pressure (hypertension) to help you manage your blood pressure.
- Behavioral Health programs to help you manage your behavioral health related condition and assist with care coordination.
- End of life issues including information on advance directives with information on advance directives for your loved ones.
- If you are in the LTC program, we also offer programs for Dementia and Alzheimer's issues
- Caregiver Support and Disease Management Program
- Dementia and Alzheimer's

Quality Enhancement Programs

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

- Children's Program
- Domestic Violence Program
- Pregnancy Prevention Program
- Prenatal/Postpartum Program
- Behavioral Health Programs

- Smoking Cessation Program
- Substance Abuse Program

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

To get more information about our quality enhancement program or to give us your ideas, call Member Services.

Section 13: Your Plan Benefits: Managed Medical Assistance Services

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

There may be some services we do not cover but might still be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called "In Lieu of Services (ILOS)". To find out about these benefits, call the Agency Medicaid Help Line at (877) 254- 1055. If you need a ride to any of these services, we can help you. You can call MTM Health at (888) 298-4781 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.

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	Yes
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary	Yes, for transport between facilities
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol < Ambulatory setting substance abuse treatment or detoxification services>	• As medically necessary and recommended by us • 3 hours per day for up to 30 days	Yes
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary	Yes
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary	No
Assistive Care Services	Services provided to adults (ages 18 and older) to help with activities of daily living and taking medication	We cover 365/366 days of service per year as medically necessary	Yes
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover recipients under the age of 21 years requiring medically necessary services	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Behavioral Health Assessment Services	Services used to detect or diagnose mental illness and behavioral health disorders	We cover as medically necessary: • One initial assessment per year • One reassessment per year • Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0–18) enrolled in a DCF program	We cover 365/366 days of services per year as medically necessary, including therapy, support services and aftercare planning	Yes
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor when medically necessary: • Cardiac testing • Cardiac surgical procedures • Cardiac devices	No, in office setting

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Child Health Services Targeted Case Management	Services provided to children (ages 0-3) to help them get health care and other services OR Services provided to children (ages 0-20) who use medical foster care services	Your child must be enrolled in the DOH Early Steps program OR Your child must be receiving medical foster care services	No
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover as medically necessary: • Up to 24 visits per year, per member • X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified heath center, or a rural health clinic	We cover as medically necessary	No
Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	• As medically necessary and recommended by us • Per diem, 8-10 hours of treatment per week for 2 – 4 months	Yes
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No

Covered Medical Services

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 treatment • Peritoneal dialysis treatments	No
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	Yes
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury; durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches and other items; medical supplies are items meant for one-time use and then thrown away	As medically necessary, some service and age limits apply; call Member Services for more information	Yes
Early Intervention Services	Services to children ages 0-3 who have developmental delays and other conditions	We cover as medically necessary: • One initial evaluation per lifetime, completed by a team • Up to 3 screenings per year • Up to 3 follow-up evaluations per year • Up to 2 training or support sessions per week	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary	No
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover as medically necessary: • One adult health screening (check- up) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facility • Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover as medically necessary: • Up to 26 hours per year	Yes
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	Yes
Gastrointestinal Services	Services to treat conditions, illnesses or diseases of the stomach or digestion system	We cover as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Genitourinary Services	Services to treat conditions, illnesses or diseases of the genitals or urinary system	We cover as medically necessary	No
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover as medically necessary: • Up to 39 hours per year	No
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing; this includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor when medically necessary: • Cochlear implants • One new hearing aids per ear, once every three years • Repairs	Yes
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover when medically necessary: • Up to 4 visits per day for pregnant recipients and recipients ages 0-20 • Up to 3 visits per day for all other recipients	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Hospice Services	Medical care, treatment and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free; support services are also available for family members or caregivers	• Covered as medically necessary • Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility or in a nursing facility	No
Housing Assistance		1 unit = 15 minutes; H0043 limited to 30 days over 180-day period; H2015 344 units per month or 48 units per day	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover as medically necessary: • Up to 26 hours per year	No
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us	Yes
Inpatient detoxification hospital care	Room and board – semi-private two beds	365 days for under 21 and 45 days for over 21, not inclusive of emergency days or days under the Marchman Act	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Inpatient Hospital Services	Medical care that you get while you are in the hospital; this can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation when medically necessary: • Up to 365/366 days for recipients ages 0-20 • Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or disease	Covered as medically necessary	No
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary	No
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	No
Medication Assisted Treatment Services	Services to help people who are struggling with drug addiction	Covered as medically necessary	Yes
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Mental Health Intensive Outpatient Program	Mental Health services intensive outpatient (treatment program that operates at least), including assessment, counseling; crisis intervention, and activity therapies or education	We cover as medically necessary up to nine weeks: • 3 hours/day • 3 days/week and is based on an individualized treatment plan	Yes
Mental Health Partial Hospitalization Program Services	Treatment provided in a hospital for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us: • 90 days annually 21+ • No annual limits for children under 21	Yes
Mental Health Targeting Case Management	Services to get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us	No
MultiSystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	As medically necessary and recommended by us	Yes
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Non-Emergency Transportation Services	Transportation to and from all your medical appointments; this could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary	No
Nursing Facility Admission	Skilled Nursing Facility Room and Board	1 unit = 15 minutes; maximum of 8 units per day, 96 units per year	Yes
Nursing Facility Services	Medical care or nursing care that you get while living full- time in a nursing facility; this can be a short-term rehabilitation stay or long- term	We cover 365/366 days of services in nursing facilities as medically necessary. Copayment: see information on Patient Responsibility for room & board copayment information	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life like writing, feeding yourself and using items around the house	We cover for children ages 0-20 and for the adults under the $1,500 outpatient services cap as medically necessary: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per five years • We cover for people of all ages as medically necessary: • Follow-up wheelchair evaluations; one at delivery and one 6- months later	Yes
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary	Yes
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight; this can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	• Emergency services are covered as medically necessary • Non-emergency services cannot cost more than • $1,500 per year for recipients ages 21 and over	Yes
Pain Management Services	Treatments for long- lasting pain that does not get better after other services have been provided	Covered as medically necessary	No
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us: • Up to 30 days annually	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Physical Therapy Services	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: • One initial evaluation per year • Up to 210 minutes of treatment per week • One initial wheelchair evaluation per 5 years • We cover for people of all ages as medically necessary: • Follow-up wheelchair evaluation; one at delivery and one 6-months later	Yes
Podiatry Services	Medical Care and other treatments for the feet	We cover as medically necessary: • Up to 24 office visits per year • Foot and nail care • X-rays and other imaging of the foot, ankle and lower leg • Surgery on the foot, ankle or lower leg	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover as medically necessary: • Up to 34-day supply of drugs per prescription • Refills as prescribed	Yes
Private Duty Nurse Services	Nursing services provided in the home to people ages 0-20 who need constant care	We cover as medically necessary: • Up to 24 hours per day	Yes
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Psychological Testing Services	Test used to detect or diagnose problems with memory, IQ or other areas	We cover as medically necessary: • 10 hours of psychological testing per year	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life; they include help with basic activities such as cooking, managing money and performing household chores	We cover as medically necessary: • Up to 480 hours per year	Yes
Qualified Residential Treatment Program Services	Services for children to provide community-based, residential, and behavioral health treatment	We cover as medically necessary for members under the age of 18	Yes

Covered Medical Services

Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans; they also include portable x-rays	Covered as medically necessary	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospital that have special care centers to handle serious conditions	Covered as medically necessary	No
Reproductive Services	Services for women who are pregnant or want to become pregnant; they also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover as medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover as medically necessary: • Respiratory testing • Respiratory surgical procedures • Respiratory device management	No

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover as medically necessary: • One initial evaluation per year • One Therapy re-evaluation per six months • Up to 210 minutes of therapy treatment per week (maximum of 60 minutes per day)	Yes
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	No
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance abuse disorders	We cover as medically necessary: • Assessments • Foster care services • Group home services	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Speech-Language Pathology Services	Services that include tests and treatments to help you talk or swallow better	We cover the following services as medically necessary for children ages 0-20: • Communication devices and services • Up to 210 minutes of treatment per week • One initial evaluation per year We cover the following services as medically necessary for adults: • One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Yes
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance abuse	As medically necessary and as recommended by us	Yes
Substance Abuse Short-Term Residential Treatment Services	Treatment for people who are recovering from substance abuse disorders	As medically necessary and as recommended by us	Yes

Covered Medical Services

Service	Description	Coverage / Limitations	Prior Authorization
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover as medically necessary • Up to 9 hours per month	Yes
Transplant Services	Services that include all surgery and pre- and post-surgical	Covered as medically necessary	Yes
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0-20 • One frame every two years and two lenses every 365 days for adults 21 and older • Contact lenses • Prosthetic eyes	No
Visual Care Services	Services that test and treat conditions, illnesses and disease of the eyes	Covered as medically necessary	No

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.

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Aging in Place Housing Assistance Grant	For HCBS Waiver members, Financial assistance to help you age in place and remaining in the community for miscellaneous housing expenses	Up to $2,500 per enrollee, per lifetime	Yes
Ambulatory Detox Services	Services provided to people who are withdrawing from drugs or alcohol	Unlimited, with Prior Authorization	Yes
Biometric Equipment	Monitor blood pressure and weight	• One digital blood pressure cuff every three years • One weight scale every three years	Yes
Caregiver Transportation	For HCBS Waiver member's caregivers to visit a member who is residing at an ALF	Four one-way trips monthly	Yes
Cellular Phone Services	Additional service coverage for SafeLink phone	Additional Minutes Unlimited Text Messaging	No
Chiropractic (ages 21+)	Services provided by Chiropractors. Manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs.	One new + 35 estab. or 36 estab. (12 additional visits per year) plus x-rays	No

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Collaborative Care	Covers your PCP providing active collaborative care management with your behavioral health providers	Unlimited	No
Diapers for New Moms	After live-delivery, diapers for new moms. Must sign up for this benefit by contacting Case Management within thirty (30) days of becoming pregnant, or becoming a Molina member, whichever is later.	• One case per month for up to six months following baby's birth	Yes
Doula Services	Prenatal, postpartum and assessments and/or education in your home along with labor support visit	• Up to eight total classes/education sessions per pregnancy • One labor support during delivery per delivery/Pregnancy	Yes
Hearing Services (ages 21+)	Additional hearing services	• One Hearing Eval per two years • One Dispensing Fee per two years • One Hearing Aid per ear, per two years	Yes, except Eval does not require Auth
Home Delivered Meals – Disaster Preparedness / Relief	Meals to your home during state of emergency	One delivery annually of two meals per day for 14 days (28 meals total) of Shelf Stable meals.	Yes

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Home Delivered meals – Post- Facility Discharge (Hospital or Nursing Facility)	Meals to your home when you leave the hospital or nursing facility	Three meals per day for 30 days	Yes
Home Health Nursing/ Aide Services	Home health aide or nursing help in your home	Unlimited	Yes
Housing Assistance	Provides assistance to afford housing	Up to $500 per lifetime	Yes
Individual Therapy Sessions for Caregivers	Individual therapy sessions for Primary caregiver of a member	As needed	Yes
Life Skills Development	For children or adolescents with a diagnosed development disability to provide life skills development that help the child or adolescent keep, learn or improve skills and functioning for daily living. These services will be provided in the home or outpatient setting.	Up to 160 hours per calendar year	Yes

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Medically Tailored and Culturally appropriate meals	Meals to your home when you are Pregnant	• High Risk Pregnancy – Up to two meals per day/ up to eight weeks per Calendar Year/ Pregnancy • Non-High Risk – Up to two meals per day/up to four weeks per Calendar Year/ Pregnancy	Yes
Mobile Personal Emergency Response System (PERS)	For HCBS Wavier members, Mobile Personal Emergency Response System (PERS) and monthly service fee	Unlimited	Yes
Newborn Circumcision	Circumcision Neonate	One per lifetime (maximum age is 31 days)	No
Nutritional Counseling (ages 21+)	Services that teach you about nutrition	Limit of visits per year	Yes
Over-the- counter benefit	Pharmacy over-the-counter medicines and health-related products	• $65 per household, per month for non- pregnant members; • $70 per household, per month for pregnant members • Limited to an approved list of products from a Plan-approved vendor	No

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
PCP Visits (Ages 21+)	Office / OP visit Est.	Unlimited	No
	Nursing Facility Care	Unlimited	No
	Prev. Est. Ages: 18-64	Unlimited	No
	Per PM Re-eval Est. Pat. 65+	Unlimited	No
Pet Support	For HCBS Waiver members, Reimbursement for kenneling of their pet during an admission or expenses such as pet food or vet bills	Up to $500 per HCBS Waiver member, per Calendar year	Yes
Physical Therapy	For HCBS Waiver members, covers Aqua Therapy	Up to two months, per Calendar Year	Yes
Prenatal Services	Breast pumps and antepartum management and postpartum care	• Rented hospital-grade breast pump, max one per year • Regular breast pumps, one per two years • Antepartum management: low-risk pregnancy – 14 visits; high-risk 18 visits • Postpartum care: three visits within 90 days following delivery	• Hospital grad breast pump – No, ASO without PA • Breast pump one per two years E0603 rental – No PA required

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Service/ Therapy Animal Benefit	Service/Therapy Animal Training	With Prior Authorization, up to $5,000 total per enrollee with SMI per lifetime (may be paid over multiple years to active members). Max 20 stipends per year.	Yes
Therapy (group / individual / family) (21+)	Behavioral therapy for individuals, families or in a group	Unlimited for Individual/Family, unlimited group therapy	Yes, after 104 units (26 hours)
Therapy – Occupational (ages 21+)	Occupational therapy services	• One eval per year • One Re-eval per year • Seven therapy treatments units per week • Two applications of casting or strapping per year • One additional wheelchair eval per five years for total of two per five years	Yes

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Therapy – Physical (ages 21+)	Physical therapy services	• One eval per year • One Re-eval per year • Seven therapy treatments units per week • Two applications of casting or strapping per year • One additional wheelchair eval per five years for total of two per five years	Yes
Therapy – Respiratory (ages 21+)	Respiratory therapy services	• One eval per year • One Re-eval per year • One visit per day	Yes
Therapy – Speech (ages 21+)	Speech language pathology services	• Eval/Re-eval – one per year • Eval of Oral and Pharyngeal swallowing function – one per year • Speech Therapy visit – seven units per week • AAC Initial Eval/ Re-Eval – one per year • AAC fitting, adjustment and training – up to four 30-minute sessions per year	Yes

General Medicaid Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Vision Services (ages 21+)	Additional Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	• One pair of frames per year • One eye exam per year • The following contact lenses are dispensed in a six- month supply with a prescription: • PMMA, toric or prism ballast, per lens; gas permeable, toric, prism ballast, per lens; gas permeable, extended wear, per lens, hydrophilic, spherical, per lens, hydrophilic, toric, or prism ballast, per lens, hydrophilic extended wear, per lens; contact lens, other type	No
Waived Copayments	Waiver of Medicaid copayments	Waived copays for all services	No

Specialty Plan Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Acupuncture (ages 21+)	For HIV Specialty Plan members, covers other form of medicine using needles to help your pain	• Up to four units (15 minutes x four = 60 minutes) per visit • Up to 24 visits per year	No

Specialty Plan Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Behavioral Health Assessment Services	For SMI Specialty Plan members, covers assessments to determine current and past issues, personal and family life, and strengths and needs	Unlimited	No
Behavioral Health Day Treatment	For SMI Specialty Plan members, covers Behavioral Health Day services, comprised of individual, group or family therapy services and Therapeutic Care services	Unlimited	Yes
Behavioral Health Medical Services (Drug Screening)	For SMI Specialty Plan members, covers alcohol and other drug screenings	Unlimited	No
Behavioral Health Medical Services (Medication Management)	For SMI Specialty Plan members, covers the review of relevant laboratory test results, prior pharmacy interventions (e.g. medication doses, blood levels if available, and treatment duration), and current medication use; medication management includes the discussion of how your medicine is working for you and your treatment, risks and management strategies	Unlimited	No
Behavioral Health Medical Services (Verbal Interaction), Mental Health / Substance Abuse	For SMI Specialty Plan members, covers verbal interactions (15 minute minimum) between a qualified medical professional and a recipient; this service must be directly related to the recipient's behavioral health disorder or to monitor side effects associated with medication	Unlimited	No

Specialty Plan Expanded Benefits

Service	Description	Coverage / Limitations	Prior Authorization
Behavioral Health Screening Services	For SMI Specialty Plan members, covers a behavioral health-related medical screening service that includes a face-to-face assessment of physical status, a brief history and decision making of low complexity	Unlimited	No
Collaborative Care	Team conference with or without patient	Unlimited	No
Massage Therapy Services	Massage services	Unlimited, with Prior Authorization	Yes
Medication Assisted Treatment Services	For SMI Specialty Plan members, Alcohol and/or drug services; methadone administration and/or service (provision of the drug by licensed program)	Unlimited	No
Mental Health Targeted Case Management	Targeted case management	Unlimited	Yes
Psychosocial Rehabilitation Services	Psychosocial rehabilitation services	Unlimited	Yes

Pathways to Prosperity Expanded Benefits			
Service	**Description**	**Coverage / Limitations**	**Prior Authorization**
Childcare Assistance	Support for pregnant members, after giving birth, upon new employment to begin working	Up to $1,500 for two months, once per lifetime	Yes
Criminal Expungement Support	Criminal Expungement Support	Up to $75 per lifetime per enrollee for criminal expungement fee(s)	Yes
Food Assistance	Emergency Food support	$250 once per lifetime, per household, with authorization, for emergency food support	Yes
Housing Assistance	Provides assistance to establish or maintain housing stability	Up to $1,500 per member per lifetime, with prior authorization	Yes
GED preparation course reimbursement	GED preparation course reimbursement	Up to $140 for online prep classes once per lifetime per enrollee	Yes
Non-Medical Transportation	Transportation for Plan defined covered trip reasons, such as job interviews, volunteering, support groups, etc.	Up to 10 one-way trips for non-medical purposes, per month, per enrollee	Yes
Specialty Plan Housing Assistance	For Specialty Plan members Provides assistance to establish or maintain housing stability	Up to $2,500 per member per lifetime, with prior authorization	Yes

Your Plan Benefits: Nursing Facility Transition Assistance Benefit

Molina Healthcare of Florida, Inc. offers a Nursing Facility Transition benefit to help families of children living in a nursing facility to bring their child home. The benefit will provide assistance to the children and their families to help overcome barriers preventing the child from living at home with their family.

This benefit is available for individuals currently residing in a nursing facility and are either under 21 years old or under 30 years of age and have been living in a nursing facility before turning 21 years old.

The Nursing Facility Transition benefit may include the following:

- Home renovations
- Purchase of a generator to provide power medical equipment during outages
- Home addition to give the child space for all necessary medical equipment and care needs
- Addition of an accessible bathroom
- Adaptations to or purchase of a vehicle equipped to meet the child's transportation needs
- Deposits to help with the transition (rental security deposits, move in fees)
- Home repairs
- Other renovations and home repairs
- Funding to help with moving needed moving costs

Eligible members may receive up to $75,000 to assist with the transition home. This benefit is a once in a lifetime.

You should talk to your case manager if you think this benefit can help. They can tell you more and help you figure out what to do next.

If you need assistance with contacting your case manager, please call Member Services at (866) 472-4585 (TTY: 711), Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Your Plan Benefits: Pathways to Prosperity

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

Section 14: Cost Sharing for Services

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

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

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

Starting Services

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

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

questions about:

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

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

Developing a Plan of Care

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

- What services you are getting
- Who is providing your service (your service providers)
- How often you get a service
- When a service starts and when it ends (if it has an end date)
- What your services are trying to help you do. For example, if you need help doing light housekeeping tasks around your house, your plan of care will tell you that an adult companion care provider comes 2 days a week to help with your light housekeeping tasks.
- How your LTC services work with other services you get from outside our Plan, such as Medicare, your church or other federal programs.
- Your personal goals

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

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

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

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

Updating your Plan of Care

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

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

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

Your Back-Up Plan

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

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

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

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

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

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

LTC Covered Medical Benefits		
Service	**Description**	**Prior Authorization**
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping	Yes
Adult Day Health Care	Supervision, social programs and activities provided at an adult day care center during the day; if you are there during mealtimes, you can eat there	Yes
Assisted Living	These are services that are usually provided in an assisted living facility; services can include housekeeping, help with bathing, dressing, eating, medication assistance, and social programs	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Yes
Behavioral Management	Services for mental health or substance abuse needs	Yes
Care Management/ Case Management	Services that help you get the services and support you need to live safely and independently; this includes having a case manager and making a plan of care that lists all the services you need and receive	Yes

LTC Covered Medical Benefits		
Service	**Description**	**Prior Authorization**
Caregiving Training	Training and counseling for the people who help take care of you	Yes
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily; it can include changes like installing grab bars in your bathroom or a special toilet seat; it does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to your home	Yes
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores	Yes
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain-free; support services are also available for family members or caregivers	No
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need at a regular time	Yes
Medication Administration	Help taking medications if you can't take medication by yourself	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury; medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers and other items; Medical supplies are used to treat and manage conditions, illnesses or injury; medical supplies include things that are used and then thrown away, like bandages, gloves and other items	Yes
Medication Management	A review of all the prescriptions and over-the- counter medications you are taking	Yes

LTC Covered Medical Benefits		
Service	**Description**	**Prior Authorization**
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day- to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes
Nutritional Assessment / Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to say healthy	Yes
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Yes
Respite Care	This service lets your caregivers take a short break; you can use this service in your home, an assisted living facility or in a nursing facility	Yes
Therapy – Occupational	Occupational therapy includes treatments that help you do things in your daily life like writing, feeding yourself and using items around the house	Yes
Therapy – Physical	Physical therapy includes exercises, stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	Yes
Therapy – Respiratory	Respiratory therapy includes treatments that help you breathe better	Yes
Therapy – Speech	Speech therapy includes tests and treatments that help you talk or swallow	Yes

LTC Covered Medical Benefits		
Service	**Description**	**Prior Authorization**
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility	We may offer the choice to use this service instead of nursing facility services.
Transportation	Transportation to and from all of your LTC program services; this could be on the bus, a van that can transport disabled people, a taxi or other kinds of vehicles	No

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

Long-Term Care Participant Direction Option (PDO)*

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

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

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

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

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

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

Your Plan Benefits: LTC Expanded Benefits

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

LTC Expanded Benefits		
Service	**Description**	**Prior Authorization**
Aging in Place Housing Assistance Grant	Financial assistance to help you age in place and remaining in the community; up to $2500 per enrollee, per lifetime, for miscellaneous housing expenses	Yes
Assisted Living Facility / Adult Family Care Home- Bed Hold Days	Days your bed can be held at an assisted living facility or adult family care home; maximum 14 days per hospitalization; member must return to the facility; member must reside in the facility for a minimum of 30 days between episodes; providers must notify Molina within 48 hours of the member leaving the facility to be eligible for this benefit	Yes
ALF Move in Basket	• Member can select up to $50 worth of items once per lifetime for LTSS members currently living in an ALF and new members transitioning/ moving into an ALF	No
Biometric Equipment	Monitor blood pressure and weight • One digital blood pressure cuff every three years OR • One weight scale every three years	Yes
Caregiver Transportation	Four one-way trips for caregivers monthly to visit a member who is residing at an ALF	No
Individual Therapy Sessions for Caregivers	Individual therapy sessions for Primary caregiver of an enrollee, as needed	Yes

LTC Expanded Benefits		
Service	**Description**	**Prior Authorization**
Mobile Personal Emergency Response System (PERS)	Mobile Personal Emergency Response System (PERS) and monthly service fee	Yes
Pet Support	Reimbursement for kenneling of your pet during an admission or expenses such as pet food or vet bills, up to $500 per enrollee per Calendar Year	Yes
Physical Therapy	Up to two months of Aqua therapy per calendar year, with prior authorization	Yes
Transition Assistance – Nursing Facility to Community Setting	Financial assistance to help you move from a Nursing Facility to a community setting; $5,000 per lifetime	Yes

Section 17: Member Satisfaction

Complaints, Grievances, and Plan Appeals

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

	What You Can Do:	**What We Will Do:**
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. (866) 472-4585 (TTY: 711)	We will: • Try to solve your issue within 1 business day.

	What You Can Do:	What We Will Do:
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. Molina Healthcare Appeal and Grievance Unit PO Box 36030 Louisville, KY 40233-6030 (866) 472-4585 (TTY: 711) (877) 508-5748 (Fax) or MFLGrievanceandAppeals Department@molinahealthcare.com (Email)	We will: • Review your grievance and send you a letter with our decision within 30 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Molina Healthcare Appeal and Grievance Unit PO Box 36030 Louisville, KY 40233-6030 (866) 472-4585 (TTY: 711) (877) 508-5748 (Fax) or MFLGrievanceandAppeals Department@molinahealthcare.com (Email)	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.

	What You Can Do:	What We Will Do:
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. Molina Healthcare Appeal and Grievance Unit PO Box 36030 Louisville, KY 40233-6030 (866) 472-4585 (TTY: 711) (877) 508-5748 (Fax) or MFLGrievanceandAppeals Department@molinahealthcare.com (Email)	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ***You must finish the appeal process before you can have a Medicaid Fair Hearing.*	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal

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

Medicaid Fair Hearings (for Medicaid Members)

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

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

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

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

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

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

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

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

Review by the State (for MediKids Members)

When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 120 days after you get the notice. **You must finish your appeal process first.**

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

Health Care Administration
P.O. Box 7237
Tallassee, FL 32314-7237
(877) 254-1055 (toll-free)
(239) 338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

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

Continuation of Benefits for Medicaid Members

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

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

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

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

Section 18: Your Member Rights

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

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

LTC Members have the right to:

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

Section 19: Your Member Responsibilities

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

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

LTC Members have the responsibility to:

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

Section 20: Other Important Information

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

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

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling (866) 762-2237 toll-free, or visit the DCF Web page at **https://www.myflfamilies.com/medicaid** (scroll down to the Medicaid for Aged or Disabled section and select the document entitled 'SSI-Related Fact Sheet').

Indian Health Care Provider (IHCP) Protection

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

Emergency Disaster Plan

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

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

Tips on How to Prevent Medicaid Fraud and Abuse:

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

Fraud/Abuse/Overpayment in the Medicaid Program

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

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

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

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

Molina Healthcare of Florida Attn: Compliance Department
Westside Plaza I, Ste 120A,
8400 NW 33rd St
Doral, FL 33122

Remember to include the following information when reporting:

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

Abuse/Neglect/Exploitation of People

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

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

You can also call the hotline if you know of someone else that is being mistreated. Domestic Violence is also abuse. Here are some safety tips:

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

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

Advance Directives

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

- A Living Will
- Health Care Surrogate Designation
- An Anatomical (organ or tissue) Donation

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

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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at (866) 472-4585 (TTY: 711), or the Agency by calling (888) 419-3456.

Getting More Information

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

- Your member record
- A description of how we operate
- A free copy of the rules we used to make our decision
- Information about provider incentives

Section 21: Additional Resources

http://floridahealthfinder.gov/

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

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

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

Elder Housing Unit

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

MediKids Information

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

Aging and Disability Resource Center

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

Independent Consumer Support Program

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

Section 22: Forms

1. Member Grievance/Appeal Request Form
2. Appointment of Representative (AOR) Form

Member Grievance/Appeal Request Form

Mail this form to:

Molina Healthcare of Florida
Appeal and Grievance Unit PO
Box 36030
Louisville, KY 40233-6030
Toll Free: (866) 472-4585 (TTY: 711)
Fax Number: (877) 508-5748

Please Print

Member's Name

Today's Date

Name of person requesting, if other than the member, please complete Appointment of Representative form attached.

Member's ID

Daytime telephone

Specific issue(s):

(attach another sheet of paper to this form if more space is needed)

Member Signature

Date

If you would like assistance with your request, we can help. You can call or write us at:

Molina Healthcare of Florida
Appeal and Grievance Unit PO
Box 36030
Louisville, KY 40233-6030
Toll Free: (866) 472-4585 (TTY: 711)
Fax Number: (877) 508-5748

Member Grievance/Appeal Request Form

Instructions for filing a grievance/appeal:

Fill out this form completely. Describe the issue(s) in as much detail as possible.

1. Fill out this form completely. Describe the issue(s) in as much detail as possible.
2. Attach to this form, copies of any records you wish to submit. (Do Not Send Originals).
3. You may present your information in person. To do this, call us at (866) 472-4585 (TTY: 711).
4. We can help you write your request, and we can help you in the language you speak.
5. If you are over the age of 18 and have someone else acting on your behalf, a signed Appointment of Representative (AOR) form is needed. Please use the AOR Form that is enclosed.
6. You, and/or someone you have chosen to act on your behalf, can review your appeal file before or during the appeal process. Your appeal file includes all of your medical re- cords and any other documents related to your case.
7. Return this completed form to
   Molina Healthcare of Florida
   Appeal and Grievance Unit PO
   Box 36030
   Louisville, KY 40233-6030
   Fax: (877) 508-5748
8. We will send a written verification of receipt of your request.

Thank you for using the Molina Healthcare Member Grievance Process.

Appointment of Representative (AOR) Form

Member Name

Molina Member ID Number

Appointment of Representative

I agree to name _____

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

_____(specific issue).

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

Signature (member)

Address

Telephone Number (with Area Code)

Date

Acceptance of Appointment

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

I am a/an

(Attorney, union representative, relative, etc.)

Signature (member)

Address

Telephone Number (with Area Code)

Date

Nondiscrimination of Healthcare Service Delivery

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

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

Section 1557 Investigations

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

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

Please note: If you have a disability and need more help, we can help you. If you need someone that speaks your language, we can also help. You may call our Member Services Department at (866) 472-4585 for more help from 8:00 am to 7:00 pm. If you are blind or have trouble hearing or communicating, please call 711 for TTY/TTD services. We can help you get the information you need in large print, audio (sound), and braille. We provide you with these services for free.

Tenga en cuenta lo siguiente: si tiene una discapacidad y necesita más ayuda, podemos ayudarlo. También podemos ayudarlo si necesita a alguien que hable en su idioma. Para obtener más ayuda, puede llamar a nuestro Departamento de Servicios para Miembros al (866) 472-4585, de 8:00 a. m. a 7:00 p. m. Si es ciego o tiene problemas de audición o comunicación, llame al 711 para acceder a servicios de TTY/TDD. Podemos ayudarlo a obtener
la información que necesita en letra de molde grande, audio (sonido) y en sistema Braille. Estos servicios son gratuitos.

Remake: Si ou gen yon andikap epi ou bezwen plis èd, nou kapab ede w. Si ou bezwen yon moun ki pale lang ou an, nou kapab
ede w tou. Ou gendwa rele Depatman Sèvis Manm nou an nan (866) 472-4585 pou jwenn plis èd soti 8è:00 a.m. rive 7è:00 p.m. Si ou avèg oswa ou gen difikilte pou tande oswa pou kominike, tanpri rele 711 pou sèvis TTY/TTD yo. Nou kapab ede w jwenn enfòmasyon oubezwen an gwo karaktè, odyo (son) ak an Bray. N ap ba w sèvis sa yo pou gratis.

Xin lưu ý: Nếu quý vị là người khuyết tật và cần thêm trợ giúp, chúng tôi có thể giúp quý vị. Nếu quý vị cần người có thể nói ngôn ngữ của quý vị, chúng tôi cũng có thể giúp. Quý vị có thể gọi cho Bộ phận Dịch vụ thành viên của chúng tôi theo số (866) 472-4585 để được trợ giúp thêm từ 8:00 am đến 7:00 pm. Nếu quý vị bị mù hoặc có vấn đề về thính giác hoặc giao tiếp, vui lòng gọi 711 cho dịch vụ TTY/TTD. Chúng tôi có thể giúp quý vị nhận thông tin quý vị cần bằng bảng chữ in lớn, âm thanh và chữ nổi Braille. Chúng tôi cung cấp miễn phí các dịch vụ này cho quý vị.

Non-Discrimination Notification

Molina Healthcare of Florida, Inc.

Medicaid

Discrimination is against the law. Molina Healthcare of Florida, Inc. (Molina) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Molina:

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

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact Molina Member Services at (866) 472-4585 (TTY: 711).

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

Civil Rights Coordinator
200 Oceangate, Ste 100
Long Beach, CA 90802
Phone: (866) 472-4585 (TTY: 711)
Fax: (877) 508-5738
Email: **civil.rights@molinahealthcare.com**

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

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

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

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

Non-Discrimination Tag Line – Section 1557

Molina Healthcare of Florida, Inc.

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

MOLINA® HEALTHCARE