“If you do not speak English, call us at 1-800-327-8613 (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.”

Spanish: “Si usted no habla inglés, llámenos al 1-800-327-8613 (TTY 711). Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.”

French: Si vous ne parlez pas anglais, appelez-nous au 1-800-327-8613 (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 communiquer avec vous dans votre langue.

Haitian Creole: Si ou pa pale lang Anglè, rele nou nan 1-800-327-8613 (TTY 711). Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian: "Se non parli inglese chiamaci al 1-800-327-8613 (TTY 711). Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua."

Russian: «Если вы не разговариваете по-английски, позвоните нам по номеру 1-800-327-8613 (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». 
### Important Contact Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Helpline</strong></td>
<td>1-800-327-8613</td>
</tr>
<tr>
<td><strong>Member Help Line TTY</strong></td>
<td>711</td>
</tr>
<tr>
<td><strong>Website</strong></td>
<td><a href="http://www.MCCofFL.com">www.MCCofFL.com</a></td>
</tr>
<tr>
<td><strong>Address</strong></td>
<td>P.O. Box 691029 Orlando, FL 32869</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transportation</strong></td>
<td>Veyo</td>
</tr>
<tr>
<td></td>
<td>1-800-424-8268</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>1-800-327-8613 (TTY 711)</td>
</tr>
<tr>
<td></td>
<td>1-800-96-ABUSE (1-800-962-2873)</td>
</tr>
<tr>
<td></td>
<td>TTY 711 or 1-800-955-8771</td>
</tr>
<tr>
<td><strong>Florida Medicaid Choice Counselors</strong></td>
<td>1-877-711-3662</td>
</tr>
<tr>
<td><strong>For Medicaid Eligibility</strong></td>
<td>1-866-762-2237</td>
</tr>
<tr>
<td></td>
<td>TTY: 711 or 1-800-955-8771</td>
</tr>
<tr>
<td><strong>To report Medicaid Fraud and/or Abuse</strong></td>
<td>1-888-419-3456</td>
</tr>
<tr>
<td></td>
<td><a href="https://apps.ahca.myflorida.com/mpi-complaintform/">https://apps.ahca.myflorida.com/mpi-complaintform/</a></td>
</tr>
<tr>
<td><strong>To file a complaint about a health care facility</strong></td>
<td>1-888-419-3450</td>
</tr>
<tr>
<td><strong>To request a Medicaid Fair Hearing</strong></td>
<td>1-877-254-1055</td>
</tr>
<tr>
<td></td>
<td>1-239-338-2642 (fax)</td>
</tr>
<tr>
<td></td>
<td><a href="mailto:MedicaidHearingUnit@ahca.myflorida.com">MedicaidHearingUnit@ahca.myflorida.com</a></td>
</tr>
<tr>
<td><strong>To file a complaint about Medicaid services</strong></td>
<td>1-877-254-1055</td>
</tr>
<tr>
<td></td>
<td>TDD: 1-866-467-4970</td>
</tr>
<tr>
<td><strong>To find information for elders</strong></td>
<td>1-800-96-ELDER (1-800-963-5337)</td>
</tr>
<tr>
<td></td>
<td><a href="http://elderaffairs.state.fl.us/doea/arc.php">http://elderaffairs.state.fl.us/doea/arc.php</a></td>
</tr>
</tbody>
</table>
| To find out information about domestic violence | 1-800-799-7233  
TTY: 1-800-787-3224  
http://www.thehotline.org/ |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To find information about health facilities in Florida</td>
</tr>
<tr>
<td>To find information about urgent care</td>
</tr>
</tbody>
</table>
| For an emergency | 9-1-1  
Or go to the nearest emergency room |
Table of Contents

Welcome to Magellan Complete Care’s Statewide Medicaid Managed Care Plan ................. 8
Section 1: Your Plan Identification Card (ID card) ............................................................... 9
Section 2: Your Privacy ........................................................................................................ 10
  Protected Health Information ............................................................................................ 10
  Release of Information on Sensitive Conditions ............................................................... 10
Section 3: Getting Help from Member Services ................................................................. 11
  Contacting Member Services .......................................................................................... 11
  Contacting Member Services After Hours ...................................................................... 11
Section 4: Do You Need Help Communicating? ................................................................. 11
Section 5: When Your Information Changes ..................................................................... 12
Section 6: Your Medicaid Eligibility .................................................................................. 12
  If You Lose Your Medicaid Eligibility ........................................................................... 12
  If You Have Medicare ....................................................................................................... 12
  If You Are Having a Baby ................................................................................................. 13
Section 7: Enrollment in Our Plan ..................................................................................... 13
  Open Enrollment ............................................................................................................... 13
  Enrollment in the SMMC Long-Term Care Program ....................................................... 13
Section 8: Leaving Our Plan (Disenrollment) .................................................................... 15
  Removal From Our Plan (Involuntary Disenrollment) ..................................................... 15
Section 9: Managing Your Care .......................................................................................... 16
  Changing Case Managers ............................................................................................... 16
  Important Things to Tell Your Case Manager ................................................................. 16
  Request to Put Your Services on Hold ............................................................................ 17
Section 10: Accessing Services ......................................................................................... 17
  Providers in Our Plan ....................................................................................................... 17
  Providers Not in Our Plan ............................................................................................... 17
  When We Pay for Your Dental Services ........................................................................ 18
  What Do I Have To Pay For? ............................................................................................ 18
  Services for Children ....................................................................................................... 18
  Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Magellan Complete Care ....................................................................................... 19
  Moral or Religious Objections ........................................................................................ 19
Section 11: Helpful Information About Your Benefits ........................................ 20
Choosing a Primary Care Provider (PCP) ................................................................. 20
Choosing a PCP for Your Child .............................................................................. 20
Specialist Care and Referrals .............................................................................. 21
Second Opinions .................................................................................................... 21
Review of New Treatment Options .................................................................... 21
Urgent Care ........................................................................................................... 21
Hospital Care ........................................................................................................ 22
Emergency Care .................................................................................................... 22
Out of Area Emergency Services ........................................................................ 22
Filling Prescriptions ............................................................................................... 23
Mail Order Pharmacy Information ...................................................................... 23
Specialty Pharmacy Information ......................................................................... 24
Over-The-Counter Medication Supplies ............................................................... 24
Behavioral Health Services .................................................................................. 24
Member Reward Programs ................................................................................... 25
Case Management and Disease Management Programs ................................... 25
Quality Enhancement Programs .......................................................................... 26

Section 12: Your Plan Benefits: Managed Medical Assistance Services .......... 27
Your Plan Benefits: Covered Medical Services ................................................... 27
In Lieu of Services ................................................................................................ 44
Your Plan Benefits: Expanded Benefits ............................................................. 45

Section 13: Member Satisfaction .......................................................................... 58
Complaints, Grievances, and Plan Appeals ............................................................ 58
Fast Plan Appeal .................................................................................................... 60
Medicaid Fair Hearings (for Medicaid Members) .................................................. 60
Review by the State (for MediKids Members) ....................................................... 60
Continuation of Benefits for Medicaid Members ................................................ 61

Section 14: Your Member Rights .......................................................................... 61

Section 15: Your Member Responsibilities ........................................................ 63

Section 16: Other Important Information .......................................................... 63
Patient Responsibility ............................................................................................. 63
Indian Health Care Provider (IHCP) Protection ..................................................... 64
Emergency Disaster Plan ...................................................................................... 64
Tips on How to Prevent Medicaid Fraud and Abuse: ................................................................. 64
Fraud/Abuse/Overpayment in the Medicaid Program ............................................................. 64
Abuse/Neglect/Exploitation of People .................................................................................. 65
Advance Directives ................................................................................................................ 65
Getting More Information ................................................................................................... 66

Section 17: Additional Resources ....................................................................................... 66
Floridahealthfinder.gov ....................................................................................................... 66
Elder Housing Unit ............................................................................................................... 66
MediKids Information ......................................................................................................... 67
Aging and Disability Resource Center ................................................................................. 67
Independent Consumer Support Program .......................................................................... 67

Section 18: Forms .................................................................................................................. 67
Welcome to Magellan Complete Care’s Statewide Medicaid Managed Care Plan

Magellan Complete Care has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the Statewide Medicaid Managed Care (SMMC) Program. You are enrolled in our SMMC plan. This means that 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 that 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 1-800-327-8613 (TTY 711).
Section 1: Your Plan Identification Card (ID card)

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

Carry your ID card at all times and show it each time you go to a health care appointment. 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:

---

**Magellan COMPLETE CARE**

P.O. Box 691029
Orlando, FL 32869
MagellanCompleteCareofFL.com

Member Name: xxxMEMBERNAMExxx
Member #: xxMEMBERNBR-xx
Group: xxxxxx
Enrollment Date: xx/xx/xxxx
PCP Name: xxxPCPNamexxxx

Utilize Medicaid Participating Pharmacies
BIN #: 016523  PCN #: 622  RxGroup: XXXXXXX

---

Customer Service, Claims/Billing, and Transportation:
1-800-327-8613 (Monday – Friday 8 a.m. – 7 p.m. EST)
If you are hearing impaired, call our TTY number at 711

Emergency Services: Seek treatment at the nearest emergency room or urgent care center or call 911. Notify your doctor and the health plan within 48 hours or as soon as possible if you are admitted to the hospital.

Authorizations/Eligibility (Participating and Non-Participating Providers):
1-800-327-8613

Mail Claims to: Magellan Complete Care
PO Box 2097
Maryland Heights, MO 63043

Payor ID #: 01260

Possession of an ID card does not guarantee eligibility or payment for services provided.
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:

Protected Health Information
Magellan Complete Care follows the Health Insurance Portability and Accountability Act of 1996 (HIPAA). We have rules to protect your health information (PHI). This includes oral, written and electronic PHI. Examples of information that will be protected:

- Member name
- Member ID number
- Member address
- Member telephone
- Social security number
- Date of birth
- Health status
- Name of the doctors that provide you care

The Notice of Privacy Practices lists your rights under HIPAA. You have the right to see, correct, and get copies of your PHI. Magellan Complete Care can use PHI for health plan activities. This includes paying doctor bills or the care we give you. We may have to share this information if required by state or federal law.

Your Health Guide will go over the Authorization to Use and Disclose (AUD) form. This form asks if you want to share your information with other people to coordinate all of your health care. Your Health Guide will give you the form or you can call Member Services. You can cancel your permission at any time.

If you need help with completing the form, please contact your Health Guide or call Member Services toll free at 1-800-327- 8613 (TTY 711).

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 Magellan Complete Care Authorization to Use and Disclose Protected Health Information (AUD) form you can give us your permission. This form can be found at www.MCCofFL.com.
Section 3: Getting Help from Member Services

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

Contacting Member Services
You may call us at 1-800-327-8613 (TTY 711), Monday to Friday, 8 a.m. to 7 p.m. Eastern time, but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. (If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services After Hours
If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our after-hours staff at 1-800-327-8613 (TTY 711). Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

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

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

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 1-800-327-8613. They will connect you to us.
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.
Section 5: When Your Information Changes

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

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

Section 6: Your Medicaid Eligibility

In order for you to go to your health care appointments and for Magellan Complete Care to pay for your services, you have to be covered by Medicaid and enrolled in our plan. This is called having Medicaid eligibility. DCF decides if someone qualifies for Medicaid.

Sometimes things in your life might change, and these changes can affect whether or not 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 that 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 and we can help you check on it.

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

Section 7: Enrollment in Our Plan

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 this 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
Open enrollment is a period that starts 60 days before the end of your year in our plan. The State’s Enrollment Broker will send you a letter letting you know that you can change plans if you want. This is called your Open Enrollment period. You do not have to change plans. If you leave our plan and enroll in a new one, you will start with your new plan at the end of your year in our plan. Once you are enrolled in the new plan, you will have another 60 days to decide if you want to stay in that plan or change to a new one before you are locked-in for the year. You can call the Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

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

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

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs’ Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, your name will go on a wait list. When you get to the top of the wait list, the Department of Elder Affairs Comprehensive Assessment and
Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

You can find the phone number for your local ADRC using the following map. They can also help answer any other questions that you have about the LTC program.

---

**AREA AGENCIES ON AGING OFFICES**

**PSA 1**
Northwest Florida Area Agency on Aging,
500 Commerce Park Circle
Pensacola, FL 32505
(850) 431-7000
www.nwfla.org

**PSA 2**
Area Agency on Aging
for North Florida, Inc.
2414 Mahan Drive
Tallahassee, FL 32308
(850) 481-0050
www.anfnf.org

**PSA 3**
Elder Options
150 SW 7th Street, Suite 301
Gainesville, FL 32607
(352) 378-6649
www.elderoptions.org

**PSA 4**
Eldersource
The Area Agency on Aging of Northwest Florida
10068 Old 301 Augustine Road
Jacksonville, FL 32257
(904) 561-6600
www.eldersource.org

**PSA 5**
Area Agency on Aging of Pasco-Pinellas, Inc.
5550 Keger Boulevard
Gulfport Blvd., Suite 100
St. Petersburg, FL 33707
(727) 530-9695
www.agingcenter.org

**PSA 6**
Senior Connection Center, Inc.
8926 Brittany Way
Tampa, Florida 33619
(813) 740-3888
www.seniordconnectioncenter.org

**PSA 7**
Senior Resource Alliance
990 Windrock Road, Suite 200
Orlando, FL 32801
(407) 534-1880
www.seniordresourcealliance.org

**PSA 8**
Area Agency on Aging for Southwest Florida
15101 North Cleveland Avenue
Suite 1100
North Fort Myers, FL 33903
(239) 652-6990
www.swflafl.org

**PSA 9**
Area Agency on Aging of Palm Beach/Treasure Coast
4400 N. Congress Avenue
West Palm Beach, FL 33407
(561) 842-5858
www.pallyingresourcecenter.org

**PSA 10**
Aging and Disability Resource Center of Broward County, Inc.
5700 Pineapple Road
Sunrise, FL 33351
(954) 964-5624
www.adrcbroward.org

**PSA 11**
Alliance for Aging, Inc.
750 N.W. 167th Avenue
Suite 314, 2nd Floor
Miami, FL 33172
(305) 670-6500
www.allianceforaging.org

---

Questions? Call Member Services at 1-800-327-8613 (TTY 711)
Section 8: Leaving Our Plan (Disenrollment)

Leaving a plan is called disenrolling. If you want to leave our plan while you are locked-in, you have to call the State’s Enrollment Broker. By law, people cannot leave or change plans while they are locked-in except for very special reasons. The Enrollment Broker will talk to you about why you want to leave the plan. The Enrollment Broker will also let you know if the reason you stated allows you to change plans.

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

- You are getting care at this time from a provider that is not part of our plan but is a part of another Plan
- We do not cover a service for moral or religious reasons
- You are an American Indian or Alaskan Native
- 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:

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

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

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

---

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

2 To learn how to ask for an appeal, please turn to [Section 13], Member Satisfaction, on page [55].
• You lose your Medicaid
• You move outside of where we operate, or outside the State of Florida
• You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
• You fake or forge prescriptions
• You or your caregivers behave in a way that makes it hard for us to provide you with care

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

Section 9: 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. You can also call Member Services if you have questions or want to join the case management program.

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

Changing Case Managers
If you want to choose a different case manager, call Member Services. There may be times when we will have to change your case manager. We will work with you to make sure a new case manager is assigned to you.

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 work with you to ensure you get the services you need when you are ready.

Section 10: Accessing Services

Before you get a service or go to a health care appointment, we have to make sure that 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. The provider directory gives you information such as the name, address, and telephone numbers of providers in our network. If you want a copy of the provider directory, call 1-800-327-8613 (TTY 711) to get a copy or visit our website at www.MCCofFL.com.

For more information about a doctor or health provider; such as their professional qualifications, please call Member Services at 1-800-327-8613 (TTY 711). Professional qualifications include:
- Medical school attended
- Where your doctor or health provider did their residency after medical school
- Board certification

Providers Not in Our Plan
There are some services that you can 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 Magellan Complete Care of Florida. The table below will help you to decide which plan pays for a service.

<table>
<thead>
<tr>
<th>Type of Dental Service(s):</th>
<th>Dental Plan Covers:</th>
<th>Medical Plan Covers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services</td>
<td>Covered when you see your dentist or dental hygienist</td>
<td>Covered when you see your doctor or nurse</td>
</tr>
<tr>
<td>Scheduled dental services in a hospital or surgery center</td>
<td>Covered for dental services by your dentist</td>
<td>Covered for doctors, nurses, hospitals, and surgery centers</td>
</tr>
<tr>
<td>Hospital visit for a dental problem</td>
<td>Not covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription drugs for a dental visit or problem</td>
<td>Not covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation to your dental service or appointment</td>
<td>Not covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>

Contact Member Services at 1-800-327-8613 (TTY 711) for help with arranging these services.

What Do I Have To Pay For?
You may have to pay for appointments or services that are not covered. A covered service is a service that we have to provide in the Medicaid program. All of the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean that you will need it. You may have to pay for services if we did not approve it first.

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

Services for Children3
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:

3 Also known as “Early and Periodic Screening, Diagnosis, and Treatment” or “EPSDT” requirements.
• No dollar limits; or
• No time limits, like hourly or daily limits

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

Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Magellan Complete Care

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

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

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

Moral or Religious Objections
If we do not cover a service because of a religious or moral reason, we will tell you that the service is not covered. In these cases, you must call the State’s Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970). The Enrollment Broker will help you find a provider for these services.
Section 11: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)
If you have Medicare, please contact the number on your Medicare ID card for information about your PCP. You do not have to change your Medicare PCP to get medical services. You can keep your same Medicare PCP. If you do not have a Medicare PCP, we can help you find one.

If you have Medicaid or MediKids but you do not have Medicare, 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 see your PCP for 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 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.4

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.

There is no charge for well child visits.

4 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 www.aap.org.
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.

Review of New Treatment Options
Magellan Complete Care of Florida works closely with the Agency for Health Care Administration (AHCA) to find out what new treatment options can be covered as part of your benefits. MCC of FL reviews new treatment and technology options as part of the quality improvement commitment. Experimental treatments are not part of your benefits. For more information, call us at 1-800-327-8613 (TTY 711).

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, you can go to an urgent care clinic.

Urgent care clinics are there for you and your family when you need to see a doctor and your doctor is not able to see you or the office is closed. Some urgent care clinics are open 24/7 and have short wait times. Health problems that can be treated in urgent care clinics include:

- Common colds and flu symptoms
- Ear pain
- Minor cuts and scrapes
- Sprains or strains
- Sore throat
- Minor burns
- Allergic reaction without shortness of breath
- Rash

Questions? Call Member Services at 1-800-327-8613 (TTY 711)
• Pink or irritated eyes
• Wheezing/regular cough
• Thick runny nose/stuffy nose/pain in face
• Painful/frequent urination

You may also find the closest Urgent Care center to you by using our online Provider Search. Or, you can speak with a nurse toll-free at 1-800-327-8613 (TTY 711).

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

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

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

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

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

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

Out of Area Emergency Services
If you are out of the MCC of FL service area and need immediate care, please get help from the nearest urgent care center or hospital. Please call MCC of FL at 1-800-327-8613 (TTY 711) when you are out of the service area with required urgent care or emergency services. We want to make sure that we're able to help you get the care you need.
Filling Prescriptions
We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. You can find this list on our website at [https://www.magellancompletecareoffl.com/for-members/benefits-overview/pharmacy-benefits/](https://www.magellancompletecareoffl.com/for-members/benefits-overview/pharmacy-benefits/)

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.

Mail Order Pharmacy Information
Save time and get your medicines by mail. Magellan Rx Home helps you get some of your medicines sent to your home every three months.

**How to Get Started**
First, ask your doctor to write two prescriptions:
- 30-day supply to fill at your local pharmacy
- 90-day supply plus refills, to fill by mail

Next, you will need to send in your 90-day supply order. You can:
- Mail your prescription and order form to PO Box 620968 Orlando, FL 32862
- Ask your doctor to e-prescribe to Magellan Rx Pharmacy, LLC (Mail-ORL) or fax your prescription to 1-888-282-1349
  - Fax can only be sent by a doctor’s office
  - Fax must include your information and diagnosis

**How to Get Refills**
You can get refills by choosing one of the following steps:
- Fill in the refill portion of the order form and mail to PO Box 620968 Orlando, FL 32862.
- Call Magellan Rx Pharmacy at 1-800-424-8274 (TTY 711). Please have your prescription number ready.

If you have any questions or need help getting your prescriptions you can call Magellan Complete Care of Florida at 1-800-327-8613 (TTY 711). Our hours are 8 a.m. to 7 p.m. Monday to Friday Eastern Time.
Specialty Pharmacy Information
Magellan Complete Care is working with Magellan Rx specialty pharmacy to make it easy for you to quickly get your specialty medicine. These medicines often need special storage or handling. The specialty pharmacy will help you by providing written information about your condition and medicine. You get free delivery of your medicine to your home or another address. Nurses are there to answer your questions.

You can call the specialty pharmacy at 1-866-554-2673 (TTY/TDD 1-800-424-0328). If you do not want to use Magellan Rx as your specialty pharmacy, you can call them and let them know.

Over-The-Counter Medication Supplies
• You can get your over the counter medicines and supplies as part of your benefits.
  • All covered over-the-counter items are either:
    o A medicine
    o An ointment or spray
    o Used for treatment of a condition with active medical ingredients.
  • Covered first aid supplies include:
    o Bandages
    o Dressings
    o Non-sport tapes

About the Program:
• Your benefit is $25 per month per household
• Your over-the-counter funds do not carry over to the next month
• Your order total cannot go over your benefit amount
• We cannot accept payment if you want to buy items once you have used your monthly benefit

You Can Order Three Ways:
• Order online
• Order by phone
  o To place your order by phone, call 1-888-628-2770 (TTY 711)
    • 9:00 am to 5:00 pm Eastern Time, Monday through Friday.
• In-store pickup
  o To find a participating CVS pharmacy near you, visit the online store locator here: https://www.cvs.com/otchs/magellanfl/storelocator

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

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

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

• Calling 1-800-327-8613 (TTY 711)
• Looking at our provider directory
• Going to our website, www.MCCofFL.com, and using the Provider Search

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

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

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

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

• Quit smoking
• Drug / substance abuse
• Weight gain / obesity
• Pregnancy

Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us at 1-800-327-8613 (TTY 711).

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

Cancer – this program is for members who are living with cancer. The program will help you with:

• Talking about how cancer affects you
• Your medications and treatments
• How to work with your doctors
• Getting other support services

Diabetes – this program is for adults living with diabetes. The program will help you learn about:

• The types of diabetes
• How to take your medicines
• Healthy lifestyle changes

Asthma – this program is for adults living with asthma. The program will help you learn about:

• Asthma triggers
• Early warnings
• How to work with your doctors
• How to take your medicines

High blood pressure (hypertension) – this program is for adults with high blood pressure, coronary artery disease or congestive heart failure. The program will help you learn about:

• High blood pressure and heart disease
• How to take your medicines
• Healthy lifestyle changes

If you have questions or want to join any of these programs, please call us at 1-800-327-8613 (TTY 711).

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:

- Domestic violence prevention
- Pregnancy prevention
- Pregnancy services
- Healthy Start Service Assistance
- Nutritional assessment/counseling
- Behavioral health
- Enhanced telemedicine

You can find many of these resources online by searching on our easy-to-use Community Resource Guide. It is available here: https://www.magellancompletecareoffl.com/for-members/member-materials-and-tools/find-local-resources/. For more information, call us at 1-800-327-8613 (TTY 711). Your PCP can also help.

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 12: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary in order for us to pay for them\(^5\).

There may be some services that we do not cover, but that might still be covered by Medicaid. To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call 1-800-424-8268 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 effective date of the change.

Your Plan Benefits: Covered Medical Services

There are no copayments for Magellan Complete Care of Florida members.

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

\(^5\) You can find the definition for Medical Necessity at http://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions Receiving Facility Services</td>
<td>Services used to help people who are struggling with drug or alcohol addiction</td>
<td>As medically necessary and recommended by us</td>
<td></td>
</tr>
<tr>
<td>Allergy Services</td>
<td>Services to treat conditions such as sneezing or rashes that are not caused by an illness</td>
<td>We cover blood or skin allergy testing and up to 156 doses per year of allergy shots</td>
<td>Yes – for some services</td>
</tr>
<tr>
<td>Ambulance Transportation Services</td>
<td>Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities</td>
<td>Covered as medically necessary</td>
<td>No – emergency transportation</td>
</tr>
<tr>
<td>Ambulatory Detoxification Services</td>
<td>Services provided to people who are withdrawing from drugs or alcohol</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulatory Surgical Center Services</td>
<td>Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)</td>
<td>Covered as medically necessary</td>
<td>Yes - for some procedures</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>Services to keep you from feeling pain during surgery or other medical procedures</td>
<td>Covered as medically necessary</td>
<td>Yes - for some services</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Assistive Care Services</td>
<td>Services provided to adults (ages 18 and older) to help with activities of daily living and taking medication</td>
<td>We cover 365/366 days of services per year</td>
<td>No – in-network providers</td>
</tr>
</tbody>
</table>
| Behavioral Health Assessment Services | Services used to detect or diagnose mental illnesses and behavioral health disorders | We cover:  
• 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 - for in-network providers |
| Behavioral Health Overlay Services | Behavioral health services provided to children (ages 0 – 21) enrolled in a DCF program | We cover 365/366 days of services per year, 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:  
• Cardiac testing  
• Cardiac surgical procedures  
• Cardiac devices | Yes - for some procedures |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Health Services Targeted Case Management</td>
<td>Services provided to children (ages 0 - 3) to help them get health care and other services</td>
<td>Your child must be enrolled in the DOH Early Steps program</td>
<td>No</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>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</td>
<td>We cover:</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 24 established patient visits per year, per member</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• X-rays</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See expanded benefits</td>
<td></td>
</tr>
<tr>
<td>Clinic Services</td>
<td>Health care services provided in a county health department, federally qualified health center, or a rural health clinic</td>
<td>Visit to a federally qualified health center or rural health clinic</td>
<td>No</td>
</tr>
<tr>
<td>Crisis Stabilization Unit Services</td>
<td>Emergency mental health services that are performed in a facility that is not a regular hospital</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Questions? Call Member Services at 1-800-327-8613 (TTY 711)
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clubhouse Services</td>
<td>Services to improve people's potential for establishing and maintaining social relationships and obtaining occupational and educational achievements</td>
<td>We cover up to 1920 units per fiscal year. These units count against psychosocial rehabilitation service units</td>
<td>No - unless it exceeds 480 units in a 3-month period</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 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:  
- Hemodialysis treatments  
- Peritoneal dialysis treatments | No - at an in-network free standing facility |
|                                |                                                                             |                                                                                      |                                 |
| 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 | Some service and age limits apply. Call 1-800-327-8613 (TTY 711) for more information | Yes - for some services |

Questions? Call Member Services at 1-800-327-8613 (TTY 711)
| Early Intervention Services | Services to children ages 0 - 3 who have developmental delays and other conditions | We cover:  
- 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 |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Transportation Services</td>
<td>Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
</tbody>
</table>
| Evaluation and Management Services | Services for doctor’s visits to stay healthy and prevent or treat illness | We cover:  
- One adult health screening (check-up) per year  
- Well child visits are provided based on age and developmental needs  
- One visit per month for people living in nursing facilities  
- Up to two office visits per month for adults | No - in-network providers |
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
<th>Coverage</th>
<th>Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Therapy</td>
<td>Services for families to have therapy sessions with a mental health professional</td>
<td>We cover up to 26 hours per year</td>
<td>No</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Services to treat conditions, illnesses, or diseases of the stomach or digestion system</td>
<td>We cover as medically necessary</td>
<td>Yes - for some procedures</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Services to treat conditions, illnesses, or diseases of the genitals or urinary system</td>
<td>We cover as medically necessary</td>
<td>Yes - for some procedures</td>
</tr>
<tr>
<td>Group Therapy</td>
<td>Services for a group of people to have therapy sessions with a mental health professional</td>
<td>We cover up to 39 hours per year</td>
<td>No</td>
</tr>
</tbody>
</table>
| 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:  
- Cochlear implants  
- One new hearing aid per ear, once every 3 years  
- Repairs | Yes - for some services |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
</table>
| **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:  
- Up to 4 visits per day for pregnant recipients and recipients ages 0-20  
- Up to 3 visits per day for all other recipients                                                                                                     | Yes                 |
| **Hospice Services**         | Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain-free. Support services are also available for family members or caregivers | Covered as medically necessary  
Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility | No                  |
| **Individual Therapy Services** | Services for people to have one-to-one therapy sessions with a mental health professional | We cover up to 26 hours per year                                                                                                                                                                                      | No – unless this exceeds 104 units per fiscal year |
| **Inpatient Hospital Services** | Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits | We cover the following inpatient hospital services based on age and situation:  
- Up to 365/366 days for recipients ages 0-20                                                                                                           | No – emergency  
Yes – elective behavioral and medical admissions  
No – maternity/ newborn delivery |

Questions? Call Member Services at 1-800-327-8613 (TTY 711)
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage Details</th>
<th>Example Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integumentary Services</td>
<td>Services to diagnose or treat skin conditions, illnesses or diseases</td>
<td>Covered as medically necessary</td>
<td>Yes – for some services</td>
</tr>
<tr>
<td>Laboratory Services</td>
<td>Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases</td>
<td>Covered as medically necessary</td>
<td>No - in-network providers</td>
</tr>
<tr>
<td>Medical Foster Care Services</td>
<td>Services that help children with health problems who live in foster care homes</td>
<td>Must be in the custody of the Department of Children and Families</td>
<td>No</td>
</tr>
<tr>
<td>Medication Assisted Treatment Services</td>
<td>Services used to help people who are struggling with drug addiction</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Medication Management Services</td>
<td>Services to help people understand and make the best choices for taking medication</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Partial Hospitalization Program Services</td>
<td>Treatment provided for more than 3 hours per day, several days per week, for people who are</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to 45 days for all other recipients (extra days are covered for emergencies)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes – transplant</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes – electroconvulsive therapy (ECT)</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Covered as medically necessary</td>
<td>Eligibility</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Mental Health Targeted Case Management</td>
<td>Services to help get medical and behavioral health care for people with mental illnesses</td>
<td>Yes - Adults</td>
<td>No - Children up to 150 units in a 3-month period</td>
</tr>
<tr>
<td>Mobile Crisis Assessment and Intervention Services</td>
<td>A team of health care professionals who provide emergency mental health services, usually in people’s homes</td>
<td>As medically necessary and recommended by us</td>
<td>No</td>
</tr>
<tr>
<td>Neurology Services</td>
<td>Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system</td>
<td>Covered as medically necessary</td>
<td>Yes - for some procedures</td>
</tr>
</tbody>
</table>
| Non-Emergency Transportation Services           | Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles | We cover the following services for recipients who have no transportation:  
- Out-of-state travel  
- Transfers between hospitals or facilities  
- Escorts when medically necessary | Yes – trips greater than 50 miles. Advanced life support, basic life support and bariatric wheelchairs; Out-of-area trips  
Advanced scheduling required three business days prior to trip except for:  
discharges, dialysis, cancer treatment, pre and post-surgery, surgery, wound care, and same-day mental health |
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
<th>Additional Information</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Facility Services</td>
<td>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</td>
<td>We cover 365/366 days of services in nursing facilities as medically necessary.</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Copayment: See information on Patient Responsibility for room &amp; board copayment information</td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy Services</td>
<td>Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house</td>
<td>We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap:</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One initial evaluation per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Up to 210 minutes of treatment per week</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One initial wheelchair evaluation per 5 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>We cover for people of all ages:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Follow-up wheelchair evaluations, one at delivery and one 6-months later</td>
<td></td>
</tr>
<tr>
<td>Oral Surgery Services</td>
<td>Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the</td>
<td>Covered as medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
<td>Coverage</td>
<td>Eligibility</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Orthopedic Services</td>
<td>Services to diagnose or treat conditions, illnesses or diseases of the bones or joints</td>
<td>Covered as medically necessary</td>
<td>Yes - for some procedures</td>
</tr>
<tr>
<td>Outpatient Hospital Services</td>
<td>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</td>
<td>- Emergency services are covered as medically necessary</td>
<td>Yes - for some services</td>
</tr>
<tr>
<td>Pain Management Services</td>
<td>Treatments for long-lasting pain that does not get better after other services have been provided</td>
<td>Covered as medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Partial Hospitalization Services</td>
<td>Services for people leaving a hospital for mental health treatment</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Physical Therapy Services</td>
<td>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</td>
<td>We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap:</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One initial evaluation per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Up to 210 minutes of treatment per week</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>- One initial wheelchair evaluation per 5 years</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Podiatry Services</td>
<td>Medical care and other treatments for the feet</td>
<td>We cover:</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Up to 24 office visits per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Foot and nail care</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• X-rays and other imaging for the foot, ankle and lower leg</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Surgery on the foot, ankle or lower leg</td>
<td></td>
</tr>
<tr>
<td>Prescribed Drug Services</td>
<td>This service is for drugs that are prescribed to you by a doctor or other health care provider</td>
<td>We cover:</td>
<td>Yes - for some services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Up to a 34-day supply for most drugs, Up to a 100-day supply for some maintenance drugs per prescription</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Refills, as prescribed</td>
<td></td>
</tr>
<tr>
<td>Private Duty Nursing Services</td>
<td>Nursing services provided in the home to people ages 0 to 20 who need constant care</td>
<td>We cover up to 24 hours per day</td>
<td>Yes</td>
</tr>
<tr>
<td>Psychiatric Specialty Hospital Services</td>
<td>Emergency mental health services that are performed in a facility that is not a regular hospital</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Medical Condition**

We cover for people of all ages:
- Follow-up wheelchair evaluations, one at delivery and one 6-months later

**Service Description**

**Coverage/Limitations**

**Prior Authorization**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological Testing Services</td>
<td>Tests used to detect or diagnose</td>
<td>We cover 10 hours of psychological testing per year</td>
<td>No</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
<td>Covered as medically necessary</td>
<td>Approval Required</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation Services</td>
<td>Services to help people re-enter everyday life. These include help with basic activities such as cooking, managing money and performing household chores.</td>
<td>We cover:</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td>- up to 1920 units per fiscal year</td>
<td>- These units count against clubhouse service units</td>
<td></td>
</tr>
<tr>
<td>Radiology and Nuclear Medicine Services</td>
<td>Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays.</td>
<td>Covered as medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Regional Perinatal Intensive Care Center Services</td>
<td>Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions.</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Reproductive Services</td>
<td>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.</td>
<td>We cover 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.</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Respiratory Services</td>
<td>Services that treat conditions, illnesses or diseases of the lungs or respiratory system</td>
<td>We cover: • Respiratory testing • Respiratory surgical procedures • Respiratory device management</td>
<td>Yes</td>
</tr>
<tr>
<td>Respiratory Therapy Services</td>
<td>Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease</td>
<td>We cover: • One initial evaluation per year • One therapy re-evaluation per 6 months • Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)</td>
<td>Yes</td>
</tr>
<tr>
<td>Specialized Therapeutic Services</td>
<td>Services provided to children ages 0-20 with mental illnesses or substance use disorders</td>
<td>We cover the following: Assessments: • Foster care services • Group home services</td>
<td>Yes</td>
</tr>
<tr>
<td>Speech-Language Pathology Services</td>
<td>Services that include tests and treatments to</td>
<td>We cover the following services for children ages 0-20:</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td>Visual Aid Services</td>
<td>Visual Aids are items such as glasses, contact lenses and</td>
<td>We cover the following services when prescribed by your doctor:</td>
<td>No - one (1) pair of glasses every twelve (12) months</td>
</tr>
<tr>
<td>Statewide Inpatient Psychiatric Program Services</td>
<td>Services for children with severe mental illnesses that need treatment in the hospital</td>
<td>Covered as medically necessary for children ages 0-20</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapeutic Behavioral On-Site Services</td>
<td>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</td>
<td>We cover: Up to 9 hours per month</td>
<td>Yes</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Services that include all surgery and pre- and post-surgical care</td>
<td>Covered as medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Visual Care Services</td>
<td>Services that test and treat conditions, illnesses and diseases of the eyes</td>
<td>Covered as medically necessary</td>
<td>Yes – for some services</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Prosthetic (fake) eyes</td>
<td>• Two pairs of eyeglasses for children ages 0-20 • Contact lenses • Prosthetic eyes</td>
<td>Yes - additional pairs of glasses</td>
<td></td>
</tr>
</tbody>
</table>
In Lieu of Services
Magellan Complete Care offers replacement services or “In Lieu of Services” to our members. This is decided by the Agency for HealthCare Administration. These services are:

<table>
<thead>
<tr>
<th>In Lieu of Service</th>
<th>Description</th>
<th>Eligible Enrollees</th>
<th>Allowable Units/ Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions Receiving Facility Services</td>
<td>Services used to help people who are struggling with drug or alcohol addiction</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulatory Detoxification Services</td>
<td>Ambulatory setting substance abuse treatment or detoxification services, per diem</td>
<td>Multiple failures in inpatient detoxification treatment</td>
<td>Up to three (3) hours per day, for up to thirty (30) days.</td>
</tr>
<tr>
<td>Crisis Stabilization Units (CSU)</td>
<td>Crisis Intervention, mental health, per diem</td>
<td>Multiple admissions to inpatient Psychiatric Hospital</td>
<td>Up to 45 days per fiscal year for recipients age 21 years or older</td>
</tr>
<tr>
<td>Detoxification or Addictions Receiving Services</td>
<td>Acute detoxification (hospital inpatient)</td>
<td>Multiple admissions to Detoxification Hospital</td>
<td>Up to 45 days per fiscal year for recipients age 21 years or older</td>
</tr>
<tr>
<td>Mental Health Partial Hospitalization Program Services</td>
<td>Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Mobile crisis assessment and intervention for enrollees in the community</td>
<td>Crisis intervention service, per 15 minutes</td>
<td>Multiple /frequent emergency admissions</td>
<td>Ninety-six (96) fifteen-minute (15) units per year, and a maximum of eight (8) units per day.</td>
</tr>
<tr>
<td>Nursing facility services</td>
<td>Initial Nursing Facility Care Subsequent Nursing Facility Care</td>
<td>Members discharged from Inpatient hospitals who requires a lower level of care/ subacute nursing services</td>
<td>As long the member meets Medical necessity</td>
</tr>
<tr>
<td>Partial Hospitalization Services</td>
<td>Partial Hospitalization Services</td>
<td>Multiple admissions to inpatient Psychiatric Hospital</td>
<td>Ninety (90) days annually for adults ages twenty-one (21) and older; there is no annual limit for children under the age of twenty-one (21).</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>----------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Self-Help/Peer Services</td>
<td>Self-Help/Peer Services, per 15 min</td>
<td>All members</td>
<td>Service can be provided up to 16 units per day</td>
</tr>
</tbody>
</table>

**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.

**Medical/Pain Management/Miscellaneous**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chiropractic</td>
<td>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</td>
<td>Unlimited</td>
<td>Yes -After meeting Medicaid limitations</td>
</tr>
<tr>
<td>Collaborative Care (Medical team conferences)</td>
<td>Medical Team Conference, Direct Contact with Patient and/or Family</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs</td>
<td>• 1 assessment for hearing aid every 2 years; • 1 hearing aid fitting/checking every 2 years; • 1 hearing aid monaural in ear every 2 years;</td>
<td>Yes</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Home-Delivered Meals Post-Discharge (Hospital or Nursing Facility)</td>
<td>Meals delivered to your home at the start of your recovery, to support healing and reduce readmissions.</td>
<td>Three home-delivered meals per day for enrollee and up to three family members, limited to two days post-discharge; Enrollee is required to give the Plan 48 hours’ prior notice.</td>
<td>No</td>
</tr>
</tbody>
</table>
| Massage Therapy                              | Services that provides manual manipulation muscles, connective tissue, tendons and ligaments to enhance a your health and well-being | • Unlimited services  
• Limited to those enrollees diagnosed with AIDS and who | Yes                 |
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Circumcision</td>
<td>Covered circumcisions may be performed while the baby is in the hospital or in an office setting between hospital discharge and 28 days of life.</td>
<td>1 per lifetime</td>
<td>No</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Type of assessment made which analyzes various health needs regarding diet and exercise.</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
</tbody>
</table>
| Occupational Therapy                | Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house | • One occupational therapy evaluation per year  
• One occupational therapy reevaluation  
Up to 7 occupational therapy treatment units per week | Yes                  |
<p>| Outpatient Hospital Services        | Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you | Unlimited            | Yes                 |
| Over-the-Counter Medication Supplies | Services to help members get over the                                         | • Twenty-five dollars ($25) per | No                  |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>counter drugs and</td>
<td>household per month</td>
<td>• Limited to an approved list of products from a Plan-approved vendor</td>
<td></td>
</tr>
<tr>
<td>supplies by mail</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>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</td>
<td>• One physical therapy evaluation per year</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One physical therapy reevaluation per year</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Up to 7 physical therapy treatment units per week</td>
<td></td>
</tr>
<tr>
<td>Prenatal/Perinatal</td>
<td>Services provided to pregnant women and newborns given before, during, and after delivery</td>
<td>• Fourteen (14) visits for routine pregnancy care</td>
<td>No - for antepartum and postpartum visits</td>
</tr>
<tr>
<td>Services</td>
<td></td>
<td>• Eighteen (18) antepartum visits for high-risk members</td>
<td>Yes – PA required for rental of hospital grade breast pump only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 1 breast pump per 2 years</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Max of one hospital grade breast pump rental per year</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>-------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>Services that include health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings</td>
<td>Three postpartum care visits within 90 days following delivery</td>
<td>No</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Services that include tests and treatments help you breathe better</td>
<td>One respiratory therapy evaluation/re-evaluation per year</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to 1 respiratory therapy visit per day.</td>
<td></td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Services that include tests and treatments help you talk or swallow better</td>
<td>One evaluation /re-evaluation per year; 1 evaluation of oral &amp; pharyngeal swallowing function per year</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Up to 7 speech therapy treatment units per week</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 AAC initial evaluation and 1 AAC re-evaluation per year</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Substance Abuse Intensive Outpatient Program Services</td>
<td>Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Vaccines</td>
<td>Services provided to get protection to a particular disease</td>
<td>• TDaP – one per pregnancy;</td>
<td>TDaP – No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Flu – unlimited;</td>
<td>Flu – No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shingles – one per year;</td>
<td>Shingles – Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pneumonia – unlimited;</td>
<td>Pneumonia – Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hepatitis A -2 per enrollee</td>
<td>Hepatitis A - No</td>
</tr>
<tr>
<td>Vision Services</td>
<td>Services that test and treat conditions, illnesses and diseases of the eyes</td>
<td>• 6 months supply with prescription of contact lens, PMMA, spherical, per lens</td>
<td>No additional frames require prior authorization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply with prescription of contact lens, PMMA, toric, prism ballast, per lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply with prescription of contact lens, gas permeable, toric,</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>prism ballast, per lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply contact lens, gas permeable, extended wear, per lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply with prescription contact lens, hydrophilic, spherical per lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply with prescription of contact lens, hydrophilic, toric, or prism ballast, per lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply with prescription of contact lens, hydrophilic, extended wear, per lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• 6 months supply with prescription of contact lens</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• One (1) pair of glasses every twelve (12) months</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Waived Copayments</td>
<td>There are no copayments for certain services.</td>
<td>There are no copayments for any of the below services:</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Chiropractor services, per provider or group provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community behavioral health services, per provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Home health services, per provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hospital outpatient services, per visit;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Federally qualified health center visit, per clinic, per day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Independent laboratory services, per provider, per day</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nurse practitioner services, per provider or group provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Optometrist services, per</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Coverage/Limitations</td>
<td>Prior Authorization</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
<td>----------------------</td>
<td>--------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>provider or group provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pharmacy services:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physician and physician assistant services, per provider or group provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Podiatrist services, per provider or group provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Portable x-ray services, per provider, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rural health clinic visit, per clinic, per day;</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use of the hospital emergency department for non-emergency services</td>
<td></td>
</tr>
</tbody>
</table>

**Behavioral Health**

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Assessment to determine current and past issues, personal and family life, and strengths and needs</td>
<td>Unlimited</td>
<td>No</td>
</tr>
</tbody>
</table>

Questions? Call Member Services at 1-800-327-8613 (TTY 711)
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Unlimited</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Day Treatment</td>
<td>Behavioral health day services are comprised of individual, group, or family therapy services, and therapeutic care services</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Verbal Interaction), Mental Health/Substance Abuse</td>
<td>Covers a verbal interaction (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</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Drug Screening)</td>
<td>Covers alcohol and other drug screenings</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Screening Services</td>
<td>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</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Brief Individual Psychotherapy</td>
<td>Brief individual medical psychotherapy is treatment activity designed to reduce maladaptive behaviors related to the recipient’s behavioral health disorder, to maximize behavioral self-control, or to restore</td>
<td>Unlimited</td>
<td>No - unless it exceeds 104 units per year</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Unlimited</td>
<td>Medicaid Limitations</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-----------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Intensive Outpatient Psychiatric and Substance Abuse</td>
<td>An intensive outpatient program (IOP) is a freestanding or hospital-based program that maintains hours of service are defined as having the capacity for planned, structured, service provision of at least 2 hours per day and 3 days per week, although some patients may need to attend less often</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
<tr>
<td>Medication Assisted Treatment</td>
<td>Methadone treatment for opioid addition. Recipients receiving methadone treatment can be prescribed take-home doses after 30 days of treatment, if it is clinically indicated</td>
<td>Unlimited</td>
<td>No - unless it meets Medicaid limitations</td>
</tr>
<tr>
<td>Medication Management</td>
<td>The review of relevant laboratory test results, prior pharmacy interventions (e.g., medication dosages, blood levels if available, and</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
<td>Limitations</td>
<td>Approval Required</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Psychological Testing – Community Behavioral Health Setting</td>
<td>Psychological testing is the use of one or more standardized measurements, instruments or procedures to observe or record human behavior, and requires the application of appropriate normative data for interpretation or classification</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation</td>
<td>Psychosocial rehabilitation services are intended to restore a recipient's skills and abilities to help members live independently. Activities include: development and maintenance of necessary daily living skills; food planning and preparation; money management; maintenance of the living environment; and training in appropriate use of community services</td>
<td>Unlimited with prior authorization and meeting medical necessity criteria</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Abuse Treatment or Detoxification</td>
<td>The ambulatory detoxification service</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
<tr>
<td>Detoxification Services (Outpatient)</td>
<td>includes clinical and medical management of the physical and psychological process of withdrawal from alcohol and other drugs on an outpatient basis in a community-based setting. This service is used to stabilize the recipient physically and psychologically using accepted detox protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Therapy (Individual/Family)</td>
<td>Individual and family therapy may involve the member, the member's family without the member present, or a combination of therapy with the member and the member's family. The focus or primary beneficiary of individual and family therapy services must always be the member</td>
<td>Unlimited</td>
<td>No – unless it exceeds 104 units per year</td>
</tr>
<tr>
<td>Therapy (Group)</td>
<td>Therapy for individual member or the member's family. In addition to counseling, group therapy services to member families or other responsible persons include educating, the sharing of clinical information, and guidance on how to assist the member</td>
<td>Unlimited</td>
<td>No</td>
</tr>
</tbody>
</table>
## Section 13: Member Satisfaction

### Complaints, Grievances, and Plan Appeals

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

<table>
<thead>
<tr>
<th>If you are not happy with us or our providers, you can file a <strong>Complaint</strong></th>
<th>What You Can Do:</th>
<th>What We Will Do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can:</td>
<td>We will:</td>
<td></td>
</tr>
<tr>
<td>Call us at any time.</td>
<td>Try to solve your issue within 1 business day.</td>
<td></td>
</tr>
<tr>
<td>1-800-327-8613 (TTY 711)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you are not happy with us or our providers, you can file a <strong>Grievance</strong></th>
<th>What You Can Do:</th>
<th>What We Will Do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You can:</td>
<td>We will:</td>
<td></td>
</tr>
<tr>
<td>Write us or call us at any time.</td>
<td>Review your grievance and send you a letter with our decision within 90 days.</td>
<td></td>
</tr>
<tr>
<td>Call us to ask for more time to solve your grievance if you think more time will help.</td>
<td>If we need more time to solve your grievance, we will:</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 691029 Orlando, FL 32869</td>
<td>Send you a letter with our reason and tell you about your rights if you disagree.</td>
<td></td>
</tr>
<tr>
<td>1-800-327-8613 (TTY 711)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you do not agree with a decision we made about your services, you can ask for an <strong>Appeal</strong></td>
<td><strong>What You Can Do:</strong></td>
<td><strong>What We Will Do:</strong></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>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.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 691029 Orlando, FL 32869</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For clinical appeals only: P.O. Box 2064 Maryland Heights, MO 63043</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-800-327-8613 (TTY 711)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you think waiting for 30 days will put your health in danger, you can ask for an <strong>Expedited or “Fast” Appeal</strong></th>
<th><strong>What You Can Do:</strong></th>
<th><strong>What We Will Do:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>You can: Write us or call us within 60 days of our decision about your services.</td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 691029 Orlando, FL 32869</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1-800-327-8613 (TTY 711)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you do not agree with our appeal decision, you can ask for a <strong>Medicaid Fair Hearing</strong></th>
<th><strong>What You Can Do:</strong></th>
<th><strong>What We Will Do:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>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. <strong>You must finish the appeal process before you can have a Medicaid Fair Hearing.</strong></td>
<td>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.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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 60127
Ft. Meyers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

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

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

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

- Why you think the decision should be changed
- Any medical information to support the request
- Who you would like to help with your fair hearing

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

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

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

You may ask for a review by the State by calling or writing to:
Agency for Health Care Administration
P.O. Box 60127
Ft. Myers, FL 33906
1-877 254-1055 (toll-free)
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 that you 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 14: Your Member Rights**

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

- Be treated with courtesy and respect
- Have your dignity and privacy considered and respected at all times
- Receive a quick and useful response to your questions and requests
- Receive information about MCC of FL, its services, its practitioners and providers, and member rights and responsibilities.
- 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
- Participate with practitioners in making decisions about your health care
• Be given easy to follow information about your diagnosis, the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you, regardless of cost or benefit coverage

• Make choices about your health care and 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 and voice complaints 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

• Make suggestions about MCC of FL’s member rights and responsibilities policy

• 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

• Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

• Request and receive a copy of your medical records and ask that they be amended or corrected
Section 15: Your Member Responsibilities

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

- Give accurate information (to the extent possible) 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 your health condition and participate in developing a course of action and what is expected of you to the degree possible
- Listen to your provider, follow instructions for care that you have agreed to with your provider and ask questions
- Keep your appointments or 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 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

Section 16: Other Important Information

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

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling 1-866-762-2237 toll-free, or visit the DCF Web page at https://www.myflfamilies.com/service-programs/access/medicaid.shtml (scroll down to the Medicaid for Aged or Disabled section and select the document entitled ‘SSI-Related Fact Sheets’).

Indian Health Care Provider (IHCP) Protection

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

Emergency Disaster Plan

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

Tips on How to Prevent Medicaid Fraud and Abuse:

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

Fraud/Abuse/Overpayment in the Medicaid Program

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

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

- Magellan’s Corporate Compliance Hotline: 1-800-915-2108
- Magellan’s Compliance Unit Email: Compliance@MagellanHealth.com
- You can also contact Magellan’s Special Investigations Unit at 1-800-755-0850 or SIU@MagellanHealth.com.
- Magellan Complete Care of Florida SIU Hotline: 1-877-269-7624
Abuse/Neglect/Exploitation of People
You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

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

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

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

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

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

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

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

You can download an advanced directive form from this website: http://www.floridahealthfinder.gov/reports-guides/advance-directives.aspx.

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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-800-327-8613 (TTY 711) or the Agency by calling 1-888-419-3456.
Getting More Information
You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member record
- A description of how we operate
- Resources in your community

Section 17: Additional Resources

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

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

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

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 http://elderaffairs.state.fl.us/doea/housing.php 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 ISCP works with the Statewide Long-term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit http://elderaffairs.state.fl.us/doea/smmcltc.php.

Section 18: Forms
Appeals Form

Thank you for contacting Magellan Complete Care. All appeals must be submitted in writing to:

Magellan Complete Care
Attn: Grievance and Appeals Department
P.O. Box 691029
Orlando, FL 32869

Magellan Complete Care (for clinical appeals only)
Attn: Complaint Coordinator
P.O. Box 2064
Maryland Heights, MO 63043

Member name: | Member ID:

Address:

Cell phone number: | Home telephone number:

The following items are included with my appeal:

- Copy of the original claim
- Medical Records enclosed
- Proof of Eligibility
- Prior authorization from Magellan Complete Care
- Other documents

What is the best time to speak with you?  ○ 8:30 am – 12:30 pm  ○ 1:00 pm – 5:00 pm

I have received a copy of my Appeal Rights in my Member Handbook. If I need assistance with understanding my Rights, Magellan Complete Care will assist in explaining this to me.

----------------------------------------------------------------------------------------------------------------------------------------
Signature of Member/Representative/Legal Guardian          Date

----------------------------------------------------------------------------------------------------------------------------------------
Print Name of Member/Representative/Legal Guardian

----------------------------------------------------------------------------------------------------------------------------------------
Contact telephone number: | Relationship if not member:

Type of Appeal:  ○ Regular appeal
                  ○ Expedited appeal (must demonstrate proof of medical emergency)

Need assistance? Please call 1-800-327-8613 (TTY 711)
Consent to Release Protected Health Information (PHI)

Magellan Complete Care will manage your care under Florida Medicaid. This includes mental and physical health benefits. This also includes services from the people listed below. We can help you best if we all have the same information about you. Part of Magellan Complete Care’s program is to have a file for your health facts that all of your doctors can see and add to.

By signing this form, you are telling us that it is OK for Magellan Complete Care and the people you list in Part 3 to share your health information with each other. If you do not sign this form, your Medicaid benefits will stay the same. These people may still share your information even if you do not sign this form but only in the way it says in the law.

If you have questions, please ask the person who gave you this form or call us at 1-800-327-8613 or our TTY number 711 if you are hearing impaired.

### Part 1
**Who is the enrollee?**
I say it is OK to let Magellan Complete Care and the providers listed below in Part 3 use/disclose the health information listed below in Part 2.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Assistance ID number (MAID #, required)</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Phone Number (with area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Part 2
**What PHI can we share?**
My health information will be shared if I sign this form. This includes medicines and any communicable diseases. It also includes my mental health, alcohol, drug and/or sexual abuse facts and treatment. This does not cover psychotherapy notes that are not in my medical records or psychological testing material. **IF** my files have drug and/or alcohol or HIV-related facts, I want to share that information as shown below:

**Drug and Alcohol Information** - **IF** my records have drug and alcohol information, I **want** to share it with the partners and the providers in Part 3 of this form.

- ☐ Yes, all drug/alcohol
- ☐ No.

**HIV/AIDS Information** - **IF** my records have HIV/AIDS information, I **want** to share it with the partners and the providers in Part 3 of this form.

- ☐ Yes, all HIV/AIDS information.
- ☐ No.

### Part 3
**Who can the PHI be given to?**
Besides Magellan Complete Care, this information can also be shared with:

<table>
<thead>
<tr>
<th>☐ Primary Care Office (PCP)</th>
<th>☐ Medical Specialist Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Mental Health Office</td>
<td></td>
</tr>
<tr>
<td>☐ Other Health Care Office</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Provider Group Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

AHCA Approved on 12/27/2019

*Magellan Complete care is a Managed Care Plan with a Florida Medicaid contract.*
Part 4  Why are you giving out this PHI?
Sharing information about my health helps providers that care for me work together. I know this means that there will be a health file about me. The people listed above will see it so they can help me better.

Part 5  Your Rights and Important Facts

- Giving your OK is up to you.
- You do not have to share more information than what the law allows.
- You do not have to OK this paper.
- You will still get benefits and treatment if you do not sign this form.
- You can take back your OK. You need to do this in writing.
- You may need help with this. Call 1-800-327-8613, TTY:711.
- Mail to: Magellan Complete Care, PO BOX 691029, Orlando, FL 32869-9903
- Information that is shared from this form may be shared again by those who get it. If this happens, it may not be protected by federal or state privacy laws. These laws do not always apply to everyone.
- **My drug and alcohol information and my HIV status cannot be shared outside of this program. I need to give another OK in writing.**
- You have a right to get a copy of this signed OK. If you need another copy, call Magellan Complete Care at 1-800-327-8613, TTY:711.
- If you do not understand, or have questions, we can help. Call Magellan Complete Care at 1-800-327-8613, TTY:711.

Part 6  When does my OK end?
My OK lasts from when I sign this form until I am no longer part of Magellan Complete Care. It also ends if I take back my OK. My OK stays in place if I have a break in my Medicaid coverage but it is fixed within six (6) months. I know that if I stop being part of Magellan Complete Care my information can be shared between my providers for up to forty-five (45) days. This way they can keep working together on my care.

Part 7  Signature of Enrollee
I give my OK to share the information as described in this paper.

---

Magellan Complete care is a Managed Care Plan with a Florida Medicaid contract.
<table>
<thead>
<tr>
<th>Part 8</th>
<th>Signature of Authorized Representative (if any)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Authorized Representative</strong></td>
<td>means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature of person signing on behalf of enrollee</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Printed Name</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

You should get a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present or future. It includes facts like your address and date of birth.

**NOTICE TO ANYONE OTHER THAN THE PATIENT**
This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
Protected Health Information (PHI) means information about your health. Federal and state laws protect the privacy of your PHI. The laws say we cannot give anyone other than your doctors or the State of Florida (AHCA) your PHI unless you say it is OK. By signing this paper, you give us your OK. We will only give out the PHI that you say we can share. And, we will only give it to the people or agencies that you list. Do you have questions? We can help. Call Magellan Complete Care at 1-800-327-8613 or our TTY number 711 if you are hearing impaired.

Part 1   Who is the enrollee?

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Initial</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ID Number</th>
<th>Date of Birth (MM/DD/YYYY)</th>
<th>Phone Number (with area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address  
City  
State  
Zip Code

Check One  
☐ I am the enrollee  OR  
☐ I have the legal right to act for this person. (Check one below; if “other” fill in blank)  
I’m his or her:  ☐ Parent  OR  ☐ Guardian,  OR  ☐ Other ________________

Part 2   Who can give out the PHI?

Magellan may give out your PHI. Magellan Complete Care manages your mental health and/or drug and alcohol treatment for Florida Medicaid.

Part 3   Who can the PHI be given to?

<table>
<thead>
<tr>
<th>Name (a person, like family members who live with me, or a place of business)</th>
<th>Phone Number (with area code)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Address  
City, State, and Zip Code

Part 4   What PHI can we share?

We will only share the PHI that you OK. This OK includes facts about your medicine. It also includes facts about your mental health and/or your alcohol and drug treatment that are in your records. It does not cover notes that are not in your medical records. Tell us the health information from your records that can be shared. Give the date or place if you can.

If you give us your OK to share this kind of health information, tell us by checking the box.

☐ HIV/AIDS  ☐ Alcohol/Substance Abuse Records  ☐ Sexual/Physical/Mental Abuse

Part 5   Why are you giving out this PHI?

Tell us why you want us to share your PHI?

Turn this page over.

MCC FL – AUD Release for Specific Information  AHCA Approved 12/27/2019

Magellan Complete Care is a Managed Care Plan with a Florida Medicaid contract.
Part 6  When does my OK end?

Your OK will end when you tell us it does. **Tell us when you want your OK to end:**

☐ My OK ends on this date  (It cannot be more than one year from your OK)

OR

☐ My OK ends when this happens:

(It can be something like - you can share my information this one time. Or “when I come out from the hospital in one month”. It cannot be “forever” or “when I die”. The event must be within one year from when you sign)

Part 7  Your Rights and Important Facts

- Giving your OK is up to you. You do not have to share your information.
- You do not have to OK this paper. You will still get benefits and treatment.
- You can take back your OK. You must tell us in writing. Mail it to Magellan Complete Care, PO Box 691029, Orlando, FL 32869-9903
- What if you take back your OK? This will not take back the PHI that we have already shared. But, we will not share any more of your PHI.
- If we share your PHI with the people or agencies that you named, they may share it with others. Not everyone has to follow privacy rules.
- You have a right to get a copy of this signed OK. If you need another copy, call Magellan Complete Care at 1-800-327-8613, TTY:711.
- If you do not understand, or have questions, we can help. Call Magellan Complete Care at 1-800-327-8613, TTY:711.

Part 8  Signature of Enrollee

I give my OK to share the information listed in this paper.

Signature or Mark of Enrollee  Date

Part 9  Signature of Authorized Representative (if any)

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the enrollee is less than 18 years old, a parent or guardian should sign for the minor.

Signature of person signing on behalf of enrollee  Date

Printed Name:

Address:

Phone:

You should get a copy of this signed paper. Remember, Protected Health Information (PHI) means any information about your health in the past, present, or future. It includes facts like your address and date of birth. A full definition of PHI is at 45 CFR §160.103.

NOTICE TO ANYONE OTHER THAN THE ENROLLEE

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by
the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
**Adult Health Assessment**

Please complete this form and send it back in the pre-paid envelope. Or you can complete this form online at www.MCCofFL.com. If you need help filling out this form, please call us at 800-327-8613 (TTY 711).

Magellan Complete Care, your health plan, wants to help you feel better and enjoy a healthy life.

These health questions will help us to better understand how you are feeling. It will help us know what services and resources you will need to stay healthy and feel well. The questions will take you about 15 minutes to complete.

As your health plan it is key that we work very closely with your doctors. We will make sure you get the care you need. If you give us the OK, we can share this information with your doctors. This will make sure you get good care and help your doctors talk to each other. Without your OK, we will not share any information with anyone.

Do you agree for us to share this information with your doctors? ○ Yes ○ No

Fields mark with an * are required.

<table>
<thead>
<tr>
<th>About You</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Enrollee’s Name</td>
</tr>
<tr>
<td>*Date of Birth</td>
</tr>
<tr>
<td>What language do you, your family, or caregiver speak?</td>
</tr>
<tr>
<td>*Sex: Male Female</td>
</tr>
<tr>
<td>*Address</td>
</tr>
<tr>
<td>*Home Phone #</td>
</tr>
</tbody>
</table>

Other Insurance:
- ○ Medicare
- ○ Long Term Care
- ○ Waiver Program
- ○ Veteran Benefits
- ○ Other

*Do you have reliable transportation to your medical appointments?*
- ○ Yes
- ○ No
- ○ Unsure

*Best day/time to reach you? ________________________________________________________________
*Where do you currently live? (select all that apply)

- House
- Apartment
- Supervised
- Homeless
- Assisted living: Name: _____________________________ Contact: _____________________________
- Shelter: Name:________________________________________
- Other: _______________________________________________

*Who do you live with? (select all that apply)

- Alone
- Roommate
- Adult family
- Minor children
- Relative/friend
- Other

Are you worried you may not have stable housing in the next two months? This could be housing that you own, rent or where you stay with family or friends.

- Yes
- No
- Unsure

Do you have a caregiver or someone we can contact if we can’t reach you?

- Yes
- No

If yes is selected, please give details: Name: _______________ Contact information: ________________

If yes, do you give Magellan Complete Care permission to give information to this person?

- Yes
- No
- Unsure

Details: _______________________________________________

**About Your Physical Health**

*Height (inches): __________________________ *Weight (lbs): __________________________

*Compared to others your age, how would you rate your overall health?*

- Poor
- Not Good
- Average
- Good
- Excellent

*Do you have any concerns about your health or physical well-being?*

- Yes
- No
- Unsure

Details: _______________________________________________

Do you have any of the following conditions:

- Arthritis/Musculoskeletal
- Asthma
- Cancer
- Depression
- Diabetes
- Heart Problems
- Hearing Impaired
- Hepatitis C
- High Blood Pressure
- HIV/AIDS
- Kidney Disease
- Liver Disease
- Schizophrenia
- Sickle Cell Anemia
- Transplant
- Visually Impaired
- Other: __________________________

Are you currently pregnant?

- Yes
- No
- Unsure

Estimated due date: __________________________

*A case manager will be reaching out to you to give more information about our Maternity program.*
About Care You Receive

*How many times have you been seen in the Emergency Room in the last 3 months?
- 0
- 1
- 2
- More than 2

*How many times have you been admitted to the hospital in the last 3 months?
- 0
- 1
- 2
- More than 2

*How many different prescriptions/medications (other than vitamins) do you take?
- None
- 1 – 3
- 4 – 7
- 8 – 11
- 11 or more

*Do you use any medical equipment or other assistive devices?
- Yes
- No
- Unsure

If yes, select type:
- Wheelchair
- Cane
- Walker
- Reacher
- Brace
- Hospital Bed
- Feeding Aides
- Oxygen
- Lifts
- Vent
- Nebulizer
- Other: ________________

Do you get assistance with Activities of Daily Living such as dressing, feeding, bathing?
- Yes
- No
- Unsure

If yes, give details: ____________________________________________________________________________

What number best describes how much, during the past week, pain has affected with your general activity?

<table>
<thead>
<tr>
<th>Does not affect</th>
<th>Completely affects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

*What is the name of your primary care provider? PCP Name: ________________________________
- N/A

*What is the name of your primary behavioral health provider? PBHP Name: ____________________
- N/A

*What is the name of your dentist? Dentist Name: ________________________________
- N/A

Do you see any other healthcare providers? If so what are their names and what do you see them for?
_____________________________________________________________________________________

Have you had any of the following done in the last 12 months?
- Flu Vaccination
  Date: ________ Provider Name: ________________ Location: ________________
- Pneumonia Vaccination
  Date: ________ Provider Name: ________________ Location: ________________
- Mammogram (women)
About Your Lifestyle

*How many meals do you eat on a regular day?
- Fewer than 3
- 3
- 4 to 6
- More than 6

*How often do you eat fast food, processed foods (such as chicken nuggets, hot dogs, bologna) or fried foods?
- Daily
- Almost every day
- Sometimes
- Never

*Which best describes your use of tobacco products?
- Never used
- Current user trying to quit
- Current user not trying to quit
- Previous user

*How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a day?
- 0
- 1 or more

*How many drinks of alcohol do you have in a typical week? (A drink = 12 oz. of beer, a 5 oz. glass of wine, a 12 oz. wine cooler, or a shot of whisky)
- None
- 1 to 7
- 8 to 14
- >14

*Do you have any substance use concerns?
- Yes
- No
- Unsure

Details: ____________________________________________________________

*How would you describe your physical activity/exercise level?
- High
- Moderate
- Low

In the past 4 weeks, how many days did you miss from work or school because of problems with your physical or mental health? (Please include only days missed for your own, not someone else’s health.)
- None
- 1 to 2 times
- 3 to 4 times
- 5 or more times

During the past 7 days, how much did your physical or mental health affect you being able to do things at work or at school?
- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

About Your Safety

*Do you keep your doors locked at night?
- Yes
- No
- N/A

*Do you keep emergency supplies in your home (such as a first aid kit and canned food)?
- Yes
- No
- N/A
Details: ____________________________________________________________

*Do you wear a seatbelt when traveling in a motor vehicle?  
   - Yes  
   - No  
   - N/A

*Do you talk or text on the phone while driving?  
   - Yes  
   - No  
   - N/A

About Your Emotional Health
How often do you feel stressed?  
   - Never  
   - Sometimes  
   - A lot  
   - All of the time

Over the past 2 weeks, how often have you been bothered by any of the following problems?  
*Little interest or pleasure in doing things  
   - Not at all  
   - Several days  
   - More than half days  
   - Nearly every day

*Feeling down, depressed or hopeless  
   - Not at all  
   - Several days  
   - More than half days  
   - Nearly every day

About Your Future Health
*How important is it to you to make a change to your health right now?  
   - Not sure  
   - Somewhat sure  
   - Very sure

   0 1 2 3 4 5 6 7 8 9 10

*How confident are you about making a change to your health right now?  
   - Not sure  
   - Somewhat sure  
   - Very sure

   0 1 2 3 4 5 6 7 8 9 10

*How ready are you to make a change to your health right now?  
   - Not sure  
   - Somewhat sure  
   - Very sure

   0 1 2 3 4 5 6 7 8 9 10
**Child Health Assessment**

Please complete this form and send it back in the pre-paid envelope. Or you can complete this form online at www.MCCofFL.com. If you need help filling out this form, please call us at 800-327-8613 (TTY 711).

Magellan Complete Care, your health plan, wants to help you or your child feel better and enjoy a healthy life.

These health questions will help us to better understand how you or your child is feeling. It will help us know what services and resources you will need to stay healthy and feel well. The questions will take you about 15 minutes to complete.

As your or your child’s health plan it is key that we work very closely with your doctors. We will make sure you get the care you need. If you give us the OK, we can share this information with your or your child’s doctors. This will make sure you or your child gets good care and help your (your child’s) doctors talk to each other. Without your OK, we will not share any information with anyone.

Do you agree for us to share this information with your doctors? ○ Yes ○ No

Fields mark with an * are required. Date completed: _____________________

**About You/Your Child**

<table>
<thead>
<tr>
<th>*Enrollee’s Name</th>
<th>*Medicaid ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>*Date of Birth</td>
<td>Age</td>
</tr>
<tr>
<td>What language do you, your family, or caregiver speak?</td>
<td>Race/Ethnicity</td>
</tr>
<tr>
<td>*Sex: Male Female</td>
<td>*Date of Enrollment</td>
</tr>
<tr>
<td>*Address</td>
<td></td>
</tr>
<tr>
<td>*Home Phone #</td>
<td>Cell Phone #</td>
</tr>
</tbody>
</table>

Other Insurance:
○ Medicare ○ Long Term Care ○ Waiver Program ○ Veteran Benefits ○ Other

*Do you/your child have reliable transportation to appointments? ○ Yes ○ No ○ Unsure

*Best day/time to reach you (to go over information about your child)? _________________________
Where do you (or your child) currently live? (select all that apply)
- House
- Apartment
- Homeless
- Assisted living: Name: ___________________________ Contact: ___________________________
- Shelter: Name: ___________________________
- Other: _______________

Who do you (or your child) live with? (select all that apply)
- Mother
- Father
- Both parents
- Relative/friend
- Protective custody
- Foster care
- Other

Do you / (Does your child) have a caregiver or someone we can contact if we can’t reach you?  ○ Yes  ○ No
If yes is selected, please give details: Name: ___________________________ Contact information: ___________________________
If yes, do you give Magellan Complete Care permission to give information to this person?  ○ Yes  ○ No
Details: __________________________________________________________

About You/Your Child’s Physical Health
*How tall (inches) are you (your child)? ____________
*How much do you (your child) weigh (lbs)? ____________
*Do you have any concerns about your (your child’s) overall health?  ○ Yes  ○ No  ○ Unsure

In the past 4 weeks, how many days did you (your child) miss from work or school because of problems with your/their physical or mental health? (Please include only days missed for your own/your child’s health, not someone else’s health.)
- None
- 1 to 2 times
- 3 to 4 times
- 5 or more times

During the past 7 days, how much did your (the child’s) physical or mental health affect you/your child being able to do things at work or at school?
- Not at all
- A little bit
- Moderately
- Quite a bit
- Extremely

Do you (your child) have any of the following:
- Asthma
- Anxiety
- Cancer
- Cerebral Palsy
- Cystic Fibrosis
- Depression
- Diabetes
- Down Syndrome
- Epilepsy/Seizure disorder
- Heart Problems
- Hearing Impaired
- Hemophilia
- Hepatitis C
- High Blood Pressure
- HIV/AIDS
- Kidney Disease
- Learning Disabilities
- Liver Disease
- Schizophrenia
- Sickle Cell Anemia
- Transplant
- Visually Impaired
- Other: _______________

Are you (your child) currently pregnant?  ○ Yes  ○ No  ○ Unsure  Estimated due date: ____________

A case manager will be reaching out to you to give more information about our Maternity program.
About Care You/Your Child Receives

*How many times have you (has your child) been seen in the Emergency Room in the last 3 months?
- 0
- 1
- 2
- More than 2

*How many times have you/ (has your child) stayed overnight in a hospital room in the past 3 months?
- 0
- 1
- 2
- More than 2

*Have you (your child) had any major falls or injuries in the last 6 months? ○ Yes ○ No ○ Unsure

*Do you/ (does your child) use any medical equipment? ○ Yes ○ No ○ Unsure
If yes, select type:
- Wheelchair
- Cane
- Walker
- Reacher
- Brace
- Hospital Bed
- Feeding Aides
- Oxygen
- Lifts
- Vent
- Nebulizer
- Other: ________________________

Do you (the child) get assistance with Activities of Daily Living such as dressing, feeding, bathing?
- Yes
- No
- Unsure
If yes, give details: ________________________________________________________________

What number best describes how much, during the past week, pain has affected with your (your child’s) general activity?

<table>
<thead>
<tr>
<th>Does not affect</th>
<th>Completely affects</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>

*How many different prescriptions/medications (other than vitamins) do you (does your child) take?
- None
- 1 – 3
- 4 – 7
- 8 – 11
- 11 or more

*What is the name of your (your child’s) primary care provider?
PCP Name: ________________________ ○ N/A

*What is the name of your (your child’s) primary behavioral health provider?
PBHP Name: ________________________ ○ N/A

*What is the name of your (your child’s) dentist?
Dentist Name: ________________________ ○ N/A

Do you/ (Does your child) see any other healthcare providers? If so what are their names and what do you (does your child) see them for? ______________________________________________________________

*Have you/(Has your child) had any of the following health screenings in last 12 months? Please document the date of the last exam for each of the items that apply.

- Routine Physical Exam (CHCUP)
  Date: ________________________
  Provider Name: ________________________
  Office Location: ________________________

- Tetanus Vaccination (ages 10-13 only)
  Date: ________________________
  Provider Name: ________________________
  Office Location: ________________________
About Your/Your Child’s Lifestyle

*How many meals do you (your child) eat on a regular day?
- Fewer than 3
- 3
- 4 to 6
- More than 6

*How often do you (does your child) eat fast food, processed foods (such as chicken nuggets, hot dogs, bologna) or fried foods?
- Daily
- Almost every day
- Sometimes
- Never

*How would you describe your (the child’s) physical activity/exercise level?
- High
- Moderate
- Low

*On average how many hours of sleep do you (your child) get per night?
- Less than 5
- More than 5 but less than 7
- 7 to 8 hours
- More than 8 hours

*Do you (your child) currently use tobacco products?  ○ Yes  ○ No  ○ Unsure

*Are there any substance use concerns for you (your child)?  ○ Yes  ○ No  ○ Unsure

About Your/Your Child’s Emotional Health

Over the past 2 weeks, how often have you (has your child) been bothered by any of the following problems?

*Little interest or pleasure in doing things?
- Not at all
- Several days
- More than half days
- Nearly every day

*Feeling down, depressed or hopeless?
- Not at all
- Several days
- More than half days
- Nearly every day

About Your/Your Child’s Safety

*Do you keep your doors locked at night?
- Yes
- No
- N/A

*Do you keep emergency supplies in your home (such as a first aid kit and canned food)?
- Yes
- No
- N/A

Details: ____________________________________________________________________________
*Do you/your child wear a seatbelt when traveling in a motor vehicle?  
  ○ Yes  ○ No  ○ N/A

*Do you talk or text on the phone while driving?  
  ○ Yes  ○ No  ○ N/A

**About Your/Your Child’s Future Health**

*How important is it to you/your child to make a change to your health right now?*

<table>
<thead>
<tr>
<th>Not sure</th>
<th>Somewhat sure</th>
<th>Very sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

*How confident are you/your child about making a change to your health right now?*

<table>
<thead>
<tr>
<th>Not sure</th>
<th>Somewhat sure</th>
<th>Very sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

*How ready are you/your child to make a change to your health right now?*

<table>
<thead>
<tr>
<th>Not sure</th>
<th>Somewhat sure</th>
<th>Very sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
Grievance Form

Mail to: Magellan Complete Care  
Attn: Grievance and Appeals Department  
PO Box 691029  
Orlando, FL 32769

Member name: | Member ID:  
Address:  

Cell phone number: | Home telephone number:  
Date problem occurred:  
Where did this happen:  

Did you call anyone at Magellan or the doctor's office for help?  
☐ Yes  ☐ No  
If yes, what is their name and telephone number?  
Name: | Telephone number:  

Please describe the problem that you experienced:  

Did you ask anyone to resolve the problem you encountered?  
☐ Yes  ☐ No  

What is the best time to speak with you?  
☐ 8:30 am – 12:30 pm  ☐ 1:00 pm – 5:00 pm  

I understand that Magellan Complete Care will (1) contact me within 5-working days of receipt of this form; (2) I will be notified by Magellan Complete Care regarding their initial findings; (3) I will be notified of my Rights to an appeal if I'm not satisfied with Magellan Complete Care’s findings.

Signature of Member/Representative/Legal Guardian

Date

Print Name of Member/Representative/Legal Guardian

Contact telephone number: | Relationship if not member:

Need assistance? Please call 1-800-327-8613 (TTY 711)
Living Will

Declaration made this ______ day of ______________________________, 20______,

I, ________________________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and ________ (initial) I have a terminal condition,
or ________ (initial) I have an end-stage condition,
or ________ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do ______, I do not ______ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name ___________________________________________________________________________________

Street Address __________________________________________________________________________

City ___________________________ State _______ Phone _________________________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional): ___________________________________________________________________________________

_____________________________________________________________________________________

Signed ____________________________________________ Date __________________________

Need assistance? Please call 1-800-327-8613 (TTY 711)
Signature of Witnesses:

Witness #1 ________________________________________________________________
Street Address____________________________________________________________________
City ____________________________ State _______ Phone __________________________

Witness #2 ________________________________________________________________
Street Address____________________________________________________________________
City ____________________________ State _______ Phone __________________________

At least one witness must not be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:

“End-stage condition” means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

“Persistent vegetative state” means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

“Terminal condition” means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.
Designation of Health Care Surrogate

I, _________________________________________________ , designate as my health care surrogate under s. 765.202, Florida Statutes:

Name _________________________________________________

Street Address ___________________________________________

City ____________________________ State _______ Phone ____________________________

If my health care surrogate is not willing, able or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name _________________________________________________

Street Address ___________________________________________

City ____________________________ State _______ Phone ____________________________

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to:

(Initial here) _______ Receive any of my health information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

(Initial here) _______ Make all health care decisions for me, which means she or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.

2. Apply on my behalf for private, public, government, or veteran’s benefits to defray the cost of health care.

3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.

4. Decide to make an anatomical gift pursuant to Part V of Chapter 765, Florida Statutes.

Need assistance? Please call 1-800-327-8613 (TTY 711)
Specific instructions and restrictions:

While I have decision making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THE HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:
1. SIGNING A WRITTEN STATEMENT AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
2. PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;
3. VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION;
4. SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

MY HEALTH CARE SURROGATE’S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

IF I INITIAL THIS BOX ☐, MY HEALTH CARE SURROGATE’S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

IF I INITIAL THIS BOX ☐, MY HEALTH CARE SURROGATE’S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.2014(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERCEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

SIGNATURES:

Sign and date the form here

Sign Your Name ____________________________________ Date __________________________

Print Your Name ____________________________________

Street Address _____________________________________

City __________________________ State __________________

Need assistance? Please call 1-800-327-8613 (TTY 711)
Signature of Witnesses:

First Witness

Signature __________________________________________ Date ________________________
Print Name ________________________ Street Address ________________________
City __________________________ State __________________________

Second Witness

Signature __________________________________________ Date ________________________
Print Name ________________________ Street Address ________________________
City __________________________ State __________________________
Designation of Health Care Surrogate for Minor

I/We, ________________________________________________, the natural guardian(s) as defined in s. 744.301(1), Florida Statutes; □ legal custodian(s); □ legal guardian(s) (Check One) for the following minor(s):

________________________________________
________________________________________
________________________________________
________________________________________

Pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I/We am/are not able or reasonably available to provide consent for medical treatment and surgical and diagnostic procedure:

Name _____________________________________________________________

Street Address _______________________________________________________

City ___________________________ State _________ Phone _______________________

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/We designate the following person as my/our alternate health care surrogate for a minor:

Name _____________________________________________________________

Street Address _______________________________________________________

City ___________________________ State _________ Phone _______________________

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

Need assistance? Please call 1-800-327-8613 (TTY 711)
I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name __________________________________________________________________________

Name __________________________________________________________________________

Signature ___________________________________ Date __________________________

Witnesses:

1. __________________________________________________________________________

2. __________________________________________________________________________
Uniform Donor Form

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver’s license or state identification card (at your nearest driver’s license office).

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give: (a) __________ any needed organs or parts
(b) __________ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:
_______________________________________________________________________________
_______________________________________________________________________________
(c) __________ my body for anatomical study if needed. Limitations or special wishes, if any:
_______________________________________________________________________________
_______________________________________________________________________________

Signed by the donor and the following witnesses in the presence of each other:

Donor’s Signature ___________________________ Donor’s Date of Birth ________________
Date signed ___________________________ City and State ________________________________

Witness #1 ________________________________________________________________
Street Address ____________________________________________________________
City __________________________ State ________ Phone _________________________

Witness #2 ________________________________________________________________
Street Address ____________________________________________________________
City __________________________ State ________ Phone _________________________

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver’s license or state identification card (at your nearest driver’s license office).

Need assistance? Please call 1-800-327-8613 (TTY 711)
Health Care Advance Directives

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

**Health Care Advance Directives**

I, __________________________

have created the following Advance Directives:

- Living Will
- Health Care Surrogate Designation
- Anatomical Donation
- Other (specify) __________________

**Contact Information:**

Name __________________________
Address _________________________
Phone __________________________
Signature _________________________
Date _____________________________

Need assistance? Please call 1-800-327-8613 (TTY 711)
If you are a person living with a disability we offer free help and services. Please call 800-327-8613 or 711 (TTY only) if you need sign language interpreters, large print, Braille, audio, electronic or any other formats.

Si usted es una persona que vive con una discapacidad, le ofrecemos ayuda y servicios gratuitos. Llame al 800-327-8613 o al 711 (TTY únicamente) si necesita intérpretes de lenguaje de señas, letra grande, Braille, audio, electrónico o cualquier otro formato.

Si ou se yon moun ki andikape, nou ka ba ou kichòy ak sèvis gratis. Tanpri rele 800-327-8613 oswa 711 (TTY sèlman) si ou ta bezwen yon moun ki ka tradwi pou moun soud, ak gwo ekriti, ak ekriti pou moun ki pa ka wè, ak son, nan yon fòm ki elektwonik oswa nan yon lòt fason.

Si vous êtes une personne souffrant d’un handicap, nous offrons une aide et des services gratuits. Veuillez appeler le 800-327-8613 ou le 711 (ATS uniquement) si vous avez besoin d’interprètes en langue des signes, en gros caractères, en braille, en audio, en format électronique ou tout autre format.

Offriamo aiuto e servizi gratuiti alle persone con disabilità. Chiama il numero 800-327-8613 o 711 (solo DTS) se hai bisogno di un interprete di lingua dei segni, stampa a caratteri grandi, Braille, formato audio, elettronico o qualsiasi altro formato.
Мы бесплатно предлагаем помощь и услуги людям с инвалидностью. Если вам требуется помощь сурдопереводчика, нужна информация крупным шрифтом или шрифтом Брайля, в электронном, аудио- или других форматах, звоните по телефону 800-327-8613. Пользователям ТТУ следует набирать 711.

**Non-Discrimination Notice**

Discrimination is against the law. Magellan Complete Care follows the law. We treat all people equally. We do not discriminate against anyone based on:
- Race.
- Color.
- National origin.
- Age.
- Disability.
- Sex.

We provide free help and services to people with disabilities. We want you to be able to communicate with us easily. We offer:
- Qualified sign language interpreters.
- Written information in many formats. These may include:
  - Large print.
  - Audio.
  - Accessible electronic formats.
  - Other formats.

We also provide free language services to people whose first language is not English. We offer:
- Qualified interpreters.
- Information that is written in other languages.

Contact us at 1-800-327-8613 (TTY 711) if you need any of these services.

If you believe we have not provided these services or discriminated in another way, you can file a grievance with:

**Civil Rights Coordinator, Corporate Compliance Department**

8621 Robert Fulton Drive
Columbia, MD 21046
1-800-424-7721
compliance@magellanhealth.com

You can file a grievance in two ways.
- By mail.
- By email.
The civil rights coordinator is available if you need help with any of this. You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You may do this online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Or you may do this by mail or phone.

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

Complaint forms are available online. You may find them at http://www.hhs.gov/ocr/office/file/index.html.