If you do not speak English, call us at 1-855-355-9800 (TTY 1-855-358-5856). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can talk with you in your language.

Spanish: Si usted no habla inglés, llámenos al 1-855-355-9800 (TTY 1-855-358-5856). 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.


Russian: Если вы не разговариваете по-английски, позвоните нам по номеру 1-855-355-9800 (TTY 1-855-358-5856). У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке.
# Important Contact Information

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Helpline</strong></td>
<td>1-855-355-9800</td>
</tr>
<tr>
<td><strong>Member Helpline TTY</strong></td>
<td>1-855-358-5856</td>
</tr>
<tr>
<td>Website</td>
<td><a href="http://www.prestigehealthchoice.com">www.prestigehealthchoice.com</a></td>
</tr>
<tr>
<td>Address</td>
<td>11631 Kew Gardens Avenue, Suite 200</td>
</tr>
<tr>
<td></td>
<td>Palm Beach Gardens, FL 33410</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audiology and hearing aids</td>
<td>HearUSA 1-800-731-3277</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>1-855-371-3967</td>
</tr>
<tr>
<td>Dental</td>
<td>Contact your Care Manager directly, or contact our Rapid Response and Outreach Team at 1-855-371-8072 (TTY 1-855-358-5856) for help with arranging these services.</td>
</tr>
<tr>
<td>Home health, home infusion, and durable medical equipment (DME)</td>
<td>Coastal Care Services 1-855-481-0505</td>
</tr>
<tr>
<td>Nonemergency medical transportation</td>
<td>MTM (Medical Transportation Management Inc.) 1-855-371-3968</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>PerformRx℠ 1-855-371-3963</td>
</tr>
<tr>
<td>Vision</td>
<td>Premier Eye Care of Florida LLC 1-855-371-3961</td>
</tr>
</tbody>
</table>
| 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  
<p>| For Medicaid eligibility                     | 1-866-762-2237                                           |
| TTY: 711 or 1-800-955-8771                   | <a href="https://www.myflfamilies.com/service-programs/access/medicaid.shtml">https://www.myflfamilies.com/service-programs/access/medicaid.shtml</a> |
| To report Medicaid fraud and/or abuse        | 1-888-419-3456                                           |
|                                               | <a href="https://apps.ahca.myflorida.com/mpi-complaintform/">https://apps.ahca.myflorida.com/mpi-complaintform/</a> |
| To file a complaint about a health care facility | 1-888-419-3450                                           |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>To request a Medicaid Fair Hearing</td>
<td>1-877-254-1055&lt;br&gt;1-239-338-2642 (fax)&lt;br&gt;<a href="mailto:MedicaidHearingUnit@ahca.myflorida.com">MedicaidHearingUnit@ahca.myflorida.com</a></td>
</tr>
<tr>
<td>To find information for elders</td>
<td>1-800-96-ELDER (1-800-963-5337)&lt;br&gt;<a href="http://elderaffairs.state.fl.us/doea/arc.php">http://elderaffairs.state.fl.us/doea/arc.php</a></td>
</tr>
<tr>
<td>To find out information about domestic violence</td>
<td>1-800-799-7233&lt;br&gt;TTY: 1-800-787-3224&lt;br&gt;<a href="https://www.thehotline.org/">https://www.thehotline.org/</a></td>
</tr>
<tr>
<td>To find information about health facilities in Florida</td>
<td><a href="https://www.floridahealthfinder.gov/index.html">https://www.floridahealthfinder.gov/index.html</a></td>
</tr>
<tr>
<td>To find information about urgent care</td>
<td>Urgent care is a medical condition that requires care within 48 hours. If you don’t get treatment for the condition in two days or less, it could become an emergency. If you are not sure that you need urgent care, please call our 24/7 Nurse Call Line at 1-855-398-5615.</td>
</tr>
<tr>
<td>For an emergency</td>
<td>911&lt;br&gt;Or go to the nearest emergency room</td>
</tr>
</tbody>
</table>
# Table of Contents

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Welcome to Prestige Health Choice’s Statewide Medicaid Managed Care Plan

Prestige Health Choice 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 1-855-355-9800 (TTY 1-855-358-5856).
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:

![ID Card Example]

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:

The privacy and security of your health information is a top priority for Prestige Health Choice. That is why we take great care to protect and use your health information correctly. Health information that comes from you and your physicians, hospitals, and other health care providers is called protected health information. This information can be verbal, written, or electronic. Prestige Health Choice has policies and security safeguards to protect this information and the ways it is used. In general, we may use it to:

- Provide treatment.
- Provide benefits.
- Help your health team treat you and receive payment.
- Coordinate payment to other insurance companies.
- Evaluate and improve our services.
We may also use and share your health information based on the law or Prestige Health Choice policies. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security, and Breach Notification Rules are the main federal laws that protect your health information. The Privacy Rule gives you rights with respect to your health information. The Privacy Rule also sets limits on how your health information can be used and shared with others. The Security Rule sets rules for how your health information must be kept secure with administrative, technical, and physical safeguards. If you have questions about how we keep your information safe, refer to the Notice of Privacy Practices included in the welcome kit. You can also call Member Services at 1-855-355-9800 (TTY 1-855-358-5856).

Section 3: Getting Help from Our Member Services

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

Contacting Member Services

You may call us at 1-855-355-9800, or TTY 1-855-358-5856, 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 Member Services department at 1-855-355-9800 (TTY 1-855-358-5856). Our nurses are available to help you 24 hours a day, seven days a week.

Section 4: Do You Need Help Communicating?

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

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

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is 1-855-355-9800 (TTY 1-855-358-5856). 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. You may also contact the Social Security Administration (SSA) to report changes. Call SSA toll-free at 1-800-772-1213 (TTY 1-800-325-0778), Monday through Friday from 7 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your my Social Security account at https://secure.ssa.gov/RIL/SiView.do.

Section 6: Your Medicaid Eligibility

In order for you to go to your health care appointments and for Prestige Health Choice 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. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open Enrollment

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

Section 8: Leaving Our Plan (Disenrollment)

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

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

• You are getting care at this time from a provider that is not part of our plan but is a part of another plan.

• We do not cover a service for moral or religious reasons.

• You are an American Indian or Alaskan Native.

• You live in and get your LTC 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 process2:

• You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records.

• You cannot get the services you need through our plan, but you can get the services you need through another plan.

• Your services were delayed without a good reason.

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

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.

• You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like3.

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

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2 To learn how to ask for an appeal, please turn to page Section 13: Member Satisfaction, on page 42.

3 This is for LTC program enrollees only. If you have questions about your facility’s compliance with this federal requirement, please call Member Services or your case manager.
Section 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 the Rapid Response and Outreach Team at 1-855-371-8072 (TTY 1-855-358-5856) to let us know.

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 the Rapid Response and Outreach Team at 1-855-371-8072 (TTY 1-855-358-5856). 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.

Request to Put Your Services on Hold

If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a form to put your service(s) on hold.
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 1-855-355-9800 (TTY 1-855-358-5856) to get a copy or visit our website at www.prestigehealthchoice.com.

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.

<table>
<thead>
<tr>
<th>Type of Dental Service(s):</th>
<th>Dental Plan Covers:</th>
<th>Medical Plan Covers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Services</td>
<td>Covered when you see your dentist or dental hygienist</td>
<td>Covered when you see your doctor or nurse</td>
</tr>
<tr>
<td>Scheduled dental services in a hospital or surgery center</td>
<td>Covered for dental services by your dentist</td>
<td>Covered for doctors, nurses, hospitals, and surgery centers</td>
</tr>
</tbody>
</table>
### Type of Dental Service(s):

<table>
<thead>
<tr>
<th>Type of Dental Service(s):</th>
<th>Dental Plan Covers:</th>
<th>Medical Plan Covers:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital visit for a dental problem</td>
<td><em>Not covered</em></td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription drugs for a dental visit or problem</td>
<td><em>Not covered</em></td>
<td>Covered</td>
</tr>
<tr>
<td>Transportation to your dental service or appointment</td>
<td><em>Not covered</em></td>
<td>Covered</td>
</tr>
</tbody>
</table>

### 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

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.
- No time limits, like hourly or daily limits.

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

### Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Prestige Health Choice

The Medicaid fee-for-service program is responsible for covering the following services, instead of Prestige Health Choice covering these services:

- Behavior Analysis (BA).
- County Health Department (CHD) Certified Match Program.
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver.

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4 Also known as “Early and Periodic Screening, Diagnosis, and Treatment” or “EPSDT” requirements.
• Familial Dysautonomia (FD) Home and Community-Based Services Waiver.
• Hemophilia Factor-related Drugs.
• Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID).
• Medicaid Certified School Match (MCSM) Program.
• Model Home and Community-Based Services Waiver.
• Newborn Hearing Services.
• Prescribed Pediatric Extended Care.
• Substance Abuse County Match Program.

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

**Moral or Religious Objections**

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

**Section 11: Helpful Information About Your Benefits**

**Choosing a Primary Care Provider (PCP)**

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

One of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will 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 PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.
It is important that you select a PCP for your child to make sure they get their well-child visits each year. Well-child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child’s PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.\(^5\)

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

You do not need a referral for well-child visits.

There is no charge for well-child visits.

**Specialist Care and Referrals**

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

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

**Second Opinions**

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

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

**Urgent Care**

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

If you need Urgent Care after office hours and you cannot reach your PCP, please call our Nurse Call Line at **1-855-398-5615**, 24 hours a day, seven days a week.

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

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

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

Emergency Care

You have 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.prestigehealthchoice.com/provider/find-provider/index.aspx or by calling Member Services at 1-855-355-9800 (TTY 1-855-358-5856), 24 hours a day, seven days a week.
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**

Prestige Health Choice has chosen PerformSpecialty® to provide specialty pharmacy services for members. Prescriptions for specialty medications will be filled by PerformSpecialty. Specialty medications are high-cost drugs that treat complex conditions. Using them correctly requires extra support.

If you are getting a specialty medication from another pharmacy in our network, we will send your prescription to PerformSpecialty for future refills if you need them.

If you agree with this choice, you do not need to take any other steps.

If you want to choose another pharmacy, or if you have questions, please call Pharmacy Member Services at 1-855-371-3963. They are available 24 hours a day, seven days a week.

**Behavioral Health Services**

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

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

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

- Calling Behavioral Health Member Services at 1-855-371-3967 (TTY 1-888-877-5378)
- Looking at our provider directory.
• Going to our website to search for a behavioral health provider at
www.prestigehealthchoice.com > Members >
Find a doctor, medicine, pharmacy or transportation.

Someone is there to help you 24 hours a day, seven 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 Behaviors programs**. You can earn rewards while
participating in these programs. Our plan offers the following programs:

**Healthy Behaviors programs**

- **Smoking Cessation:** Quitting smoking is not easy. We can help you quit. When you sign
  up, you will get a $10 gift card. You can also get over-the-counter nicotine patches, lozenges,
  and gum at no cost. These may help you with your cravings. You can earn a $10 gift card
  for going to group sessions and seminars on quitting. When you finish the program and mail
  your certificate of completion to Prestige Health Choice, you will earn a $30 gift card.

- **Weight Loss:** You may be able to earn rewards in our weight loss program. You can earn a
  $10 gift card for visiting your primary care provider (PCP) to discuss weight loss if you have
  a body mass index (BMI) of 35 or more. You can earn more gift cards by seeing a dietitian or
  nutritionist or by following up with your PCP. If you stay in the program for three months and
  lower your BMI, you can earn a $20 gift card. This program requires that your PCP sign your
  completion form before returning it to Prestige Health Choice.

- **Alcohol and Substance Use Recovery:** Alcohol or substance use can take a toll on your
  physical and mental health. We can help you overcome it. We will mail you a $10 gift card for
  signing up to a recovery program. A Care Manager will help you join a local support group.
  You can receive $10 gift cards for being sober. You can earn the first after 30 days and the
  second after 90 days. You can then earn a $20 gift card after being sober for 180 days.

- **Limited-time Healthy Behaviors programs:** We also offer additional Healthy Behaviors
  programs for a limited time each year. Prestige Health Choice will mail a letter and
  completion form to you once these programs become active, which will include certain
  deadlines. Please be aware of these important deadlines for returning forms to Prestige
  Health Choice for program consideration. You (or your child) may enroll in more than one
  Healthy Behaviors program (if you qualify), and can receive a reward of up to $50 per
  program, per year. You (or your child) may only join each Healthy Behaviors program once
  per year. Please remember that rewards cannot be transferred. Member rewards cannot
  be used for alcohol, tobacco, gambling (including lottery), drugs (except over-the-counter),
firearms, or ammunition purchases. If you leave Prestige Health Choice for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us at 1-855-355-9800 (TTY 1-855-358-5856).

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 visit our website at www.prestigehealthchoice.com or call us at 1-855-355-9800 (TTY 1-855-358-5856).

Disease Management Programs

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

- Diabetes: Our diabetes program teaches participants how to manage their diabetes and related conditions. This includes learning how to eat healthy meals, be active, monitor blood sugar levels, take medication, and reduce the risk of developing complications or other health conditions.

- Asthma: Our asthma program is designed for enrollees who want to learn how to take control of their asthma and feel better. This includes learning how to build an asthma support team, take asthma medications correctly, and follow good health habits.

- Cardiovascular disease (CVD) and high blood pressure (hypertension): Our CVD/high blood pressure program teaches participants how to adopt a heart-healthy lifestyle. This includes learning how to reduce high blood pressure and lower the risk of heart attack, stroke, heart failure, and other complications.

- Cancer: Our cancer self-management program can help enrollees affected by cancer reduce stress, manage pain, and work to maintain an optimal lifestyle.

- Chronic obstructive pulmonary disease (COPD): Our COPD program teaches participants how to manage their condition and helps them make lifestyle changes that will allow better management of their COPD and enhance their quality of life.

- Behavioral health: If you are struggling with opioid use, Prestige Health Choice offers access to substance use services, including specialized opioid treatment for members. We will help you figure out what services you may need (for example, hospital or in-home detoxification, medication-assisted treatment with medications to help lessen the symptoms of withdrawal, counseling, and/or peer support services). Next, we will help you find the right provider and/or facility to help you meet your goals. We will continue to assess your progress, review your care plan, and connect you with resources to help you with what you need. You can call Behavioral Health Member Services at 1-855-371-3967. You can also find this number on the back of your member ID card under “Behavioral Health.” You can find Behavioral Health providers on our website at www.prestigehealthchoice.com > Members > Find a doctor, medicine, pharmacy, or transportation.

- End-of-life issues, including information on advance directives: The best way to make sure your advance directive is followed is to write it down. You can download a form from www.floridahealthfinder.gov/reports-guides/advance-directives.aspx.
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:

1. Children’s programs
   General wellness programs and information that can help you keep your child healthy from birth to 5 years old. These community services include information about proper eating, vaccines, breastfeeding, and important child health checkups.

2. Domestic violence
   Services and programs from community agencies that can assist you if you need help or information about domestic violence.

3. Pregnancy prevention
   Services and information that can help you with questions or assistance to prevent an unplanned pregnancy.

4. Pregnancy and family planning care
   Information and community resources to help you when you are pregnant or need information about family planning.

5. Healthy start services
   Information about services available to help pregnant women and infants, and services that help promote early prenatal care so that you have a healthy baby.

6. Nutritional assessment and counseling for perinatal women and children
   Information and services that help you stay healthy by providing nutritional information and counseling to women for themselves and their babies during and after pregnancy.

7. Behavioral health programs
   Outreach and services to those who may need assessment and treatment for behavioral health needs.

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

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

Section 12: Your Plan Benefits: Managed Medical Assistance Services

The tables below list 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

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6 You can find the definition for Medical Necessity at https://ahca.myflorida.com/medicaid/review/General/59G_1010_Definitions.pdf.
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 **1-855-371-3968** 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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations (You may have to pay for these services if you see a provider who is not in the Prestige Health Choice network)</th>
<th>Prior Authorization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions Receiving Facility Services</td>
<td>These services are used to help people who are struggling with drug or alcohol addiction and need hospitalization</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>Services to treat conditions such as sneezing or rashes that are not caused by an illness</td>
<td>We cover blood or skin allergy testing and up to 156 doses per year of allergy shots.</td>
<td>No</td>
</tr>
<tr>
<td>Ambulance Transportation Services</td>
<td>Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities</td>
<td>Covered as medically necessary.</td>
<td>No — Emergency ground transportation while being transported to the hospital or special support when being transported between facilities</td>
</tr>
<tr>
<td>Ambulatory Detoxification Services</td>
<td>Services provided to people who are withdrawing from drugs or alcohol without going into the hospital</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Ambulatory Surgical Center Services</td>
<td>Surgery and other procedures that are performed in a facility that is not the hospital (outpatient)</td>
<td>Covered as medically necessary.</td>
<td>Yes — Cosmetic procedures only</td>
</tr>
<tr>
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<tr>
<td>Anesthesia Services</td>
<td>Services to keep you from feeling pain during surgery or other medical procedures</td>
<td>Covered as medically necessary.</td>
<td>No</td>
</tr>
<tr>
<td>Assistive Care Services</td>
<td>Services provided to adults (ages 18 and older) help with activities of daily living and taking medication</td>
<td>We cover 365/366 days of services per year.</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral Health Assessment Services</td>
<td>Services used to identify mental health or substance abuse issues</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Overlay Services</td>
<td>Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF program</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Cardiovascular Services</td>
<td>Services that treat the heart and circulatory (blood vessels) system</td>
<td>We cover the following as prescribed by your doctor:</td>
<td>Yes — Radiology/ nuclear cardiac imaging only</td>
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<td>• Cardiac testing</td>
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<td></td>
<td>• Cardiac surgical procedures</td>
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<td></td>
<td>• Cardiac devices</td>
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</tr>
<tr>
<td>Child Health Services</td>
<td>Services provided to children (ages 0 – 3) to help them get health care and other services</td>
<td>Your child must be enrolled in the Department of Health Early Steps program</td>
<td>No</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td></td>
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<tr>
<td>Chiropractic Services</td>
<td>Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs</td>
<td>• 24 established patient visits per year</td>
<td>Yes — Enrollees younger than age 21</td>
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<td></td>
<td>• X-rays</td>
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<tr>
<td>Clinic Services</td>
<td>Health care services provided in a county health department, federally qualified health center, or a rural health clinic</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
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<tr>
<td>Crisis Stabilization Unit Services</td>
<td>Emergency mental health services are performed in a facility that is not a regular hospital</td>
<td>(You may have to pay for these services if you see a provider who is not in the Prestige Health Choice network)</td>
<td>Yes</td>
</tr>
<tr>
<td>Crisis Stabilization Unit Services</td>
<td>Emergency mental health services are performed in a facility that is not a regular hospital</td>
<td>(You may have to pay for these services if you see a provider who is not in the Prestige Health Choice network)</td>
<td>Yes</td>
</tr>
<tr>
<td>Dialysis Services</td>
<td>Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys</td>
<td>We cover the following as prescribed by your treating doctor: • Hemodialysis treatments • Peritoneal dialysis treatments</td>
<td>No — For medical care, tests, other treatments for the kidneys, dialysis supplies, and other supplies that help treat the kidneys</td>
</tr>
<tr>
<td>Durable Medical Equipment and Medical Supplies Services</td>
<td>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</td>
<td>Some service and age limits apply. Call Member Services at 1-855-355-9800 (TTY 1-855-358-5856) for more information.</td>
<td>Yes — For medical equipment such as wheelchairs, braces, crutches, and other items. Please contact Coastal Care Services at 1-855-481-0505 (TTY 711)</td>
</tr>
<tr>
<td>Early Intervention Services</td>
<td>Services to children ages 0 - 3 who have developmental delays and other conditions</td>
<td>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</td>
<td>No</td>
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<tr>
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<tr>
<td>Emergency Transportation Services</td>
<td>Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency</td>
<td>Covered as medically necessary.</td>
<td>Yes — For airplane and helicopter emergency transportation No — For ground emergency transportation and 911 transportation calls</td>
</tr>
<tr>
<td>Evaluation and Management Services</td>
<td>Services for doctor’s visits to stay healthy and prevent or treat illness</td>
<td>We cover: • One adult health screening (checkup) per year • Well child visits are provided based on age and developmental needs • One visit per month for people living in nursing facilities • Up to two office visits per month for adults to treat illnesses or conditions</td>
<td>No</td>
</tr>
<tr>
<td>Family Therapy Services</td>
<td>Services for families to have therapy sessions with a mental health professional</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Gastrointestinal Services</td>
<td>Services to treat conditions, illnesses, or diseases of the stomach or digestion system</td>
<td>We cover: • Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Genitourinary Services</td>
<td>Services to treat conditions, illnesses, or diseases of the genitals or urinary system</td>
<td>We cover: • Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
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<tr>
<td>Group Therapy Services</td>
<td>Services for a group of people to have therapy sessions with a mental health professional</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Hearing Services</td>
<td>Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs</td>
<td>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</td>
<td>No</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury</td>
<td>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</td>
<td>Yes, please contact Coastal Care Services at 1-855-481-0505 for authorization of home health services and DME and supplies provided in the home</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>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.</td>
<td>Covered as medically necessary You may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility.</td>
<td>Yes</td>
</tr>
<tr>
<td>Individual Therapy Services</td>
<td>Services for people to have one-to-one therapy sessions with a mental health professional</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
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</tbody>
</table>
| 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) | Yes — For all enrollees under the age of 21 and pregnant adults, up to 365 days. For all non-pregnant adults, up to 45 days of inpatient coverage and up to 365 days of emergency inpatient care, including behavioral health. No less than 48 hours following a normal vaginal delivery, and at least 96 hours following a cesarean section. |
<p>| Integumentary Services          | Services to diagnose or treat skin conditions, illnesses or diseases         | Covered as medically necessary                                                                                                                                                                                        | Yes — Cosmetic procedures only                                                      |
| Laboratory Services             | Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases | Covered as medically necessary                                                                                                                                                                                        | No                                                                                   |
| Medical Foster Care Services    | Services that help children with health problems who live in foster care homes | Must be in the custody of the Department of Children and Families                                                                                                                                                   | No                                                                                   |
| Medication Assisted Treatment   | Services used to help people who are struggling with drug addiction         | Covered as medically necessary                                                                                                                                                                                        | No                                                                                   |</p>
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<tr>
<td>Medication Management Services</td>
<td>Services to help people understand and make the best choices for taking medication</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Mental Health Partial Hospitalization Program Services</td>
<td>Treatment provided for 4 or more hours per day, several days per week, for people who are recovering from mental illness</td>
<td>As medically necessary and recommended by us</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Targeted Case Management</td>
<td>Services to help get medical and behavioral health care for people with mental illnesses</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Mobile Crisis Assessment and Intervention Services</td>
<td>A team of health care professionals who provide emergency mental health services, usually in people's homes</td>
<td>As medically necessary and recommended by us</td>
<td>No</td>
</tr>
<tr>
<td>Neurology Services</td>
<td>Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Nonemergency Transportation Services</td>
<td>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</td>
<td>We cover the following services for recipients who have no transportation: • Out-of-state travel • Transfers between hospitals or facilities • Escorts when medically necessary</td>
<td>No — Please call 1-855-371-3968 (TTY 711) to schedule nonemergency transportation services</td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td>Medical care or nursing care that you get while living full-time in a nursing facility. This can be a short-term rehabilitation stay or long-term</td>
<td>We cover 365/366 days of services in nursing facilities as medically necessary See information on Patient Responsibility for room and board copayment information.</td>
<td>Yes</td>
</tr>
<tr>
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</tbody>
</table>
| 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:  
  - One initial evaluation per year  
  - Up to 210 minutes of treatment per week  
  - One initial wheelchair evaluation per 5 years  

We cover for people of all ages:  
  - Follow-up wheelchair evaluations, one at delivery and one 6 months later | Yes |
<p>| Oral Surgery Services           | Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity | Covered as medically necessary | Yes — Cosmetic procedures only |
| Orthopedic Services             | Services to diagnose or treat conditions, illnesses or diseases of the bones or joints | Covered as medically necessary | No |
| Outpatient Hospital Services    | Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you | Emergency services are covered as medically necessary | Yes — Depending on procedure |
| Pain Management Services        | Treatments for long-lasting pain that does not get better after other services have been provided | Covered as medically necessary. Some service limits may apply | Yes |</p>
<table>
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</thead>
</table>
| 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:  
  • One initial evaluation per year  
  • Up to 210 minutes of treatment per week  
  • One initial wheelchair evaluation per 5 years  
 We cover for people of all ages:  
  • Follow-up wheelchair evaluations, one at delivery and one 6 months later | Yes |
| 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 | No |
| 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 | Refer to online Preferred Drug Listing [www.prestigehealthchoice.com](http://www.prestigehealthchoice.com) |
| 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 | Yes |
<p>| Psychiatric Specialty Hospital Services | Emergency mental health services that are performed in a facility that is not a regular hospital | As medically necessary and recommended by us | Yes |
| Psychological Testing Services | Tests used to identify behavioral health problems | Covered as medically necessary | Yes |</p>
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<tbody>
<tr>
<td>Psychosocial Rehabilitation Services</td>
<td>Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores.</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Radiology and Nuclear Medicine Services</td>
<td>Services that include imaging such as X-rays, MRIs or CAT scans. They also include portable X-rays.</td>
<td>Covered as medically necessary</td>
<td>Yes – For CT, MRI, MRA, PET scans and nuclear cardiac imaging No – For X-rays and portable X-rays when done by a participating provider</td>
</tr>
<tr>
<td>Regional Perinatal Intensive Care Center Services</td>
<td>Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions.</td>
<td>Covered as medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Reproductive Services</td>
<td>Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to help you plan the size of your family.</td>
<td>We cover family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are free. These services are voluntary and confidential, even if you are younger than 18 years old.</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
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</tbody>
</table>
| 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 | Yes                  |
| 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) | Yes                  |
| Self-Help/Peer Services         | Services to help people who are in recovery from an addiction or mental illness | As medically necessary and recommended by us                                           | No                  |
| Specialized Therapeutic Services | Services provided to children ages 0 – 20 with mental illnesses or substance use disorders | As medically necessary, we cover the following:  
• Assessments  
• Foster care services  
• Group home services | No                  |
| 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  
We cover the following services for adults:  
• One communication evaluation per 5 years | Yes                  |
<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Statewide Inpatient Psychiatric Program Services</td>
<td>Services for children with severe mental illnesses who need treatment in a facility</td>
<td>Covered as medically necessary for children ages 0 – 20</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapeutic Behavioral On-Site Services</td>
<td>Services provided by a team to prevent children ages 0 – 20 with behavioral health issues from being placed in a hospital or other facility</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
<tr>
<td>Transplant Services</td>
<td>Services that include all surgery and pre and post-surgical care</td>
<td>Covered as medically necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Visual Aid Services</td>
<td>Visual aids are items such as glasses, contact lenses and prosthetic (fake) eyes</td>
<td>We cover the following services when prescribed by your doctor: • Two pairs of eyeglasses for children ages 0 – 20 • Contact lenses • Prosthetic eyes</td>
<td>No</td>
</tr>
<tr>
<td>Visual Care Services</td>
<td>Services that test and treat conditions, illnesses, and diseases of the eyes</td>
<td>Covered as medically necessary</td>
<td>No</td>
</tr>
</tbody>
</table>
Your Plan Benefits: Expanded Benefits

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

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Coverage/Limitations</th>
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</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>A treatment that is used to treat your pain</td>
<td>Annual maximum of 12 visits for members with acute and chronic pain</td>
<td>No</td>
</tr>
<tr>
<td>Adult Hearing Services</td>
<td>Adult hearing services, including hearing aids</td>
<td>One hearing aid and evaluation every two years</td>
<td>Yes</td>
</tr>
<tr>
<td>Adult Vision Services</td>
<td>Adult vision services, including eye glasses and contact lenses</td>
<td>One eye exam per year; six-month supply of contact lenses with prescription; one set of eyeglasses per year</td>
<td>Yes</td>
</tr>
<tr>
<td>Assessment Services</td>
<td>In-depth assessment for substance use issues</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Psychological testing to identify behavioral health problems</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
<tr>
<td>Behavioral Health Day Services/Day Treatment</td>
<td>Daytime treatment for behavioral health needs about everyday living</td>
<td>Unlimited; must be active in case management</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Adult day care services</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Screening Services</td>
<td>Assessments and screening services for mental health and substance use issues</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Verbal Interaction)</td>
<td>Talking with a medical professional about your mental health and/or substance use needs</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Behavioral Health Medical Services (Medication Management)</td>
<td>Services with a medical professional who can treat mental health and substance use issues with medication</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
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</tr>
<tr>
<td>Behavioral Health Medical Services (Drug Screening)</td>
<td>Alcohol and other drug screening with urine samples</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Cellular Phone Service</td>
<td>This benefit can help you stay in touch with Prestige Health Choice or your medical providers so that you can stay healthy</td>
<td>One smartphone; monthly call minutes and data; unlimited text messages; unlimited calls to Prestige Health Choice Member Services</td>
<td>No</td>
</tr>
<tr>
<td>Chiropractic Services</td>
<td>Services and treatment provided by a chiropractic provider</td>
<td>24 additional visits for a total of 48 visits per year</td>
<td>No</td>
</tr>
<tr>
<td>Computerized Cognitive Behavioral Analysis</td>
<td>Health and behavior services, including assessments and therapy with a group or your family, or one-on-one sessions with a mental health professional while you have a physical illness</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td>Family health and behavior intervention (without the patient present)</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Doula Services</td>
<td>Pregnancy services given by providers who are trained in childbirth and give support and education to pregnant members</td>
<td>Unlimited visits for pregnant members</td>
<td>No, but requires a referral from the Bright Start maternity program</td>
</tr>
<tr>
<td>Home-Delivered Meals for High-Risk Pregnant Members</td>
<td>You can have meals delivered to you at home if your provider believes you are a high-risk pregnant mom</td>
<td>Up to two meals per day for 30 days; limited to high-risk pregnant members who meet plan guidelines for medical necessity</td>
<td>Yes</td>
</tr>
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</tr>
<tr>
<td>Home-Delivered Meals — Post-Discharge</td>
<td>You can have meals delivered to your home after leaving a medical facility</td>
<td>Up to two meals per day for up to seven days for enrollees who have been recently discharged from the hospital with specific medical conditions; extension of services may be granted with Medical Director approval.</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Health Nursing/Aide Services</td>
<td>Services that can help you with activities of daily living, like bathing, getting dressed, and eating</td>
<td>Up to 48 visits per pregnancy for a home health aide; limited to high-risk pregnant members who meet plan guidelines for medical necessity and requires a physician order</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Visit by a Clinical Social Worker</td>
<td>Services to provide support and education that will help to improve the quality of life for high-risk pregnant moms</td>
<td>Limited to 24 visits per year for high risk pregnant members; requires physician order</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing Assistance</td>
<td>Help for high-risk pregnant members in finding community resources to help with housing</td>
<td>Assistance with locating community resources that support housing options and alternatives for all members; provides up to $500 per lifetime maximum for transitional housing alternatives, and financial assistance is limited to high-risk pregnant members who are homeless</td>
<td>Yes</td>
</tr>
<tr>
<td>Intensive Outpatient Treatment</td>
<td>Outpatient treatment services in a program for substance use that meets three days per week for three hours each day</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
<tr>
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<tr>
<td>Massage Therapy</td>
<td>Therapy to treat pain; massage is commonly applied with a therapist’s hands and fingers</td>
<td>Annual maximum of 12 visits for medical massage provided by a participating physical therapy or chiropractic provider.</td>
<td>Prior authorization required for physical therapist. No prior authorization needed for chiropractor.</td>
</tr>
<tr>
<td>Meals During Non-Emergency Transportation Day Trips</td>
<td>Reimbursement for the cost of meals you eat when you have to travel away from home for a medical appointment</td>
<td>Limited to $50 per day with annual maximum of $250</td>
<td>Yes</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>Medical supplies are items meant for one-time use and then thrown away</td>
<td>Some service limits apply; call Coastal Care Services at <strong>1-855-481-0505</strong> for more information</td>
<td>Yes</td>
</tr>
<tr>
<td>Incontinence products</td>
<td>200 per month; any combination of these codes can be billed, but only up to 200 units</td>
<td>Yes — needs case management referral</td>
<td></td>
</tr>
<tr>
<td>Medically Related Home Care Services</td>
<td>One carpet cleaning service that will help adults control their asthma</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Medication-Assisted Treatment</td>
<td>A licensed program that gives medication to lessen withdrawal symptoms from drugs or alcohol, along with supportive counseling</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
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</tr>
<tr>
<td>Newborn Circumcision</td>
<td>An elective surgery for baby boys</td>
<td>Available during initial hospital stay and in provider’s office for 90 days after birth</td>
<td>Yes, only if older than 90 days</td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>Provides you with information about what foods are good for you and your health condition; these services can also help you with food shopping and ways to prepare these foods at home</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>Adult occupational therapy services</td>
<td>One initial evaluation and re-evaluation per year; up to seven therapy treatment units per week</td>
<td>Yes</td>
</tr>
<tr>
<td>Over-the-Counter (OTC) Medication/ Supplies</td>
<td>Provides you with a benefit to get health supplies and items such as aspirin, vitamins, first aid items, and cough medicine</td>
<td>$25 per household per month; purchases limited to approved products</td>
<td>No</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>Adult physical therapy services</td>
<td>One evaluation and re-evaluation visit per year; up to seven therapy treatments per week</td>
<td>Yes</td>
</tr>
<tr>
<td>Prenatal/ Perinatal Visits</td>
<td>Pregnancy visits before and after giving birth</td>
<td>Unlimited</td>
<td>Yes</td>
</tr>
</tbody>
</table>

For authorization for hospital-grade breast pumps provided in your home, please contact Coastal Care Services at **1-855-481-0505**
<table>
<thead>
<tr>
<th>Service</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Visits (Non-Pregnant Adults)</td>
<td>Visits with your PCP</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Respiratory Therapy</td>
<td>Adult respiratory therapy services</td>
<td>One evaluation and re-evaluation per year; one respiratory therapy visit per day</td>
<td>No</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>Adult speech therapy services</td>
<td>One evaluation visit per year</td>
<td>Yes</td>
</tr>
<tr>
<td>Swimming Lessons (Drowning Prevention)</td>
<td>Provides swimming and water safety lessons for children to keep them safe around water</td>
<td>Each April, there will be an open enrollment for up to 1,000 children. The open enrollment period will be documented in the Member Handbook, on the plan website, and in a promotional mailing. Up to $200 per child will be paid at a plan-approved agency or to a certified instructor.</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy (Art)</td>
<td>Creative activities, such as drawing and painting, as part of your treatment</td>
<td>Up to seven outpatient sessions per year</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy (Equine)</td>
<td>Horseback riding with a behavioral health professional as part of your treatment</td>
<td>Up to three outpatient sessions per year for enrollees with a substance use disorder or chronic condition under care management</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapy (Group)</td>
<td>Therapy for a group of people with a mental health professional</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Therapy (Individual/Family)</td>
<td>Training and educational services about how to care for a member's disabling mental health problems</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
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</tr>
<tr>
<td>Therapy (Pet)</td>
<td>Volunteers and their pets help you with your treatment or therapy</td>
<td>Up to three sessions per year for members under care management for a chronic condition; inpatient care only while member is in an acute care hospital for treatment</td>
<td>Yes</td>
</tr>
<tr>
<td>Therapeutic Behavioral On-Site Services</td>
<td>Services provided by a team to support behavioral health issues and keep you from being placed in a hospital or other facility</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Targeted Case Management</td>
<td>Help with getting health care and behavioral health services</td>
<td>Unlimited</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine (TDaP)</td>
<td>A vaccine to help keep pregnant moms healthy during their pregnancy</td>
<td>One vaccine per pregnancy</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine (Influenza)</td>
<td>A vaccine to help reduce your chance of getting the flu</td>
<td>One vaccine per year, per enrollee</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine (Shingles [Varicella Zoster])</td>
<td>A vaccine to help reduce your chance of getting shingles</td>
<td>Adult enrollees who have had chickenpox and as medically advised</td>
<td>No</td>
</tr>
<tr>
<td>Vaccine (Pneumonia [Pneumococcal])</td>
<td>A vaccine the help reduce the chance of you getting pneumonia</td>
<td>Two vaccines for all adults age 65 and older and enrollees ages 21 – 64 with specific medical conditions in accordance with current Centers for Disease Control and Prevention (CDC) immunization schedule; vaccines must be given at least one year apart</td>
<td>No</td>
</tr>
<tr>
<td>Waived Copayments</td>
<td>You will not have any copayments on any of your health plan services</td>
<td>All services that have a copayment requirement in accordance with Rule 59G-1.056, FAC</td>
<td>No</td>
</tr>
</tbody>
</table>
Section 13: Member Satisfaction

Complaints, Grievances, and Plan Appeals

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

<table>
<thead>
<tr>
<th>What You Can Do:</th>
<th>What We Will Do:</th>
</tr>
</thead>
</table>
| If you are not happy with us or our providers, you can file a **Complaint** | You can:  
  • Call us at any time.  
  **1-855-355-9800**  
  **TTY 1-855-358-5856**  
  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.  
  Prestige Health Choice  
  P.O. Box 7368  
  London, KY 40742  
  **1-855-355-9800**  
  **TTY 1-855-358-5856**  
  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.  
  Prestige Health Choice  
  P.O. Box 7368  
  London, KY 40742  
  **1-855-355-9800**  
  **TTY 1-855-358-5856**  
  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. |
<table>
<thead>
<tr>
<th><strong>What You Can Do:</strong></th>
<th><strong>What We Will Do:</strong></th>
</tr>
</thead>
</table>
| 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.  
Prestige Health Choice  
P.O. Box 7368  
London, KY 40742  
1-855-355-9800 (TTY 1-855-358-5856) |
| 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)  
MedicaidFairHearingUnit@ahca.myflorida.com
If you request a fair hearing in writing, please include the following information:

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

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

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

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

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

**Review by the State (for MediKids Members)**

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

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

Agency for Health Care Administration  
P.O. Box 60127  
Ft. Myers, FL 33906  

1-877-254-1055 (toll-free)  
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 time frame, whichever is later:

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

Section 14: Your Member Rights

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

- Be treated with courtesy and respect.
- Have your dignity and privacy considered and 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 easy-to-follow information about your diagnosis, the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you.
- Make choices about your health care and 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.
- To be told prior to getting a service how much it may cost you.
- Get a copy of a bill and have the charges explained to you.
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment.
- Receive treatment for any health emergency that will get worse if you do not get treatment.
- Know if medical treatment is for experimental research and to say yes or no to participating in such research.
- Make a complaint when your rights are not respected.
• Ask for another doctor when you do not agree with your doctor (second medical opinion).

• Get a copy of your medical record and ask to have information added or corrected in your record, if needed.

• Have your medical records kept private and shared only when required by law or with your approval.

• Decide how you want medical decisions made if you can’t make them yourself (advanced directive).

• To file a grievance about any matter other than a Plan’s decision about your services.

• To appeal a Plan’s decision about your services.

• Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan.

• Speak freely about your health care and concerns without any bad results.

• Freely exercise your rights without the Plan or its network providers treating you badly.

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

• Request and receive a copy of your medical records and ask that they be amended or corrected.

**Section 15: Your Member Responsibilities**

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

• Give accurate information 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.

Section 16: Other Important Information

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

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

Indian Health Care Provider (IHCP) Protection
American Indians or Alaska Natives are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services.

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

Tips on How to Prevent Medicaid Fraud and Abuse:
• DO NOT share personal information, including your Medicaid number, with anyone other than your trusted providers.
• Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information.

• Be careful with door-to-door visits or calls you did not ask for.

• Be careful with links included in texts or emails you did not ask for, or on social media platforms.

**Fraud/Abuse/Overpayment in the Medicaid Program**

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

You can also report fraud and abuse to us directly by contacting the Prestige Health Choice Fraud Hotline toll-free at **1-866-833-9718**.

**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 at **1-800-955-8771**.

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

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

• If you are hurt, call your PCP.

• If you need emergency care, call **911** or go to the nearest hospital. For more information, see the section called Emergency Care.

• Have a plan to get to a safe place (a friend’s or relative’s home).

• Pack a small bag, give it to a friend to keep for you.

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

**Advance Directives**

An advance directive is a written or spoken statement about how you want medical decisions made if you can’t make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can’t speak for yourself.
1. A Living Will.
2. Health Care Surrogate Designation.
3. An Anatomical (organ or tissue) Donation.


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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at 1-855-355-9800 (TTY 1-855-358-5856) 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.
- To compare our Healthcare Effectiveness Data and Information Set (HEDIS®) results to other Statewide Medicaid Managed Care plans, visit https://ahca.myflorida.com/Medicaid/quality_mc/submission.shtml.

**Section 17: Additional Resources**

Floridahealthfinder.gov

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

- Up-to-date licensure information.
- Inspection reports.
- Legal actions.
- Health outcomes.
- Pricing.
- Performance measures.
- Consumer education brochures.
- Living wills.
- Quality performance ratings, including member satisfaction survey results.
The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit [https://www.floridahealthfinder.gov/HealthPlans/Default.aspx](https://www.floridahealthfinder.gov/HealthPlans/Default.aspx). You may choose to view the information by each Plan or all Plans at once.

### Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers, and nursing facilities at [http://elderaffairs.state.fl.us/doea/housing.php](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: [https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml](https://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.
LIVING WILL

Declaration made this ________ day of __________, (20__) , I ____________________, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and:

__________ (initial) I have a terminal condition, or

__________ (initial) I have an end stage condition, or

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

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

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

Name: __________________________________________
Address:_________________________________________
__________________________________________
Phone: __________________________________________

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

Additional Instructions (optional):
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Page 1 of 2
Witness Signatures:
______________________ Signature
______________________ Printed Name
______________________ Address
______________________ Phone

______________________ Signature
______________________ Printed Name
______________________ Address
______________________ Phone
DESIGNATION OF HEALTH CARE SURROGATE

I, ________________________, designate as my health care surrogate under S. 765.202, Florida Statutes:

Name:________________________
Address:________________________
________________________________
Phone:__________________________

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

Name:________________________
Address:________________________
________________________________
Phone:__________________________

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to: (Initials required in blank spaces below.)

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

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

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

I further authorize my health care surrogate to:

_______ Make all health care decisions for me, which means he or she has the authority to:

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

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

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

_____ 6. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.
Specific instructions and restrictions:
______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

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

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

This health care surrogate designation is not affected by my subsequent incapacity except as provided in Chapter 765, Florida Statutes.

Pursuant to section 765.104, Florida Statutes, I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation;
2. Physically destroying this designation through my own action or by that of another person in my presence and under my direction;
3. Verbally expressing my intention to amend or revoke this designation; or
4. Signing a new designation that is materially different from this designation.

My health care surrogate’s authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial either or both of the following boxes:

If I initial this box [_______] my health care surrogate’s authority to receive my health information takes effect immediately.

If I initial this box [______ ] my health care surrogate’s authority to make health care decisions for me takes effect immediately. Pursuant to section 765.204(3), Florida States, any instructions of health care decisions I make, either verbally or in writing, while I possess capacity shall supercede any instructions or health care decisions made by my surrogate that are in material conflict with those made by me.

Signatures: Sign and date the form here:
_________________ Date ___________________ Sign your name
_________________ Address ___________________ Print your name

_________________ ___________________
 __________________ City, State

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Signatures of Witnesses:

First Witness
_____________________ Print name
_____________________ Address
_____________________ City, State
_____________________ Signature
_____________________ Date

Second Witness
_____________________ Print name
_____________________ Address
_____________________ City, State
_____________________ Signature
_____________________ Date
Intentionally left blank
Uniform Donor Form

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

I give:

(a) _____ any needed organs or parts

(b) _____ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

(c) _____ my body for anatomical study if needed. Limitations or special wishes, if any:
_____________________________________________________________
_____________________________________________________________
_____________________________________________________________

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

Donor’s Signature ___________________________ Donor’s Date of Birth _____________
Date Signed ______________ City and State _____________________________________________
Witness _____________________________ Witness _____________________________
Street Address ________________________ Street Address ________________________
City _____________________ State ______  City _____________________ State ______

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

I, ___________________________________, have created the following Advance Directives:

___ Living Will
___ Health Care Surrogate Designation
___ Anatomical Donation
___ Other (specify) _____________________

----------------------- FOLD ----------------------------

**Contact:**
Name _____________________________
Address _____________________________
Phone _____________________________
Signature ____________________ Date _____
Non-Discrimination Notice

Discrimination is against the law.

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

Prestige Health Choice:

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

If you need these services, contact Prestige Health Choice at 1-855-355-9800 (TTY 1-855-358-5856). We are available 24 hours a day, seven days a week.

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

- Grievance and Appeals
  P.O. Box 7368
  London, KY 40742
  Phone: 1-855-371-8078 (TTY 1-855-371-8079)
  Fax: 1-855-358-5847.

- You can file a grievance by mail, fax, or phone. If you need help filing a grievance, Prestige Health Choice Member Services is available to help you.

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

U.S. Department of Health and Human Services
200 Independence Avenue S.W., Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019 (TTY 1-800-537-7697)

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.
Multi-language interpreter services

English: This information is available for free in other languages. Please contact our customer service number at 1-855-355-9800 (TTY/TDD 1-855-358-5856), 24 hours a day, seven days a week. If your primary language is not English, or to request auxiliary aids, assistance services are available to you, free of charge.

Spanish: Esta información está disponible en otros idiomas de forma gratuita. Póngase en contacto con nuestro número de servicios al cliente al 1-855-355-9800 (TTY/TDD 1-855-358-5856), las 24 horas del día, los siete días de la semana. Si su idioma principal no es el inglés, o necesita solicitar ayudas auxiliares, hay servicios de asistencia a su disposición de forma gratuita.

Haitian Creole: Enfòmasyon sa yo disponib gratis nan lòt lang. Tanpri kontakte ekip sèvis kliyan nou an nan 1-855-355-9800 (1-855-358-5856 pou moun ki pa tande byen yo), 24 è sou 24, sèt jou sou sèt. Si anglè pa lang manman w oswa si w ta renmen mande yon èd konplemantè, ou ka resevwa sèvis ki gratis pou ede w.

French: Ces informations sont disponibles gratuitement dans d'autres langues. Veuillez contacter notre équipe service clientèle au 1-855-355-9800 (1-855-358-5856 pour les malentendants), 24 heures sur 24, sept jours sur sept. Si l’anglais n’est pas votre langue maternelle ou si vous souhaitez demander une aide auxiliaire, des services d’aide sont gratuitement mis à votre disposition.
Questions? Call Member Services at 1-855-355-9800 or TTY 1-855-358-5856.


Polish: Poniższa informacja jest dostępna bezpłatnie w innych językach i formatach. Prosimy o kontakt z Działem obsługi klienta pod numerem telefonu 1-855-355-9800 (TTY/TDD 1-855-358-5856), 24 godziny na dobę, siedem dni w tygodniu. Jeśli angielski nie jest Twoim pierwszym językiem lub w celu uzyskania dodatkowej pomocy, możesz korzystać z bezpłatnej obsługi w tym zakresie.


Japanese: この情報は他の言語でも無料でご利用いただけます。年中無休で対応しておりますので、弊社カスタマーサービスのフリーダイヤル 1-855-355-9800 (TTY/TDD 1-855-358-5856) までお問い合わせください。若国語が英語でない場合は、無料のサービスをご利用いただけます。