Simply healthcare

An Anthem Company

Florida Medicaid member handbook

Simply Healthcare Plans, Inc.

Managed Medical Assistance: 1-844-406-2396 (TTY 711)
Long-Term Care: 1-877-440-3738 (TTY 711)
www.simplyhealthcareplans.com/medicaid

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SIMPLY HEALTHCARE PLANS, INC.
FLORIDA MEDICAID MEMBER HANDBOOK

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“If you do not speak English, call us at 1-844-406-2396 (TTY 711) for Managed Medical Assistance (MMA) or 1-877-440-3738 (TTY 711) for Long-Term Care (LTC). 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 1-844-406-2396 (TTY 711) para MMA o al 1-877-440-3738 (TTY 711) para LTC. 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 1-844-406-2396 (ATS 711) pour MMA ou 1-877-440-3738 (ATS 711) pour LTC. 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 1-844-406-2396 (TTY 711) pou MMA oswa 1-877-440-3738 (TTY 711) pou LTC. 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 1-844-406-2396 (TTY 711) per MMA o 1-877-440-3738 (TTY 711) per LTC. 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 1-844-406-2396 (TTY 711) для MMA или 1-877-440-3738 (TTY 711) для LTC. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Important Contact Information

Member Services/24-hour Nurse HelpLine	1-844-406-2396 for Managed Medical Assistance (MMA) 1-877-440-3738 for Long-Term Care (LTC)	Available 24 hours
Member Services/24-hour Nurse HelpLine TTY	711	Available 24 hours
Website	www.simplyhealthcareplans.com/medicaid	
Address	Simply Healthcare Plans 9250 W. Flagler St., Suite 600 Miami, FL 33174-9925	

To get transportation to nonemergency doctor visits	For members in Broward, Miami-Dade and Monroe counties: MCT Express 1-844-628-0388 For members in all other counties: LogistiCare 1-877-931-4753 (TTY 1-866-288-3133)
To get dental care	Contact your case manager directly or call Member Services at 1-844-406-2396 (TTY 711) for Medicaid or 1-877-440-3738 for Long-Term Care (TTY 711) for help with arranging these services.
To get eye care	EyeQuest 1-855-418-1627 https://www.dentaquest.com/vision/members
To get behavioral health services	Beacon Health Options 1-844-375-7215 www.beaconhealthoptions.com
To get help managing your chronic health condition	Simply Disease Management 1-888-830-4300 (TTY 711); ask for a care manager

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 http://www.myflfamilies.com/service-programs/abuse-hotline
For Medicaid Eligibility	1-866-762-2237 TTY: 711 or 1-800-955-8771 http://www.myflfamilies.com/service-programs/access-florida-food-medical-assistance-cash/medicaid
To report Medicaid Fraud and/or Abuse or to file a complaint about a health care facility	1-888-419-3456 https://apps.ahca.myflorida.com/mpi-complaintform/
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/complaints_recip.shtml
To find information for elders	1-800-96-ELDER (1-800-963-5337) http://elderaffairs.state.fl.us/doea/arc.php
To find out information about domestic violence	1-800-799-7233 TTY: 1-800-787-3224 http://www.thehotline.org/
To find information about health facilities in Florida	http://www.floridahealthfinder.gov/index.html
To find information about urgent care	Go to www.simplyhealthcareplans.com/medicaid and use our **Find A Doctor** tool to search for a network urgent care center near you. If you're not sure if you need urgent care, call your PCP. They will tell you what to do. Or you can call a nurse for advice anytime, day or night, at 1-844-406-2396.
For an emergency	9-1-1 Or go to the nearest emergency room

Table of Contents

Welcome to Simply Healthcare Plans Inc.'s Statewide Medicaid Managed Care Plan

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

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

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

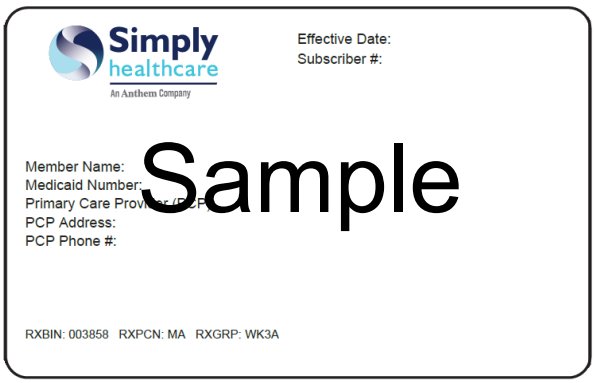
This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at 1-844-406-2396 for Managed Medical Assistance (MMA) or 1-877-440-3738 for Long-Term Care (LTC).

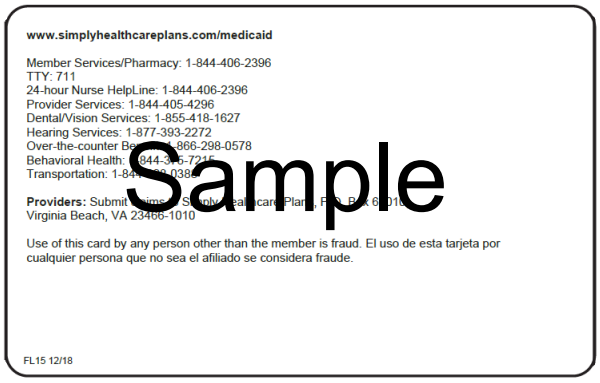
Section 1: Your Plan Identification Card (ID card)

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

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

Your ID card will look like this:





Section 2: Your Privacy

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

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

HIPAA Notice of Privacy Practices

The original effective date of this notice was April 14, 2003. The most recent revision date is shown at the end of this notice.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs and hospitals so we can OK and pay for your health care.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?
We can share your PHI with your family or a person you choose who helps with or pays for your health care if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please visit www.simplyhealthcareplans.com/medicaid/pages/privacy.aspx for more information.
- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
  - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But, we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to worker's compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**
- You can ask us to change the medical record we have for you if you think something is wrong or missing.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of health care, payment, everyday health care business or some other reasons we didn't list here.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.

- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you
We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call 1-844-203-3796 to add your phone number to our Do Not Call list.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-844-406-2396** for Managed Medical Assistance or **1-877-440-3738** for Long-Term Care. If you're deaf or hard of hearing, call **TTY 711**.

What if you have a complaint?
We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth St. SW
Atlanta, GA 30303-8909
Phone: 1-800-368-1019
TDD: 1-800-537-7697
Fax: 1-404-562-7881

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at www.simplyhealthcareplans.com/medicaid/pages/privacy.aspx.

Race, ethnicity and language
We get race, ethnicity and language information about you from the state Medicaid agency. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need
- Create programs to improve health outcomes
- Create and send health education information
- Let doctors know about your language needs
- Provide interpretation and translation services

We do **not** use this information to:
- Issue health insurance
- Decide how much to charge for services
- Determine benefits
- Share with unapproved users

Your personal information
We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact our Member Services number at 1-844-406-2396 (TTY 711) for Managed Medical Assistance or 1-877-440-3738 (TTY 711) for Long-Term Care Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Revised March 1, 2018

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 1-844-406-2396 for MMA or 1-877-440-3738 for LTC, or TTY 711, Monday to Friday, 8 a.m. to 7 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 HelpLine at 1-844-406-2396. 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 1-844-406-2396 for MMA or 1-877-440-3738 for LTC. 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 (ACCESS) account at https://dcf-access.dcf.state.fl.us/access/index.do.

Section 6: Your Medicaid Eligibility

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

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

If you lose your Medicaid eligibility

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

If you have Medicare

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

If you are having a baby

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

Section 7: Enrollment in Our Plan

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in this region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. After being in our plan for one year, you can choose to stay with us or select another plan. This happens every year you have Medicaid and are in the SMMC program.

Open Enrollment

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

Enrollment in the SMMC Long-term Care Program

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

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

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

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

AREA AGENCIES ON AGING OFFICES

PSA 1

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

PSA 2

Area Agency on Aging
for North Florida, Inc.
2414 Mahan Drive
Tallahassee, FL 32308
(850) 488-0055
www.aaanf.org

PSA 3

Elder Options
100 SW 75th Street, #301
Gainesville, FL 32607
(352) 378-6649
www.agingresources.org

PSA 4

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

PSA 5

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

PSA 6

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

PSA 7

Senior Resource Alliance
988 Woodcock Road, Suite 200
Orlando, FL 32803
(407) 514-1800
www.seniorresourcealliance.org

PSA 8

Area Agency on Aging
for Southwest Florida
15201 North Cleveland Avenue
Suite 1100
North Fort Myers, FL 33903
(239) 652-6900
www.aaaswfl.org

PSA 9

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

PSA 10

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

PSA 11

Alliance for Aging, Inc.
760 NW 107th Avenue
Suite 214, 2nd Floor
Miami, FL 33172
(305) 670-6500
www.allianceforaging.org

PSA - Planning and Service Area

Section 8: Leaving Our Plan (Disenrollment)

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

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

- You are getting care at this time from a provider that is not part of our plan but is a part of another Plan
- We do not cover a service for moral or religious reasons
- You are an American Indian or Alaskan Native
- You live in and get your Long-term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

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

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

If you have any questions about whether you can change plans, call Member Services or the State's Enrollment Broker at 1-877-711-3662 (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
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions
- You or your caregivers behave in a way that makes it hard for us to provide you with care

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

[2] To learn how to ask for an appeal, please turn to page Section 15, Member Satisfaction, on page 62.

- 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 9: Managing Your Care

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

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 that 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.

Important Things to Tell Your Case Manager

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

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

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

Section 10: Accessing Services

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

Providers in Our Plan

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

You will find a list of providers that are in our network in our provider directory. If you want a copy of the provider directory, call 1-844-406-2396 for MMA, 1-877-440-3738 for LTC or TTY 711 to get a copy or visit our website at www.simplyhealthcareplans.com/medicaid.

If you are in the LTC program, your case manager is the person who will help you choose a service provider 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 can get from providers who are not in our provider network. These services are:

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

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

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

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

What Do I Have To Pay For?

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

If you get a bill 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.

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.

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

Section 11: Helpful Information about Your Benefits

Choosing a Primary Care Provider (PCP)

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

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

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

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

Choosing a PCP for Your Child

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

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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 www.aap.org.

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 HelpLine at 1-844-406-2396. Nurses are available to answer your health questions anytime, day or night.

You may also find the closest Urgent Care center to you by calling us. We can help you find a center near you. Or view the provider directory online at www.simplyhealthcareplans.com/medicaid. Click on **Find A Doctor** and search for Urgent Care Centers.

Hospital Care

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

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

Emergency Care

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

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

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

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

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

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

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Formulary**. You can find this list on our Web site at www.simplyhealthcareplans.com/medicaid 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

Simply covers specialty medications at all in-network pharmacies (drugstores). Some specialty medications require special handling, and local drugstores may not have them in stock. If your local drugstore doesn't have your specialty medication, Simply partners with Accredo Specialty Pharmacy to provide them to you. Accredo has the experience to handle your specialty drug(s) and also has these helpful services:

- Pharmacists and nurses to answer your questions toll-free at 1-800-501-7210
- Safe, on-time and free delivery directly to your home Monday through Friday at a time you choose that works for you
- Special temperature-moderating packaging if required for your drug
- A call to remind you when it's time to refill your drugs
- Needles and syringes automatically sent if you need them to take your drugs
- Help tracking your drug information to make sure it's safe for you to take your drugs together

You can call Accredo at 1-800-501-7210 (TTY 1-877-804-9222), Monday through Friday from 8 a.m. to 8 p.m. Eastern time. Your doctor can call Accredo at 1-800-987-4904 or fax your prescription to 1-888-302-1028.

You do not have to use Accredo. There are also other specialty pharmacies in the Simply network. If you would like to use another specialty pharmacy in the network, please call Member Services for help choosing one.

Behavioral Health Services

There are times when you may need to speak to a therapist or counselor 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 1-844-406-2396 (MMA) or 1-877-440-3738 (LTC) or Beacon Health Options at 1-844-375-7215
- Looking at our provider directory
- Going to our website at www.simplyhealthcareplans.com/medicaid or Beacon's website at www.beaconhealthoptions.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:

Healthy Behaviors Reward Programs

Our members can earn extra rewards for doing things to get and stay healthy through our Healthy Behaviors Reward Programs. We will offer these programs to our members who want to stop smoking, lose weight, address any abuse problems, have a baby or keep their children healthy.

We can help members make a plan and set goals for these topics:

- Alcohol and substance abuse – help and support through coaching and being part of community groups
- Smoking cessation – help and support through coaching and being part of community groups
- Weight management and nutrition – help and support from your doctor and nutritionist to make good exercise and food choices
- Maternity – help and support from your doctor and case manager to have a healthy pregnancy and a healthy baby
- Well-child visits – help and support from the child's doctors to maintain good health

Through the program, you'll get tips, help and support from doctors, case managers and nutritionists. When you join and meet your goals, you will earn reward points. One point is worth $1. Members can earn up to 50 points for completing a program. Points can be used to select gift cards. The more goals you meet, the more gift cards you can get!

Your doctor or a case manager can refer you to one or more of these programs. You can also refer yourself. If you would like to learn more, send us an email (HealthyBehaviors@simplyhealthcareplans.com) or call Member Services. Ask about the Healthy Behaviors Rewards Program.

Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us 1-844-406-2396 for MMA or 1-877-440-3738 for LTC.

Disease Management Programs

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

- Diabetes
- Asthma
- High blood pressure (hypertension)
- Behavioral health
- Bipolar disorder
- Major depressive disorder — adult
- Major depressive disorder — child/adolescent
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)
- Schizophrenia
- Substance use disorder
- HIV/AIDS

DM case managers work with you to make health goals and help you build a plan to reach them. As a member in the program, you will benefit from having a case manager who:

- Listens to you and takes the time to understand your specific needs.
- Helps you make a care plan to reach your health care goals.
- Gives you the tools, support and community resources that can help you improve your quality of life.
- Provides health information that can help you make better choices.
- Assists you in coordinating care with your providers.

As a Simply member enrolled in a DM program, you have certain rights and responsibilities.

You have the right to:

- Have information about Simply; this includes all Simply programs and services as well as our staff's education and work experience; it also includes contracts we have with other businesses or agencies.
- Refuse to take part in or leave programs and services we offer.
- Know who your case manager is and how to ask for a different case manager.
- Have Simply help you to make choices with your doctors about your health care.
- Learn about all DM-related treatments; these include anything stated in the clinical guidelines, whether covered by Simply or not; you have the right to talk about all options with your doctors.
- Have personal data and medical information kept private.
- Know who has access to your information and know our procedures used to ensure security, privacy and confidentiality.
- Be treated with courtesy and respect by Simply staff.

- File complaints to Simply and get guidance on how to use the complaint process, including how long it will take us to respond and resolve issues of quality and complaints.
- Get information that is clear and easy to understand.

You are encouraged to:

- Follow health care advice offered by Simply.
- Give Simply information needed to carry out our services.
- Tell Simply and your doctors if you decide to leave the DM program.

If you have one of these health issues or would like to know more about our DM program, please call 1-888-830-4300 Monday through Friday from 8:30 a.m. to 5:30 p.m. Eastern time. Ask to speak with a DM case manager. Or you can leave a private message for your case manager 24 hours a day. You can also visit our website at www.simplyhealthcareplans.com/medicaid or call us if you would like a copy of DM information you find online. Calling can be your first step on the road to better health.

For cancer or end of life issues, including information on advance directives, our Plan Case Management team has programs and information to help you. Talk to your case manager for help with these issues.

If you are in the LTC program, we also offer programs for Dementia and Alzheimer's issues. Talk to your case manager for help with these concerns.

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:

CARES Program

The Simply CARES program is a field-based behavioral health case management program for members with behavioral health and substance abuse disorders. We want to make sure you're getting the care and support you need if we can't reach you by phone. In this program, you get in-person help from a case manager with things like making sure you're taking your medications and getting follow-up care. This ensures you get the treatment, wellness and recovery services you need to support your care plan. For questions about the program, talk to your behavioral health case manager or call Member Services.

Rising Star Program

Some days are better than others when you have a behavioral health condition. As a member in the Rising Star program, you can get customized care from a team of people who knows you and your history and can help you. This team includes a home hospital, psychiatrist and a Simply behavioral health case manager. Your case manager works with you, your home hospital, psychiatrist, and pharmacist on a plan for you to get and stay healthy. If you qualify, you can choose to be in the program; it is not required. For questions about the program, talk to your behavioral health case manager or call Member Services.

Healthy Family Lifestyle/Healthy Families Program

Healthy Family Lifestyle/Healthy Families is a six-month program for members ages 7-17 designed to help you and your family lead healthier lives. With this program, you and your family get:

- Fitness and healthy behavior coaching
- Written nutrition information
- Online and community resources

Parents or guardians of qualifying members will take part in this program on their family's behalf. To learn more or to enroll in the program, call us at 1-844-421-5661.

Children's Programs

We offer programs to help you get the care you need for your child. School-based clinics are open in select locations to make it easier to get health care services for your child. Children 5 years and younger are referred to the Florida Women, Infants, and Children (WIC) program for help with meeting their nutritional needs.

If your child is behind on well-child visits and immunizations, you may get a phone call or a letter to remind you to schedule a visit. If you need help making a visit or getting a ride to the visit, call Member Services. We can help.

Domestic Violence

Domestic violence is abuse. Abuse is not healthy or safe. It is never OK for someone to hurt you or make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect you and your family. If you feel you are a victim of abuse, tell your doctor or case manager. We can help you. We also offer home visits through the Healthy Start program for pregnant mothers who may be fearful of being at home or are facing domestic violence.

Safety tips for your protection:

- If you're hurt, call your PCP. Call 911 or go to the nearest hospital if you need emergency care.
- Have a plan on how you can get to a safe place, like a women's shelter or a friend's or relative's home.
- Pack a small bag and give it to a friend to keep for you until you need it.

If you have questions or need help, please call:

- Member Services toll free at 1-844-406-2396 (MMA), 1-877-440-3738 (LTC) or TTY at 711; follow the prompts to our 24-hour Nurse HelpLine
- National Domestic Violence Hotline at 1-800-799-7233 (TTY 1-800-787-3224)
- Abuse hotline at 1-800-96-ABUSE

Pregnancy Prevention

Simply provides various tools to help members take important steps to stay healthy. This is whether you're thinking of having a baby, trying to have a baby or not yet ready to have a baby. You have access to many reproductive health and wellness materials that talk about contraceptive methods and family planning. If you would like information on family planning, please talk to your doctor, visit your county health department or call Member Services.

Pregnancy-related Programs

If you're pregnant or trying to get pregnant, Simply provides information on how to prepare and how to stay healthy through your pregnancy. You can get information about preconception health, the importance of prenatal care, postpartum care, birth spacing and critical health topics such as the Zika virus. If you're pregnant, you will get a questionnaire in the mail and/or a call that asks you important questions about your health and your pregnancy. It's important for you to answer these questions so Simply can help you and tailor a program just for you. You will get calls telling you what to expect at each stage of your pregnancy. You will also get reminders about prenatal visits, postpartum visits, well-child visits and more. Simply has case managers that specialize in pregnancy and are available for you.

Taking Care of Baby and Me® program

Our program for all pregnant members is called Taking Care of Baby and Me®. Care while you're pregnant (or prenatal care) is important even if you've already had a baby. It can help you have a healthy baby. With our program, members get health information and rewards for getting prenatal and postpartum (after birth) care. Our program also helps pregnant members with complex health care needs. Nurse case managers work closely with these members to give:

- Education
- Emotional support

- Help in following their doctor's care plan
- Information on services and resources in your community like:
    - Transportation
    - Women, Infants, and Children (WIC) Program
    - Home-visitor programs
    - Breastfeeding support and counseling

Our nurses also work with doctors and help with other services members may need. The goal is to promote better health for members and the delivery of healthy babies.

My Advocate® — quality care for you and your baby

At Simply, we want to give you the very best care during your pregnancy. That's why we invite you to enroll in My Advocate®, which is part of our Taking Care of Baby and Me® program. My Advocate® gives you the information and support you need to stay healthy during your pregnancy. My Advocate® delivers maternal health education by phone, text message and smartphone app that is helpful and fun. You will get to know Mary Beth, My Advocate's automated personality. Mary Beth will respond to your changing needs as your baby grows and develops. You can count on:

- News you can use
- Communication with your case manager based on My Advocate® messaging if you should have questions or issues
- An easy communication schedule
- No cost to you

With My Advocate®, your information is kept secure and private. My Advocate® calls give you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn and answer a question or two over the phone. If you tell us you have a problem, you'll get a call back from a case manager in 1-2 business days. My Advocate® topics include:

- Pregnancy and postpartum care
- Well-child care
- Dental health
- Immunizations
- Healthy living tips

If you think you are pregnant:

- Call your PCP or OB/GYN provider right away. If you don't have an OB/GYN, we can help you find one in the Simply network. You don't need a referral from your PCP to see an OB/GYN. Your OB/GYN should see you within two weeks.

When you find out you are pregnant:

- Call Member Services and your Department of Children and Families (DCF) caseworker.
    - This will help your baby get Simply health care benefits when they are born. You will need to choose a PCP for your baby in your last trimester. If you don't choose one during this time, we'll choose one for you.
    - We will send you a prenatal education package. It includes helpful information about the Taking Care of Baby and Me® program, self-care book, brochure and more.

While you're pregnant:

- You need to take good care of your health. You may be able to get healthy food from the WIC program if you qualify for Medicaid. Call Member Services for the WIC program close to you.
- You must visit your PCP or OB/GYN often. Your PCP or OB/GYN and your pregnancy education package will tell you how often.

When you have a new baby:

- You and your baby may stay in the hospital at least 48 hours after a vaginal delivery or 72 hours after a Cesarean section (C-section). You may stay in the hospital less time if your PCP or OB/GYN and the baby's provider see you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.
- Simply pays for elective circumcisions for newborn members up to 28 days of age. Circumcision will be a one-time, lifetime benefit.

After you have your baby:

- You must call Simply Member Services to let your care manager know you had your baby. We will need to get details about your baby. We can help you pick a PCP for your baby if you have not already picked one before they were born.
- You must call your DCF caseworker. If you do not wish for the baby to become a member, you must call an Enrollment Broker toll free at 1-877-711-3662 (TTY 1-866-467-4970) to pick a different health plan for them.
- Simply will send you the Taking Care of Baby and Me® postpartum education package. It includes a baby-care book and brochures about the reward program, postpartum depression, and making a family life plan.
- You will still get health promotion calls while enrolled in the program for up to 12 weeks if you enrolled in My Advocate® during your pregnancy.
- Set up a visit with your PCP or OB/GYN for your postpartum checkup. This is very important to ensure you're healing well. This visit should be done between 21 to 56 days after you deliver.

- If you delivered by C-section, your PCP or OB/GYN may ask you to come back for a two-week post-surgery checkup. This is not considered a postpartum checkup. You will still need to go back and see your provider within 21 to 56 days after your delivery for your postpartum checkup.

If you need help making your appointments for your prenatal or postpartum visits or have any questions, call Member Services. We can help.

Healthy Start Services

Simply partners with the Healthy Start Coalition to make sure you have a healthy pregnancy and healthy baby. Healthy Start offers classes on:

- How to have a healthy pregnancy
- Eating well while you are pregnant
- How to stop smoking
- Breastfeeding
- How to care for your baby
- Family planning
- Childbirth
- Parenting

To find Healthy Start services near you, call Member Services or visit www.healthystartflorida.com/about-us/coalition-map.

Nutritional Assessment and Counseling

Members who are pregnant, breastfeeding or postpartum and children from birth to 5 years of age can get a nutritional assessment, counseling and referrals to the Florida WIC program. Your doctor will assess your eating habits, educate on breast milk alternatives and give custom diet counseling and a nutrition care plan. You should get a copy of the WIC referrals your doctor makes.

Simply also provides a Gestational Diabetes program for women who have been diagnosed with gestational diabetes and may need more support to eat right.

We also offers these services to LTC members:

- A safety review of your home and ways to prevent falls
- Disease education about how to manage your symptoms and identify your risks
- Advance directive and end-of-life education

Your case manager can help you with these services. You can also call Member Services for health education materials on these topics.

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

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

Section 12: Your Plan Benefits: Managed Medical Assistance Services

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

There may be some services that we do not cover, but might still be covered by Medicaid. To find out about these benefits, call the Agency Medicaid Help Line at 1-877-254-1055. If you need a ride to any of these services, we can help you. You can call 1-844-406-2396 (TTY 711) to schedule a ride.

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

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	Required
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover blood or skin allergy testing and up to 156 doses per year of allergy shots	Not required
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.	Required for nonemergent transportation services
Ambulatory Detoxification Services	Services provided to people who are withdrawing from drugs or alcohol	As medically necessary and recommended by us	Required

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

Service	Description	Coverage/Limitations	Prior Authorization
Ambulatory Surgical Center Services	Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	Required
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	Not required
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.	Required
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover: - One initial assessment per year - One reassessment per year - Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	Not required
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0-18) enrolled in a DCF program	We cover 365/366 days of services per year, including therapy, support services and aftercare planning	Required
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor: - Cardiac testing - Cardiac surgical procedures - Cardiac devices	May be required for cardiac testing and surgical procedures
Child Health Services Targeted Case Management	Services provided to children (ages 0-3) to help them get health care and other services	Your child must be enrolled in the DOH Early Steps program.	Required

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: - One new patient visit - 24 established patient visits per year - Maximum of one visit per day - X-rays - Ultrasound or electrical stimulation	Not required
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic		Not required
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	Required
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	Not required
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys.	We cover the following as prescribed by your treating doctor: - Hemodialysis treatments - Peritoneal dialysis treatments	Required
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	Required

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.	Some service and age limits apply. Call 1-844-406-2396 (TTY 711) for more information.	Required
Early Intervention Services	Services to children ages 0-3 who have developmental delays and other conditions	We cover: - One initial evaluation per lifetime, completed by a team - Up to 3 screenings per year - Up to 3 follow-up evaluations per year - Up to 2 training or support sessions per week	Not required
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.	Required for air ambulances
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover: - One adult health screening (check-up) per year - Well child visits are provided based on age and developmental needs	Not required

Service	Description	Coverage/Limitations	Prior Authorization
		- One visit per month for people living in nursing facilities - Up to two office visits per month for adults to treat illnesses or conditions	
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover up to 26 hours per year of Family or Individual Therapy Services, one hour per day.	Not required
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.	Required
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	Covered as medically necessary.	May be required for diagnostic tests and procedures
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	Covered as medically necessary.	May be required for diagnostic tests and procedures
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover up to 39 hours per year.	Not required

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: - Cochlear implants - One new hearing aid per ear, once every 3 years - Repairs - Up to 3 pairs of ear molds per year - One fitting and dispensing service per ear every 3 years - One hearing test every 3 years to determine the need for hearing aid and the most appropriate hearing aid - Up to 2 newborn hearing screenings for recipients under 12 months of age; a second screening may be performed only if the recipient does not pass the first hearing screening in one or both ears	Required for cochlear implants and bone anchored hearing aids
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover: - Up to 4 visits per day for pregnant recipients and recipients ages 0-20 - Up to 3 visits per day for all other recipients	Required
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them	Covered as medically necessary.	Not required

Service	Description	Coverage/Limitations	Prior Authorization
	comfortable and pain free. Support services are also available for family members or caregivers.		
Individual Therapy Services	Services for people to have one-to-one therapy sessions with a mental health professional	We cover up to 26 hours per year of Family or Individual Therapy Services, one hour per day.	Not required
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	Required
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: - Up to 365/366 days for recipients ages 0-20 - Up to 45 days for all other recipients (extra days are covered for emergencies)	Required for elective inpatient admissions
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	Covered as medically necessary.	Requires a referral from your PCP
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary.	Required for genetic testing
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families.	Required
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	Covered as medically necessary.	Not required

Service	Description	Coverage/Limitations	Prior Authorization
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary.	Not required
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	Required
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary.	Required
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	Required
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary.	May be required for diagnostic tests and procedures
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 other means of transportation: - Out-of-state travel - Transfers between hospitals or facilities - Escorts when medically necessary Managed by the vendor, MCT Express (in Broward, Miami-Dade and Monroe counties) or LogistiCare (in all other counties)	PA is required for out-of-state travel and transfers between hospitals or facilities.

Service	Description	Coverage/Limitations	Prior Authorization
Nursing Facility Services	Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term	We cover 365/366 days of services in nursing facilities as medically necessary.	Required
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years - Up to 2 casting and strapping applications per day - One therapy re-evaluation every 5 months We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6 months later	Required
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary.	Required
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary.	May be required for diagnostic tests and procedures
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are	- Emergency services are covered as medically necessary	Required for non-emergent services

Service	Description	Coverage/Limitations	Prior Authorization
	not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you.	- Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	
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. - Up to 12 facet joint injections in a 6-month period - Up to 4 percutaneous radiofrequency neurolysis in a 4-month period	May be required for diagnostic tests and procedures
Physical Therapy Services	Physical therapy includes exercises , stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap: - One initial evaluation per year - One therapy re-evaluation every 5 months - Up to two casting and strapping applications per day - Up to 210 minutes of treatment per week - One initial wheelchair evaluation per 5 years We cover for people of all ages: - Follow-up wheelchair evaluations, one at delivery and one 6 months later	Required

Service	Description	Coverage/Limitations	Prior Authorization
Podiatry Services	Medical care and other treatments for the feet	We cover: - 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	Not required
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover: - Up to a 34-day supply of drugs, per prescription - Refills, as prescribed - Up to two 72-hour emergency supplies per prescription within 30 consecutive days	Required for some drugs. Call Member Services for more information.
Private Duty Nursing Services	Nursing services provided in the home to people ages 0-20 who need constant care	We cover up to 24 hours per day.	Required
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover 10 hours of psychological testing per year.	Required
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 up to 480 hours per year.	Required

Service	Description	Coverage/Limitations	Prior Authorization
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	- Covered as medically necessary - Up to 2 biophysical profiles per pregnancy - One fetal echocardiograpy per pregnancy; up to 2 follow-up tests for a high-risk pregnancy - One mammography screening per year - Up to 3 obstetrical ultrasounds per pregnancy	May be required
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.	Not required
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 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.	Not required
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover: - Respiratory testing - Respiratory surgical procedures - Respiratory device management	May be required for diagnostic tests and procedures

Service	Description	Coverage/Limitations	Prior Authorization
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover: - 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)	Required
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	Required
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders	We cover the following: - Assessments - Foster care services - Group home services	Required
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following services for children ages 0-20: - Communication devices and services - Up to 210 minutes of treatment per week - One initial evaluation per year - One re-evaluation every 5 months We cover the following services for adults: - One communication evaluation per 5 years	Required
Statewide Inpatient Psychiatric Program Services	Services for children with severe mental illnesses that need treatment in the hospital	Covered as medically necessary for children ages 0-20.	Required

Service	Description	Coverage/Limitations	Prior Authorization
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	Required
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	Required
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 up to 9 hours per month.	Required
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary.	Required
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover these services when prescribed by your doctor: - Two pairs of eyeglasses for children ages 0-20 - Contact lenses - Prosthetic eyes	May be required for prosthetic devices
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	Covered as medically necessary.	May be required for procedures and some tests

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
Acupuncture	Treatment that eases pain and treats physical, mental and emotional conditions	Thirty (30) minutes of treatment once a week for up to three months for members 21 years and older	Required
Behavioral Health Day Services/Day Treatment	Treatment or services that give structured, daily activities for persons with behavioral health disorders	For members 21 years and older: - 10 extra units per year of day treatment - One day per week and up to 52 days per year of day care services	Not required
Behavioral Health Medical Services (Drug Screening)	Behavioral health services to screen for alcohol or other drugs	Eight extra behavioral health-related medical services per year for members 21 years and older	Required
Behavioral Health Medical Services (Medication Management)	Behavioral health services to manage medicines for persons with alcohol or other substance abuse conditions	Eight extra behavioral health-related medical services per year for members 21 years and older	Required
Behavioral Health Medical Services (Verbal Interaction)	Behavioral health services to talk with persons with behavioral health disorders	Eight extra behavioral health-related medical services per year for members 21 years and older	Required
Behavioral Health Screening Services	Behavioral health services to screen for a behavioral health disorder	One extra screening per year for members 21 years and older	Not required
Cellular Phone Service	Members can sign up for the Lifeline program and get a free smartphone, free monthly minutes and a minimum of 500 MB of data and text messaging	One Lifeline smartphone benefit per member 18 years and older We offer members: - Free minutes for calls to and from Member Services - Extra data for health text messages	Not required

Service	Description	Coverage/Limitations	Prior Authorization
Chiropractic Services	Services to diagnose and treat misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles and organs	Thirty-five (35) extra visits per year for eligible members 21 years and older Medicaid covers 24 visits each year. We offer these extra visits after your Medicaid visits are used.	Required
Computerized Cognitive Behavioral Analysis	Health and behavior assessments, like clinical interviews, behavioral observations, psychophysiological monitoring and questionnaires	Unlimited assessments through the Simply Online Well Being tool for members 21 years and older	Not required
Doula Services	Home visits for prenatal and postnatal monitoring, assessment and follow-up care; and newborn care and assessment. Prenatal includes fetal heart rate, non-stress test, uterine monitoring and gestational diabetes monitoring.	Unlimited visits per pregnancy for members 21 to 54 years old	Not required
Electric Stimulators (pain management)	Transcutaneous electrical nerve stimulation (TENS) device for pain management	We cover members 21 years and older with: - One TENS device (2 leads) every five years - Two TENS devices (4 or more leads) every five years - 2 TENS Leads supply — max. of one per month - 4 TENS Leads supply — max. of two per month - One spinal electrical osteogenesis stimulator per episode as medically necessary	Required

Service	Description	Coverage/Limitations	Prior Authorization
Hearing Services	Services to assess a person's hearing for the need for hearing aids or test a person's hearing aids	We offer these extra services for members 21 years and older every two years: - One evaluation - One assessment - One hearing aid per ear - One hearing aid fitting/checking - One hearing aid dispensing fee Medicaid covers hearing services once every three years for eligible members	Not required
Home-Delivered Meals — Post-Facility Discharge (Hospital or Nursing Facility)	Home-delivered meals, including preparation (per meal), for persons who have left a hospital or nursing facility	We cover for members 18 years and older: - Two meals per day for seven days It must be after a three-day or more surgical hospital stay.	Required
Home Health Nursing/Aide Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	One extra unit of service per day for members 21 years and older	Required
Housing Assistance	Help finding housing and paying for monthly housing cost	A $500 one-time, lifetime benefit for members 21 years and older	Required
Intensive Outpatient Treatment — Substance Abuse	Intensive outpatient services with therapy and treatment to help with alcohol and/or drug related issues	We cover pregnant female members ages 21 and older for up to 8 weeks. This includes services for: - Three hours a day - Three days a week With a total limit of 9 hours per week.	Required

Service	Description	Coverage/Limitations	Prior Authorization
		Medicaid covers these services for eligible members. We offer this extra benefit after your Medicaid benefits are used.	
Massage Therapy	Services to help with pain relief through: - Massage - Mobilization - Manipulation - Manual traction	Two hours of therapy for eligible members 21 years and older with acute musculoskeletal pain	Required
Meals — Non-emergency Transportation Day-Trips	Non-emergency rides for a member and their caregiver to medically-necessary doctor visits over 100 miles each way. Includes meals.	Transportation and meal costs for members 21 years and older can get: - Up to $200 per day - Up to $1,000 per year	Required
Newborn Circumcision	The surgical removal of the skin covering the tip of the penis on newborn boys	Circumcision as a one-time benefit for newborns within the first 28 days after birth	Not required
Nutritional Counseling	Visits from a dietitian to help with a nutrition plan and healthy eating habits	Up to six visits per year for eligible members	Required
Occupational Therapy	Occupational therapy assessments and treatment visits to help members with physical or mental disabilities	We cover members 21 years and older with: - One evaluation per year - One re-evaluation per year - Up to seven therapy sessions per week Medicaid covers occupational therapy for ages 0-20 and eligible adults. We offer these extra visits after your Medicaid benefits are used.	Required
Outpatient Hospital Services	Outpatient services or medical care you get at the hospital without staying overnight	Extra $200 per year on top of the $1,500 plan benefit for outpatient costs for members 21 years and older. This excludes lab services.	Required

Service	Description	Coverage/Limitations	Prior Authorization
Over-the-Counter Benefit	Low- to no-cost over-the-counter (OTC) supplies and medicines like allergy medicine or bug spray	$25 each month per household towards the cost of OTC items	Not required
Physical Therapy	Physical therapy assessments and treatment visits to help members with physical injuries	We offer extra services for members 21 years and older: - One evaluation per year - One re-evaluation per year - Up to seven therapy sessions per week Medicaid covers physical therapy for ages 0-20 and eligible adults. We offer these extra visits after your Medicaid benefits are used.	Not required
Pregnancy Services — Prenatal/ Perinatal Visits	Prenatal and postnatal care services for pregnant members	We cover: - Hospital-grade breast pump (rental, max. of 1 per year) - Breast pump (rental, 1 per 2 years) - 14 visits for low-risk pregnancies - 18 visits for high-risk pregnancies - Three visits within 90 days following delivery	Required for the hospital-grade breast pump only; not required for other listed benefits
Primary Care Visit Services for Adults	Visits with a primary care provider (PCP) to get or stay healthy	Unlimited visits for members 21 years and older	Not required
Respiratory Supplies	Supplies to help improve breathing ability and open airways	For eligible members 21 years and older	Required
Respiratory Therapy	Therapy to help you breathe better or treatments for a respiratory condition	We offer extra benefits for members 21 years and older: - One initial evaluation per year - One re-evaluation per year	Not required

Service	Description	Coverage/Limitations	Prior Authorization
		- One respiratory therapy visit per day Medicaid covers respiratory therapy for ages 0-20. We offer these extra benefits after your Medicaid benefits are used.	
Speech Therapy/ Speech Language Pathology	Services, including treatments and tests, to help you talk or swallow better	We offer these extra benefits for members 21 years and older: - One evaluation/re-evaluation per year - One evaluation of oral and pharyngeal swallowing function per year - Up to seven therapy treatment units per week - One initial AAC evaluation per year - One AAC re-evaluation per year - Up to four 30-minute sessions for AAC fitting, adjustment and training sessions per year Medicaid covers speech therapy for ages 0-20 and certain services for eligible adults.	Not required
Art Therapy	Music, dance, art or play therapies included as part of a care plan to help members with mental health issues	Unlimited sessions for members receiving behavioral health services.	Required
Vaccine — Influenza	Shot to prevent you from getting the flu	Covered for all members 21 years and older.	Not required
Vaccine — Pneumonia (Pneumococcal)	Shot to prevent you from getting pneumonia	Covered for all members 21 years and older.	Required for members 19-64 years old

Service	Description	Coverage/Limitations	Prior Authorization
Vaccine — Shingles (Varicella-Zoster)	Shot to prevent you from getting shingles	One vaccine per lifetime for members 60 years and older.	Not required
Vaccine — TDaP	Shot to prevent you from getting tetanus, diphtheria, and pertussis (TDaP)	One vaccine per pregnancy for pregnant members 21-54 years old.	Required
Vision Services	Eye exam and glasses or contacts	We offer these extra benefits for members 21 years and older: - One exam per year - One frame for eyeglasses per year - Six months of contact lenses with prescription Medicaid covers vision services for eligible members	Not required
Waived Copayments	No copays for these services: - Birthing Center - Chiropractic - Community Behavioral Health - Federally Qualified Health Center - Inpatient and outpatient hospital care - Independent labs - Non-emergency transportation - Optometrist care - Care from a doctor, nurse practitioner, physician assistant or registered nurse first assistant - Podiatry - Portable X-ray - Rural Health Clinic	For members of all ages	Not required

Section 13: Long-term Care Program Helpful Information

(Read this section if you are in the LTC program. If you are not in the LTC program, skip to Section 15.)

Starting Services

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

At this first visit, you case manager will tell you about the LTC program and our Plan. She or he will also ask you questions about your health, how you take care of yourself, how you spend your time, who helps takes care of you, and other things. These questions make up your **initial assessment.** The initial assessment helps us learn about what you need to live safely in your home. It also helps us decide what services will help you the most.

Developing a Plan of Care

Before you can begin to get services under the LTC program, you have to have a **person-centered plan of care (plan of care)**. Your case manager makes your plan of care. 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 small chores 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 chores.
- 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 Plan and the services we decided.

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 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 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 14: 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
Companion Care	This service helps you fix meals, do laundry and light housekeeping	Required
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.	Required
Assistive Care Services	These are 24-hour services if you live in an adult family care home or an assisted living facility	Required
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.	Required
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	Required
Behavioral Management	Services for mental health or substance abuse needs	Required
Caregiver Training	Training and counseling for the people who help take care of you	Required

[7] You can find a copy of the Statewide Medicaid Managed Care Long-term Care Program Coverage Policy at http://ahca.myflorida.com/medicaid/review/Specific/59G-4.192_LTC_Program_Policy.pdf

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.	Not required
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.	Required
Home Delivered Meals	This service delivers healthy meals to your home	Required
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores	Required
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.	Required
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Required
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.	Required

Service	Description	Prior Authorization
	Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	
Medication Administration	Help taking medications if you can't take medication by yourself	Required
Medication Management	A review of all of the prescription and over-the-counter medications you are taking	Required
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	Required
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	Required
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Required
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Required
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 Home.	Required
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	Required

Service	Description	Prior Authorization
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	Required
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better	Required
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow	Required
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.	Not required

Long-term Care Participant Direction Option

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.

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
Bed Holds for Assisted Living Facilities and Adult Family Care Homes	We will pay to hold a bed for you when you go into the hospital if you live in an in-network assisted living facility or adult family care home.	Up to 30 days for adults 18 years of age and older. Member must: • Stay in the facility for at least 30 days between episodes • Plan to return to the facility and keep making all room and board and/or patient responsibility payments Providers must tell Simply within 48 hours of the member leaving the facility to be eligible for repayment.	Not required
Community Reintegration Support	Up to $5,000 per member to help pay for moving costs, security and utility deposits, and household furnishings	Maximum of $5,000 allowance per member per lifetime for adults 18 years of age and older	Required
Individual Therapy Sessions for Caregivers	Therapeutic behavioral services for caregivers	Limit of four units per day for a maximum of 12 days per year for adults 18 years of age and older. One unit of service is 15 minutes.	Required
Non-emergency Transportation — Non-Medical Purposes	Eligible members will get extra rides to non-provider appointments to help them stay active in the community.	For members 18 years of age and older. Limit of four one-way rides per member per month. Maximum of 48 one-way rides per member per year. Up to 25 miles covered each drive between stops.	Not required

Section 15: 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. Call 1-844-406-2396 for MMA or 1-877-440-3738 for LTC.	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. Grievance & Appeals Coordinator Simply Healthcare Plans 4200 W. Cypress St., Suite 900 Tampa, FL 33607 Phone: 1-877-372-7603, ext. 106-121-0301 (TTY 711) Fax: 1-866-216-3482 Email: flmedicaidgrievances@simplyhealthcareplans.com	We will: • Review your grievance and send you a letter with our decision within 90 days. If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
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. Grievance & Appeals Coordinator Simply Healthcare Plans 4200 W. Cypress St., Suite 900 Tampa, FL 33607 Phone: 1-877-372-7603, ext. 106-121-0301 (TTY 711) Fax: 1-866-216-3482 Email: flmedicaidgrievances@simplyhealthcareplans.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. Grievance & Appeals Coordinator Simply Healthcare Plans 4200 W. Cypress St., Suite 900 Tampa, FL 33607 Phone: 1-877-372-7603, ext. 106-121-0301 (TTY 711) Fax: 1-866-216-3482 Email: flmedicaidgrievances@simplyhealthcareplans.com	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 60127
Ft. Meyers, FL 33906
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

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

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

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

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

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

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

Review by the State (for MediKids Members)

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

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

Agency for Health Care Administration
P.O. Box 60127
Ft. Myers, FL 33906
1-877 254-1055 (toll-free)
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 that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

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

- 10 days after you receive a Notice of Plan Appeal Resolution (NPAR), or
- On or before the first day that your services will be reduced, suspended or terminated

Section 16: Your Member Rights

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

- Be treated with courtesy and respect
- Have your dignity and privacy respected at all times
- 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 information about your diagnosis, the treatment you need, choices of treatments, risks, and how these treatments will help you
- Say no 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
- 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)
- File a grievance about any matter other than a Plan’s decision about your services

- 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
- Get information about our Plan, services, practitioners and providers, and member rights and responsibilities
- Take part in making decisions with providers about your health care
- An honest talk about treatment options that are appropriate or medically necessary for your conditions, no matter what the cost or benefit coverage
- Voice complaints or appeals about the Plan or the care it provides
- Suggest changes to the Plan's member rights and responsibilities policy

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 17: 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 and ask questions
- Keep your appointments or notify your provider if you will not be able to keep an appointment
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff with respect
- Tell us if you have problems with any health care staff
- Use the emergency room only for real emergencies

- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment
- Understand your health issues and take part in developing treatment goals with your providers

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 18: Other Important Information

Patient Responsibility

You have to pay for the **patient responsibility** when you live in a facility, like an assisted living facility or adult family care home. Patient responsibility is the money you must pay towards the cost of your care. DCF will tell you the amount of your patient responsibility. Patient responsibility is based on your income and will change if your income changes.

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.

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 the Special Investigations Unit. Call 1-844-406-2396 (MMA) or 1-877-440-3738 (LTC). When you call, ask to speak to the Special Investigations Unit. You can also email your report to SIU@simplyhealthcareplans.com. Please give as many details as possible.

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 understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

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

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

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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-844-406-2396 (MMA) or 1-877-440-3738 (LTC) 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
- www.FloridaHealthFinder.gov, where you can learn about Simply quality performance ratings and more. See the next section for more information.

Section 19: 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 homes, assisted living facilities, ambulatory surgery centers and hospitals. You can find the following types of information on the website:

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

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

Elder Housing Unit

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

MediKids Information

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

Aging and Disability Resource Center

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

Independent Consumer Support Program

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

Do you need help with your health care, talking with us, or reading what we send you? Call us toll free at 1-844-406-2396 (TTY 711) for Managed Medical Assistance (MMA) or 1-877-440-3738 (TTY 711) for Long-Term Care (LTC) to get this for free in other languages or formats.

¿Necesita ayuda con su cuidado de la salud, para hablar con nosotros o leer lo que le enviamos? Llámenos a la línea gratuita al 1-844-406-2396 (TTY 711) para MMA o 1-877-440-3738 (TTY 711) para LTC para recibir esto gratuitamente en otros idiomas o formatos.

Èske ou bezwen èd ak swen sante ou, èd pou pale ak nou, oswa pou li sa nou voye ba ou? Rele nou gratis nan 1-844-406-2396 (TTY 711) pou MMA oswa 1-877-440-3738 (TTY 711) pou LTC pou w jwenn sa gratis nan lòt lang oswa nan lòt fòma.

Vous avez besoin d’aide pour vos soins de santé, pour communiquer avec nous ou pour lire les documents que nous vous envoyons ? Appelez-nous à notre numéro gratuit 1-844-406-2396 (TTY 711) pour MMA ou 1-877-440-3738 (TTY 711) pour LTC afin d’obtenir ceci gratuitement dans d’autres langues ou formats.

Ha bisogno di supporto con l’assistenza sanitaria, per parlare con noi oppure leggere ciò che le abbiamo inviato? Ci contatti al numero gratuito 1-844-406-2396 (TTY 711) per MMA o 1-877-440-3738 (TTY 711) per LTC per ottenere supporto senza costi aggiuntivi in altre lingue o formati.

Вам нужна помощь с медицинским обслуживанием, консультацией или материалами, которые мы вам прислали? Позвоните нам по бесплатному номеру 1-844-406-2396 (TTY 711) в случае MMA или 1-877-440-3738 (TTY 711) в случае LTC, чтобы получить эти материалы на другом языке или в другом формате.

Non-Discrimination Notice

Simply Healthcare Plans, Inc. follows Federal civil rights laws. We don't discriminate against people because of their:

- Race
- Color
- National origin
- Age
- Disability
- Sex or gender identity

That means we won't exclude you or treat you differently because of these things.

Communicating with you is important

For people with disabilities or who speak a language other than English, we offer these services at no cost to you:

- Qualified sign language interpreters
- Written materials in large print, audio, electronic and other formats
- Help from qualified interpreters in the language you speak
- Written materials in the language you speak

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-877-372-7603, ext. 106-121-0301 (TTY 711).

Your rights

Do you feel you didn't get these services or we discriminated against you for reasons listed above? If so, you can file a grievance (complaint). File by mail, email, fax or phone:

Grievance Coordinator
Simply Healthcare Plans
4200 W. Cypress St.
Suite 900
Tampa, FL 33607

Phone: 1-877-372-7603, ext. 106-121-0301 (TTY 711)
Fax: 1-866-216-3482
Email: flmedicaidgrievances@simplyhealthcareplans.com

Need help filing? Call our Grievance Coordinator at the number above. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- **On the web:** https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- **By mail:** U.S. Department of Health and Human Services
  200 Independence Ave. SW
  Room 509F, HHH Building
  Washington, DC 20201
- **By phone:** 1-800-368-1019 (TTY/TDD 1-800-537-7697)

For a complaint form, visit www.hhs.gov/ocr/office/file/index.html.

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