Welcome
To Tango Plan

We are happy that you selected Sunshine State Health Plan’s Tango Plan. As a member of Tango Plan you are eligible for important services. This handbook explains how to get medical care, support at home and residential services, as well as provides other information.

Sunshine State Health Plan is a Health Maintenance Organization (HMO) which operates only in the State of Florida. Tango Plan is a program of Sunshine State Health Plan, and it is funded through Medicaid to provide a wide range of services. Some of the services are: personal care aides, home delivered meals, respite, and assisted living.

Our goal is to help you be as healthy as possible so that you can continue to live in your home and community. Our approach is to have participation from you, your caregiver, physicians, and others, to ensure access to services you need. You will have a Tango Plan Care Manager working with you to coordinate and arrange services.

With Tango Plan, you can be assured that we are here to serve YOU! If you have any questions, or need more information, please call our Care Management Department, Monday through Friday, 8:30 a.m. to 5:00 p.m. (ET) at 1-866-769-1158. Hearing and speech impaired members, please dial 711 for Florida Relay Service.

Sincerely,

Tango Plan
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Living Will

Member Rights and Responsibilities
Rights
Responsibilities

Tango Plan
3505 E. Frontage Road, Suite 300
Tampa, FL 33607
Tango Plan Phone: 1-866-769-1158
Tango Plan NurseWise® Line: 1-866-769-1158
Grievance and Appeals Phone: 1-866-769-1158
Dial 711 for Florida Relay Service
Dental: Call Tango Plan for assistance for both Opticare and Dental MCNA.
Opticare: 1-800-334-3937
TDD/TTY: Dial 711 for Florida Relay Service
Website: www.sunshinestatehealth.com
Florida Abuse Hotline: 1-800-96ABUSE or 1-800-962-2873
Agency for Health Care Administration Consumer Call Center, Tallahassee, FL: 1-888-419-3456

Eligibility
To be eligible for the Tango Plan you must:
• Be 65 years of age or older.
• Be enrolled in Medicare Parts A and B.
• Live in the Tango Plan Service Area.
• Meet the clinical eligibility requirements (for example, need help with daily living activities like bathing, dressing, walking, getting out of a chair, or you have a chronic condition requiring nursing services).
• Meet Medicaid financial eligibility requirements up to the Institutional Care Program Level.
Getting Started

Identification Card
You will receive an identification card (ID Card) from Tango Plan. The card will include your name, care management phone number, and claims address. When you receive medical services, show your Tango Plan ID card to medical providers. Your Medicare coverage provides primary coverage, and your Tango Plan benefit provides coverage for Medicare deductibles and co-payments.

You will also receive a Gold identification card from the Medicaid office. This card can be used to obtain transportation services covered by the Medicaid program. Call your Care Manager for assistance.

Care Management
The Tango Plan Care Management Department is dedicated to helping you. The Care Manager will work together with you, your caregiver, and doctor, to develop a plan for services. A care plan is developed based on your health needs, home situation, and the amount of support available from your family and friends. Your Care Manager will review information with you over time and make changes in your care plan.

Translation services are available free of charge. Call your Care Manager to get these services.

Your Care Manager will meet with you in your home and will also discuss your concerns via phone. We encourage you to call your Care Manager whenever your needs change. It is important to contact the Care Management Department when you are admitted to a hospital, you move, or your health needs change. You can contact a Care Manager at 1-866-769-1158, Monday through Friday, 8:30 a.m. – 5:00 p.m. (ET).

Status Change
Contact your Care Manager if you:
• Change your address or telephone number.
• Get other health care coverage.
• Are admitted to a hospital or nursing home.
• Enroll in Hospice.
Coordination of Tango & Medicare Benefits

Tango Plan is funded by Medicaid and offers coverage for long term care services, and payment of Medicare deductibles and coinsurance. Please refer to the Services section of this handbook for a full list of covered services.

Members of Tango Plan also have Medicare coverage, either through traditional Medicare or through a Medicare health maintenance organization. Your Medicare coverage is separate from your coverage with Tango Plan. Most of your medical services (such as physician and hospital services) will be obtained through your Medicare coverage. Tango Plan will pay providers for the Medicare deductible and coinsurance according to Medicaid guidelines or according to a contracted amount. Tango Plan does not pay for Medicare HMO or Medicare Supplement deductibles or coinsurance.

If you are a member of a Medicare HMO, you will receive Medicare services according to the guidelines of that program. Please call the Care Management Department if you have any questions about payment for Medicare deductibles or coinsurance.
Services and Limitations

In order for services to be covered by Tango Plan, you must follow proper procedures. Covered services must be authorized by Tango Plan. You will always have the freedom to choose the provider of your services from our network of participating providers. Services by out of network providers may not be payable unless prior authorization is obtained by your Care Manager.

There are two types of services:
Home and Community Services are provided according to the member’s care plan. The Care Management Department develops the care plan based on an assessment, other information and in consultation with you, your family/caregiver, and other involved parties. In accordance with Medicaid guidelines, the care plan is guided by delivering services in the least restrictive, appropriate and cost-effective setting.

Medical Services are covered when they are determined to be medically necessary and are authorized by Tango Plan. However, you will receive most medical services through your Medicare coverage and not through Tango Plan.

You will continue to receive Medicare covered services from your Medicare program. Medicare coverage or other health coverage is used before services are covered by Tango Plan. Tango Plan does not need to authorize services you receive through Medicare. This includes emergency services covered by Medicare. To obtain emergency services you should follow the instructions provided by your Medicare carrier to include dialing 911 for assistance and seeking out treatment at hospitals and other providers that provide emergency services and post stabilization service’s covered by Medicare. Prior authorization is not required for emergency and post stabilization services. Tango Plan will pay for Medicare deductibles and co-insurance according to Medicaid guidelines or a contracted amount.

Many of the services listed on the following pages are covered through the Medicare program. We encourage you to contact Tango Plan’s Care Management Department with any questions concerning whether a service is covered through Medicare or Tango Plan.

Tango Plan pays for services that are authorized, determined to be medically necessary, in accordance with the member’s care plan, do not duplicate another provider’s service, and are:

- Limited to covered services as specified in the contract between Tango Plan and the Department of Elder Affairs.
- Individualized, specific, consistent with impairments, symptoms or confirmed diagnosis of the illness or injury under treatment and not in excess of the member’s needs.
- Not experimental or investigational.
- Reflect the level of services that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available.
- Furnished in a manner not primarily intended for the convenience of the member, member’s caregiver or the provider.

The fact that a provider has prescribed, recommended or approved medical or ancillary care, goods or services, does not, in itself, make such care, goods or services medically necessary or a covered service.
Home and Community Services

Coverage is provided for the following services when they are essential to the health and welfare of the member instead of the member’s family or caregiver:

**Personal Care**
- Assistance in the home with bathing, dressing, eating, personal hygiene and other activities.

**Homemaker**
- General household activities, such as meal preparations and routine home chores.

**Chores**
- Assistance with heavy household chores, such as washing floors and windows and moving heavy items of furniture to provide safe entry and exit.

**Escort to Medical Appointments**
- Assistance for a member who requires an individual to accompany them when going to a medical appointment.

**Respite**
- Personal care or supervision provided to a member on a short-term basis due to the absence or need for relief of the person normally providing the care.

**Adult Day Health Center**
- Social and health activities in an organized day program at a center.
- Meal included when member is at the center during meal time.

**Care Management**
- Help member to obtain, coordinate and integrate services.
- Develop personal care plan.
- Visit member to discuss needs.

**Consumable Medical Supplies**
- Disposable diapers, gloves and other consumable medical supplies.
- Not included are personal toiletries, and household items such as detergent, bleach, and paper towels.

**Meals**
- Home delivered meals for members who have difficulty preparing food without assistance.
- Nutritional supplements for members who have a medical need.

**Sunshine Health Nurse Care Line**
- A nurse is available 24 hours a day, 7 days a week to help answer medical questions you may have. The number for the 24 hour Sunshine Health NurseWise™ Line is 1-866-796-0530 option 7.

**Personal Emergency Response Systems**
- Electronic device that helps a member at high risk to get help in an emergency.
- Limited to members who live alone or who are alone for significant parts of the day and who would otherwise require extensive supervision.
Nutritional Assessment/Risk Reduction
• Assessment and guidance about nutrition.

Adult Companion Services
• Non-medical care, supervision and socialization.

Home Adaptation Services
• Adaptations to the member’s home which are necessary to ensure health, welfare and safety, or which help the member to function with greater independence in the home and without which the member would require institutionalization.
• Excludes those adaptations or improvements to the home that are of general use and are not of direct medical or remedial benefit to the member.

Family Training
• Training and counseling services for the families of the member.

Financial Assessment/Risk Reduction
• Assessment and guidance regarding financial activities.

Nursing Home
• Nursing home services are available for members who require such services.
• Skilled nursing home services are covered by Medicare.
• The Florida Department of Children and Families will determine a patient's financial responsibility.

Assisted Living Services
• Services such as personal care, housekeeping, medication oversight and social programs to assist the member in an assisted living facility.
• The member is responsible for paying the assisted living facility room and board amount. The Florida Department of Children and Families (DCF) will evaluate the member’s income to determine if additional money needs to be paid to the assisted living facility by the member.
• If the member resides in a room other than a standard semi-private room, the facility may possibly charge an additional amount. Family supplementation is allowed to pay the difference in cost between a shared and private room as long as the payment is made directly to the facility.

Home and Community Services (cont.)
Medical Services

Medical services are covered by Tango Plan to the extent that they are not covered by Medicare or other insurance. When a member has coverage under Medicare or other insurance, Tango Plan reimburses providers for secondary coverage according to Medicaid guidelines.

**Physicians**

**Inpatient Hospital**
- Limitation: Inpatient coverage is for a maximum of 45 days per year beginning July 1 and ending June 30.

**Outpatient Hospital/Emergency Medical Services**

**Post-Stabilization Services**

**Lab and X-rays**

**Home Health Nurse**

**Occupational, Physical, Respiratory, and Speech Therapy Services**

**Vision**
- Eye exam.
- Eyeglasses: one pair per 365 days; a second pair if needed.
- Eyeglass repair.

**Hearing**
- Hearing evaluation and testing.
- Hearing aid fitting and dispensing for each ear every 3 years.
- Hearing aid repairs.
- One cochlear implant for either ear, but not both, if medical criteria is met.

**Dental**

Tango Plan covers dentures and additional dental benefits at no charge. In order to receive the following benefits, you must see a participating dentist:
- Oral exam (two per calendar year) or problem focused exam.
- X-rays.
- Cleaning (two per calendar year).
- Restorative fillings.
- Full or partial dentures: one set a lifetime.
- Extractions.

Exclusions and limitations apply. For more information, refer to the Schedule of Benefits for dental services or call the dental number in the front of this book, under Important Contact Information. You can call the dental number in the front of this book to get participating dentist information. You may schedule an appointment by calling a participating dental office. When you call to make an appointment, be sure to tell the office that you are a member of Sunshine Health / MCNA dental plan.
Medical Services (cont.)

Medical Equipment and Supplies

Mental Health
• Psychiatric services.

Prescription Drugs
Members of Tango Plan receive most prescription drugs under their Medicare coverage. However, some prescription drugs are excluded from Medicare and are covered under Medicaid. Tango Plan will cover these limited Medicaid covered prescription drugs, which include: barbiturates, benzodiazepines, and in select package sizes aspirin, Tylenol, and iron preparations. Contact your Care Manager for possible coverage of certain drugs.

Guidelines include:
• Drugs prescribed by a physician and dispensed by a participating pharmacy for the prevention, mitigation, control and cure of disease; and covered by Medicaid.
• Prescriptions will be a generic drug, when available.
• Use your Sunshine Health / Tango Plan identification card to get these drugs at participating pharmacies.

Part D Copayments
The plan covers up to $25.00 per month for Medicare Part D drug copayments. To obtain reimbursement for a Part D drug copayment, send to Tango a pharmacy receipt containing: member name, pharmacy name and address, date of service, drug name, drug/prescription number, co-payment amount and proof of payment to Tango. If the payment is to someone other than the member, specify the name and address of the party to be paid. The copayment information must be submitted within three months of the date of service to be reimbursed.

Over-the-Counter Items
You can receive certain over-the-counter items. Over-the-counter drugs and first-aid supplies will be delivered to your home through our mail order service. If you need an order form, call your Care Manager or Tango Plan and one will be mailed to you. Some of the products available are aspirin, vitamins, antacids, and personal hygiene products.

Please check with your doctor first to see if it is safe for you to take any of the over-the-counter medications. Some items are not appropriate for everyone. Some over-the-counter medications are not safe to take with prescription drugs.
How to Obtain Care

Care Manager
Call your Care Manager if you need a service or your needs change. For example, if you need grab bars or your caregiver is going away and you need help with meal preparation, call your Care Manager. Your Care Manager will review the changes with you and make adjustments in your plan of care.

Care Management staff can help you obtain services, such as:
- Home delivery of meals.
- Consumable supplies.
- Personal care aides.
- Change of residence to an assisted living facility or nursing home.
- Coordination with hospitals and home health agencies.

You can reach our Care Management staff at 1-866-769-1158.

Provider Directory
The Tango Plan Provider Directory lists the providers who participate in Tango Plan. Call the Care Management Department if you need a directory. Your Care Manager is available to help you choose providers and to arrange services. You may choose a provider(s) from the Tango Plan Provider Directory. For most services, it is necessary to call your Care Manager and not the provider to obtain services. For example, if you need a personal care aide, call your Care Manager to review your needs and to authorize the service.

If you are receiving services through your Medicare coverage, you do not need to use the Tango Plan Provider Directory for these services. If you are a member of a Medicare HMO, you need to follow the guidelines provided by that company to obtain covered services.

Use of Participating Providers
It is necessary to use participating providers for services covered by Tango Plan. Tango Plan is not liable for payment of services obtained from providers that are not authorized by Tango Plan.

Medical Services Covered by Medicare
You do not need authorization from Tango Plan to get services available through your Medicare coverage, although we encourage you to notify your Care Manager. For example, you will see physicians and go to a hospital under your Medicare coverage and will be using your Medicare coverage as the primary for those services. If you are a member of a Medicare Advantage HMO, you need to follow the guidelines of that program to obtain Medicare services.

Second Medical Opinion
You have a right to a second medical opinion if you do not agree with your physician’s opinion about the right medical care or surgery for you. Your Care Manager can arrange for this in the network or out of network at no cost to you.
**Disenrollment**

**Voluntary Disenrollment**
Call Tango Plan’s Care Management Department to obtain a disenrollment form and to get help in resolving problems. A disenrollment form will be promptly sent to you. If you wish to meet in person, please let us know by calling the Care Management Department at 1-866-769-1158.

**Send the disenrollment request in writing to:**
Sunshine State Health Plan
Tango Plan
3505 E. Frontage Road, Suite 300
Tampa, FL 33607

Members may request disenrollment at any time, but it is not effective until the State’s fiscal agent processes the disenrollment. If voluntary disenrollment is requested on or before the 15th of the month, disenrollment will be effective the first of the next month. If voluntary disenrollment is requested after the 15th of the month, disenrollment will be effective on the first day of the second calendar month following the month the request was received.

**Involuntary Disenrollment**
- Permitting unauthorized use of your member identification card.
- Disruptive or abusive behavior.
- Failing to follow recommended plan of care.
- Moving out of Tango Plan’s service area.

**Loss of Medicaid Eligibility**
Individuals may lose their Medicaid eligibility for a variety of reasons such as moving, loss of financial eligibility due to change in income or assets, or missing a recertification appointment for Medicaid. If you lose your Medicaid eligibility, the State will disenroll you. Tango Plan will assist you with maintaining your medical and financial eligibility. Tango Plan cannot provide you with services until you are eligible again.

**Reinstatement Process**
If you are disenrolled due to loss of Medicaid eligibility and regain your eligibility within 60 days, the State will automatically reinstate you as a member of Tango Plan.
Grievance and Appeal Procedures

If you have a concern or question about any of your benefits or services, you should call our Care Management Department, Monday through Friday 8:30 a.m. – 5:00 p.m. (ET) at 1-866-769-1158.

A Care Manager will help to resolve your concern. If you are not happy with the resolution, you have a right to file a Grievance or Appeal. The Grievance System is used for reviewing and resolving your Grievances and Appeals. It includes the Grievance process, and the Appeals process.

Tango Plan will not take any action against you or your provider just because you or your provider file a Grievance or Appeal, or because your provider supports you filing a Grievance or Appeal.

Inquiries
An inquiry is a call received in the Tango Plan Care Management Department from you about any part of your health care benefits or services. A Care Manager will help to resolve your concern. If you are not happy with the response, the Care Manager will send your concern to the Grievance Coordinator.

Grievances
A Grievance is an expression of dissatisfaction about any matter other than an Action (defined in the Standard/Regular Appeals section). The term Grievance is also used to refer to the overall system that includes Grievances and Appeals handled by the Plan and your right to access the Medicaid Fair Hearing process. Examples of Grievances include, but are not limited to, the quality of care or services provided, rudeness of a provider or employee, or failure to respect your rights.

You have 365 days from the date of the event that led to your concern to file a Grievance. A Care Manager can help you do this. A Grievance Coordinator will send you a letter to acknowledge that we have received your Grievance, review your Grievance and, in most cases, resolve your Grievance within 60 days. We will send you a closure letter telling you what we decided and why we made that decision. If you are not happy with the outcome, you can ask for a review by the Appeal & Grievance Committee. To ask for a review, you must call us within 30 days of the date of the closure letter.

You can contact the Grievance Coordinator
Monday through Friday 8:00 a.m. to 5:00 p.m.
The Grievance Department’s phone number: 1-866-769-1158
TDD/TTY dial 711 for Florida Relay Service

Address:
Sunshine State Health Plan
Grievance Department
1301 International Parkway
Suite 400
Sunrise, FL 33323
Standard / Regular Appeals

If you do not agree with a decision made by the Plan about health care services, you or a provider acting on your behalf can file an Appeal. A Care Manager can help you do this. If your provider files an Appeal for you, he or she must have your written authorization (permission) to do so. Actions that can be Appealed are:

- The denial or limited authorization of a requested service, including the type or level of service.
- The reduction, suspension, or termination of a service that was already authorized.
- The denial, in whole or in part, of payment for a service.
- The Plan does not provide services in a timely manner as defined by the State.
- The Plan does not resolve your Grievance or Appeal within the timeframes defined by the State.
- The denial of a request for services outside of the Sunshine Health network if you live in a rural area where Sunshine Health is the only managed care organization offered.

To file an Appeal, you or your authorized representative can call our Grievance Coordinator, Monday through Friday 8:00 a.m. – 5:00 p.m. (ET) at 1-866-769-1158 (TDD/TTY dial 711 for Florida relay service). You can also send us a letter. If you file your Appeal orally, you must also give us a written and signed Appeal. Before or during the Appeal process, you or your authorized representative can look at information, including medical records or any other documents or records, that we have on file for you. You can also give us more information, for example medical records, about your Appeal either in person or in writing. We will consider you, your representative, or an estate representative of a deceased member as parties to the Appeal.

An Appeal must be filed within 30 days of the date we give you or your provider our decision in writing. If we do not give you or your provider our decision in writing, you have 365 days from the date we tell you our decision to file. A Grievance Coordinator will send you a letter to acknowledge that we have received your Appeal, coordinated the review of your Appeal, and in most cases, resolved your Appeal within 30, but no more than 45 days from the date we got your Appeal. We can add 14 days to this timeframe if you ask us to or if we think it is in your best interest. If we need extra time, we will send you a letter to let you know why. If you are not happy with the outcome, you can ask for a review of your Appeal by the Sunshine Health Appeals Committee. You can ask for this review by calling us within 30 days of the date of the closure letter.
**Expedited/Fast Appeals**

If the regular timeframe of the Appeals process would seriously jeopardize your life, health or ability to regain maximum function, you or your provider can request an Expedited/Fast Appeal. This request can be submitted verbally or in writing. You will not get a letter from us to acknowledge we have received your Expedited/Fast Appeal. In this case, a verbal and written decision will be made and given to you or your provider as your health condition requires, but no more than 72 hours from the time we get your request for an Expedited/Fast Appeal.

You can also give us more information, for example medical records, about your Appeal either in person or in writing. Because of the limited time we have to give you an answer to your Expedited/Fast Appeal, we ask that you provide any additional information as soon as possible. Sunshine Health or you can add 14 days to this timeframe if you ask us to or if we think it is in your best interest. If we need extra time, we will send you a letter to let you know why.

If we deny your request for an Expedited/Fast Appeal, we will process your Appeal within the timeframes for Standard/Regular Appeals. We will call you and send you a letter within two calendar days letting you know that we have denied your request for an Expedited/Fast Appeal.

**Medicaid Fair Hearing**

You have the right to request a Medicaid Fair Hearing at any time in addition to pursuing the Plan’s Grievance process. If you have finished our Grievance or Appeal process, and are not happy with the outcome, you can ask for a Medicaid Fair Hearing. You have 90 days from the date of our written decision to do this. A Care Manager can help you do this. You can ask for a hearing from the Department of Children and Families Office of Public Assistance Appeals Hearings in person at their local district office or by sending a letter to:

**Office of Public Assistance Appeals Hearings**

1317 Winewood Boulevard, Building 5, Room 203
Tallahassee, FL 32399-0700
Continuation of Benefits
If you ask for an Appeal or Medicaid Fair Hearing, you can ask the Plan to keep giving you benefits if:
   a) The Appeal is filed on or before the later of the following:
      • the date our decision is effective.
      • within 15 days of the date on the notice of action.
   b) Your Appeal is about stopping, suspending or reducing service(s) already authorized.
   c) The services were ordered by an authorized Plan provider.
   d) The authorization period has not expired.
   e) You requested an extension of benefits.

If the final decision of your Appeal or Medicaid Fair Hearing is in your favor, the Plan will:
   • Authorize or provide services as quickly as your medical condition requires if you did not keep getting benefits while your Appeal or Hearing was being processed.
   • Pay for the services in the timeframes required by the State if you kept getting benefits while your Appeal or Hearing was being processed.

If you keep getting benefits while your Appeal or Medicaid Fair Hearing is being processed the Plan, will keep giving you benefits until one of the following happens:
   • You withdraw your request for an Appeal or Medicaid Fair Hearing.
   • You ask for an Appeal or a Medicaid Fair Hearing with a continuation of benefits more than 15 days from the date of our written Action.
   • The Medicaid Fair Hearing agrees with the Plan’s action you are appealing (the decision is not in your favor).
   • The authorization expires or authorized service limits are met.

If the final decision of your Appeal or Medicaid Fair Hearing is not in your favor, you may have to pay for benefits or services you got while your Appeal or Medicaid Fair Hearing was being processed.

If you have questions about the Grievance or Appeals process, you can refer to the Quick Reference Chart on the next page, or call the Care Management Department, Monday through Friday from 8:30 a.m. to 5:00 p.m. (ET) at 1-866-769-1158.
## Quick Reference Chart

<table>
<thead>
<tr>
<th>Time Frame for:</th>
<th>Inquiries</th>
<th>Grievances</th>
<th>Standard Appeals</th>
<th>Expedited Appeals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member to File with Sunshine Health</td>
<td>You are encouraged to call within 365 days from the date of the occurrence</td>
<td>You must file within 365 days from the date of the occurrence</td>
<td>You must file within 30 days from the date we give you written notice of our action, or 365 days from the date we tell you our action (written notice not given)</td>
<td>You must file within 30 days from the date Sunshine Health sends notice to you and/or your provider</td>
</tr>
<tr>
<td>Sunshine Health to Send Closure Letter to Member</td>
<td>During call</td>
<td>Usually within 60 business days*</td>
<td>Usually within 30 business days and no more than 45 business days*</td>
<td>Within 48-72 hours*</td>
</tr>
<tr>
<td>Member to Ask for Sunshine Health Grievance Committee Review</td>
<td>Not Applicable</td>
<td>Within 30 days from the date of the Sunshine Health closure letter</td>
<td>Within 30 days from the date of the Sunshine Health closure letter</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Member to Ask for a Medicaid Fair Hearing</td>
<td>Not Applicable</td>
<td>Within 90 days from the date of the Sunshine Health closure letter</td>
<td>Within 90 days from the date of the Sunshine Health closure letter</td>
<td>Within 90 days from the date of the Sunshine Health closure letter</td>
</tr>
</tbody>
</table>

* Sunshine Health may add 14 days to this timeframe if you ask us to or if we think it is in your best interest. If we need extra time, we will send you a letter to let you know why.
Information about Our Privacy Practices

This section describes how health information about you may be used and shared with others and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Sunshine Health is required by federal and State laws to protect the privacy of your health information. You have the right to know about our privacy practices, our legal duties, and your rights concerning your health information. This information will remain in effect unless we are required to change our privacy practices. If we make changes we will mail you a new notice and post it on our web site, www.sunshinestatehealth.com.

Protected Health Information

Protected health information is information that we get from you and:

• Is created or received by a health care provider, health plan, employer, or health care clearinghouse.
• Relates to your past, present or future physical or mental health condition and/or payment for health care services.
• Relates to the provision of your health care.
• Has your name, date of birth, social security number or other information that can be used to identify you.

How We Use Protected Health Information

• We may use the information that your health care provider sends us to review and process claims for health care services you received.
• We may use the information for case management, quality improvement activities or to provide you with information on health related programs.

How We Share Information

Sunshine Health does not release your confidential health care information unless it is necessary to administer plan benefits, to support health care services or as required by law.

We may share information for:

• public health activities.
• law enforcement purposes.
• judicial and administrative proceedings.
• worker’s compensation.
• prevention of a serious threat to health or safety.
• health care oversight activities (for example AHCA, government audits and/or fraud and abuse investigations)
• research.
• government functions.
We may give information to:
- coroners, medical examiners, funeral directors or organ donation organizations.
- the U.S. Department of Health and Human Services
- our business associates.
- people involved in your health care services or payment.
- authorities to report victims of abuse, neglect or domestic violence.

Highly Confidential Information/
Special Consents
If none of the previously mentioned reasons applies, we are required to get your written authorization to use or disclose your protected health information. Federal and State laws require special privacy protections/consent for highly confidential/sensitive health care information. This type of information includes, but may not be limited to:
- HIV/AIDS
- Mental health services
- Alcohol and/or drug abuse

Confidentiality of Records
Member records will be regarded as confidential information. Providers involved in the member’s care will have access to the member information for the purpose of providing care. If requested, Sunshine Health must disclose member records to the Department of Elder Affairs and the Agency for Health Care Administration.
Information about Our Privacy Practices (cont.)

Your Rights
• You can get a copy of our privacy practices, including detailed explanations/examples for each of the bulleted items in this summary, and any changes made to our practices by visiting our web site, www.sunshinestatehealth.com or by contacting our Care Management Department at the number listed in the front of this handbook.
• You can get a copy of your enrollment and claims payment information by sending a letter to our Customer Service Department. We have the right to deny the release of certain information, including psychotherapy notes, certain laboratory results, information that may cause harm to you or another person, or information gathered for research or legal proceedings.
• You can ask us to correct information in our files if you think it is incorrect. To do this you can call or send a letter to our Care Management Department. We have the right to not make the change. If we won’t make the change, we will send you a letter telling you why.
• You will receive a copy of your care plan. You have the right to ask us to correct any information that is incorrect.
• If you sign an authorization, you can cancel it, or ask to limit the use or disclosure of your information.
• If you can’t agree or object to signing an authorization, for example in an emergency situation, we may release information if it is in your best interest. If you have an Advanced Directive we will give information to the person who has the legal right to act or make decisions for you.
• You may tell us how to communicate with you and where to send confidential information.
• Upon request, you can get a list of the times that we or our business associates gave out your health information for other than for treatment, payment or health care operations.
• Upon request, the policies and procedures related to confidentiality and disclosure of the enrollee medical records will be made available to you.

Questions and Complaints.
If you have any questions, want additional information on our privacy practices, or want to file a complaint, you can contact our Care Management Department, Monday through Friday 8:30 a.m. – 5:00 p.m. (ET) at the number listed in the front of this handbook.

You may also notify the Secretary of the U.S. Department of Health and Human Services at the address below if you believe your privacy rights have been violated. We will not take any action against you for filing a complaint.

Secretary of the U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201
Nondiscrimination Information

Sunshine Health does not discriminate on the basis of handicap, race, national origin, religion, gender, age, or on any basis deemed unlawful under federal or State law or employment in our programs and activities. Participants have a right to file a complaint of discrimination with Sunshine Health’s Grievance Coordinator, the Florida Department of Elder Affairs or the U.S. Department of Health and Human Services.
Advanced Directives

Many people are concerned about the medical care they would get if they become seriously ill and are unable to make their own choices. The Patient Self-determination Act, under Florida Law, lets you make decisions about your medical care. This includes your right to accept or refuse medical or surgical treatment and the right to have an advanced directive.

Your Right to Decide
If you have a serious illness or injury and are unable to make decisions about your medical treatment you have the right to name someone to make these decisions for you. You can do this using an advanced directive.

What is an Advanced Directive?
An advanced directive is a written or oral statement, made and witnessed before a serious illness or injury that tells your health care providers and family what care and life-support measures to take if you are unable to make these decisions. You may also choose another person, or surrogate, to make health care decisions for you if you become mentally or physically unable to do so. An advanced directive may be in the form of a Living Will, a Health Care Surrogate Designation, or both.

Living Will
A Living Will tells the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a Living Will because it takes effect while you are still living. Florida law provides a suggested form for a living will. We have included a copy of this form in this booklet. You may use it or use some other form. You may also wish to speak to a lawyer or physician to make sure that you have completed the Living Will correctly so that your wishes will be understood.

Health Care Surrogate Designation
A Health Care Surrogate Designation is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you if you should become unable to make them for yourself. You may also name a second person if your first choice is not available. You can include instructions about any treatment you want or do not want. Florida law also provides a suggested form for designation of a health care surrogate. We have included a copy of this form in this book. You may use it or some other form. You may also wish to speak to a lawyer or physician to make sure that you have completed the Health Care Surrogate Designation correctly so that your wishes will be understood.
Advanced Directives (cont.)

Which Form Is Better?
A Living Will and Health Care Surrogate Designation are two different, yet similar documents. You can have two documents or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you if you are unable to make decisions for yourself. Which form of advanced directive you use is your decision and you can change your mind or cancel your decision at any time.

The only time an advanced directive may be used is when you are physically and/or mentally disabled and cannot make health care decisions for yourself. Once you are able to make these choices on your own again, the advanced directive will not be in effect. Your advanced directive will remain on ‘stand-by’ if you ever become disabled again and cannot make health care decisions for yourself.

What Should I Do With My Advanced Directive If I Choose To Have One?
Make sure that someone such as your doctor, lawyer or family member knows that you have an advanced directive and where it is located. You may also want to consider the following:

• If you have designated a health care surrogate, give a copy of the written designation form or the original to the person(s) you have named to make health care decisions for you.
• Give a copy of your advanced directive to your doctor for your medical file.
• Keep a copy of your advanced directive in a place where it can be found easily.
• Keep a card or note in your purse or wallet which States that you have an advanced directive and where it is located.
• If you change your advance directive, make sure your doctor, lawyer and/or family member has the latest copy.

Is An Advanced Directive Required Under Florida Law?
No. You are not required to have an advanced directive and you cannot be denied care if you do not have one.

Additional Information
Your primary care physician is required to provide you with education on advanced directives and document such in your medical record. You can also download additional information regarding advance directives by visiting the Agency for Health Care Administration web site, www.fdhc.state.fl.us.
Living Will
Your Right to Decide and Make Your Wishes Known

On this ______ day of __________, 20__ I, (Last Name) __________________________ (First Name) __________________ (MI) _______ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated (initial) ______, I have a terminal condition or (initial) _____ and I have an end-state condition or (initial) _____ and I am in a persistent vegetative state and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: ___________________________ Address: ___________________________
City: ___________________________ State: ___________ Zip Code: ___________ Phone: ________________

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. Additional Instructions (optional): ____________________________________________________________

Signed: ___________________________

Witness #1: ___________________________ Address: ___________________________
City: ___________________________ State: ___________ Zip Code: ___________ Phone: ________________
Witness #2: ___________________________ Address: ___________________________
City: ___________________________ State: ___________ Zip Code: ___________ Phone: ________________

(At least one witness must be neither a spouse nor a blood relative of the signatory.)
LIVING WILL

Name: __________________________________________
In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _________________________________________
Address: ______________________________________
City: ________________________________ State: _____ Zip Code: _________ Phone: _______________________

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _________________________________________
Address: ______________________________________
City: ________________________________ State: _____ Zip Code: _________ Phone: _______________________

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

Additional Instructions (optional): ________________________________________________________________

I further affirm that this designation is not being made as condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name: _________________________________________
Name: _________________________________________

Signed: ________________________________ Date: __________________
Witness #1: ________________________________
Witness #2: ________________________________
(At least one witness must be neither a spouse nor a blood relative of the signatory.)
Member Rights and Responsibilities

As a member of Sunshine Health it is important that you know your rights and responsibilities. These rights and responsibilities are provided to you in accordance with the Florida Patient’s Bill of Rights and Responsibilities.

Rights

As a patient, you have the right to:

• Be treated with courtesy and respect and to have your individual dignity and privacy respected at all times.
• Receive a prompt and reasonable response to a question or request regarding your medical services.
• Know what patient support services are available, including whether an interpreter is available if you do not speak English.
• Know what rules and regulations apply to your conduct.
• Know the name, function and qualifications of each health care provider who is providing medical services.
• Be provided with information concerning diagnoses, planned course of treatment, alternatives, risks, and prognosis.
• Refuse any treatment, except as otherwise provided by law.
• Be given, upon request, full information and counseling about other financial sources available to pay for your health care.
• Receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.

• If you are eligible for Medicare, you have the right to know, upon request and in advance of treatment, if the health care provider or facility accepts the Medicare assignment rate.
• Receive a copy of a reasonably clear and understandable, itemized bill, and, upon request, to have the charges explained.
• Have access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
• Receive treatment for any emergency medical condition that will get worse from failure to receive medical treatment.
• To obtain family planning services from any participating Medicaid provider without prior authorization for such services.
• Know if medical treatment is for purposes of experimental research and to give consent or refusal to participate in such experimental research.
Member Rights and Responsibilities (cont.)

- Confidential handling / protection of your personal health information, including your medical records, and, except as provided by law, be given the chance to approve or refuse their release.
- Express Grievances regarding any violation of your rights, as stated in Florida law, through the Grievance procedure of the health care provider or health care facility that served you and to the appropriate State licensing agency.
- To obtain, upon request, a description from Sunshine Health about post-stabilization services, cost sharing, physician incentives, prescription drug benefits, our credentialing process, our quality assurance program, member satisfaction data, complaints, information on the structure and organization of Sunshine State Health Plan, Grievance and Appeals policies and procedures, our referral and authorization process, the process used to determine medical necessity, accessing interpretation services and alternate communication systems, and the process used to approve or deny experimental or investigational medical treatment.

Responsibilities

As a patient, you have a responsibility to:
- Provide the health care provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to your health.
- Report unexpected changes in your condition to the health care provider.
- Report to the health care provider whether you understand the contemplated course of action and what is expected of you.
- Follow the treatment plan recommended by the health care provider.
- Keep appointments, and, when you are unable to do so for any reason, notify the health care provider or facility.
- Understand that you are responsible for your actions if you refuse treatment or do not follow the health care provider’s instructions.
- Assure that the financial obligations of your health care are fulfilled as promptly as possible.
- Follow health care facility rules and laws about patient care and conduct.
- Notify Sunshine State Health Plan immediately when there is a change in your address.
Caring for the Health of Seniors