sunshine health™

SUNSHINE HEALTH'S FLORIDA MEDICAID

MEMBER HANDBOOK

Sunshine Health Pathway to Shine Child Welfare Specialty Plan

1-855-463-4100
TTY 1-800-955-8770
Effective Feb.1, 2025

SunshineHealth.com/CW
CW_8488

“If you do not speak English, call us at 1-855-463-4100. 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 1-855-463-4100. 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 1-855-463-4100. 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 1-855-463-4100. 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 1-855-463-4100. 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 1-855-463-4100. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Vietnamese: “**Nếu bạn không nói được tiếng Anh**, hãy gọi cho chúng tôi theo số 1-855-463-4100. Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn."

Important Contact Information

Member Services Help Line	1-855-463-4100	Available 24 hours
Member Services Help Line TTY	1-800-955-8770	Available 24 hours
Website	SunshineHealth.com/CW	
Address	P.O. Box 459089 Fort Lauderdale, FL 33345-9089	

Transportation Services: Non-Emergency	Reservations and Ride Assist (Where's My Ride?): 1-844-352-0414 (TTY 711)
Pharmacy Services	1-800-460-8988
Disease Management	1-800-942-4008
Nurse Advice Line	1-855-463-4100
Dental Services	Contact your case manager directly or at 1-855-463-4100 for help with arranging these services.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-800-96-ABUSE (1-800-962-2873) TTY: 711 or 1-800-955-8771 https://www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse
For Medicaid Eligibility	1-866-762-2237 TTY: 711 or 1-800-955-8771 https://www.myflfamilies.com/medicaid#ME
To report Medicaid Fraud and/or Abuse	1-888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	1-888-419-3456 http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml
To request a Medicaid Fair Hearing	1-877-254-1055 1-239-338-2642 (fax) MedicaidHearingUnit@ahca.myflorida.com

To file a complaint about Medicaid services	1-877-254-1055 TDD: 1-866-467-4970 http://ahca.myflorida.com/Medicaid/complaints/
To find information for elders	1-800-96-ELDER (1-800-963-5337) http://www.elderaffairs.org/doea/arc.php
To find out information about domestic violence	1-800-799-SAFE (1-800-799-7233) TTY: 1-800-787-3224 http://www.thehotline.org/
To find information about health facilities in Florida	https://quality.healthfinder.fl.gov/
To find information about urgent care	Call 1-855-463-4100 or visit our website at SunshineHealth.com
For an emergency	9-1-1 Or go to the nearest emergency room
For a Behavioral Health emergency	Call 988

Table of Contents

Welcome to Sunshine Health Pathway to Shine Child Welfare Specialty Plan

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

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

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

If you are a participant in the Intellectual Developmentally Disabled (IDD) Pilot Program, most of the information in this handbook applies to you. We will let you know if something does not apply or if there is information that applies to IDD enrollees.

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 1-855-463-4100.

Section 1: Your Plan Identification Card (ID card)

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

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

Your ID card will look like this:

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:

For help to translate or understand this, please call Member Services: 1-855-463-4100 (TTY 1-800-955-8770).

Covered Entity's Duties:

Sunshine Health is a Covered Entity as defined and regulated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Sunshine Health is required by law to maintain the privacy of your protected health information (PHI), provide you with this Notice of our legal duties and privacy practices related to your PHI, abide by the terms of the Notice that is currently in affect and notify you in the event of a breach of your unsecured PHI.

This Notice describes how we may use and disclose your PHI. It also describes your rights to access, amend and manage your PHI and how to exercise those rights. All other uses and disclosures of your PHI not described in this Notice will be made only with your written authorization.

Sunshine Health reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Sunshine Health will promptly revise and distribute this Notice whenever there is a material change to the following:

- The Uses or Disclosures
- Your rights
- Our legal duties
- Other privacy practices stated in the notice

We will make any revised Notices available on our website or through a separate mailing.

Internal Protections of Oral, Written and Electronic PHI:

Sunshine Health protects your PHI. We are also committed to keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential. We have privacy and security processes to help.

These are some of the ways we protect your PHI:

- We train our staff to follow our privacy and security processes.
- We require our business associates to follow privacy and security processes.
- We keep our offices secure.
- We talk about your PHI only for a business reason with people who need to know.
- We keep your PHI secure when we send it or store it electronically.
- We use technology to keep the wrong people from accessing your PHI.

Permissible Uses and Disclosures of Your PHI:

The following is a list of how we may use or disclose your PHI without your permission or authorization:

- **Treatment:** We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- **Payment:** We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, and reviewing services for medical necessity.

- **Healthcare Operations:** We may use and disclose your PHI to perform our healthcare operations. These activities may include providing customer service, responding to complaints and appeals, and providing care management and care coordination.
  In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:
    - Quality assessment and improvement activities
    - Reviewing the competence or qualifications of healthcare professionals
    - Case management and care coordination
    - Detecting or preventing healthcare fraud and abuse

Your race, ethnicity, language, sexual orientation and gender identity are protected by the health plan's systems and laws. This means information you provide is private and secure. We can only share this information with healthcare providers. It will not be shared with others without your permission or authorization. We use this information to help improve the quality of your care and services. This information helps us to:

- Better understand your healthcare needs.
- Know your language preference when seeing healthcare providers.
- Providing healthcare information to meet your care needs.
- Offer programs to help you be your healthiest.

This information is not used for underwriting purposes or to make decisions about whether you are able to receive coverage or services.

- **Group Health Plan/Plan Sponsor Disclosures:** We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

Other Permitted or Required Disclosures of Your PHI:

- **Fundraising Activities:** We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- **Underwriting Purposes:** We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- **Appointment Reminders/Treatment Alternatives**: We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- **As Required by Law**: If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- **Public Health Activities:** We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.
- **Victims of Abuse and Neglect**: We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings**: We may disclose your PHI in response to an administrative or court order. We may also be required to disclose your PHI to respond to a subpoena, discovery request, or other similar requests.
- **Law Enforcement**: We may disclose your relevant PHI to law enforcement when required to do so for the purposes of responding to a crime.
- **Coroners, Medical Examiners and Funeral Directors**: We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- **Organ, Eye and Tissue Donation**: We may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of cadaveric organs, eyes, and tissues.
- **Threats to Health and Safety**: We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

- **Specialized Government Functions**: If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security concerns, intelligence activities, The Department of State for medical suitability determinations, the protection of the President, and other authorized persons as may be required by law.
- **Workers' Compensation**: We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations**: We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- **Inmates**: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- **Research:** Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

We are required to obtain your written authorization to use or disclose your PHI, with limited exceptions, for the following reasons:

- **Sale of PHI:** We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- **Marketing:** We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- **Psychotherapy Notes:** We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

You have the right to revoke your authorization, in writing at any time except to the extent that we have already used or disclosed your PHI based on that initial authorization.

Individuals Rights

The following are your rights concerning your PHI. If you would like to use any of the following rights, please contact us using the information at the end of this Notice.

- **Right to Request Restrictions:** You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment, or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.
- **Right to Access and Receive a Copy of your PHI:** You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed. We will also tell you how to ask for such a review or if the denial cannot be reviewed.
- **Right to Amend your PHI:** You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to

inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

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

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY 1-866-788-4989) or visiting the U.S. Department of Health & Human Services website at https://www.hhs.gov/hipaa/filing-a-complaint/what-to-expect/index.html.

WE WILL NOT TAKE ANY ACTION AGAINST YOU FOR FILING A COMPLAINT.

- **Right to Receive a Copy of this Notice**: You may request a copy of our Notice at any time by using the contact information listed at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.

Contact Information

Questions about this Notice: If you have any questions about this notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone:

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

Section 3: Getting Help from Our Member Services

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

Contacting Member Services

You may call us at 1-855-463-4100 (TTY 1-800-955-8770). Monday to Friday, 8 a.m. to 8 p.m., but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. **(**If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call our 24 Hour Nurse Advice Line at 1-855-463-4100 (TTY 1-800-955-8770). 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 1-855-463-4100 (TTY 1-800-955-8770). They will connect you to us
- Information and materials in large print, audio (sound); and braille
- Help in making or getting to appointments
- Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

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

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

Section 6: Changes to your Health Plan

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

Section 7: Your Medicaid Eligibility

You must be covered by Medicaid and enrolled in our plan for Sunshine Health Pathway to Shine Child Welfare Specialty Plan to pay for your health care services and health care appointments. This is called having **Medicaid eligibility**. If you receive SSI, you qualify for Medicaid. If you do not receive SSI, you must apply for Medicaid with DCF.

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

If you Lose your Medicaid Eligibility

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

If you have Medicare

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

If you are having a baby

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

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

Section 8: Enrollment in Our Plan

Initial Enrollment

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

Open Enrollment Period

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

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

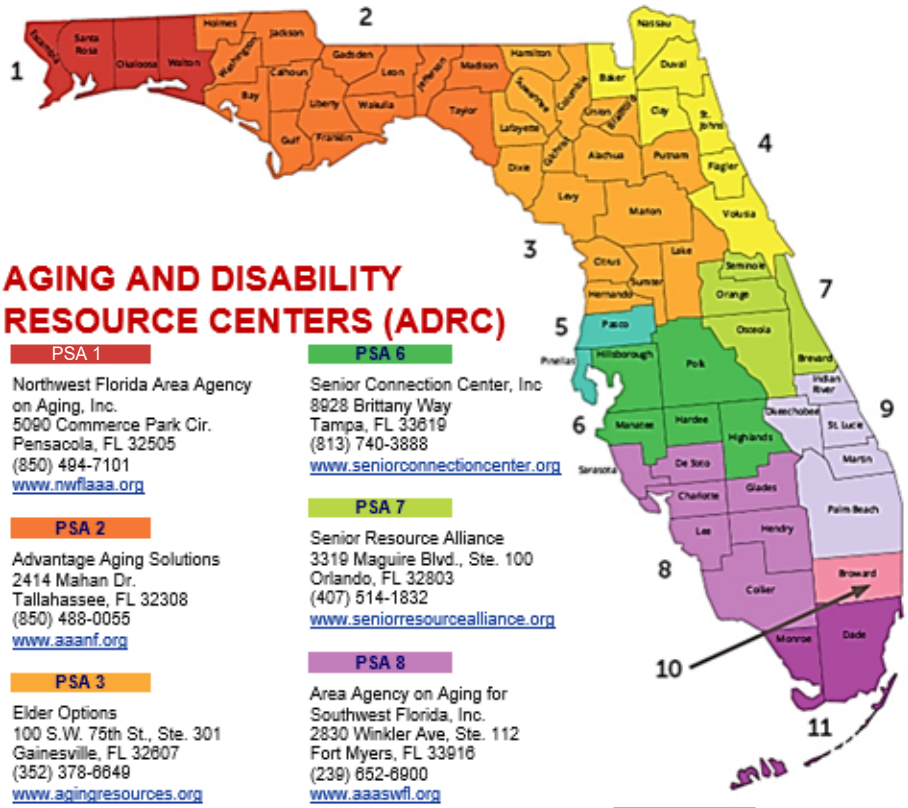
Enrollment in the SMMC Long-Term Care Program

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

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

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list and a space becomes available for you in the LTC program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

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



AGING AND DISABILITY RESOURCE CENTERS (ADRC)

PSA 1

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

PSA 2

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

PSA 3

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

PSA 4

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

PSA 5

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

PSA 6

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

PSA 7

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

PSA 8

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

PSA 9

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

PSA 10

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

PSA 11

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Section 9: Leaving Our Plan (Disenrollment)

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

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

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

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

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

If you have any questions about whether you can change plans, call Member Services 1-855-463-4100 (TTY 1-800-955-8770) or the State's Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

Removal from Our Plan (Involuntary Disenrollment)

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

- You lose your Medicaid eligibility
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions

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

[2] To learn how to ask for an appeal, please turn to Section 16, Member Satisfaction, on page 66.

- You or your caregivers behave in a way that makes it hard for us to provide you with care
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[3]

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

Section 10: Managing Your Care

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

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

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

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

Important Things to Tell Your Case Manager
If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

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

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

- Your name, telephone number, address, or county changes

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

Section 11: Accessing Services

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

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

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call 1-855-463-4100 (TTY 1-800-955-8770) to get a copy or visit our website at SunshineHealth.com.

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

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

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

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

you use a provider that is not in our provider network. If you have questions, call Member Services.

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Sunshine Health. Contact Member Services at 1-855-463-4100 (TTY 1-800-955-8770) for help with arranging these services.

What Do I Have To Pay For?

You may have to pay for appointments or services that are not covered**.** A **covered service** is a service we must provide in the Medicaid program. All the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

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

Services for Children[4]

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

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

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

Services Covered by the Medicaid Fee-for-Service Delivery System, Not Covered Through Sunshine Health Pathway to Shine Child Welfare Specialty Plan

The Medicaid fee-for-service program is responsible for covering the following services, instead of Sunshine Health Pathway to Shine Child Welfare Specialty Plan covering these services:

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

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

- 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 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)
If you have Medicare, please contact the number on your Medicare ID card for information about your PCP.

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

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

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

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

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and

how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.[5]

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

You do not need a referral for well child visits. Also, there is no charge for well child visits.

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

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

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

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

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

If you need Urgent Care after office hours and you cannot reach your PCP, call our 24-hour Nurse Advice Line at 1-855-463-4100. You will be connected to a nurse. Have your Sunshine Health ID card number handy. The nurse may help you over the phone or direct you to other care. You may have to give the nurse your phone number. During normal office hours, the nurse will assist you in contacting your PCP.

You may also find the closest Urgent Care center to you by calling Member Services at 1-855-463-4100 or visiting our website at SunshineHealth.com and clicking "Find a Provider.

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

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

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

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

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

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

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

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

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

Provider Standards for PCP and Specialist Appointment Scheduling

PCP Appointment Type	Access Standard
Urgent Care	Within 48 hours for service that does not require prior authorization and within 96 hours for services that do require prior authorization
Regular and Routine Well Exam	Within 30 days
After Hours Care	Primary Care Providers must have a call receiving service that connects members with a provider. Most primary care providers also offer after hours appointment availability to Medicaid members.

Specialist Appointment Type	Access Standard
New Patient Appointment	Within 60 days of request with appropriate referral
Routine Prenatal Exams	Within four weeks until week 32, every two weeks until week 36 and every week thereafter until delivery
Oncology: New Patient Appointment	Within 30 days of request
Follow Up After Physical Health Admission	Within seven days of discharge from the hospital

Behavioral Health Appointment Type	Access Standard
Non-life-Threatening Emergency	Within six hours
Urgent Access	Within 48 hours
Initial Visit for Routine Care	Within 10 business days
Follow Up for Routine Care	Within 30 calendar days
Follow Up After Behavioral Health Hospital Admission	Within seven calendar days
After Hours	Your BH provider must have a call receiving service that is answered by a live person.

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. You can find this list on our Web site at SunshineHealth.com/cw-pharmacy or by calling Member Services.

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

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

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

Specialty Pharmacy Information
Some drugs are not available at a local pharmacy. These drugs are supplied by a specialty pharmacy provider. These drugs may need prior approval before your prescription can be filled. The pharmacy will tell your doctor if the drugs have to be supplied by a specialty pharmacy and if you need a prior approval.

Sunshine Health partners with AcariaHealth to provide specialty drugs. These are drugs that treat complex conditions. They require extra support to make sure they are used correctly. You will be offered the option to select a different specialty pharmacy by mail, after your initial specialty medication is filled. If you want a different specialty pharmacy, complete the Specialty Pharmacy Change Request Form provided, and we will review and let you know if it is approved.

If you have questions about any of the pharmacy services or need help with this form, call Member Services at 1-855-463-4100.

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

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

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

- Calling Member Services at 1-855-463-4100
- Looking at our provider directory
- Going to our website at SunshineHealth.com

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:

Health Coaching Programs

Focus Area	Activity	Reward Amount & Frequency
Tobacco Cessation	Ages 10 years and older. Must consent to participate and pledge to stop tobacco use. Complete four sessions by phone with a health coach within six months.	Up to $20 per calendar year, $5 after each session.
Weight Management	Ages 10 years and older. Must consent to participate and pledge to lose weight within 30 days. Complete six sessions by phone with a health coach within six months.	$20, one reward per calendar year.
Substance Use	Ages 12 years and older. Enrollment in Care Management is required. Must consent to participate. Complete three sessions with a Care Manager within three months.	$10, one reward per calendar year.

What is a Health Coaching Session?

The sessions are completed over the phone to fit your schedule. During these sessions, our Health Coaches can help answer questions about how to improve your health. They can also provide education and support to help our members set goals and make better lifestyle choices.

How can you schedule a Health Coaching Session?

To get connected to a Health Coach, please call Member Services at 1-855-463-4100 (TTY: 1-800-955-8770), Monday through Friday from 8 a.m. to 8 p.m. Eastern.

Preventative Care Programs

Focus Area	Activity	Reward Amount & Frequency
Annual Well Child Visit	For children and adolescents, ages 0-21 years. Complete one wellness visit per calendar year with a primary care provider.	$30, one reward per calendar year.
Childhood Immunization Status (Combo 3)	For children to complete before their 2nd birthday. Complete series of immunizations: • 4 doses diphtheria, tetanus, and pertussis (DTaP) • 3 doses inactivated poliovirus (IPV)	$30, one reward per lifetime.

	• 1 dose measles, mumps, and rubella (MMR) • 3 doses haemophilus influenza type B (HiB) • 3 doses hepatitis B • 1 dose varicella-zoster virus (chicken pox or VZV • 4 doses pneumococcal conjugate vaccinations (PCV)	
Immunizations for Adolescents (Combo 2)	For adolescents, ages 10-13 years, to complete by their 13th birthday. Complete series of immunizations: • 1 dose meningococcal vaccine • 1 dose tetanus, diphtheria, pertussis (Tdap) • 2-3 doses human papillomavirus (HPV)	$20, one reward per lifetime.
HPV Vaccine Series	For children and young adults, ages 13-26 years. Complete 2-3 doses human papillomavirus (HPV) vaccine.	$20, one reward per lifetime.
Lead Screening in Children	For children to complete by their 2nd birthday. Complete an annual blood test for lead poisoning screening.	$20, one reward per calendar year, up to age 2.
HRA for New Members	For new members within 60 days of enrollment. Complete a health risk assessment (HRA).	$20, one reward per lifetime.

Pregnancy Programs

Focus Area	Activity	Reward Amount & Frequency
Notification of Pregnancy (1st Trimester)	Complete and sign a Notification of Pregnancy (NOP) form. Submit it to the health plan within the first trimester.	$20, one reward per calendar year.
Prenatal Visit	Complete three prenatal visits during pregnancy.	$50, one reward per calendar year.
Postpartum Visit	Complete one postpartum follow up visit between 7-84 days after delivery.	$40, one reward per calendar year.
TDAP for Pregnant Women	One dose of tetanus, diphtheria, pertussis (Tdap) vaccine during pregnancy.	$20, one reward per calendar year.

Chronic Conditions & Mental Health Programs

Focus Area	Activity	Reward Amount & Frequency
Dilated Eye Exam	Diagnosed with diabetes. Complete a dilated eye exam once per calendar year.	$10, one reward per calendar year.
HbA1c Test	Diagnosed with diabetes, ages 18-75 years. Complete a HbA1c test once per calendar year.	$20, one reward per calendar year.
Hematologist Visits	Diagnosed with sickle cell disease. Complete two hematologist visits per calendar year.	$20, one reward per calendar year.
Follow Up After Inpatient Admission for Mental Illness	Ages 6 years and older. Complete an outpatient follow up appointment with a behavioral health provider within 7 days after discharge from an inpatient facility.	$20, two rewards per calendar year.
Follow Up After Emergency Department Visit for Mental Illness	Ages 6 years and older. Complete an outpatient follow up appointment with a provider within 7 days after an emergency room visit.	$20, two rewards per calendar year.

Earning rewards is easy! When you make certain healthy choices, reward dollars will automatically be put on your rewards card. If it's your first reward, a card will be mailed to you. You will receive rewards for any claims-related items once Sunshine Health has paid the provider's claim.

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 1-855-463-4100 (TTY 1-800-955-8770).

Chronic Disease Management Programs

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

Cancer and Cancer Prevention: Our program will focus on your individualized care and treatment plan, providing resources, tools, reviewing benefits, and assessment of other needs to assist in your journey. We will also provide on measures to reduce the risk of cancer and recommended screenings.

Diabetes and Diabetes Prevention: Our Diabetes Chronic Condition Management Program will focus on education, providing resources and tools, measures to prevent complications of diabetes and improve health outcomes. We will provide education on measures to reduce the risk of diabetes and/or complications. We also offer a diabetes telemonitoring program for members that meet criteria to help manage condition.

Depression and Depression Prevention (including suicide prevention) Our Program will focus on the management of Depression and activities to reduce worsening symptoms. Through our Care Management team, we will provide education and tools in self-management activities, review benefits, and provide resources on community programs. Our program also will focus on suicide prevention education including assessment, treatment options and referrals.

Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and HIV prevention: Our program will focus on supporting our members on reducing viral load including medication adherence and PrEP therapies, education on healthy lifestyle and HIV management, access to testing and community resources. Our program also will focus on prevention activities and HIV awareness.

Dementia: Our Dementia program will focus on education on disease process and progression including caregiver support. Our program will also provide resources and tools to help you and/or caregiver to remain in a safe home environment. We will review benefits and community programs to help support your needs including referrals.

We will help you get the things you need. We will provide tools to help you learn and take control of your condition. For more information, call Member Services at 1-855-463-4100 (TTY 1-800-955-8770), and ask to speak with a case manager. We will work with you to create a person-centered care plan that includes goals and interventions to address your needs. This program is based on personal care planning and a cohesive team approach. It provides education and resources to promote member choice and improve your understanding of services and supports available to you.

If you are in the LTC program, we also offer programs for Dementia and Alzheimer's issues.

Sunshine Health's Alzheimer's & Dementia program focuses on LTC members diagnosed with these conditions. We will work with you to create a person-centered care plan that includes goals and interventions to address your needs.

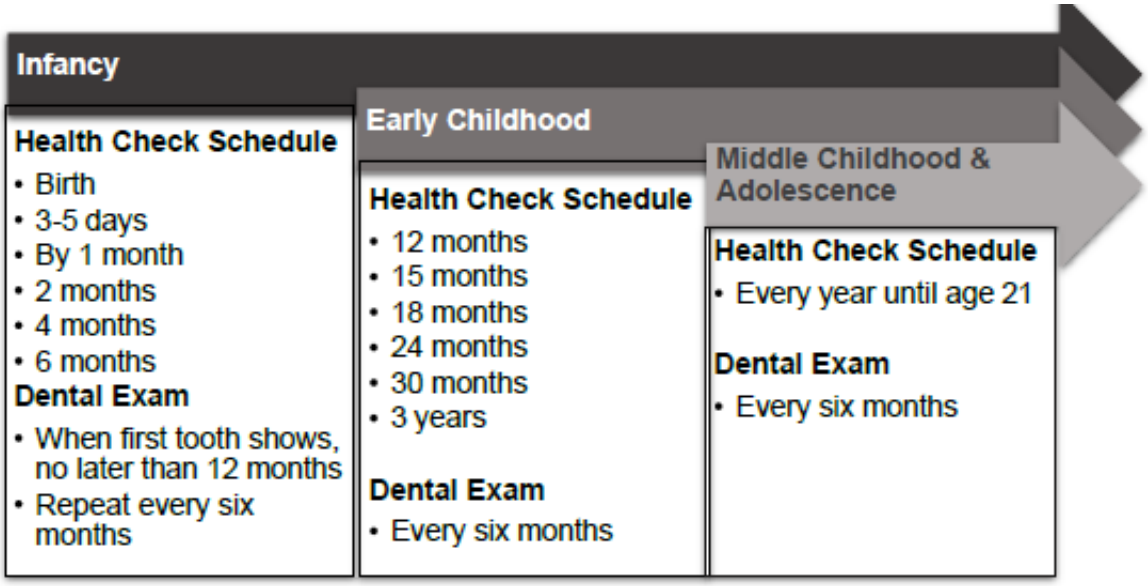
This program is based on personal care planning and a cohesive team approach. It provides education and resources to promote member choice and improve your understanding of services and supports available to you

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:

Well Child Visits

Children and young people need to see their doctor regularly even when they are not sick. This chart shows when babies, children and young adults need to see their doctor for a preventive health check. We don't want your child to miss any key steps toward good health as they grow.



Doctors and nurses will examine your child or teenager. They will give shots for diseases when necessary. Shots are important to keep your child healthy. They will also ask questions about health problems and tell you what to do to stay healthy. To schedule a Well Child Visit, call your doctor. If you have problems getting a visit, please call Member Services at 1-855-463-4100 (TTY 1-800-955-8770).

Domestic Violence
If you are facing abuse or suffered abuse in the past, please talk to your doctor or your case manager to find a local program in your community to get help in a safe and private setting.

Pregnancy Prevention
Sunshine Health's pregnancy prevention program brings together existing community programs to talk to members. Doctors team up with these programs to give more facts around pregnancy, sexual transmitted diseases and contraceptive methods. Some of the organizations Sunshine Health partners with are Duval County Health Department, Catholic Charities, Planned Parenthood, Healthy Start, Oasis Pregnancy Center, Hope for Miami, Project U-Turn and Plan Be Trinity Church Teen Pregnancy Prevention Program. If you want help with pregnancy prevention, your doctor or your case manager can help you find a local program in your community.

Pregnancy Related Programs
Start Smart for Your Baby (Start Smart) is our special program for women who are pregnant. Sunshine Health wants to help you take care of yourself and your baby through your whole pregnancy. Information can be provided to you by mail, telephone and at SunshineHealth.com/cw-pregnancy. Our Start Smart staff can answer questions and give you support if you are having a problem. We can even arrange for a home visit if needed.

If you are pregnant and smoke cigarettes, Sunshine Health can help you stop smoking. We have a special stop smoking program for pregnant women. There is no cost to you. The program has trained health coaches who are ready to work with you. They will provide education, counseling and the support you need to help you quit smoking. Working as a team over the telephone, you and your health coach can make a plan to make changes in your behavior and lifestyle. These coaches will encourage and help you to stop smoking.

We have many ways to help you have a healthy pregnancy. Before we can help, we need to know you are pregnant. Please call Member Services at 1-855-463-4100 (TTY 1-800-955-8770) as soon as you learn you are pregnant. We will help you set up the special care that you and your baby need. Sunshine Health does not restrict services including counseling or referrals for moral or religious objections.

Healthy Start Partnerships
Sunshine Health has teamed up with Healthy Start Coalitions to help pregnant members set up services. Our Healthy Start partners can speak with you in your community and help with prenatal care. This program educates and supports pregnant members who are at risk to have difficult births. We will explain the role of prenatal visits to the health of your baby, help with making your appointments and link you with agencies, like Healthy Start and WIC, while making more community referrals. Our maternity case managers will work with you at the start of your pregnancy until after you give birth. If you need help with your pregnancy, please let your doctor or case manager know to begin this program.

Nutritional Assessment and Counseling
Sunshine Health wants to help you and your family eat healthy. We can help find local food pantries, markets and food programs near you. If you need help with food, tell your doctor. With your doctor, you will be able to make a plan for a better diet and get help with referrals to local WIC offices, if needed. You will get a copy of the referrals, diet and nutrition plans you make with the Healthy Start nutritionist. Then, a case manager will follow up with you to assist with any issues you have and help you find more local resources to help you get the services needed to follow your plan, even if the services are outside of what Medicaid covers.

Behavioral Health
Sunshine Health case managers can help find local mental health services and community resources to lower your risk of going to the hospital or other consequences due to your mental health. Your case manager can help by asking you questions about risky behaviors. Your case manager will also help find shelters, food and other needs that may be adding to your risky behaviors. If needed, the case manager will make referrals and help schedule appointments with local providers to help decrease risky behaviors and get the help needed.

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

To get more information about our quality enhancement program or to give us your ideas, call Member Services at 1-855-463-4100 (TTY 1-800-955-8770).

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

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

Section 13: Your Plan Benefits: Managed Medical Assistance Services

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

There may be some services we do not cover but might be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called "In Lieu of Services (ILOS)." To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call the numbers at the beginning of this handbook for a ride.

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

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

Service	Description	Coverage/Limitations	Prior Authorization
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	No prior authorization required for the first three days of involuntary behavioral health inpatient admission. After the first three days, prior authorization required. Prior authorization is required for voluntary admissions.
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots	No

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

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

Service	Description	Coverage/Limitations	Prior Authorization
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover, as medically necessary: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare planning	Yes
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program	As medically necessary and recommended by us	No
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor, when medically necessary: - Cardiac testing - Cardiac surgical procedures - Cardiac devices	Yes, for some services.
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services OR Services provided to children (ages 0 – 20) who use medical foster care services	Your child must be enrolled in the DOH Early Steps program OR Your child must be receiving medical foster care services	No

Service	Description	Coverage/Limitations	Prior Authorization
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover, as medically necessary: - 24 patient visits per year, per member - X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	Covered as medically necessary	No
Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a mental health treatment facility	As medically necessary and recommended by us	Yes
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor, when medically necessary: - Hemodialysis treatments - Peritoneal dialysis treatments	No
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	No

Service	Description	Coverage/Limitations	Prior Authorization
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	As medically necessary, some service and age limits apply. Call Member Services for more information.	Prior authorization may be required for some equipment or services.
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover medically necessary: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week	No
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	No

Service	Description	Coverage/Limitations	Prior Authorization
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover medically necessary: - One adult health screening (check-up) per year - Well child visits are provided based on age and developmental needs - One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover medically necessary: - Up to 26 hours per year	No
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	No
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: - Covered as medically necessary	Yes, for some services.
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: - Covered as medically necessary	Yes, for some services.
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover medically necessary: - Up to 39 hours per year	No

Service	Description	Coverage/Limitations	Prior Authorization
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs	Yes, for some services.
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover, when medically necessary: - Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients	Yes
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	Covered as medically necessary	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover medically necessary: - Up to 26 hours per year	No
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us	No

Service	Description	Coverage/Limitations	Prior Authorization
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation, when medically necessary: - Up to 365/366 days for recipients ages 0-20 - Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	- Covered as medically necessary	Yes, for some services.
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	- Covered as medically necessary	Yes, for some services.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	- Covered as medically necessary	No
Medication Management Services	Services to help people understand and make the best choices for taking medication	- Covered as medically necessary	No
Mental Health Partial Hospitalization Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from mental illness	As medically necessary and recommended by us	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	No
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us	No
Multisystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	As medically necessary and recommended by us	No
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary	Yes, for some services.
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, for any trip over 100 miles.
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	- We cover 365/366 days of services in nursing facilities as medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes, for some services.
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	- Covered as medically necessary	Yes, for some services.
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	- Covered as medically necessary	Yes, for some services.
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	- Emergency services are covered as medically necessary - Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Yes, for some services.

Service	Description	Coverage/Limitations	Prior Authorization
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	- Covered as medically necessary. Some service limits may apply	Yes
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	Yes
Physical Therapy Services	Physical therapy includes exercises , stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: - Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes, for some services.
Podiatry Services	Medical care and other treatments for the feet	We cover, as medically necessary: - Up to 24 office visits per year - Foot and nail care - X-rays and other imaging for the foot, ankle and lower leg - Surgery on the foot, ankle or lower leg	Yes, for some services.
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover, as medically necessary: - Up to a 34-day supply of drugs, per prescription - Refills, as prescribed	Yes, for some services.

Service	Description	Coverage/Limitations	Prior Authorization
Private Duty Nursing Services	Nursing services provided in the home to people ages 0 to 20 who need constant care	We cover, as medically necessary: - Up to 24 hours per day	Yes
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover, as medically necessary: - 10 hours of psychological testing per year	No
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover, as medically necessary: - Up to 480 hours per year	No
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	Covered as medically necessary	Yes, for some services.
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	Yes, for some services.

Service	Description	Coverage/Limitations	Prior Authorization
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are under 18 years old.	No
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover medically necessary: - Respiratory testing - Respiratory surgical procedures - Respiratory device management	Yes, for some services.
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover medically necessary: - One initial evaluation per year - One therapy re-evaluation per 6 months - Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	No
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	No
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders	We cover the following medically necessary: - Assessments - Foster care services - Group home services	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following medically necessary services for children ages 0-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year We cover the following medically necessary services for adults: - One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20	Yes
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover medically necessary services: - Up to 9 hours per month	No

Service	Description	Coverage/Limitations	Prior Authorization
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Yes
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following medically necessary services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 0-20 - One frame every two years and two lenses every 365 days for adults ages 21 and older - Contact lenses - Prosthetic eyes	Yes, for some services.
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	Covered as medically necessary	Yes, for some services.

Your Plan Benefits: Expanded Benefits

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

Service	Description	Coverage/Limitations	Prior Authorization
Behavioral Health Integration/ Collaborative Care	Unlimited visits for members with providers who manage both physical and mental health needs.	None.	No
Biometric Equipment	Digital blood pressure cuff and weight scale	Ages 13 years and older. One (1) digital blood pressure cuff every three (3) years; One (1) weight scale every three (3) years	No

Service	Description	Coverage/Limitations	Prior Authorization
Camp Scholarship	$150 voucher to attend children's camp. Must be enrolled in Care Management and have completed annual wellness exam.	Ages 4-18.	Contact your care manager to determine eligibility.
Care Grant	Up to $150 per year for tutoring, gym memberships, swimming lessons, sports equipment/supplies, or art supplies/workbooks.	Ages up to 18	Contact your care manager to determine eligibility.
Caregiver Swimming Lessons	One group session, up to 8 lessons from local YMCA. In areas where a YMCA does not exist, members may use a local swim vendor.	Ages 18 and older. In areas where YMCA doesn't exist, members may use a local swim vendor.	No
Cellular Services	Members can receive a free smartphone. The phone includes minutes, data and texts.	Ages 16 years and older.	No
Childcare	Voucher for childcare to help parents identified with childcare needs on Pathways to Prosperity screening.	$150 limit. Must be age 16 and older.	Contact your care manager to determine eligibility.
Circumcision (newborns only)	Male circumcision is a common procedure typically performed in the first month after birth. Can be provided in a hospital, office or outpatient setting.	Birth to 28 days old. One per lifetime if medically necessary.	No
Dental Kit	One dental hygiene kit per year for pregnant members who attend a Sunshine Health-sponsored event.	Ages 13 and older	No

Service	Description	Coverage/Limitations	Prior Authorization
Doula Services	Pregnancy, postpartum and newborn care and assessment provided in your home by a doula. Using a doula during pregnancy, birth, and postpartum has been shown to be an effective best practice that can enhance the birthing experience, reduce complications, and improve outcomes for women and infants.	Ages 13 and older. No limits.	No
Durable Medical Equipment/ Asthma Supplies	Unlimited hypoallergenic bedding and one (1) high-efficiency particulate air (HEPA) filter vacuum cleaner for members diagnosed with asthma.	Must have asthma or COPD diagnosis.	Contact your care manager to determine eligibility.
Educational Vouchers	$150 voucher after completion of Sunshine Health Works Launchpad Educational Modules	Ages 16 and older	No
Expanded Prenatal Services	14 visits for low-risk pregnancy 18 visits for high-risk pregnancy Breast pump, hospital grade rental Breast pump	Ages 13 and up One per calendar year; Ages 13 and up One every 2 calendar years; ages 13 and up	No No Yes No
Flu Prevention Kit	1 Flu Prevention kit; 3 ply face masks – 10 piece; oral digital thermometer; hand sanitizer	Ages 18 years and older. Eligible for the first 1,000 members who have received their flu vaccine.	No

Service	Description	Coverage/Limitations	Prior Authorization
Foster Care Comfort Kits	A sturdy backpack or duffle bag filled with items to make entering a foster home easier, such as a blanket, journal and pen, hygiene supplies, educational books and games, soft bear, stress ball, fidget spinner, and/or earbuds.	Must be enrolled in Sunshine Health Pathway to Shine Child Welfare Specialty Plan. Up to 18 years old.	No.
Grocery Benefit	$50 food gift card per household per year for enrollees who identify as food insecure on Pathways to Prosperity screening	Ages 16 and older	Contact your care manager to determine eligibility.
Housing Assistance	A maximum of $250.00 per community-based enrollee per year to assist with housing related expenses (rent, utilities, etc.)	Must be 16 years or older. Funds are paid directly to the utility company or place where assistance is needed.	Contact your care manager to determine eligibility.
Home Delivered Meals - General & Disaster Preparedness	Access to healthy food during an emergency, such as a natural disaster, can be difficult. 1 emergency meal kit annually		Yes
Home Delivered Meals - Post Transition Meals	Access to healthy food during an emergency, such as health-related, can be difficult. Meals delivered to your home after discharge from hospital or nursing facility.	No age limit. Unlimited as deemed medically necessary	Yes
Home Delivered Meals for Enrollees who are Pregnant	266 meals to enrollees who are at least 20 weeks pregnant and have a qualifying medical condition.	Up to four months postpartum	Contact your care manager to determine eligibility.
Homemaker Services (e.g. hypoallergenic carpet cleanings)	Preventing allergen build up in home carpets is a vital measure to help alleviate symptoms.	Up to two cleanings per year. Must be diagnosed with asthma to qualify.	Contact your care manager to determine eligibility.

Service	Description	Coverage/Limitations	Prior Authorization
Joy for All Battery Operated Plus Companion Pet	Designed to bring comfort, companionship, and fun to individuals experiencing social isolation, loneliness, or any type of cognitive decline.	One pet per member.	Contact your care manager to determine eligibility.
Legal Guardianship	Legal guardianship can help protect an individual who is no longer able to make decisions for themselves that are in the best interest of their health and well-being. Maximum of five hundred dollars ($500) per eligible enrollee per lifetime	This is available to members who are in a SNF or PDN setting and parent is obtaining guardianship to protect those who are unable to care for their own well-being. Available for members aged 17 through 21.	Contact your care manager to determine eligibility.
Meal Stipend (available for long distance medical appointment day-trips)	To support enrollees of all ages who need to travel long distance for medical appointments, available for long distance medical appointment day-trips.	Up to twenty dollars ($20) per meal up to 3 meals per day, up to two hundred dollars ($200) per day up to one thousand dollars ($1,000) per year for trips greater than one hundred (100) miles.	Yes
Over-the-Counter Benefit	Coverage for cold, cough, allergy, vitamins, supplements, ophthalmic/otic preparations, pain relievers, gastrointestinal products, first aid care, hygiene products, insect repellent, oral hygiene products and skin care.	All ages. Up to $50 per household, per month.	No
Peer Support Certification	Up to $600 voucher to become a Peer Support Specialist for members who identify as needing job support on a Pathways to Prosperity screening.	Ages 16 and older	Contact your care manager to determine eligibility.

Service	Description	Coverage/Limitations	Prior Authorization
Respite Care	Provides caregivers a temporary rest from caregiving of members with special healthcare needs	Up to 200 hours in-home and up to 10 days out-of-home per year. Must have exhausted all covered and community-based respite benefits	Yes
Sensory Kit	Sensory support kit tailored to the developmental and diagnosis needs of enrollees.	Ages 3 and older.	Contact your Care Manager to determine eligibility.
Swimming Lessons (children only)	Children under age 21 can receive group swim sessions which include up to 8 lessons from a local YMCA.	One group session, up to 8 lessons from local YMCA. In areas where a YMCA does not exist, members may use a local swim vendor.	No
Tattoo Removal	Voucher for members who have completed Sunshine Health Works Launchpad Educational modules who provide proof of workforce need.	One per lifetime; $500 limit, Age 18 - 26	Contact your Care Manager to determine eligibility.
Tutoring	Voucher to aid in removing educational barriers.	Twelve (12) annual tutoring sessions up to 2 hours of tutoring time per session. Ages 16 and up.	Contact your Care Manager to determine eligibility.
Transportation Services to Non-Medical Appointments/ Activities	Up to three trips a month for non-medical purposes such as shopping or social events.	Ages 0 to 21 years old. Must not have another means of transportation to qualify.	No
Vital Records Support	$50 reimbursement for copies of personal documentation, such as driver's license or birth certificate	Ages 16 and older	No

Service	Description	Coverage/Limitations	Prior Authorization
Welcome Baby! Bundle	One gift package for pregnant members. Choose one option per pregnancy: 1) Safe Sleep Survival Kit with Cribette, 2) Car Seat with safe sleep educational materials, 3) Highchair with safe sleep educational materials, 4) Baby Shower in a Box, or 5) Stroller with safe sleep educational materials.	Must complete three prenatal visits and attend a Sunshine Health-sponsored event	No
YMCA Membership	For individuals or family of four. Includes access to free standing YMCA facilities and Y360 virtual platform.	Ages 18 and older. Caregiver, parent or guardian must be present for ages 17 and under.	No

Your Plan Benefits: Pathways to Prosperity

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

Section 14: Cost Sharing for Services

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

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

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

Starting Services

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

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

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

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

Developing a Plan of Care

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

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

  We don’t just want to make sure that you are living safely. We also want to make sure that you are happy and feel connected to your community and other people.

When your case manager is making your plan of care, they will ask you about any **personal goals** you might have. These can be anything, really, but we want to make sure that your LTC services help you accomplish your goals. Some examples of personal goals include:

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

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

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

Updating your Plan of Care

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

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

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

Your Back-Up Plan

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

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

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

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

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

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

Service	Description	Prior Authorization
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping.	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home.	Yes
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	No
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Yes
Behavioral Management	Services for mental health or substance abuse needs	No
Caregiver Training	Training and counseling for the people who help take care of you	Yes

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

Service	Description	Prior Authorization
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	No
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to your home.	Yes
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores.	Yes
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	No
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Yes

Service	Description	Prior Authorization
Medication Administration	Help taking medications if you can't take medication by yourself	Yes
Medication Management	A review of all the prescription and over-the-counter medications you are taking	Yes
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Yes
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Facility.	Yes
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.	Yes
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition.	Yes

Service	Description	Prior Authorization
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	Yes
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	Yes
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility	We may offer the choice to use this service instead of nursing facility services.
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	Yes, if over 100 miles.

Long-Term Care Participant Direction Option (PDO)*

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

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

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

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

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

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

Your Plan Benefits: LTC Expanded Benefits

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

Service	Description	Coverage/ Limitations	Prior Authorization
Assisted Living Facility/Adult Family Care Home - Bed Hold Days	Services such as personal care, housekeeping, medication oversight and social programs to assist the member in an assisted living facility.	Ages 18 and older. Beds can be held for 30 days if the member has Presided in facility for a minimum of 30 days between episodes.	No
Healthy Living Benefit	Assistive devices and adaptive aids to help enrollees maintain independence in their homes. Enrollees can select two from the following items: digital scale, home blood pressure cuff, peak flow meter, reachers/grabbers, lumbar pillow, personal fan, clip on lamp, walker bag, or an assistive technology device such as a smart home device (ie Amazon Echo).	Ages 21 and older	No
Home Allowance	Up to $250.00 annually for Home and Community-Based (HCBS) LTC members needing financial assistance to maintain residency in a community setting.	Ages 16 and older	Contact your Care Manager to determine eligibility.
Home Delivered Meals – General	Up to 10 meals per event for nutritional support.	Ages 18 and older	Yes

Home Delivered Meals – Disaster Preparedness	Healthy food delivered to your home during an emergency, such as a natural disaster.	1 emergency meal kit annually.	Yes
Individual Therapy Sessions for Caregivers	Therapeutic counseling to support primary caregivers who reside with LTC enrollees in a private home.	Ages 18 and older	No
Joy for All Battery Operated Plus Companion Pet	Designed to bring comfort, companionship, and fun to individuals experiencing social isolation, loneliness, or any type of cognitive decline.	One pet per member.	Contact your Care Manager to determine eligibility.
Nursing Facility to Community Setting Transition Assistance	Up to $5,000 to transition safely to independent living situations.	Ages 18 and older, must reside in nursing facility	Contact your Care Manager to determine eligibility.
Pathways to Purpose: Transportation Services to Non-Medical Appointments/Activities	Up to three trips a month for non-medical purposes such as mentoring or volunteering.	Ages 18 and older. Must not have another means of transportation to qualify.	No
Sensory Kit	Sensory support kit tailored to the developmental and diagnosis needs of enrollees.	Must be enrolled in Long Term Care. Ages 3 and older.	Contact your Care Manager to determine eligibility.
Transportation Services to Non-Medical Appointments/Activities	Up to three trips a month for non-medical purposes such as shopping or social events.	Ages 18 and older. Must not have another means of transportation to qualify.	No
Welcome Home! Basket	A gift basket with up to $50 worth of items to help them get transitioning LTC members in their new home.	Ages 21 and older. Must be an LTC member	No

Section 17: Member Satisfaction

Complaints, Grievances, and Plan Appeals

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

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. 1-855-463-4100	We will: • Try to solve your issue within 1 business day.
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Write us or call us at any time. • Call us to ask for more time to solve your grievance if you think more time will help. Contact us at: Sunshine Health P.O. Box 459087 Fort Lauderdale, FL 33345-9087 1-855-463-4100 Fax: 1-866-534-5972 Sunshine_Appeals@centene.com	We will: • Review your grievance and send you a letter with our decision within 30 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Sunshine Health P.O. Box 459087 Fort Lauderdale, FL 33345-9087 1-855-463-4100 Fax: 1-866-534-5972 Sunshine_Appeals@centene.com	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.

	What You Can Do:	What We Will Do:
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. Sunshine Health P.O. Box 459087 Fort Lauderdale, FL 33345-9087 1-855-463-4100	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings. • Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ****You must finish the appeal process before you can have a Medicaid Fair Hearing.***	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed. • Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

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

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

Agency for Health Care Administration
Medicaid Fair Hearing Unit
P.O. Box 7237
Tallahassee, FL 32314-7237
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

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

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

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

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

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

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

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

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

Agency for Health Care Administration
P.O. Box 7237
Tallahassee, FL 32314-7237
1-877 254-1055 (toll-free)
1-239-338-2642 (fax)

MedicaidHearingUnit@ahca.myflorida.com

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

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

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

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

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

Section 18: Your Member Rights

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

- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected
- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment

- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly
- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation
- Receive information on beneficiary and plan information
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS))

LTC Members have the right to:

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

Section 19: Your Member Responsibilities

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

- Give accurate information about your health to your Plan and providers

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

LTC Members have the responsibility to:

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

Section 20: Other Important Information

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

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

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling 1-866-762-2237 toll-free, or visit the DCF Web page at https://www.myflfamilies.com/medicaid (scroll down, review the links on the left side of the webpage and select the document entitled 'SSI-Related Medicaid Program Fact Sheet').

Indian Health Care Provider (IHCP) Protection

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

Emergency Disaster Plan

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

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

Tips on How to Prevent Medicaid Fraud and Abuse:

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

Fraud/Abuse/Overpayment in the Medicaid Program

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

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

You can also report fraud and abuse to us directly by contacting Sunshine Health's anonymous and confidential hotline at 1-866-685-8664, or by contacting the Compliance Officer at 1-866-796-0530. You may also send an email to Compliancefl@centene.com.

Abuse/Neglect/Exploitation of People

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

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

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

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

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

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

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

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

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

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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-855-463-4100 (TTY 1-800-955-8770) 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
- Community Programs
- How to enroll in Case Management program
- Information about our providers, services and your rights and responsibilities
- How new technology is evaluated to be included as a covered benefit
- Information about our providers, services and your rights and responsibilities
- More information about a provider's medical school and residency

To take a look at Sunshine Health's HEDIS results, please visit https://www.sunshinehealth.com/members/medicaid/resources/quality-improvement.html

If you think you could benefit from our care Management program, please call Member Services at 1-855-463-4100 (TTY 1-800-955-8770).

Connecting Your Healthcare: New Access to Your Digital Health Records
On July 1, 2021, the new federal Interoperability and Patient Access Rule (CMS 9115 F) made it easier for members to get their health records. You now have full access to your health records on your mobile device. That helps you manage your health and get services.

Imagine:

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

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

Section 21: Additional Resources

Floridahealthfinder.gov

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

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

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

Elder Housing Unit

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

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

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

Independent Consumer Support Program
The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ICSP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at 1-800-96-ELDER (1-800-963-5337) or visit https://elderaffairs.org/programs-services/medicaid-long-term-care-services/statewide-medicaid-managed-care-long-term-care-program/.

Section 22: Forms

1. Authorization to Use and Disclose Health Information
2. Revocation of Authorization to Use and/or Disclose Health Information

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

Authorization to Use or Disclose Protected Health Information (PHI)

Notice to Member and/or Parent or Guardian:

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

Sunshine Health
Attn: Compliance Department
P.O. Box 459089
Fort Lauderdale, FL 33345-9089
Fax: 1-866-796-0523

sunshine health

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

1 MEMBER INFORMATION:

Member Name *(print)*: _____

Member Date of Birth: _____ Member ID Number: _____

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

☐ to allow Sunshine Health to help me with my child's benefits and services, **OR**

☐ to permit Sunshine Health to use or share my child's health information for

_____

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

Name (person or group): _____

Address: _____

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

4 I AUTHORIZE SUNSHINE HEALTH TO USE OR SHARE THE FOLLOWING HEALTH INFORMATION *(NOTE: Select the first statement to release ALL health information or select the below statement to release only SOME health information.* ***Both CANNOT be selected.****)*

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

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

OR

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

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

_____

THIS AUTHORIZATION ENDS ON THIS DATE/EVENT:

5 _____

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

6 **MEMBER OR LEGAL REPRESENTATIVE SIGNATURE:**

_____

DATE:_____

IF LEGAL REPRESENTATIVE - Relationship to Member:

_____

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

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

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

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

Name (individual or entity):
Address:
City: State: Zip: Phone:

Name (individual or entity):
Address:
City: State: Zip: Phone:

Name (individual or entity):
Address:
City: State: Zip: Phone:

Name (individual or entity):
Address:
City: State: Zip: Phone:

Name (individual or entity):
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City: State: Zip: Phone:

Name (individual or entity):
Address:
City: State: Zip: Phone:

Name (individual or entity):
Address:
City: State: Zip: Phone:

Name (individual or entity):
Address:
City: State: Zip: Phone:

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

Revocation of Authorization to Use and/or Disclose Health Information

I want to cancel, or revoke, the permission I gave to Sunshine Health to use my child's health information for a particular purpose or to share my child's health information with a person or group:

PERSON OR GROUP THAT RECEIVED THE INFORMATION:

Name (person or group):_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Authorization Signed Date (if known):_____

MEMBER INFORMATION:

Member Name (print): _____

Member Date of Birth:_____ Member ID Number:_____

I understand that my child's health information (including, where applicable, my child's substance use disorder records) may have already been used or shared because of the permission I gave before. I also understand that this cancellation only applies to the permission I gave to use my child's health information for a particular purpose or to share my child's health information with the person or group. It does not cancel any other authorization forms I signed for health information to be used for another purpose or shared with another person or group.

Parent/Guardian Signature:_____
Date: _____

If you are signing for the Member, describe your relationship below. If you are the Member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

_____

_____

Sunshine Health will stop using or sharing your child's health information when we receive and process this form. Use the mailing address or fax number below. You can also call Member Services for help at **1-855-463-4100 (TTY 1-800-955-8770).**

Sunshine Health
Attn: Compliance Department
P.O. Box 459089
Fort Lauderdale, FL 33345-9089
Fax: 1-866-796-0523

Section 23: Community Resources

Sunshine Health Connects

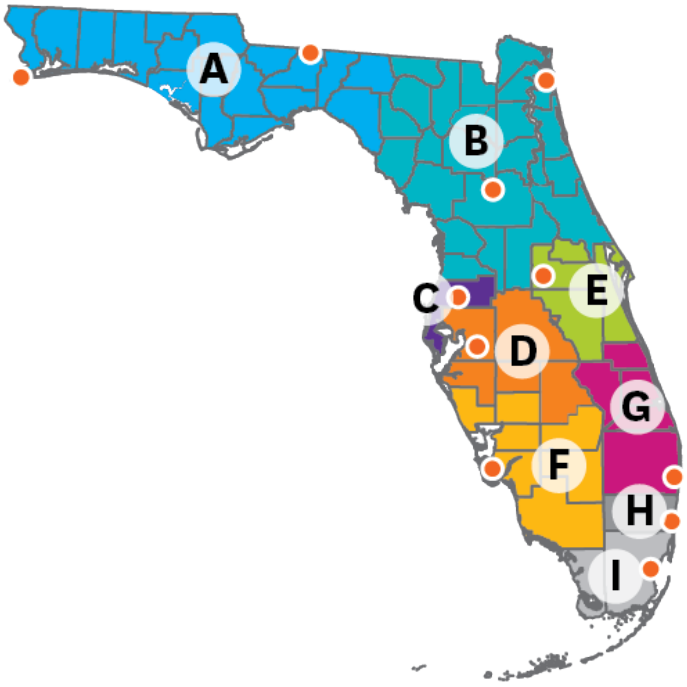
Sunshine Health Connects helps members and caregivers find community resources. Our database makes it easy for people with health related social needs – and those who help others – to find community resources. These community organizations provide help with food, shelter, healthcare, money and education, jobs and more. Visit CommunityResources.SunshineHealth.com to search by zip code. Or, call the Community Connections Help Line at 1-866-775-2192.

Community Connections Centers

Members, caregivers and families can get help and support at our Community Connections Centers. You can also go to health and education events there. There are many ways you can use them:

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

Here is a list of the Community Connections Centers across Florida.



Region A
2620 Creighton Road, Suite 401
Pensacola, FL 32504
1-850-473-2801

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

Region B
2724 NE 14th St.
Ocala, FL 34470
1-352-840-1101

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

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

Region D
200 W Waters Ave.
Tampa, FL 33604
1-813-470-5651

Region E
6801 W Colonial Drive, Suite E
Orlando, FL 32818
1-407-253-7602

Region F
4901 Palm Beach Blvd., Suite 80
Fort Myers, FL 33905
1-239-690-5722

Region G
4278 Okeechobee Blvd.
West Palm Beach, FL 33409
1-561-337-3508

Region H
1299 NW 40th Ave., Suite C
Lauderhill, FL 33313
1-954-400-6479

Region I
9552 SW 160th St.
Miami, FL 33157
1-786-573-7801

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

Sunshine Health:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Sunshine Health at 1-866-796-0530 (TTY 1-800-955-8770).

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

- **1557 Coordinator**
- **P.O. Box 31384, Tampa, FL 33631**
- **Phone: 1-855-577-8234 (TTY 711**)
- **Fax: 1-866-388-1769**
- **Email: SM_Section1557Coord@centene.com**

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our **1557 Coordinator** is available to help you.

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

U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. Phone: 1-800-368-1019 (TTY 1-800-537-7697). Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

This notice is available at **Sunshine Health's** website:
SunshineHealth.com/members/medicaid/resources/non-discrimination-notice.html

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

This information is available for free in other languages. Please contact Member Services at 1-866-796-0530, TTY 1-800-955-8770 Monday through Friday, 8 a.m. to 8 p.m.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con nuestro número de servicio al cliente al 1-866-796-0530, TTY 1-800-955-8770 de lunes a viernes, de 8 a.m. a 8 p.m.

Si oumenm, oubyen yon moun w ap ede, gen kesyon nou ta renmen poze sou Sunshine Health, ou gen tout dwa pou w jwenn èd ak enfòmasyon nan lang manman w san sa pa koute w anyen. Pou w pale avèk yon entèprèt, sonnen nimewo 1-866-796-0530 (TTY 1-800-955-8770).

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sunshine Health, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-866-796-0530 (TTY 1-800-955-8770).