Georgia Pathways to Coverage

2026 Member Handbook

peach state health plan™

pshp.com | 1-866-874-0633 • TTY: 1-800-255-0056 | April 2026

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

Peach State Health Plan:

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 Peach State Health Plan at 1-800-704-1484 (TTY/TDD 1-800-255-0056).

If you believe that Peach State Health Plan 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:

Peach State Health Plan Complaints Department
1100 Circle 75 Parkway, Suite 1100, Atlanta, GA 30339, 1-800-704-1484 (TTY/TDD 1-800-255-0056), Fax 1-855-678-6982.

You can file a grievance in person or by mail, fax, or email.

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Welcome

Thank you for choosing Peach State Health Plan as your new health plan for Medicaid or PeachCare for Kids.® Peach State Health Plan offers our members quality healthcare services and the personal attention they deserve. This handbook tells you how to get medical care. Please read this Member Handbook. Keep it handy. It tells you about benefits and services. It also tells you who to call when you have questions.

Please check the Peach State Health Plan ID card you received in the mail. Make sure it is correct. If you find a mistake, please call our Member Services Department at 1-800-704-1484 or visit us at www.pshp.com. We will change it for you.

Members should bring their Peach State Health Plan ID card and Medicaid card or PeachCare for Kids® card with them when they see the doctor. They should also bring the cards with them when they go to the hospital or pharmacy. Keep these cards in a safe place.

Peach State Health Plan members need to see a Primary Care Provider (PCP) for regular checkups and immunizations. A PCP will provide all of your primary care services. If you have not chosen a PCP, please choose one now. You may call our Member Services Department.

You can also find information about our programs and services on the Peach State Health Plan website. Go to www.pshp.com.

Thank you for choosing Peach State Health Plan!
Wishing you a healthy year,
—Peach State Health Plan, Inc.

In this handbook you will see the words “member” or “you.” If you are a Peach State Health Plan member, the information is for you. If the member is a minor (or under 18 years of age), the information is for the parent or guardian of the member.

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Important Resources

Peach State Health Plan believes in valuing individual differences through our actions, ideas, practices and policies. If you have questions or concerns, please call 1-800-704-1484 (TTY 1-800-255-0056) or visit www.pshp.com.

How to Contact Us

If you have any questions, Member Services will help you. Our staff is here 7 a.m. to 7 p.m. (EST) Monday through Friday. Member Services is closed on state holidays.

You can also write to us at:	**Peach State Health Plan** **1100 Circle 75 Parkway** **Suite 1100** **Atlanta, GA 30339**

Visit us online: www.pshp.com

Important Phone Numbers

If you have any questions, Member Services will help you.

Member Services 1-800-704-1484
Fax 1-800-659-7518
TTY/TDD 1-800-255-0056
24/7 Nurse Advice Line 1-800-704-1484
Dental & Vision 1-800-704-1484
Pharmacy 1-800-704-1484
Community Resource Coordination Department 1-800-504-8573
Start Smart for Your Baby™ 1-800-504-8573
Mental Health & Substance Abuse 1-800-947-0633
Emergency 911
Website ..... www.pshp.com

Information you receive electronically from us can be saved and printed. You can also get a copy of electronic information in paper form at no cost. Call us at: 1-800-704-1484. You will receive the paper form within five business days.

How to File a Claim (speak to your doctor to request a claims form)

Send all medical claims to:	**Peach State Health Plan** **PO Box 3030** **Farmington, MO 63640-3812**

Non-Emergency Medical Transportation Services (NEMT)

Georgia Medicaid will provide members with a ride to and from their healthcare appointments. Call the company that serves the member's area. Call at least 3 business days before the member's appointment if you can.

Members can book online by visiting https://member.verida.com/. Verida call center representatives are available Monday - Friday from 7:00am to 6:00pm EST at the phone numbers listed below.

- Atlanta: 404-209-4000 (Verida)
- Central: 1-888-224-7981 (Verida)
- Southwest: 1-888-224-7985 (Verida)
- North: 1-678-510-4555 or 1-866-388-9844 (Verida)
- Southeast/East: 1-888-224-7988 (Verida)

Please have the following information ready when booking:

- Medicaid ID
- Appointment date, time, and location
- Type of transportation needed
- Any special accommodations

Interpreter and Translation Services

Members have the right to get free translations at health visits. Interpreter services are provided free of charge to members. Peach State Health Plan's language line is available 24 hours a day, 7 days a week.

To receive translation services:

- Call Member Services at 1-800-704-1484. If you are hearing impaired, call our TDD/TTY at 1-800-255-0056.
- Tell them the language the member speaks. We will make sure an interpreter is on the phone.

Our Member Services line is available Monday- Friday from 7am to 7pm. Choose Option 2 for Member Services then Option 4 to speak to a nurse if you are calling after hours. The nurse will help you speak with a translator.

If the member needs help in person, Peach State Health Plan can visit them at their home.

To receive translation services when calling a provider's office to make an appointment:

- Tell them the member needs help with a translator.
- Tell them what language the member speaks.

Call Member Services prior to the member's appointment if you need assistance getting a translator for a doctor's visit. Make sure to call at least three (3) business days before the appointment to get a translator.

To choose a provider who speaks the member's language, please call Member Services. We can help. Members can also search for a provider that speaks their language on our website. Go to www.pshp.com and click on the "Find a Provider" link, then select "Start a Provider Search", and then click on "filter" to select the language.

If the Member is Hearing, Speech or Visually Impaired

Do you need help understanding this? You can get information in another language, large print, braille or audio. Call Member Services at 1-800-704-1484 (TTY/TDD 1-800-255-0056).

Member Website

Peach State Health Plan's website helps you get the answers you need. The website has resources and features that make it easy to get quality care.

Visit us online to learn about benefits and services. You can also find these resources:

- Member Handbook members can search
- Provider Directory members can search
- Community Resource Guide
- Information about Peach State Health Plan's programs
- Member Rights & Responsibilities
- Member Privacy Notice

Special Features:

- Members can change their Primary Care Provider (PCP)
- Print a temporary ID card
- Check Eligibility and Claim Status
- Review Explanation of Benefits
- Check authorizations
- Ask questions and give suggestions to Peach State Health Plan through Member Message.
  - A member service representative will respond to your needs as soon as possible.
- Locate a new provider or change providers.
  - Find a Provider helps members search for a doctor by name, location, hospital and language.
- Submit a grievance

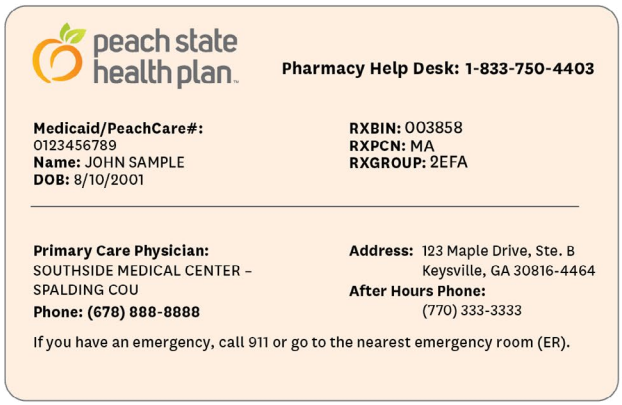
For more information, you can visit our website at www.pshp.com. If you need help understanding this information, call Member Services at 1-800-704-1484. If you are hearing impaired call 1-800-255-0056.

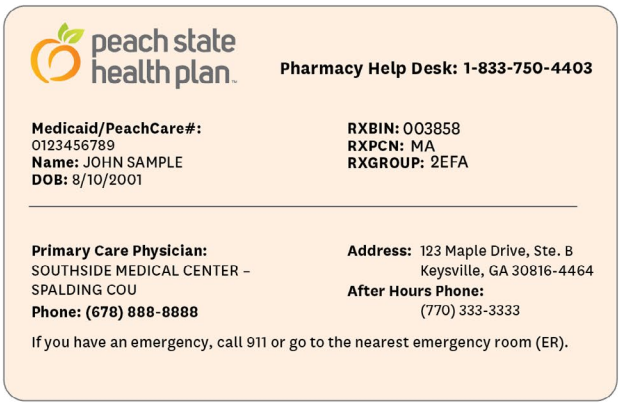
Member Identification (ID) Card

Members need to show their Peach State Health Plan ID card when they get medical care. They also need to show their Medicaid or PeachCare for Kids® ID card. Members may have problems getting care or prescriptions if they do not have a card. Members should bring other health insurance cards they may have to their appointments.

The ID cards can only be used by the member whose name is on the cards. Members should not let anyone else use their cards. If they do, they may be responsible for the costs. They could also lose their eligibility for Medicaid.

Sample ID Cards





Temporary ID Cards

We want to help you keep your Medicaid and PeachCare for Kids® benefits. In order to keep your coverage active, you must complete your review on time or you may lose your Medicaid or PeachCare for Kids® coverage. This will cause a break in your healthcare coverage. If you have questions about the review process, contact Gateway at 1-877-423-4746, or visit their website https://gateway.ga.gov/. For more information about reviewing or reinstating your benefits, please give us a call at 1-800-704-1484 or TDD/TTY at 1-800-255-0056.

We Want to Hear from Our Members

We want to know what members like and do not like about Peach State Health Plan. We want to make sure that we are exceeding their expectations for service. We want to know what we need to do to improve our service delivery to our members. Members can call us at: 1-800-704-1484 Monday through Friday, 7 a.m. to 7 p.m. excluding holidays to tell us what they think. Members may also log on to our website to provide feedback on our benefits and services.

Major Life Changes

If a Georgia Families Medicaid member has had a major change in their life, their caseworker needs to know. This could be a change in the member's:

- Address
- Telephone Number
- Family size
- Job

Georgia Families Medicaid Members should call your Division of Family and Children Services (DFCS) caseworker as soon as they move to a new address. After they call their caseworker, they should call Gateway to change their address. The number is 1-877-423-4746. Changes can also be made online at: https://gateway.ga.gov.

Members should call Peach State Health Plan's Member Services Department and tell us about the change. They will continue to get health care services until the address is changed.

How to Renew

We want to help our members keep their Medicaid and PeachCare for Kids® benefits. Members must renew on time or they may lose their Medicaid or PeachCare for Kids® coverage.

For questions about the renewal process call:1-877-423-4746. For more information about renewing or reinstating your benefits, please give us a call at 1-800-704-1484 or TDD/TTY at 1-800-255-0056.

Primary Care Provider

Provider Network & Provider Directory

Peach State Health Plan local provider network is the group of doctors, hospitals and other healthcare providers who have agreed to provide you with your healthcare services. To search the Provider Directory, visit pshp.com and use the Find a Provider tool.

This tool will have the most up to date information about the provider network, including information such as name, address, telephone numbers, whether they are accepting new patients, professional qualifications, languages spoken, gender, specialty and board certification status. For more information about a provider's medical school and residency, call Member Services. A printed copy of the provider directory is available upon request.

A member's Primacy Care Provider (PCP) should provide all of their primary care services.

The PCP is a part of the member's medical home. This means that he or she will:

- Take care of referrals for specialty care.
- Update the member's medical record. This includes keeping track of the care that they get from them and from specialists.
- Provide services in the same manner for all patients.
- Give the member regular physical exams as needed.
- Provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
- Give the member regular immunizations as needed.
- Keep track of their preventive health needs.
- Make sure the member can contact them at all times.
- Discuss what advance directives are and file the directive appropriately to the member's medical record.
- Listen and discuss the member's care.
- Advise the member of the appropriate place for care based on the urgency of your needs.
- Identify and treat common conditions.

Choosing a PCP

Peach State Health Plan members may choose a PCP. The member's PCP may be one of the following:

- Family Practitioner
- General Practitioner
- Internist
- Nurse Practitioner
- Pediatrician (children and adolescents)
- OB/GYN (women)

It is important for members to call their PCP first when they need care. The PCP will manage all of the member's healthcare needs. The PCP works with the member to get to know their health history and helps them take care of their health. Members have the option to choose the same PCP for their entire family, or each family member can have a different PCP.

Members should always call their PCP's office when they have a question about their healthcare. He or she can help the member get other services they may need. Women may choose an OB/GYN doctor or a nurse midwife in addition to their

PCP. There are Peach State Health Plan PCP's who are sensitive to the needs of many cultures. There are providers who speak the member's language and understand their family's traditions and customs.

Members may have selected a PCP when they joined Peach State Health Plan. If they did not, Peach State Health Plan assigned the member to a PCP.

Members can find information on where their doctor attended medical school, completed a residency program or if he/she is Board Certified by calling member services.

Changing a PCP

Members may change their PCP if they are not satisfied. Members may change their PCP once a month during the first 90 days of enrollment with Peach State Health Plan. After 90 days, members can change their PCP once every six months. They may also get services from any Peach State Health Plan participating Primary Care Provider at any time regardless of assignment.

There are other cases when the member may change their PCP. The member may change at any time if:

- The PCP is no longer in the area.
- The PCP does not provide the services the member seeks because of religious or moral reasons.
- The member wants the same PCP as other family members.

The Role of the Medical Home

A Medical Home provides our members with the right care at the right time in a way that best meets their healthcare needs.

At a Medical Home, members can:

- Get help from their doctor about their care.
- Get coordinated care and support.
- Improve their health and increase satisfaction in their care.
- Get a referral to see a specialist. They can also discuss and evaluate care plans provided by a specialist.
- Discuss their health history.
- Get help with understanding how to take their medicines.
- Get help with following and meeting their doctor's care plan and goals.
- Receive resources and support to make decisions about their health care needs.

Role of a Dental Home

A Dental Home serves as the member's primary care dentist (PCD) for all of their oral health care. The PCD has an ongoing relationship with the member to provide comprehensive, accessible, coordinated and family-centered care. The PCD also makes referrals to dental specialists when needed. Federally Qualified Health Centers (FQHC), general dentists and pediatric dentists can serve as main dental homes.

Choosing a PCD

Peach State Health Plan members who are under the age of 21 should have a PCD. It is important to call the PCD when dental care is needed. To choose a PCD, call Peach State Health Plan's Member Services at: 1-800-704-1484 or visit our website at pshp.com.

Changing a PCD

A member may change their PCD if they are not satisfied. Members may change their PCD once a month during the first 90 days of enrollment with Peach State Health Plan. After the 90 days, members can change their PCD once every six months. They may choose to receive services from any Peach State Health Plan participating Primary Care Dentist at any time regardless of assignment. There are other cases when a member may change their PCD.

Members may change their PCD at any time if:

- The PCD is no longer in the area.
- The PCD does not provide the services the member seeks because of religious or moral reasons.
- The member wants the same PCD as other family members.

Scheduling Dental Appointments

Peach State Health Plan can help members schedule dental appointments. Members can call us at: 1-800-704-1484 if they need help getting an appointment.

Continuity and Coordination of Care

Peach State Health Plan will let our members know if their PCP is no longer in the Peach State Health Plan network. Peach State Health Plan will help the member change their PCP. We will also let the member know if their specialist leaves our network. We will help the member find another specialist.

Accessing Care

The following services require the member's provider to contact Peach State Health Plan for prior approval:

- Nursing facility services
- Home healthcare
- Hospice care (care for terminally ill, for example, cancer patients)
- Inpatient hospitalization
- In-patient hospital services (Hospital care is arranged by your PCP except in the case of an emergency. In-patient hospital care is provided at one of the hospitals associated with Peach State Health Plan. These hospitals are listed in your Provider Directory).
- Partial hospitalization
- Residential Care for behavioral health
- Medical supplies (some diabetic supplies for insulin and blood glucose monitoring do not require authorization)
- Durable Medical Equipment
- Speech and hearing services, including hearing aids
- Physical and occupational therapy
- Non-routine dental care (for example, surgery)
- Non-routine vision (optical) services (for example, surgery)
- Non-emergency ambulance transportation
- Plastic and reconstructive surgery
- Certain diagnostics tests (MRI/MRA, PET Scans)
- Sleep Studies
- Transplant procedures and related services, regardless of age
- Chemotherapy
- Radiation cancer treatment

Before going to a Specialist members should see their PCP first. Their PCP may be able to treat the problem. Their PCP will recommend or request that the member see a specialist if he or she is not able to treat the member's problem. Our Member Services team is ready to answer questions about the PCP. They can also help with questions about how to see a specialist.

Appointment Procedures

Members should be able to get an appointment with their PCP as follows:

- PCP (routine visits) should be provided within 14 calendar days.
- PCP (adult sick visit) should be provided within 24 hours.
- PCP (pediatric sick visit) should be provided within 24 hours.
- Dental Providers (routine visits) should not exceed 21 calendar days.
- Dental Providers (urgent care) should not exceed 48 hours.
- Specialist visits should be provided within 30 calendar days.
- Urgent Care Provider visits should be provided within 24 hours.
- Emergency care should be received immediately and available 24 hours a day, 7 days a week and without prior authorization.
- Non-emergency elective hospital stays should be provided within 30 calendar days.
- Behavioral Health/Mental Health visits should be provided:
  - Immediately for emergency services.
  - Within 6 hours for non-life threatening emergencies.
  - Within 24 hours of the request for urgent care.
  - Within 10 calendar days of the request for routine care.
- OB (initial pregnancy visit) appointment should be provided within 14 days of the request.
  - First Trimester – Within (14) Calendar Days of the request.
  - Second Trimester – Within seven (7) Calendar Days of the request.
  - Third Trimester – Within three (3) Business Days of the request.

Members that are having trouble getting an appointment should call Member Services at 1-800-704-1484 or TTY 1-800-255-0056 for help.

Members not able to schedule a non-life threatening Behavioral Health/Mental Health visit within 6 hours should to go to the nearest emergency room.

Members should bring their Peach State Health Plan Member ID card and Medicaid or PeachCare for Kids® ID card to all appointments. Members should be on time so they can be seen as scheduled.

Office Wait Time

PCP's should follow the following standards if a member is waiting for an appointment:

- Scheduled appointment wait times should not go over 60 minutes.
- Walk-in patients with non-urgent needs should be seen within 90 minutes or scheduled for an appointment.
- Emergency patients should be seen right away.

Nurse Advice Line

Everyone has questions about their health. Peach State Health Plan wants to make sure members get answers to their questions and help when they need it. The Nurse Advice Line is a 24-hour free health information phone line. Nurses can answer questions and help members with questions about:

- Pregnancy.
- What to do when their child gets sick.
- How to get a ride to the doctor's office.
- How to get their medicine.

Call the Nurse Advice Line at 1-800-704-1484 and Choose Option 2 for Member Services then Option 4 to speak to a nurse.

Urgent Care

Urgent Care is needed when the member has an injury or illness that must be treated within 24 hours. It is usually not life threatening but the member can't wait for a routine doctor's visit. Urgent Care is not emergency care.

Members should follow these steps when they need urgent care:

1. Call their PCP first. The name and phone number of their PCP is on their ID card. An after-hours number may also be listed. You may be given directions over the phone.

2. If it is after hours and the member cannot reach their PCP, they should call the Nurse Advice Line at 1-800-704-1484. Follow the prompt to speak with a nurse. Members should have their Peach State Health Plan ID card number handy. The nurse may direct members to other care, or the nurse may offer help over the phone. Members may have to give the nurse their phone number. During normal office hours, the nurse will assist members in contacting their PCP.

If members are told to see another doctor or go to the nearest hospital emergency room they should:

- Bring their Peach State Health Plan ID card and their Medicaid or PeachCare for Kids® card.
- Ask their doctor or hospital to call their PCP or Peach State Health Plan as soon as possible.

Hospital Services

Peach State Health Plan covers inpatient hospital services. If you need to be admitted to a hospital and it is not an emergency, your PCP or specialist will arrange for you to go to a hospital in the Peach State Health Plan network and will follow your care even if you need other doctors during your hospital stay. Peach State Health Plan must approve all services.

To find out if a hospital is in the Peach State Health Plan network or if you have any other questions on hospital services, please call Member Services 1-800-704-1484 (TTY 1-800-255-0056) or go to the provider directory on Peach State Health Plan website at pshp.com If you have an emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital.

Emergency Care

When members have severe pain, illness or injury it may be an emergency. It could result in danger to them. Members should call 911 right away if they have an emergency or go to the nearest emergency room. Members do not need a doctor's approval to get emergency care. If members are not sure if it is an emergency they can call their PCP. Their PCP will tell them what to do.

Emergency rooms are for emergencies. Members should go to the nearest hospital emergency room if they are experiencing an emergency. It is all right if the hospital does not belong to the Peach State Health Plan network. Peach State Health Plan members can use any hospital for emergency services.

Post stabilization is covered as a part of emergency and urgent care services. Post-stabilization care services are covered services that members receive after emergency and urgent medical care. Members get these services to help keep their condition stable. A prior authorization is not needed for emergency and post stabilization services.Members should call their PCP within 24 hours after visiting the emergency room. If the member cannot call, they may have someone else call for them. Their PCP will give or arrange any follow-up care. We will also help members get follow-up care. Members can call our 24-hour emergency number at 1-800-704-1484 and Choose Option 2 for Member Services then Option 4 to speak to a nurse.

Peach State Health Plan does not require prior authorization for Emergency, post stabilization services or urgent care. The hospital must notify the health plan within 1 business day of the member's admission to the hospital. Peach State Health Plan will work with you, your provider and the hospital to put services in place when you go home from the hospital.

How to Get Medical Care Outside Of the Service Region

If you are out of the area and have an emergency, go to the nearest emergency room. Show your Peach State Health Plan ID card. Be sure to call us and report your emergency within 48 hours. If you have problems at the pharmacy, call Member Services. We can help you fill your prescription. You may have a small co-payment when you get certain kinds of care. It will depend on whether you are enrolled in Medicaid or PeachCare for Kids®. Except for the co-payment, you do not have to pay for care when you go to the hospital. You are not responsible for paying for covered services. No one can deny you a covered service if you can't pay for it. If you are away and have an emergency, go to the nearest emergency room. Be sure to show your Medicaid or PeachCare for Kids® ID card and your Peach State Health Plan ID card.

Benefit Information

Services Covered By Peach State Health Plan

We provide access to all covered services. But they must be medically necessary. Some services may be limited. Some need a doctor's order. Some need prior approval. Some Medicaid members may not have all the benefits listed.

Service	Coverage Limits
Ambulatory Surgical Services	
Behavioral Health Services	May have limits. Community Rehabilitation Services covered when there is a written treatment plan. Initial outpatient Behavioral Health (mental health and substance abuse) evaluation, diagnostic testing, and assessment services are provider without authorization and for members twenty-two (22) year of age or younger shall be allowed to have three (3) evaluations per year without authorization (GA 4.6.11.6). Twelve (12) or more outpatient therapy/counseling services will be covered without a preauthorization. Additional therapy/ counseling services will require a preauthorization (GF 4.6.11.7).
Care Management Services	
Childbirth Education	• Limit of 8 classes
Dental Care: Periodic check-ups / exams, Teeth cleaning, Bitewing X-rays Simple extractions, Restorative Services, Orthodontia	• Include: Teeth cleaning for adults • EPSDT services for members under 21 years old • Additional services covered for pregnant women • Orthodontic treatment – when medically necessary
Dialysis and services for end-stage renal disease.	
Doctor and nurses' office visits. Visits must be for checkups, lab tests, exams or treatment	
Durable medical equipment (DME) ordered by a doctor. This includes: Wheelchairs, Crutches, Walkers, Enteral products, Nebulizers, Medical supplies	Devices and equipment that are primarily and customarily used for non-medical purposes are not covered. Some items that are not covered include: comfort or convenience items, physical fitness equipment, and safety alarms and alert systems. Additional non-covered products under DME: Shakes, Meal Bars, Snack Bars, Supplement Thickeners, Cereals, Pudding, Vitamins/Minerals, Blended or pureed food in a personal care or LTC facility. Nutritional products as part of a reduced calorie diet for Diabetes, Gastric Bypass, Obesity or Bariatric Surgery. For children under the age of 21, when medically necessary, these items will be covered under the EPSDT benefit.
Early and Periodic Screening, Diagnostic and Treatment Services or EPSDT/Health Check	For Medicaid Children under twenty-one (21) years of age, to correct or ameliorate physical and Behavioral Health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit regardless of whether those services are included in the State Health Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act. The EPSDT benefit is also available to PeachCare for Kids® members up to 19 years of age.

Emergency Ambulance	
Emergency Services	
Exams and treatments for children, which includes shots.	
Family Planning Services	
Federally Qualified Health Centers (FQHC)	• May have limits
Hearing Services	Hearing aids, batteries, repairs and any additional items or services pertaining to hearing aids are not covered for members twenty-one (21) years and older, this includes external replacement components and repairs for cochlear implants. They are offered under EPSDT/Health Check.
Home health services or supplies received in your home. Services include: Part-time nursing, Physical therapy, Home health aides	Must be ordered by a doctor. Services not covered are: Social services, Chore services, Meals on wheels, Hearing services at home
Hospice care provided by a Medicaid hospice provider	• Covered if the member is expected to live no longer than six(6) months
IDEA (Individuals With Disabilities Education Act – Part C)	• Ages 0 to 2, as medically necessary
Inpatient hospital services. Services include room and board. They also include drugs, lab tests and other services.	
Laboratory and Radiological Services	
Nurse Practitioner Services	
Nurse visits in the home after the baby is born, if needed	
Nursing Facilities	• 30 day or less when medically necessary. • Not covered: Long-term nursing facility (over 30 Consecutive Days)
Nursing Midwife Services	
Obstetrical Services	
Occupational Therapy	These services are covered for children under age 21 as medically necessary. Therapy Services are covered for adults age 21 and older when medically necessary in the treatment of acute illness, injury or impairment when the condition is less than 90 days duration.
Oral Surgery	
Orthotic and Prosthetic Services	Includes such items as artificial limbs and replacement devices, breast prostheses, and prosthetic eyes and braces, diabetic and custom molded shoes.
Outpatient Hospital Services	
Outpatient Surgical Services	
Pediatric Private Duty Home Nursing Services	When medically necessary for children approved for the Georgia Assistance Pediatric Program (GAPP) between hospital discharge and the start of GAPP coverage.

Physical Therapy	These services are covered for children under the age 21 as medically necessary Therapy Services are covered for adults age 21 and older when medically necessary in the treatment of acute illness, injury or impairment when the condition is less than 90 days duration.
Podiatric Services	Services for flatfoot, subluxation, routine foot care, supportive devices and vitamin B-12 injections are not covered.
Pregnancy Services	
Prescription Drugs	See our Preferred Drug List (PDL) for the drugs we cover.
Rural Health Clinic Services	
Second Medical Opinions	Must be provided by a doctor in the network, when available. This is provided at no cost to the member.
Speech Therapy Services	These services are covered for children under the age 21 as medically necessary. Therapy Services are covered for adults age 21 and older when medically necessary in the treatment of acute illness, injury or impairment when the condition is less than 90 days duration.
Substance Abuse Treatment	May have limits. Treatment is covered as part of a written treatment plan. It includes inpatient and outpatient care. P4HB limited to detoxification and Intensive Outpatient Services.
Swing Bed Services	• Services not requiring direct professional nursing care/nursing supervision are not covered • Service must be provided within the State Hospital must have a swing bed agreement.
Transplants – all recognized, non-experimental organ transplants are covered if deemed medically necessary for members under the age of 21.	Kidney, liver, bone marrow and cornea are only covered transplants for age 21 and older.
Vision Care	• Covered services include exams and prescription eyewear • FREE eye exam each year for members age 21 and over. No copay • No office copay for PeachCare for Kids members age six and under • FREE pair of glasses. Once per year for members age 21 and over. No copay. Contact lenses if medically necessary • $100 allowance towards glasses, broken frames or contact lenses outside of what is covered by Medicaid • 20% discount on a second pair of prescription glasses or sunglasses • Free vision care supplies for adults • Upgrades for adults (The option to receive one of four “upgrades” during the year: Scratch-resistant coating, tint, polycarbonate lenses including UV, anti-reflective coating)

Services Not Covered By Peach State Health Plan

Some services are not covered by Peach State Health Plan. These services include:

- Abortions except in the case of a rape, incest or when medically necessary to save the mother's life.
- Acupuncture.
- Biofeedback services.
- Care for the treatment of obesity unless medically necessary.
- Care or supplies that are not medically necessary (e.g. HEPA filters, humidifiers, etc. For a complete list, call the Member Services Department).
- Comfort items in the hospital (for example, TV or phone).
- Cosmetic surgery.
- Experimental care, such as drugs and supplies that Medicaid will not pay for.
- Experimental or investigative services.
- Father/child testing.
- Herbal supplements.
- Home assistant or personal assistant.
- Infertility care for men or women.
- Investigational or experimental treatment.
- Some transplants are not covered for members twenty-one (21) years of age and over. Call Member Services for a list of non-covered organ transplants.
- Products which are not included on the Pharmacy Program List and also not listed on the state's Physician Administered Drug List are not covered benefits in the office/outpatient setting.
- Reversal of sterilization services.
- Services outside of the country.
- Services performed by a Chiropractor.
- Services/procedures provided by non-participating providers and/ or facilities when services can be given by participating providers and/or facilities.
- Services to find cause of death.
- Sex or marriage therapy.
- Sterilization of a mentally incompetent, institutionalized person under age 21 years.
- Special Vaccines or shots to travel outside the country.

We can help you get the services you need. Call Member Services at 1-800-704-1484 to discuss the resources that may be available to you but not covered by Peach State Health Plan.

Medically Necessary Services

Services that are medically necessary are those that:

- Prevent or treat physical or mental illness and conditions.
- Treat pain and body problems based on your doctor's referrals and plan to improve your care.
- Agree with medical standards.
- Have a safe setting based on your diagnosis and treatment plan.
- Have a low-cost setting.
- Covered services for custodial care.
- Provide resources for services or treatment not covered by Peach State Health Plan.

Peach State Health Plan wants our members to be healthy. Authorizations may be granted outside of the benefit plan when medically necessary.

Self-Referrals

These services do not require prior approval and they do not require a referral from the member's PCP:

- Emergency services and post stabilization services.
- Ambulance service.
- OB/GYN services.
- Services provided by a Federally Qualified Health Center (FQHC).
- Services provided by a certified nurse midwife or nurse practitioner.
- Services provided by a Community Mental Health Center.
- Chemical dependency and substance abuse services.
- Family planning services.
- Supplies from a qualified family planning provider.
- Routine dental services.
- Routine vision care that does not require surgery.
- Translation services.
- PCP - Includes office visits and EPSDT (Early and Periodic Screening Diagnostic and Treatment) visits.
- Routine x-ray and certain diagnostic tests and procedures.
- Urgent Care.
- Routine OB Ultrasounds.
- Ophthalmology.
- Dermatology.
- Hearing Evaluations
- HIV Testing
- Sexually Transmitted Disease Services

Be sure to obtain the above services from a Peach State Health Plan provider. Services from a provider who is not in the Peach State Health Plan network must be approved ahead of time. This does not apply to emergency services or family planning services.

Referrals

If a member needs care that their PCP cannot provide, the PCP can refer the member to a Peach State Health Plan specialist. Paper referrals are not required.

The following are services that may require a referral:

- Specialist services
- Diagnostic tests
- Outpatient hospital services
- Clinic services
- Services for children with medical handicaps (Title V)
- Renal dialysis (kidney disease)

Second Medical Opinion

Members can have a second opinion about their healthcare. Members may choose a participating provider or a provider of their choice. This is a free service covered by the health plan. The member's PCP will review the second opinion.

Utilization Management

Utilization Management (UM) is the process used by Peach State Health Plan to make sure requested services or care is covered, medically necessary and provided to you in the right place. The UM team works with your healthcare provider to approve services before you get care, complete hospital reviews while you are receiving care, and help plan care when you leave the hospital.

Peach State Health Plan uses Change HealthCare InterQual guidelines and Centene Clinical Policies to review medical care. These guidelines are used to review hospital care, outpatient services, and referrals to specialists. To request a copy of our guidelines, please call a Member Services Representative at 1-800-704-1484 or TDD/TYY 1-800-255-0056 or 711.

Medical decisions about care are made by the member's doctor. The Member or Provider may request an authorization extension. The UM team may give an extension for an authorization request if the extension is in the member's best interest.

Prior Authorization

Some treatments and services require approval from the health plan before the service is provided. The provider performing the treatment or service will submit a request for authorization to the health plan along with medical information that supports the treatment. All prior authorizations and pre-certifications will be reviewed by a licensed and trained staff member of Peach State Health Plan.

Time Frames for Authorization Requests

Standard Service Authorizations: Peach State Health Plan will decide on non-urgent care services within 3 business days after the request is received. The member or the provider can ask to extend the non-urgent time frame up to 14 calendar days. All decisions and notifications will occur within the extended period 14 calendar days if the time frame is extended.

Expedited Service Authorizations: The member's doctor can ask for an expedited review if it is thought that a delay will cause harm to the member's health. Peach State Health Plan will notify the member's doctor of a decision within 24 clock hours after we get the request, but no later than 72 hours after receipt of the request for service. The member or their doctor can ask to extend the expedited time frame up to 5 business days. All decisions and notifications will occur by the end of the 5 business days if the time frame is extended.

Communication with the Utilization Management Staff

Authorization requests must be submitted by your doctor via the Centralized Prior Authorization Portal: www.mmis.georgia.gov.

Members may contact the UM staff to check coverage for medically necessary services via toll-free phone lines at 1-800- 704-1483 or TDD/TYY 1-800-255-0056 or 711. The phone lines are open for authorization requests and UM related questions and or issues 24 hours a day, 7 days a week. Calls are directed to the UM department from 8:00 am to 5:30 pm, Monday through Friday (excluding State holidays). calls are directed to the UM department. After normal business hours and on State holidays, calls to the UM department are automatically routed to the Nurse Advice Line (1-800-704-1483). Our Nurse Advice Line staff does not make authorization decisions. The Nurse Advice Line staff will take authorization information for next business day response by the Health Plan or notify the Peach State Health Plan on-call nurse in cases requiring an immediate response.

Pharmacy

Peach State Health Plan covers needed drugs for Medicaid and PeachCare for Kids members. Peach State Health Plan must approve some drugs before the member gets them. The member should ask their doctor if their prescription requires this approval. If it does, the member should ask if there is another medicine that can be used that does not require prior authorization.

The member's doctor can decide if it is necessary to have a non-preferred drug. If so, they must give Peach State Health Plan a request for a prior authorization. If Peach State Health Plan does not approve the request, we will notify the member. We will give the member information about the appeal and State Fair Hearing processes.

Peach State Health Plan requires members to try at least 2 preferred drugs before they can get a non-preferred drug. Members need to ask their doctor to write a prescription for a preferred drug first.

Peach State Health Plan's doctors have been notified in writing of:

- The drugs included in the Preferred Drug List (PDL).
- How to request a prior authorization.
- Special procedures set up for urgent requests.

The Peach State Health Plan Formulary, or Preferred Drug List (PDL), is a guide to available brand and generic drugs that are approved by the Food and Drug Administration (FDA) and covered through your prescription drug benefit. The PDL is available on the Peach State Health Plan website at pshp.com.

You may call a Member Service Representative for a list of drugs Peach State Health Plan covers. We update the list of covered drugs often. You may also use the "drug Lookup" Tool in the Secure Member Portal to see if your drug is covered.

The PDL lists drugs covered by Peach State Health Plan. It includes drugs that do not need Prior Authorization (PA) and drugs that have the limits for PA, Quantity Limits (QL), or Step Therapy (ST). Members can get PDL drugs at local retail pharmacies. The PDL is made by the Pharmacy and Therapeutics (P&T) Committee to ensure medicines for a lot of illnesses are covered. The Committee is made up of the Chief Medical Officer, the Chief Medical Director of Pharmacy Services, and several Peach State Health Plan primary care physicians, pharmacists, and specialists. The PDL is not meant to be a complete list of the drugs covered by the benefits. Not all forms or strengths of a drug may be covered. This list is looked every three months. Major changes are sent to providers and members as needed.

How does a member get their prescriptions?

- Go to a Peach State Health Plan doctor for a prescription.
- Go to a pharmacy that is signed up with Peach State Health Plan.
- Show them the member's Peach State Health Plan ID card.
- Give them the prescription order.

See the Provider Directory for the names of local pharmacies. Member Services can also help you find a pharmacy. You also can find a pharmacy by using the 'Find a Provider' feature in the Secure Member Portal.

Pharmacy Lock-In Program

Peach State Health Plan is required to have a Lock-In program by the Georgia Department of Community Health (DCH). The Lock-In program is for the protection of our members. Peach State Health Plan reviews members that receive medical services. This review makes sure that benefits are used properly. In our review, we look to see if members have any of the following:

- Prescriptions written on a stolen, fake, or changed prescription blank.
- Prescribed drugs that should not be used for the member's medical condition.
- Filled prescriptions at more than two pharmacies per month or more than five pharmacies per year.
- Received more than five different drugs per month.
- Received more than three controlled drugs (examples: pain medicine, medicine to help sleep, and medicine to control attention deficit disorder) per month.
- Received two or more drugs that work the same way from different providers.

- Received prescriptions from more than two doctors per month.
- Been seen in a hospital emergency room more than two times per year.
- Received a diagnosis of drug poisoning or drug abuse.
- Number of prescriptions for controlled drugs exceeds 10% of total number of prescriptions.
- Fills three or more opioid pain medicines at the same time as some central nervous system depressants (examples: anxiety medicine, nerve pain medicine, and seizure medicine).
- Received opioid prescriptions at the same time which make their daily dose more than 90mg morphine-equivalents.

We receive information from providers and DCH. Pharmacies may also tell us about members that may need to have their use of drugs reviewed. If the member has one or more of the items above, the member will be assigned to one pharmacy to fill all drugs. The member may also be restricted to one doctor to write for controlled drugs.

Members placed into the Pharmacy Lock-In Program will receive a letter detailing the pharmacy and or controlled substance prescriber that is selected for them. A copy of this notice is also sent to the Lock-In Pharmacy and the Controlled Substance Prescriber or the Primary Care Physician on file.

This program lasts at least one year. Having one pharmacy fill all prescriptions can prevent a member from being harmed by drugs that do not work together.

We expect all pharmacies who manage lock-in patients to uphold the following:
- Verify controlled substance prescriptions by phone when multiple physicians are involved in the patient's care.
- Do not allow early refills on controlled substances.
- Make sure that all physicians writing prescriptions for controlled substances know that other physicians are also writing prescriptions for controlled substances for the same patient. This may not apply if the member is restricted to one provider.

If a member has moved and their Pharmacy or Medical Provider is no longer within driving distance from the new home, they should be sure DCH has updated their records with the new address. Members can call Peach State Health Plan Member Services at 1-800-704-1484 and request a provider change based on the new location.

The member or the provider acting with the member's written consent, may obtain an appeal of this decision or file a grievance pertaining specifically to the pharmacy or physician.

Medication Safety

Important Reminders for using Medication Safely
- Medications can be safe if you take them correctly.
- Medicines can help you get better when you are sick.
- Medicines can also keep a health problem under control.

Medication Reminders
- Read and follow the directions on the label.
- Take the exact amount written on the label.
- Take each dose around the same time each day.
- Use the spoon, cup, or dropper included with liquid medicine.
- Use the same pharmacy for all of your prescriptions.
- Don't share your medicine or take someone else's medicine.
- Check the expiration date on the label and don't take it past that date.
- If you have out of date medicine, add water or something that smells or tastes bad (like salt or dirt).

Then put in the trash. You may also talk to your local pharmacy about how to safely get rid of it.

- Keep all medicines out of the reach of children.
- Don't keep medicine in sunlight or in a damp area.
- Keep medicine in a cool, dry place.
- Tell your doctor and pharmacist about all of the medicines you take.
- Tell them about the prescription medicine and over the counter medicine you take.

Over the counter medicines include:

- Pain Medicine
- Cold Medicine
- Stomach Medicine
- Vitamins
- Herbal Medicine
- Dietary Supplements
- Other drugs you buy at the store

Tell your doctor and pharmacist about any allergies to drugs and foods and about problems you had with medicines in the past. If you have questions, call your doctor or pharmacist.

Questions You Should Ask:

- What is the name of the medicine?
- Why do I need to take it?
- How much do I take?
- How often should I take it?
- How long do I keep taking it?
- Will it make me sleepy or feel bad?
- Can I take it with my other medicine?
- Are there any foods or drinks I should avoid?
- Should I stop taking it when I feel better?
- What should I do if I forget to take it?
- What should I do if I take too much?
- Can I crush, chew or break the pill?

Payment for Services

Peach State Health Plan will only pay for the services it approves.

Georgia Families Co-Payments

A Medicaid Member may have to make a small co-payment when they get care. Peach State Health Plan will pay for most, if not all of the bill. Doctors, hospitals or other providers in the Medicaid program must accept Medicaid as payment. But they may bill the member for their co-payment.

Those who do not have co-payments are:

- Medicaid members under age 21
- Pregnant women
- Members with breast and/or cervical cancer
- Nursing home members
- Members in hospice care
- American Indians
- Alaska Natives

Peach State Health Plan providers cannot deny members for a covered service if they cannot pay their co-pay. You are not responsible to pay for covered services.

Prescription	Member Copayment
Preferred Drug List (PDL) Medicines	$0.50
Non-PDL Medicines	
Under $ 10.00	$ 0.50
Between $ 10.01 - $ 25.00	$ 1.00
Between $ 25.01 - $ 50.00	$ 2.00
More than $ 50.01	$ 3.00

Co-Payments are required for the following services:	
Ambulatory Surgical Centers	$ 3.00
Federally Qualified Health Centers/Rural Health Clinics	$ 2.00
Outpatient Non-Emergency Hospital Visits	$ 3.00
Inpatient Hospital Services	$ 12.50
Emergency Department Visits for Non-Emergency Conditions	$ 3.00
Oral Maxillofacial Surgery	$10.00 or less: $0.50 $10.01 to $25.00: $1.00 $25.01 to $50.00: $2.00 $50.01 or more: $3.00

Co-payments are not required for the following services:

- Family planning services
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Emergency services that are a considered a medical emergency
- Prescriptions for family planning services
- Prescriptions generated from an emergency room visit

PeachCare for Kids® Co-Payments

The charts below show co-pay amounts listed by services. There are no co-payments for children under 6 years old.

Type of Service	Co-Payment Amount
Ambulatory Surgical Centers / Birthing	$3.00
Durable Medical Equipment	$1.00 or $3.00 (service based)
Federally Qualified Health Centers	$2.00
Free Standing Rural Health Clinic	$2.00
Home Health Services	$3.00
Hospital-based Rural Health Center	$2.00
Inpatient Hospital Services	$12.50
Oral Maxillofacial Surgery	Co-pay amount based on cost of service* *See chart on the next page.*
Orthotics and Prosthetics	$3.00
Outpatient Hospital Services	$3.00
Pharmacy – Preferred Drugs	$0.50

Type of Service	Co-Payment Amount
Pharmacy – Non-Preferred Drugs	Co-pay amount based on cost of service* See chart below
Physician Services	Co-pay amount based on cost of service* See chart below.
Podiatry	Co-pay amount based on cost of service* See chart below
Vision Care	Co-pay amount based on cost of service* See chart below

Cost of Service Co-Payments*

*The co-payment amounts below are for the following services:

Oral Maxillofacial Surgery, Pharmacy – Non-Preferred Drugs, Physician Assistant Services, Physician Services (Doctor's office visits), Podiatry and Vision Care.

Prescription	Member Copayment
Preferred Drug List (PDL) Medicines	$0.50
Non-PDL Medicines	
Under $ 10.00	$ 0.50
Between $ 10.01 - $ 25.00	$ 1.00
Between $ 25.01 - $ 50.00	$ 2.00
More than $ 50.01	$ 3.00

Georgia Pathways Co-Payment

As a Pathways member, you will be asked to pay a small co-pay when you get care. Doctors, hospitals, and other Medicaid providers must accept Medicaid as payment. If you cannot pay your co-pay, you cannot be denied care for a covered service. Peach State Health Plan providers are not allowed to refuse care for a covered service if you are unable to pay your co-pay. Co-payments are not required for Pathways members under age 21.

The charts below show co-pay amounts listed by service types.

Service	Amount
Inpatient Hospitalization	$12.50 for entire stay
Outpatient Hospital Visit	$3.00 per visit
Non-Emergency Use of the ED	$3.00
Primary Care	$0.00
Specialist	$2.00
Durable Medical Equipment	$3.00; $1.00 for rentals and supplies
Pharmacy	$10.00 or less: $0.50 $10.01 to $25.00: $1.00 $25.01 to $50.00: $2.00 $50.01 or more: $3.00

Pathways copayment amounts as detailed in Georgia Medicaid State Plan, Attachment 4, Amendment 4.18-A

If you have any questions about the co-payments, please contact Peach State Health Plan's Member Services Department toll free at 1-800-704-1484. You can call Monday through Friday from 7:00 a.m. to 7:00 p.m. Eastern Time. If you are hearing impaired, please call TTY 1-800-255-0056.

Value-Added Benefits

Take care of your family with full access to free programs and services from Peach State Health Plan. Value-added benefits provides additional benefits beyond those offered by the basic Medicaid plan. Visit pickpeachstate.com to learn more about additional value-added benefits available to you and your family. Value-Added Benefits begins on July 1, 2024

Dental and Vision

Members that are 21 years and older qualify for enhanced dental benefits that cover preventive exams, cleanings and x-rays every six months. Members that are 21 years and older can also receive one free, no co-pay eye exam per year, and $100 annually toward glasses, contact lenses, or broken frames and more. (The option to receive one of four "upgrades" during the year: Scratch-resistant coating, tint, polycarbonate lenses including UV, anti-reflective coating.)

myhealthpays® Rewards

Members can earn myhealthpays® Rewards from Peach State Health Plan when they complete healthy activities. After members complete a healthy activity, we will add the reward earned directly to a My Health Pays® Visa® Prepaid Card.

Peach State Health Plan is unable to process My Health pays Rewards (MHP) without a claim available.

All active members are eligible for this program. To receive a reward, members must first complete a healthy activity. Following completion, a claim will be submitted, processed, and paid.

After the claim is paid, members will receive a prepaid debit card via mail. Please allow 6-8 weeks for claims to be processed by your provider.

Please note: Providers have up to 6 months to submit a claim.

We will mail the My Health Pays® Visa® Prepaid Card after members complete their first healthy activity. Members can keep earning My Health Pays® rewards by completing more healthy activities. Rewards will be added to the card once we are notified.

For more information about the myhealthpays® program, call a Member Services representative at 1-800-704-1484.

This card is issued by The Bancorp Bank, N.A., pursuant to a license from Visa U.S.A. Inc. Card cannot be used everywhere Visa debit cards are accepted.

Programs

Behavioral Health Services

There are times when you may need to speak to a therapist, counselor, or doctor 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
- Parenting concerns

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

- Calling Member Services at 1-800-704-1484.
- Visiting our website at pshp.com

You do not need a referral from your PCP for mental health and substance abuse problems. After hours, you can also call our Nurse Advise Line at 1-800-704-1484 or our mental health crisis line at 1-800-704-1484. They are available 24/7, FREE and provide bilingual help.

Members can also enroll in care management to get help with care and community support groups like special groups for pregnant woman and parents. If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room 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 mental health or substance abuse 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.

Mental Health and Substance Abuse Services (Drugs and Alcohol)

Peach State Health Plan can help members with their mental health treatment. We also help with drug and alcohol abuse. Peach State Health Plan can help members get treatment in many ways. This is how we can help:

- We will refer the member to a doctor. Members can also attend a community support group. There are special groups for pregnant women and parents.
- Members will have a care manager to help with care.
- After hours, you can also call the Nurse Advice Line at 1-800-704-1484. The Nurse Advice Line is a FREE 24/7 bilingual help line.

Start Smart for Your Baby™

Start Smart for Your Baby™ is our special program for women who are pregnant. This program helps members take good care of themselves and their baby. Start Smart for Your Baby™ gives members information about their baby. It also helps with problems that come up during pregnancy. We know having a baby can be hard on members and their family. We want to help.

We care about the health of our members and their babies. Members should go to their doctor as soon as they find out they are pregnant. It is important to take babies to the doctor after they are born. They will need shots and health screenings. For newly pregnant Moms who complete a prenatal visit within the first trimester or 42 days of joining the plan, Peach State Health Plan will give them a SPECIAL GIFT. You can claim your gift on Peach State website at: www.pshpgeorgia.com. This is our way of saying thank you to our members for taking good care of themselves and their baby!

We have many ways to help you have a healthy pregnancy. We need to know when Peach State Health Plan members become pregnant. Members should call us at 1-800-504-8573 as soon as they learn they are pregnant. We will set up the special care our members and their babies need.

Community Resource Coordination Department

The Community Resource Coordination Department promotes preventive health and connects members to quality healthcare and community social services while addressing the social needs of health. Community Resource Coordination Department Representatives are certified Community Health Workers who provide support to Peach State Health Plan members enrolled in Care and Disease Management Services. They can help members determine which doctors are available in their area, find support services, and help arrange for needed services.

Community Resource Coordination Department Representatives work with Peach State Health Plan's Care Managers to ensure member's healthcare needs are addressed. The Community Resource Coordination Department host baby

showers, and healthy lifestyle events throughout the state of Georgia. Community Resource Coordination Team can also visit members in their homes to help with healthcare needs, benefit overview, and social service needs. Please call Care Management at 1-800-504-8573.

Drivers of Health Department

Do you need community resources?

Peach State Health Plan has a Drivers of Health Department. We encourage our members to stay healthy with regular check-ups and wellness visits. We can also help connect you to healthcare and community resources. Our programs include:

Community Connection Help Line (CCHL):

Our Community Connections Help Line phone number is 1-866-775-2192.

- This is a national, toll-free helpline for members, non-members, and doctors.
- Callers are connected with peer coaches that complete a social needs assessment.
- Once completed callers are given community resource referrals.
- Our peer coaches will also follow up to make sure all needs are met.

Find **Help**: *A free Drivers of Health data base to find free and reduced cost services by zip code.

Social Work Care Management:

Peach State Health Plan's Social Work Care Management team are here to help you with care needs after a hospital stay. This includes:

- Hospital discharge planning for members with social needs
- Follow-up services after you leave the hospital
- Social worker support for members with complex social needs
- Find Help: *A free Drivers of Health data base to find free and reduced cost services by zip code.

Community Health Services:

Peach State Health Plan's Community Resource Coordination team can assist you with finding doctors and scheduling appointments. Other assistance and benefits includes:

- Health Coaching
- Health Education
- Help with finding community resources
- Free community events, such as baby showers

CONNECTIONS Plus

ConnectionsPlus is part of the Community Resource Coordination Departments program that provides free cell phones to certain high risk members who are actively involved in Case and Disease Management Services and do not have safe, reliable access to a telephone. Care managers will assess whether members qualify for this program. This program allows our members to have 24-hour instant access to physicians, care managers, Coordinated Care staff, transportation services, and 911.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program

Peach State Health Plan wants parents/guardians to schedule a well visit for their children. EPSDT is a preventive health program for members under the age of 21. The EPSDT program covers complete health checkups at no cost. It also covers the cost of fixing any problems found during a health checkup.

For Parents/Guardians: Why Health Check Ups Are Important

Checkups are important for children's health. Checkup visits for children are Well Child Visits. Children may look and feel well but still have a health problem. Children should go to the doctor for regular checkups, not just when they are sick.

Children need more health checkups than adults do. Children that are new Peach State Health Plan members should have a Health Checkup within 90 days of becoming a member. If the child is younger than 9 months, they may need to visit the doctor sooner. Call the child's doctor to see when they need a checkup visit.

Babies need to see their primary care provider at least 8 times by the time they are thirty (30) months old and more times if they get sick.

The EPSDT program helps:

- Find and treat children's health problems early.
- Let members know about special services for their children.
- Provide children healthcare not otherwise covered.

At Well Child Visits, the child's doctor will perform services such as:

- Health and developmental history
- Physical exam
- Behavior and mental health assessments
- Immunizations
- Laboratory tests and a lead screening
- Health education
- Vision and hearing screenings

At certain visits, the doctor may also perform:

- TB Risk review and skin test
- Lead risk assessment
- Cervical Dysplasia screening as recommended by the Bright Futures Schedule.
- Blood tests

The doctor will also provide health education and counseling. They will tell parents what to expect as their child grows. Children should have a dental home. They should have their first dental exam no later than 12 months of age. We can help find a dentist and schedule a visit for your child. Call us at 1-800-704-1484 for more information.

When to get a Well Child Visit

The first well child visit will happen in the hospital right after the baby is born. Peach State Health Plan will help schedule the follow up visits babies needs after they leave the hospital.
Call us at 1-800-704-1484 for help scheduling an appointment.

Health Exams

Health exams can help tell if a child has a physical or mental illness. Well child visits are recommended at the following ages:

- Newborn before going home from the hospital
- 3-5 days
- By the time they are 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3 years
- 4 years
- Annual visits from age 5 up through age 20

When a child misses a Health Checkup

It is important to make sure children see their doctor regularly. If a child does not get a health checkup on time, make an appointment with the child's PCP as soon as possible. Call Member Services at 1-800-704-1484 (TTY/TDD at 1-800-255-0056) for help making an appointment.

Oral Health

Dental checkups are important to a child's health. They help stop cavities and gum disease. Take these steps to help children have a healthy smile:

- Limit Snacks.
- Do not put small children to bed with a bottle of milk or juice.
- Make sure children brush their teeth twice a day and floss once a day.
- Make sure children get checkups every six months by a dentist.
- Visits to the dentist should start as soon as the first tooth comes in and no later than twelve (12) months of age.
- Speak with the child's dentist about sealants that protect teeth.
  Call your child's dentist to make an appointment. Please call our Member Services department for questions about checkups. We can be reached at 1-800-704-1484 (TTY/TDD at 1-800-255-0056).

Health Checkups for Adults

Health Checkups are not just for kids. Adults need to see their PCP for an annual health checkup and immunizations. Checkups can help doctors catch health problems early. If members need help making an appointment call Member Services. If you are hearing impaired call 1-800-255-0056.

Care Management (CM)

Peach State Health Plan is pleased to let you know that we have a care management program. The care management program helps members learn more about their health care condition.

Who is eligible?

All covered members are eligible for care management services. Any member can refer themselves or be referred for care management services. Call the Care Management Department at 1-800-504-8573 for information on the services offered. The care management staff can help members find out more about care management services and/or enroll.

How can members use care management?

Members can use care management to:

- Find doctors and other providers, such as mental health providers.
- Get services, such as medical equipment or home health.
- Work with doctors to help you stay healthy.
- Receive community resources.
  - Our Care Management team is made up of nurses, social workers, pharmacists, and outreach workers. They work with members to help them maintain good health. They also help members arrange services that they may need to manage their health. The goal of our program is to learn what information or services members need in order to become more independent in meeting their health care needs.

Care Management and Disease Management (DM) Programs

Care Management (CM)

- Adult and Pediatric Complex and Catastrophic Care
- High Risk Pregnancies
- Short Term Care Coordination
- ER Diversion
- Lead
- Sickle Cell
- Integrated Care Management - Medical and Behavioral Health

Disease Management (DM)

- Asthma
- Diabetes
- Hypertension
- Depression
- Substance Abuse

Disease Management Programs (DM) / Health Coaching

The DM programs target members who have been diagnosed and treated for diabetes mellitus, asthma, hypertension, depression, and substance abuse. Members are stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. The members receive education, disease management services, and health coaching to enhance positive clinical outcomes.

Adult and Pediatric Complex and Catastrophic Care Management Program

The Adult and Pediatric CM program provides individual care management services for members who have chronic, complex, high-risk, high-cost or other catastrophic conditions. The program is designed to enhance the member's quality of life.

High Risk Pregnancies Care Management Program (HROB CM)

The HROB CM program is designed to educate pregnant members about their condition. It also helps members create care plans with their physicians, specialists and family. The HROB CM program also provides community resources and advocates on the member's behalf. The program helps the member get timely and cost effective services. The goal is to promote healthy outcomes for the mother and baby.

Short Term Care Coordination

The Care Coordination unit provides individual care management services for members who have short-term care coordination needs. The unit coordinates care including behavioral health needs. It also assists the member in finding and getting community resources. The unit arranges for short-term services as needed.

Emergency Room Care Management Program (ER CM)

The ER CM program is designed to support members with frequent or inappropriate ER usage patterns and connect them with a care manager who can help them discover more appropriate solutions to their medical needs. The goal of the program is to connect members to their PCP to promote a patient centered medical home. The program also helps decrease avoidable ER visits and improve our member's compliance with their medicines.

Disease Management Programs (DM)

The DM programs target members who have been diagnosed and treated for diabetes mellitus, asthma, hypertension, depression, and substance abuse. Members are stratified based on the severity of their illness so that interventions can be targeted to the appropriate population. The members receive education, disease management services, and health coaching to enhance positive clinical outcomes.

Lead Care Management Program (LCMP)

Peach State Health Plan's Lead Care Management Program (LCMP) is for children with high lead levels. Families of children with high lead levels will get:

- Screenings.
- Help to find out what is causing the high levels of lead.
- Recommendations for treatment.

Peach State Health Plan's Care Managers work with the member and their PCP to provide support and resources for lead management. They also help monitor the member's blood lead levels.

It is the goal of the LCMP to make sure children with blood lead poisoning get treatment. We also try to find the source of lead poisoning.

Integrated Care Managment - Medical and Behavioral Health

Peach State provides an integrated physical and behavioral health program by integrating Medical Nurses and Behavioral Health clinician Care Managers to bring a whole person focus to each member's care and services. If a member has both medical and behavioral health needs, the Nurse and the Behavioral Health Care Manager works together in delivering a holistic approach that addresses the full range of the member needs.

Complex Care Management

When a member is in the hospital and well enough to get visitors, a Peach State Health Plan nurse or social worker may come to the hospital room. They will discuss:

- Discharge care
- The care management program

Our staff will always check with the hospital staff first before entering a member's room. We want to make sure the timing is right for us to visit the member. Additionally: The member may receive a call from one of our care management staff members. They may ask the member to participate in our Complex Care Management Program.

Complex Care Management is a high level of care management services. This is for members who are seriously ill and need help with finding their way through the health care system. We know that everyone may not want to take part in this program. You have the right to participate or decline to participate at any time.

- Peach State Health Plan staff will talk to your PCP and other service providers to coordinate care.
- Peach State Health Plan staff will provide information to help you understand how to care for yourself and how to get services.

New Technology

Peach State Health Plan has a committee called the Centene Clinical Technology and Assessment Committee. This group consists of doctors. They review new treatments for people with certain illnesses to determine how new advancements can be included in the benefits that Peach State Health Plan members receive. They also review existing and new technologies from industry changes to make sure members receive safe and effective care. This group of doctors reviews new technology in medical procedures, behavioral health procedures, pharmaceuticals and medical devices.

The new treatments are shared with Peach State Health Plan's providers. The doctors will decide if the new treatment is the best treatment for our members. An example of new technology is the Cochlear Implant. This is a special hearing tool for people with a great deal of hearing loss.

Peach State Health Plan Now Offers Telemedicine Services

Peach State Health Plan is pleased to tell you about a service for members. It is called telemedicine. The service gives members access to more doctors and specialists.

Telemedicine helps patients get medical care so they do not need to travel long distances. The patient connects with the doctor using video technology at a site close their home. The doctor sees and treats the patient remotely using special medical cameras. For more information about this service call: 1-800-704-1484. You can also visit: www.pshp.com.

Family Planning Services

We offer private family planning to all members. This includes members less than eighteen years of age. You can go to any family planning clinic that accepts your Georgia Medicaid or PeachCare for Kids® card. We encourage you to use a Peach State Health Plan doctor. This helps us manage your entire healthcare.

There are several types of family planning methods you can choose from. We can assist with planning the number of pregnancies, how to space between pregnancies, and how to obtain confirmation of pregnancy. Family Planning services and supplies include at a minimum:

- Education and counseling necessary to make informed choices and understand contraceptive methods.
- Initial and annual complete physical examinations.
- Follow-up, brief and comprehensive visits.
- Pregnancy testing.
- Contraceptive supplies and follow-up care.
- Diagnosis and treatment of sexually transmitted diseases.

Members can talk to their PCP about family planning. They can also call our Member Services Department at 1-800-704-1484 (TTY 1-800-255-0056) for help.

Planning for Healthy Babies

Planning for Healthy Babies (P4HB) is a program from the Georgia Department of Community Health. P4HB offers no cost family planning services. This program includes:

- Family planning services.
- Inter-pregnancy care (IPC) services. This is limited to mothers who give birth to a baby weighing less than 3 pounds 5 ounces.
- Resource Mother
  - This is a care management service. The care manager will help mothers who had a baby that weighs less than 3 pounds 5 ounces learn how to care for their babies.

This program is an option for members that have completed 12 months of Postpartum Medicaid. It may also be an option for our members who deliver a baby weighing less than 3 pounds and 5 ounces. If members have any questions or need help understanding the Planning for Healthy Babies program, call Member Services at 1-800-704-1484 (TTY 1-800-255-0056).

Georgia Pathways to Coverage Program

Georgia Pathways to Coverage (Pathways) Program gives Georgians that do not qualify for Medicaid today the chance to get quality healthcare coverage through the Georgia Medicaid program. Pathways members are eligible for most benefits provided to other Medicaid groups, with the exception of Non-Emergency Medical Transportation (NEMT).Georgia Pathways to Coverage members ages 19 and 20 may access NEMT as part of their benefits. Pathways members will need to pay a small copay when you get care, just like other Medicaid members.

Eligibility Requirements

Requirements to join the Georgia Pathways to Coverage program differ from other Georgia Medicaid programs.

To be eligible, you must:

- Be a Georgia resident
- Be a U.S. citizen or legal resident
- Not be eligible for any other category of Medicaid
- Be at least 19 years old and between the ages of 19 and 64
- Have a household income below the poverty line. For Federal Poverty Level information please visit https://aspe.hhs.gov/poverty-guidelines
- Not be incarcerated in a public institution
- Prove that they are doing one or more qualifying activities for at least 80 hours per month

Georgia Pathways members are eligible to receive the same State Plan benefits as other Medicaid groups. Coverage effective date begins the first date of the month in which the member applies.

Maintaining Georgia Pathways to Coverage Eligibility

To remain eligible for Medicaid coverage through Georgia Pathways, it is expected that you complete at least 80 hours of qualifying activities per month, though there is no requirement to report and upload proof of qualifying activity completion monthly. Qualifying activities will only be verified at initial application, annual renewal, and when an individual reports a change.

Members are required to report a change in circumstance to the State, even if that change may impact their eligibility. All Pathways members are required to report a change within ten (10) days.

For any reported change, Pathways members will be reviewed for eligibility for all Medicaid categories of assistance, including Pathways.

You can submit a change request through one of the following options below:

- Gateway Customer Portal (CP): You can access Gateway by visiting www.gateway.ga.gov.
- Paper/Mail: Mail your Change Request to your local Department of Family & Children's Services (DFCS) office.
- In-Person: Visit your local DFCS office.
- Telephone: You may call by phone at 1-877-423-4746 or 711 for those who are deaf, hard of hearing, deaf-blind or have difficulty speaking, to attest to your hours and activities.

Qualifying Activities

Qualifying activities help you keep your Georgia Pathways to Coverage. Each activity includes a description and how it can be verified. You must show that you are completing one or more qualifying activities for at least 80 hours each month.

Qualifying Activity	Description	Verification
Employment	• Includes full- and part-time work	• Electronic verification sources through Employment Income Verification System (EIVS) data • Pay stubs • Written statement from source/employer • Gross earnings (if hourly pay is known) • Timesheet
Self-employment	• Some examples include but are not limited to owning one's own business, cutting grass, collecting cans for recycling, babysitting, selling food items, taxi/food delivery service, etc.	• Electronic verification sources • Signed Standardized Work/Participation Calendar from member indicating hours engaged (Member may fill in a standardized worksheet template indicating total weekly hours worked per client/activity; OR submit a snapshot of their actual work calendar from the reporting month (e.g. Photo of ledger of appointments or screenshot of calendar with work activities)
On-the-job Training	• Training given to a paid employee while he/she is working in the job.	• Statement from supervisor sponsoring the OJT
Job Readiness	• Activities directly related to preparation for employment. Some examples include but are not limited to life-skills training, GED course enrollment, resume building, and habilitation or rehabilitation activities, including substance use disorder treatment. Rehabilitation activities must be determined to be necessary and documented by a qualified medical professional.	• Signed statement from Recognized Agency or Community Resource indicating hours engaged. (Recognized agencies include Georgia Department of Labor Career Center, Workforce Development Board, Georgia Vocational Rehabilitation Agency, Goodwill, and other agencies as authorized by the State)
Job Readiness-Skilled Nursing Facility and Job Readiness-Hospital Stay	• An inpatient hospital stay/short-term skilled nursing facility (SNF) stay is considered a habilitation or rehabilitation activity under job readiness only at initial application. For each day of an inpatient hospital stay/SNF stay, an applicant may claim 4 hours towards their monthly Qualifying Activities requirement.	• Signed statement from habilitation/ rehabilitation institution verifying hours in last four weeks
Community Service	• Approved community service programs are limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural redevelopment, welfare, recreation, public facilities, public safety, and childcare.	• Signed Standardized Work/Participation Calendar • Signed statement on organization letterhead from supervisor verifying hours

Qualifying Activity	Description	Verification
Community Service-Relative Caregiving	• This is when an individual is providing relative caregiving services also known as Structured Family Caregiving within Elderly Disabled Waiver Program (EDWP), Community Care Service Program (CCSP), or Service Options Using Resources in a Community Environment (SOURCE). If you are providing care with two or more providers, please enter a qualifying activity record for each provider.	• Pay stubs • Provider Statement Letter
Vocational Education Training	• Organized educational programs that prepare individuals for employment in current or emerging occupations. Course hour requirements for vocational education training shall be determined by the Department of Community Health (DCH).	• Electronic verification through Technical College System of Georgia (TCSG) data • Official course enrollment for the current semester from the Office of the Registrar • Copy of class schedule for the current semester
Enrollment in an Institution of Higher Education	• The student's workload may include any combination of courses, work, research, or special studies that the institution considers contributing to the individual's full-time status.	• Electronic verification through Board of Regents (BOR) data • Official course enrollment for the current semester from the Office of the Registrar • Copy of class schedule for the current semester
Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program	• Enrollment and active engagement in the GVRA Vocational Rehabilitation program.	• Signed statement from GVRA, dated within four weeks of submission by the applicant • Enrollment letter dated within four weeks of submission by the applicant
SNAP Works Program	• Compliance with the eligibility requirements to receive Supplemental Nutrition Assistance Program (SNAP) benefits under the Work Program/Able-Bodied Adults Without Dependents (ABAWD) program. An individual enrolled in this program may only meet the Pathways qualifying activity requirement if they are completing a work activity.	• System Verified
Parent and Legal Guardian of a Child Under Six Years of Age	• Parents and legal guardians who are primarily responsible for the daily care and well-being of a child younger than six years of age. • The child under six must be currently enrolled in the Medicaid program or must be on the Medicaid application also applying for Medicaid with the adult seeking Pathways coverage.	• System Verified • Proof of Legal Guardianship

Income verification will be determined prior to your enrollment in the Georgia Pathways to Coverage program.

For more information about Georgia Pathways to Coverage Program, call the Member Services department at 1-800-704-1484 or visit www.pshpgeorgia.com/members/georgia-pathways-program.html.

Pregnancy

If members are thinking about having a baby, they should see their doctor right away. Members may need to get their body ready for pregnancy. The doctor will recommend special vitamins.

There are things women can do to have a safe pregnancy. Members should see their doctor about any medical problems they have such as diabetes and high blood pressure. Do not use tobacco, alcohol or drugs now or while pregnant. Limit caffeine intake from coffee, tea, and soft drinks.

Take folic acid every day. Women should have plenty of folic acid in their body before they get pregnant. They should also have plenty of folic acid in their body during the first few months of pregnancy.

Foods that have folic acid in them include orange juice and green vegetables. Beans and peas are good sources of folic acid too, so are fortified breakfast cereals, enriched rice and whole wheat bread. It is very hard to get enough folic acid from food alone. Women should ask their doctor about taking vitamins.

See your doctor as soon as you think you are pregnant!

Some women have had problems with past pregnancies. Some problems include

- Three (3) or more miscarriages.
- Pre-term birth. This means the baby came before 37 weeks of pregnancy.
- Stillborn baby.
- High blood pressure.
- Gestational diabetes.

If members have experienced any of these things they should see their doctor before becoming pregnant.

Dental Health for Pregnant Members

Pregnant women should see a dentist at least one time during their pregnancy. They should let their dentist know that they are pregnant. The dentist needs to know about any medicines they are taking. The dentist may want to wait on giving some treatments.

Smoking and Pregnancy

Smoking is bad for you whether you are pregnant or not. If members are pregnant, smoking adds more risks for the baby. Women who smoke are more likely to have a miscarriage, have their baby too early, or have a stillborn baby. Smoking also puts babies at risk for Sudden Infant Death Syndrome (SIDS).

Peach State Health Plan covers some medications for pregnant members that will help them stop smoking. The medications that Peach State Health Plan covers include the nicotine patch, nicotine gum, nicotine lozenge, and bupropion. Members need a prescription from their doctor for these medications.

To talk to someone about how to quit smoking, please call the Nurse Advice Line. The Nurse Advice Line can be reached at 1-800-704-1484 (TTY/TDD 1-800-255-0056). Members can also call the Georgia Tobacco Quit Line at: 1-877-270-STOP (877-270-7867).

Quality Assessment and Performance Improvement (QAPI) Program

Peach State Health Plan's Quality Assessment and Performance Improvement (QAPI) Program

Peach State has a Quality Assessment and Performance Improvement (QAPI) Program. The QAPI Program is comprehensive. It reviews the quality and safety of care and services provided to Peach State Health Plan's members. The QAPI Program includes and reviews all members, services and care settings such as or primary (preventive) care,sick (specialty) care and emergency care. We conduct projects to improve health and use measurements to see how well we are doing.

Our primary QAPI goal is to improve members' health. We also want to make sure our members are happy with their doctor and Peach State. We involve our members in our QAPI Program. We involve doctors, too. We want our doctors and members to assist with making and tracking our QAPI Program. For questions about the QAPI Program and if we are meeting goals, or to give us feedback or input on our QAPI Program, call the Member Services department at 1-800-704-1484 or visit www.pshp.com.

Peach State has guidelines to help members know when and what type of care they should receive. We have guidelines for prevention and for members with certain medical issues. A few of the guidelines we have are listed below and a printed copy of all of guidelines are available upon request.

- Prenatal and postpartum care (before and after having a baby)
- Asthma
- Diabetes
- Care for children given ADHD medicines
- High blood pressure

As part of our QAPI Program, Peach State Health Plan has incentive programs for providers who encourage our members to get needed care. We incentivize members and providers for members who complete certain annual visits and get needed screenings. In addition, we pay our providers extra money to see you and make sure you have your screenings. If you want more information on the QAPI Program, guidelines, or provider incentives, call the member services department at 1-800-704-1484 (TTY 1-800-255-0056).

Member Community Advisory Board

Peach State Health Plan has a group of members and community partners who meet to provide information on the health plan. This group is called the Member Community Advisory Board. Member Community Advisory Board allows opportunities for Peach State members and Community Partners to provide feedback on existing programs and make suggestions for future programs that will be suitable and appropriate for the populations or other individuals they are representing. These meetings occur four times a year and are held virtually with members from across the state. Peach State Health Plan is committed to improving the health and wellness of our communities. We value your opinion. If you would like to attend a meeting, please contact Member Services at 1-800-704-1484 (TTY 1-800-255-0056).

Grievance Procedures

We hope our members will always be happy with us and our providers. If you are not happy, please let us know. This includes if you do not agree with a decision we have made about your care. A grievance can be filed at any time. Peach State Health Plan will try to resolve your grievance over the phone. If we cannot, you, your legal guardian or your authorized representative can file a grievance. A grievance is an expression of dissatisfaction about any matter other than an Adverse Benefit Determination —see below.

A grievance can be filed if or when:

- You are not satisfied with your provider's services or care
- Your Provider and/or staff have behavior that is not appropriate or courteous
- Your Provider is not as available to you as you would like
- Your Provider does not respect your rights even though you ask them to
- You do not want to give us extra time to respond to a service authorization.
- You want to disenroll from Peach State Health Plan.

A provider cannot file a grievance for you unless you name him or her as your authorized representative.

Your grievance can be filed in writing or you can call us to file your grievance. To file a grievance, you can call Member Services at 1-800-704-1484, TTY 1-800-255-0056. They can provide help with writing and filing a grievance. This includes help with completing any forms or steps related to a grievance. They can also help you if you need this information translated or help those who are blind or have low vision.

Or write us a letter telling us why you are not happy. Be sure to include:

1. Your first and last name.
2. Your Peach State Health Plan Member ID card number.
3. Your address and telephone number.

Mail the letter to:	**Peach State Health Plan** **Attn: Grievance & Appeals Coordinator** **1100 Circle 75 Parkway** **Suite 1100** **Atlanta, GA 30339** **Fax: 1-866-532-8855**

If you would rather have someone speak for you, let us know. Another person can speak on your behalf.

We will send you a letter in ten (10) calendar days letting you know that we received your grievance. We will look into your grievance and try to make a decision right away. If not, we will give you a written decision within ninety (90) calendar days from the date of your grievance request or sooner if your health condition calls for it. A doctor will review your grievance if it has medical issues. If you need help understanding the letter call Member Services at 1-800-704-1484.

If you are hearing impaired call 1-800-255-0056. To get the letter in large font, translated, or on audio, call Member Services.

We cannot treat you differently because you have filed a grievance. Your benefits will not be affected.

Appeals Process

There may be times when Peach State Health Plan will not pay for services that have been recommended by your doctor. If we do this, a letter will be mailed to you and your provider for services that are not approved. This letter is called an Adverse Benefit Determination letter. The adverse benefit determination will explain how you or your doctor (with your consent) or a legal representative of a deceased member's estate can ask for an appeal of the decision.

An adverse benefit determination is when Peach State Health Plan:

- Denies the care you want;
- Decreases the amount of care;
- Ends care that has already been approved;
- Does not allow you to use a different provider to obtain services outside the network if you live in a rural area and only have Peach State Health Plan coverage;
- Does not provide services in a timely manner;
- Takes too long to send you a decision on an appeal or grievance; or
- Denies payment for care. You may have to pay for it.
- Denies your request to dispute a financial liability.

An appeal is a review of an adverse benefit determination. Peach State Health Plan will ensure that the individuals who make decisions on your appeal are individuals who were not involved in any previous level of review or decision-making. These individuals are health care professionals who have the appropriate clinical expertise in treating your condition or disease. You have sixty (60) calendar days from the date on the adverse benefit determination letter to ask for an appeal. We will acknowledge your appeal in writing within ten (10) calendar days of the receipt of your request for an appeal. We will give you a written decision within (30) calendar days of the appeal request. You can request an appeal in writing or orally by calling Member Services toll free at 1-800-704-1484. We will help you with completing any forms or steps related to an appeal. If you are hearing impaired you can call 1-800-659-7487. If you request an oral appeal, a written, signed appeal is not required.

The written appeal request should be sent to the following address:	**Peach State Health Plan** **Attn: Grievance & Appeals Coordinator** **1100 Circle 75 Parkway** **Suite 1100** **Atlanta, GA 30339** **Fax: 866-532-8855**

Expedited Appeal

You, your doctor with your consent, your legal representative with your consent, or the legal representative of a deceased member may want us to make a fast decision. You can ask for an Expedited Administrative Review if you feel that your physical or mental health is at risk. If you feel this is needed, call our Member Services Department at 1-800-704-1484 (TTY 1-800- 255-0056). Peach State Health Plan will look at your request and judge if your request deserves a fast decision. If we decide your case requires a fast decision, we will provide a decision within 72 hours. We will send you a letter with the decision within 72 hours or sooner if your health condition requires it.

If we do not agree that the request for an expedited appeal is needed, we will call you or your doctor right away. We will send you a letter within two (2) calendar days letting you know that the appeal will be reviewed through the regular review process. You may file a grievance if you do not agree with this decision by calling our Member Services department.

Peach State Health Plan may request more time if needed. If this occurs, you will be notified in writing. You may file a grievance if you do not agree with this decision by calling our Member Services department. If you feel you need more time before your expedited appeal is completed, please call 1-800-704-1484 and ask for the appeals department to request an extension for up to 14 calendar days.

Peach State Health Plan will not hold it against you, if you or an authorized representative, your doctor (with your consent) or a legal representative for a deceased member's estate, files an appeal.

Requesting a Hearing with the State

Peach State Health Plan will send you a Notice of Resolution that lets you know what happened to your appeal within (30) calendar days after we receive your appeal. If you are still dissatisfied with our answer, you can request a State Fair Hearing within 120 days of the date on the Notice of Resolution. A State Fair Hearing is a request that allows the State to review Peach State Health Plan's response to your appeal of the adverse benefit determination.

Who may file a State Hearing Appeal?

- Peach State Health Plan Member.
- A person named by the Peach State Health Plan Member.
- A legal representative of a deceased member's estate.

The request for State Fair Hearing should be sent to the following address:	**Peach State Health Plan** **State Fair Hearing Coordinator** **1100 Circle 75 Parkway** **Suite 1100** **Atlanta, GA 30339** **Fax 1-866-224-9327**

You may request to continue to get care that you are currently receiving until the State Fair Hearing is completed. This does not apply to PeachCare for Kids® members. This can be up to (30) calendar days. The request for your benefits to continue must be made within ten (10) calendar days from the date we mailed the adverse benefit determination notice.

You may also ask for free mediation services after you have filed a request for a hearing by calling 404-657-2800.

The decision reached by the State Fair Hearing is final. Peach State Health Plan will comply with the State Fair Hearing decision.

If you need help requesting a State Fair Hearing, or need an interpreter, call Member Services at 1-800-704-1484. If you are hearing impaired please call our TTY line at 1-800-255-0056.

Continuation of Benefits

If you want your benefits to continue while you are waiting your Appeal review or State Fair Hearing you must request a continuation of benefits on or before the later of the following:

- Within ten (10) calendar days from the date we mailed you the adverse benefit determination notice that we would not cover or pay for a service you are already receiving.
- The intended effective date of the proposed adverse benefit determination.
- Before the date we intend to stop or reduce the service, Peach State Health Plan will continue the benefit if:
- You request an appeal or hearing about the termination, suspension, or reduction of a service you are already receiving
- Your appeal or request for hearing was filed on time
- You have requested the continuation of benefits
- The services were ordered by one of Peach State Health Plan's providers
- The covered period that the service is given has not ended.

Peach State Health Plan will continue your benefits until:

- You withdraw the appeal or State Fair Hearing request.
- Ten (10) calendar days after Peach State Health Plan mails the Notice of Resolution, unless you, within 10 calendar days request a State Fair Hearing, you will receive continuation of benefits until a decision is made.
- A decision is made during the Appeal or State Fair Hearing and is not in your favor.
- The time period or service limits of a service you are already receiving has been met.

You may have to pay for the cost of continuation of your benefits if the final decision is not in your favor. If the decisions are made in your favor, Peach State Health Plan will approve and pay for requested services that are needed but were not received during the review of your case as quickly as possible. If the decision is made in your favor and you did receive continuation of benefits during the review of your case, Peach State Health Plan will pay for those services.

Member Rights

All services that are covered and medically necessary may be obtained. All services are provided in the same way to all members. Translation services are available if you need them. This includes sign language. This service is free.

Peach State Health Plan provides covered services to all members without regard to:

- Age
- Disability
- Marital Status
- Race
- Sex
- Income
- Health Status
- Arrest or Conviction history
- Religion
- Sexual Preference
- Color
- Birth Nation
- Military Participation
- Language

You have the right to:

- Appeal any denied service according to state guidelines.
- To have all your personal information including your medical records kept private.
- To be given choices about your healthcare. To know all of your options.
- To never worry about someone forcing you to do something because it makes his or her job easier.
- To talk with your doctor about your medical records; ask for and receive a copy of your medical records at no cost; ask for a summary of your record; request that your medical records be changed or corrected; and have your records kept private
- To be able to request information on the Quality Assessment Performance Improvement Program (QAPI). The QAPI program assures that all members receive quality care and appropriate care. The QAPI program focuses on improving clinical care and non-clinical care which will result in positive health outcomes.
- To file a complaint against a doctor, hospital, the service/care you received, or Peach State Health Plan. If you file a complaint, no one can stop you from continuing to get services.
- To know how to file an appeal review for a decision not to pay for a service or limit coverage
- To know that you or your doctor (if the doctor is your authorized representative) will not be penalized for filing a complaint or appeal review
- To not pay if Peach State Health Plan runs out of money to pay their bills.
- To not pay for healthcare even if Medicaid or PeachCare for Kids® and Peach State Health Plan do not pay the doctor who treated you.
- To have medical services available to you under your Peach State Health Plan in accordance to 42 CFR 438.206 through 438.210 which include the federal access standards.
- To be free from any Peach State Health Plan's debts in the event of insolvency and liability for covered services in which the state does not pay Peach State Health Plan
- To never pay more than what Peach State Health Plan would charge, if Peach State Health Plan has to have someone else manage your care.
- To only have a small co-payment and/or deductible, as allowed by state laws and DCH regulations as described in this Member Handbook.
- To only be billed by a provider if you have agreed to the following:
  - You signed a Member Acknowledgement Statement which makes you responsible for services not covered by Peach State Health Plan
  - You agreed ahead of time to pay for services that are not covered by Peach State Health Plan or Georgia Families.
  - You agreed ahead of time to pay for services from a provider who is not in the network and/or did not receive a prior authorization ahead of time, and requested the service anyway.

- To not be billed for any service covered by Georgia Families. If you get a bill for services Peach State Health Plan should have paid, call Member Services at 1-800-704-1484. When you call, give the Member Services Staff:
  - Date of service
  - Name of provider
  - Total amount of the bill
  - Phone number on the bill
- To be free from receiving bills from providers for medically needed services that were authorized or covered by Peach State Health Plan
- To be treated with dignity, respect and privacy from Peach State Health Plan's staff, providers, physicians and their office staff.
- To have access to a PCP 24 hours a day, 365 days a year for urgent care.
- To choose a Peach State Health Plan doctor (PCP) and be told which hospitals to use.
- To change your doctor without a reason.
- To know about other doctors who can help you with treatment.
- To know your rights and responsibilities with Peach State Health Plan and to call if you have questions or comments or want to make recommendations about our member rights and responsibilities policy
- To get information about Peach State Health Plan's organization and services, providers, physicians, hospitals, policies and procedures, your rights and responsibilities and any changes made.
- To get a second opinion
- To know about all the services you will get. This includes:
  - Hours of operation.
  - How to get emergency care after hours.
  - How to get services if you are out of town.
  - What may not be covered.
  - What has limited coverage.
- To be told if your services change. To be told if we cancel a service.
- To be told if your doctor is no longer available.
- To tell us and your doctor if you need help talking to your doctor. You will not have to pay if you are hearing impaired or if you do not speak English.
- To know all information about your doctor(s) so they can care for you.
- To tell your doctor what you like and don't like about your care.
- To speak with your physician about decisions related to your health care including the right to refuse medical or surgical treatment to the extent of the law and to refuse to take part in medical research.
- To help set treatment plans with your physician, talk to your physician openly and understand your health care options: regardless of cost or benefit coverage.
- To understand your health problems and to speak with your physician about your treatment plans which you and your doctor agree.
- Decide ahead of time the kind of care you want if you become sick, injured or seriously ill by making a living will or advance directive.
- Decide ahead of time the person you want to make decisions about your care if you are not able to by making a durable power of attorney
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or revenge.
- To exercise these rights. Also, to know if you do, it will not change how you are treated by the plan, its doctors and providers.

Member Responsibilities

You have a responsibility:

- To give information about yourself to the Peach State Health Plan organization, providers, physicians, and hospitals in order to help set treatment goals.
- To give information about you and your health to your PCP.
- To understand your health problems and how to take your medicines the right way.
- To ask questions about your health care.
- To follow your instructions for care agreed upon by you and your physician or hospital.
- To help set treatment goals with your PCP.
- To read the Member Handbook to understand how Peach State Health Plan works.
- To call Peach State Health Plan and ask questions when you don't understand.
- To always carry your Peach State Health Plan Member ID card.
- To always carry your Medicaid or PeachCare for Kids® Member ID card.
- To show your ID cards to each provider.
- To schedule appointments for care with your doctor.
- To go to the emergency room when you have an emergency.
- To notify Peach State Health Plan as soon as possible if you go to the emergency room.
- To get a referral from your PCP for specialty care.
- To cooperate with people providing your health care.
- To be on time for appointments.
- To notify the doctor's office if you need to cancel an appointment.
- To notify the doctor's office if you need to change your appointment time.
- To respect the rights of all providers.
- To respect the property of all providers.
- To respect the rights of other patients.
- To not be disruptive in your doctor's office.
- To keep all your appointments. To be on time and cancel within twenty-four (24) hours if you cannot make it.
- To treat your provider with dignity and respect.

Fraud, Waste and Abuse (FWA) Program

A member, provider, or employee should never intentionally provide or submit false information or documentation for personal gain. This is a crime and may be punishable by law. Peach State Health Plan takes waste, abuse, and fraud very seriously. Our FWA program adheres to all State and Federal laws and regulations. Peach State Health Plan's Compliance Department and Centene's Special Investigations Unit work very closely with the Department of Community Health and the Georgia Medicaid Fraud Control Unit to monitor and prosecute health care fraud.

If you suspect or witness health care fraud committed by a provider, member, or employee, please contact Peach State Health Plan's Compliance Department at:	**Peach State Health Plan Office of Compliance** **1100 Circle 75 Parkway** **Suite 1100** **Atlanta, GA 30339** **PeachStateCompliance@centene.com** **Phone number: 1-866-685-8664**

Authority and Responsibility

Peach State Health Plan is committed to identifying, investigating, and prosecuting those who commit health care fraud. Peach State Health Plan's Vice President of Compliance has the overall responsibility and authority for carrying out the provisions of the Compliance and FWA programs. Or you can tell the state of Georgia about it.

Here is the state's address and phone number:	**Department of Community Health** **Office of Inspector General, Program Integrity Unit** **2 Martin Luther King Jr. Dr, SE** **East Tower, 19th Floor** **Atlanta GA 30334** **1-800-533-0686** **1-404-463-7590**

Physician Reimbursement

As a member, you may ask how we pay our providers. You may also ask if the way we pay them affects services. We will never pay a physician to withhold care. Call the Member Services Department at 1-800-704-1484. You may ask about our payment arrangements. Our providers may also be paid more as they improve the quality of care and services, improve member satisfaction and or provide needed information to Peach State Health Plan. You can ask if the services that were not done by a physician or group are covered by an incentive plan. You can also ask about:

- The type of incentive arrangement.
- The percent of withhold or bonus amount.
- The panel size.
- If the patients are pooled and method used.

If you want more information about the different ways our providers may be paid, please call Member Services at 1-800-704-1484. If you are hearing impaired, call our TDD/TTY at 1-800-255-0056.

Disenrollment

New members may change to another plan during the first ninety days of your membership. You may do this without cause. This means you have no reason for your request. After 90 days, you may ask to disenroll without cause every twelve months.

The member may request disenrollment for cause at any time. Reasons why members may request to disenroll at any time:

- Member moves out of Peach State Health Plan's service region.
- Peach State Health Plan does not, due to moral or religious grounds, provide the covered service the member seeks.
- The member needs services and not all services are available within the Peach State Health Plan network. The member, the member's provider, or another provider have determined that not receiving the services would subject the member to unnecessary risk.
- Member requests to be assigned to the same plan as family members.
- Member feels he or she received poor care.
- A Peach State Health Plan provider cannot address the member's health care needs.
- Member feels he or she received poor access to services.

Reasons why Peach State Health Plan may request disenrollment at any time:

- Member is no longer eligible for Medicaid or PeachCare for Kids®.
- Member is disenrolled by the Georgia Department of Community Health (DCH).
- Member allows someone else to use his or her Peach State Health Plan ID card.

- Member does not have a good relationship with providers.
- Member does not follow medical advice.
- Member tries to hurt other patients or make it hard for other patients to get the care they need.
- Member moves out of service region.
- Member is in prison.
- Member dies.
- Member is placed in a long term nursing facility, state institution or intermediate care facility for the mentally disabled.

Peach State Health Plan does not discriminate against our members. Reasons why Peach State Health Plan may not request disenrollment:

- Member has adverse change in health status.
- Member has missed appointments.
- A member's use of medical services.
- Member has diminished mental capacity.
- A member's pre-existing medical condition.
- A member has uncooperative or disruptive behavior because of his or her special needs.
- A member does not comply with their doctor's plan of care.
- A member files a grievance against Peach State Health Plan.

Reinstatement

If a member loses medical coverage but the coverage is reinstated within 60 days, they will be placed back in Peach State Health plan. As our member, we will send you a letter and a new ID card within 7 calendar days after you become eligible. You can keep your old doctor or you may pick a new doctor. Call our Member Services Department at 1-800-704-1484 if you have questions about your eligibility with Peach State Health Plan.

Advance Directives

You have the right to make decisions about your medical care. You have the right to accept or refuse medical or surgical treatment. You also have the right to plan and direct the types of care you may receive in the future.

This will help if you become unable to express your wishes. You may do this by completing a form. This form is called an Advance Directive for Health Care form or "advance directive". You should talk to your doctor about your wishes.

Minors no longer under the care of their parents and members over 18 years of age have rights under the Georgia Advance Directive for Health Care Act. There are three parts to the Georgia Advance Directive for Health Care Act:

- Part one lets you choose a person to make decisions for you when you cannot make them yourself; this person is called a health care agent.
- Part two lets you make choices about getting the care you want; about stopping or continuing life support; and about accepting or refusing nutrition if you are too sick to decide for yourself.
- Part three lets you choose someone you appoint as your guardian if a court says this is needed.

You can get a copy of the advance directive in several ways:

- Ask your doctor - Online at www.aging.dhr.georgia.gov - Call our Member Services department at 1-800-704-1484 (TTY 1-800-255-0056)	- Write or call: **Georgia Division of Aging Services** **47 Trinity Ave. S.W.** **Atlanta, GA 30334** **1-404-657-5258**

You should give a copy of the form with your wishes to your doctor. You should also give a copy to any person who you give permission to make decisions for you. Take a copy with you when you go to the doctor or hospital. You can change your mind anytime. If you do, tell your doctor to remove the form from your medical record. You can also make changes to your directive as you see fit. If you want to make changes, fill out and sign a new form.

If you need help you can talk to your doctor, or call our Member Services Department. We can be reached at 1-800-704-1484. If your directive is not being followed you may file a complaint.	**Georgia Department of Community Health** **Healthcare Facilities Regulations** **2 Martin Luther King Jr. Dr, SE** **East Tower, 17th Floor** **Atlanta GA 30334** **Phone number: 404-657-5700**

Affirmative Statement

Peach State Health Plan does not reward or pay its group of providers, or employees for completing medical use reviews. They do not pay its providers or employees to deny utilization reviews. Use decisions are based on the following reasons:

- Services are medically needed
- Services are covered by Medicaid and PeachCare for Kids®

Our systems allow us and our partners to:

- Identify
- Track
- And monitor the care given

This process ensures that you, our member, receive the right healthcare. We care about your health and want you to get better. We use certain methods to make sure that you receive the best healthcare for your condition. Those processes are listed below:

- Watching for under and over use of services - best course of action is taken if this occurs
- Systems in place to support the study of medical use measurements
- Detecting possible quality of care issues
- Putting into action intervention plans
- Measuring the success of the actions taken
- Processes to support stability of care across the health care field

If you need help understanding this information, call the Member Services Department at 1-800-704-1484 (TTY 1-800-255-0056)

Georgia Health Information Network (GaHIN)

Peach State Health Plan works with the Georgia Health Information Network (GaHIN) to share our member's health information in a safe and secure way. GaHIN connects Georgia hospitals, doctors, and other healthcare partners through a protected electronic network. Members can decide to opt-out at any time by completing a form from their doctor. No doctor can share a member's health information through GaHIN if the member has opted out.
Visit www.gahin.org to learn more about GaHIN.

Connecting Your Healthcare:

NEW OPTIONS FOR MANAGING YOUR DIGITAL HEALTH RECORDS

On July 1, 2021, a new federal rule named the Interoperability and Patient Access Rule (CMS 9115 F) made it easier for members to get their health records when they need it most. You now have full access to your health records on your mobile device which lets you manage your health better and know what resources are open to you.

Imagine:

- You go to a new doctor because you don't feel well and that doctor can pull up your health history from the past five years.
- You use an up-to-date provider directory to find a provider or specialist.
- That provider or specialist can use your health history to diagnose you and make sure you get the best care.
- You go to your computer to see if a claim is paid, denied or still being processed.
- If you want, you take your health history with you as you switch health plans.*

**In 2022, members can start to request that their health records go with them as they switch health plans.*

THE NEW RULE MAKES IT EASY TO FIND INFORMATION ON: **

- claims (paid and denied)
- specific parts of your clinical information
- pharmacy drug coverage
- healthcare providers

***You can get information for dates of service on or after January 1, 2016.*

For more information, visit your online member account.

Notice of Privacy Practices

EFFECTIVE MAY 5, 2023

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

For help to translate or understand this, please call 1-800-704-1484. Hearing impaired TTY 1-800-255-0056.

Si necesita ayuda para traducir o entender este texto, por favor llame al telefono. 1-800-704-1484. (TTY 1-800-255-0056).

Interpreter services are provided free of charge to you.

Covered Entities Duties

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

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

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

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

We will make any revised Notices available, as appropriate, via a delivery method such as the Member Handbook, website, or a separate mailing.

Please note: You will also receive a Privacy Notice from the State of Georgia with its rules for your health records. Other health plans and providers may have other rules when using or sharing your health records. We ask that you get a copy of their Privacy Notices and read them.

Internal Protections of Oral, Written and Electronic PHI:

Peach State Health Plan protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI. We are also committed in keeping your race, ethnicity, and language (REL), and sexual orientation and gender identity (SOGI) information confidential.

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

Permissible Uses and Disclosures of Your PHI

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

Treatment – We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.

Payment – We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include:

- processing claims
- determining eligibility or coverage for claims
- issuing premium billings
- reviewing services for medical necessity
- performing utilization review of claims

HealthCare Operations – We may use and disclose your PHI to perform our healthcare operations. These activities may include:

- providing customer services
- responding to complaints and appeals
- providing care management and care coordination
- conducting medical review of claims and other quality assessment
- Improvement activities

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

This information helps us to:

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

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

In our healthcare operations, we may disclose PHI to business associates. We will have written agreements to protect the privacy of your PHI with these associates. We may disclose your PHI to another entity that is subject to the federal Privacy Rules. The entity must also have a relationship with you for its healthcare operations. This includes the following:

- quality assessment and improvement activities
- reviewing the competence or qualifications of healthcare professionals
- care management and care coordination
- detecting or preventing healthcare fraud and abuse.

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

Other Permitted or Required Disclosures of Your PHI

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

Underwriting Purposes – We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.

Appointment Reminders/Treatment Alternatives – We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.

As Required by Law – If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.

Public Health Activities – We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness of products or services under the jurisdiction of the FDA.

Victims of Abuse and Neglect – We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.

Judicial and Administrative Proceedings – We may disclose your PHI in judicial and administrative proceedings. We may also disclose it in response to the following:

- an order of a court
- administrative tribunal
- subpoena
- summons
- warrant
- discovery request
- similar legal request.

Law Enforcement – We may disclose your relevant PHI to law enforcement when required to do so. For example, in response to a:

- court order
- court-ordered warrant
- subpoena
- summons issued by a judicial officer
- grand jury subpoena

We may also disclose your relevant PHI to identify or locate a suspect, fugitive, material witness, or missing person.

Coroners, Medical Examiners and Funeral Directors – We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.

Organ, Eye and Tissue Donation – may disclose your PHI to organ procurement organizations. We may also disclose your PHI to those who work in procurement, banking or transplantation of:

- cadaveric organs
- eyes
- tissues

Threats to Health and Safety – We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.

Specialized Government Functions – If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI:

- to authorized federal officials for national security
- to intelligence activities
- the Department of State for medical suitability determinations
- for protective services of the President or other authorized persons

Workers' Compensation – We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.

Emergency Situations – We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previous identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.

Inmates – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.

Research – Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

Sale of PHI – We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.

Marketing – We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

Psychotherapy Notes – We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or healthcare operation functions.

Individuals Rights

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

Right to Revoke an Authorization – You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.

Right to Request Restrictions – You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.

Right to Request Confidential Communications – You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.

Right to Access and Receive Copy of your PHI – You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

Right to Amend your PHI – You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Right to Receive an Accounting of Disclosures – You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes

of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.

Right to File a Complaint – If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice.

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

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

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

Contact Information

If you have any questions about this Notice, our privacy practices related to your PHI or how to exercise your rights you can contact us in writing or by phone using the contact information listed here:	**Peach State Health Plan** **Attn: Privacy Official** **1100 Circle 75 Parkway** **Suite 1100** **Atlanta, GA 30339** **1-800-704-1484 (TTY 1-800-255-0056)**

PSHP Statement of Non-Discrimination

Peach State Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). Peach State Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

Peach State Health Plan:

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 Peach State Health Plan at 1-800-704-1484 (TTY/TDD 1-800-255-0056).

If you believe that Peach State Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:	**Attn: 1557 Coordinator** **PO Box 31384** **Tampa, FL 33631** **Phone No.: 1-855-577-8234 (TTY: 711)** **Fax: 1-866-388-1769** **Email:** SM_Section1557Coord@centene.com

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

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

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

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html

This notice is available at Peach State Health Plan website: https://www.pshpgeorgia.com/statement-of-non-discrimination.html

Peach State Health Plan Service Map

Region	Counties
Atlanta	Barrow, Bartow, Butts, Carroll, Cherokee, Clayton, Cobb, Coweta, DeKalb, Douglas, Fayette, Forsyth, Fulton, Gwinnett, Haralson, Henry, Jasper, Newton, Paulding, Pickens, Rockdale, Spalding, Walton
Central	Baldwin, Bibb, Bleckley, Chattahoochee, Crawford, Crisp, Dodge, Dooly, Harris, Heard, Houston, Johnson, Jones, Lamar, Laurens, Macon, Marion, Meriwether, Monroe, Muscogee, Peach, Pike, Pulaski, Talbot, Taylor Telfair, Treutlen, Troup, Twiggs, Upson, Wheeler, Wilcox, Wilkinson.
Southwest	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Clay, Clinch, Coffee, Colquitt, Cook, Decatur, Dougherty, Early, Echols, Grady, Irwin, Lanier, Lee, Lowndes, Miller, Mitchell, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Terrell, Thomas, Tift, Turner, Webster, Worth.
North	Banks, Catoosa, Chattooga, Clarke, Dade, Dawson, Elbert, Fannin, Floyd, Franklin, Gilmer, Gordon, Habersham, Hall, Hart, Jackson, Lumpkin, Madison, Morgan, Murray, Oconee, Oglethorpe, Polk, Rabun, Stephens, Towns, Union, Walker, White, Whitfield
East	Burke, Columbus, Emanuel, Glascock, Greene, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Putnam, Richmond, Taliaferro, Warren, Washington, Wilkes
Southeast	Appling, Bacon, Brantley, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Evans, Glynn, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Pierce, Screven, Tattnall, Toombs, Ware, Wayne

Definitions

Appeal: A request for your health insurance plan to review a decision that denies a benefit or payment.

Co-payment: The part of the cost members pay for certain service or items. This is a set amount.

Durable medical equipment (DME): Equipment and supplies ordered by a health care provider for everyday or continued use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency medical condition: An illness, injury, symptom or condition so serious that a reasonable person would look for care right away to avoid severe harm.

Emergency medical transportation: Ambulance services for an emergency medical condition.

Emergency room care: Emergency services you get in an emergency room.

Emergency services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation services: Health care services that help you keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health insurance: A contract that requires your health insurer to pay some or all of your health care costs.

Home health care: Health care services a person receives at home.

Hospice services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital outpatient care: Care in a hospital that usually doesn't require an overnight stay.

MH Parity "Medical necessity," "medically necessary care," or "medically necessary and appropriate" means: With respect to the treatment of a mental health or substance use disorder, a service or product addressing the specific needs of that patient for the purpose of screening, preventing, diagnosing, managing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is:

- In accordance with the generally accepted standards of mental health or substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration; and
- Not primarily for the economic benefit of the insurer, purchaser, or for the convenience of the patient, treating physician, or other health care provider.

Physical Health "Medical necessity," "medically necessary care," or "medically necessary and appropriate" means: Care based upon generally accepted medical practices in light of conditions at the time of treatment which is:

- Appropriate and consistent with the diagnosis and the omission of which could adversely affect or fail to improve the eligible enrollee's condition;

- Compatible with the standards of acceptable medical practice in the United States;
- Provided in a safe and appropriate setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the eligible enrollee or the convenience of the health care provider or hospital; and
- Not primarily custodial care, unless custodial care is a covered service or benefit under the eligible enrollee's evidence of coverage.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating provider: A provider who doesn't have a contract with your health plan to provide services to you.

Physician services: Health care services a doctor provides or coordinates.

Plan: A benefit provided to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Participating provider: A provider who has a contract with your health plan to provide services to you.

Premium: The amount you pay for your health insurance every month.

Prescription drug coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription drugs: Drugs and medications that by law require a prescription.

Primary care physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary care provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access health care services.

Provider: A health professional who provides health care services.

Rehabilitation services and devices: Health care services or supplies that help you keep, get back, or improve skills and functioning for daily living. The skills may have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled nursing care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Urgent care: Care for an illness, injury or condition serious enough that a reasonable person would look for care right away, but not so severe it requires emergency room care.

Language Assistance

You can get free help in your language. Peach State Health Plan offers language assistance, including written and spoken language support, as well as auxiliary aids and services. Large font, and other alternative formats are also available to you at no cost. Need help? Call Member Services at **1-800-704-1484**. If you have a hearing or speech disability, call **TTY/TDD 1-800-255-0056**.

Español (Spanish):

Puede obtener ayuda gratuita en su idioma. Peach State Health Plan brinda asistencia lingüística, que incluye apoyo tanto en forma escrita como oral, además de ayudas y servicios auxiliares. También tiene a su disposición, sin costo alguno, letra grande y otros formatos alternativos. ¿Necesita ayuda? Llame a Servicios para Miembros al **1-800-704-1484**. Si tiene una discapacidad auditiva o del habla, llame al **TTY/TDD 1-800-255-0056**.

Tiếng Việt (Vietnamese):

Quý vị có thể được trợ giúp miễn phí bằng ngôn ngữ của quý vị. Peach State Health Plan cung cấp hỗ trợ ngôn ngữ, bao gồm hỗ trợ ngôn ngữ viết và nói, cũng như các dịch vụ và trợ giúp bổ sung. Phông chữ lớn và các định dạng thay thế khác cũng được cung cấp miễn phí cho quý vị. Cần hỗ trợ? Hãy gọi Dịch Vụ Hội Viên theo số **1-800-704-1484**. Nếu quý vị bị khiếm thính hay khiếm thanh, hãy gọi **TTY/TDD 1-800-255-0056**.

简体中文 (Mandarin):

您可以获得以您的母语提供的免费帮助。桃州（Peach State）**健康**计划提供语言帮助，包括书面和口头语言支持，以及辅助工具和服务。您还可以免费获得大字体和其他替代格式。需要帮助？请致电 **1-800-704-1484** 联系会员服务部。如果您有听力或语言障碍，请拨打 **TTY/TDD 1-800-255-0056**。

繁體中文(Cantonese):

您可以免費獲得母語幫助。桃州健康計畫提供語言幫助，包括書面和口頭語言支援，以及輔助工具和服務。您還可以免費獲得大字體和其他替代格式。需要幫助嗎？請致電 1-800-704-1484 聯絡會員服務。如果您有聽障或語障，請撥打 TTY/TDD 1-800-255-0056。

한국어(Korean):

원하는 언어로 무료 지원을 받을 수 있습니다. Peach State Health Plan은 문서 및 음성 언어 서비스를 포함한 언어 지원을 비롯하여 보조 기기와· 서비스를 제공합니다. 큰 글자본을 비롯해 다양한 대체 서식도 무료로 제공됩니다. 도움이 필요하세요? 회원 서비스**(1-800-704-1484)**로 연락해 주세요. 청각 또는 언어 장애가 있으시면 **TTY/TDD 1-800-255-0056**번으로 연락해 주세요.

Igbo:

Ị nwere ike inweta enyemaka n'efu n'asụsụ gị. Peach State Health Plan na-enye enyemaka asụsụ, gụnyere enyemaka asụsụ nke odide na nke nsụgharị okwu, yana ngwa nziritaozi na ọrụ enyemaka. Mkpụrụ edemede ukwu, nakwa ụdị ndị ọzọ dịkwara gị na-akwụghị ụgwọ. Ịchọrọ enyemaka? Kpọọ Onye Enyemaka Ndị Otu na **1-800-704-1484**. Ọ bụrụ na ị nwere nsogbu n'ikwu okwu maọbụ ịnụ ihe, kpọọ **TTY/TDD 1-800-255-0056**.

Français (French):
Vous pouvez recevoir une assistance gratuite dans votre langue. Le Projet sanitaire Peach State Health propose une assistance linguistique, notamment un appui linguistique écrit et oral, ainsi que des aides et des services auxiliaires. Une grande police de caractères et d'autres formats alternatifs sont également possibles sans frais. Besoin d'aide ? Appelez les Services aux adhérents au **1-800-704-1484**. Si vous présentez un handicap auditif ou d'élocution, appelez par téléscripteur/ATS au **1-800-255-0056**.

Anglè (French-Creole):
Ou ka jwenn èd gratis nan lang ou. Plan Sante Peach State la ofri asistans lang, ki gen ladan sipò lang alekri ak aloral, ak asistans ak sèvis oksilyè tou. Tèks an gwo karaktè ak lòt fòma disponib pou ou tou gratis. Ou bezwen èd? Rele Sèvis Kliyantèl la nan **1-800-704-1484**. Si ou genyen yon andikap pou tande oswa nan langaj, rele TTY/TDD nan **1-800-255-0056**.

हिंदी (Hindu):
आप अपनी भाषा में मुफ्त सहायता प्राप्त कर सकते हैं। Peach State Health Plan द्वारा लिखित और मौखिक भाषा सहायता और सहायक उपस्करण तथा सेवाओं सहित भाषा सहायता उपलब्ध कराई जाती है। आपके लिए बड़े अक्षर और वैकल्पिक फॉर्मेट बिना अतिरिक्त लागत के उपलब्ध हैं। सहायता चाहिए? **1-800-704-1484** पर सदस्यता सेवा को कॉल करें। यदि आपको सुनने या बोलने में समस्या है, तो **TTY/TDD 1-800-255-0056** पर कॉल करें।

አማርኛ (Amharic):
በራስዎ ቋንቋ ነጻ እርዳታ ማግኘት ይችላሉ። የፒች ግዛት የጤና እቅድ የጽሁፍ እና የንግግር ድጋፍን ጨምሮ የቋንቋ ድጋፍን እንዲሁም አጋዥ መሳሪያዎችን እና አገልግሎቶችን ይሰጣል። እንዲሁም ትልቅ ቅርጸ-ቁምፊ እና ሌሎች አማራጭ ቅርጸቶች ለእርስዎ ያለምንም ወጪ ይገኛሉ። እርዳታ ይፈልጋሉ? በ **1-800-704-1484** ለአባል አገልግሎት ይደውሉ። የመስማት ወይም የመናገር እክል ካለብዎ ወደ **TTY/TDD 1-800-255-0056** ይደውሉ።

Gujarati:
તમને તમારી ભાષામાં નિઃશુલ્ક મદદ મળી શકે છે. પીચ સ્ટેટ હેલ્થ પ્લાન (Peach State Health Plan) લખવા અને બોલવાના કૌશલ્ય સંબંધિત ભાષા સંબંધિત સહાયની સાથે-સાથે સહાયક સહાય અને સેવાઓ પ્રદાન કરે છે. મોટા અક્ષરો અને અન્ય વૈકલ્પિક ફોર્મેટ પણ તમારા માટે કોઈપણ ખર્ચ વિના ઉપલબ્ધ છે. મદદની જરૂર છે? સભ્ય સેવાઓને **1-800-704-1484** પર કૉલ કરો. જો તમને સાંભળવા અથવા બોલવા સંબંધિત અક્ષમતા હોય, તો **TTY/TDD 1-800-255-0056** પર કૉલ કરો.

Português (Portuguse):
Pode obter ajuda gratuita no seu idioma. O Peach State Health Plan (plano de saúde Peach State - estado da Geórgia) proporciona assistência linguística, incluindo apoio linguístico escrito e oral, bem como ajudas e serviços auxiliares. Os formatos de letra grande e outros formatos alternativos também estão disponíveis gratuitamente. Precisa de ajuda? Contacte os Serviços para Membros através do número **1-800-704-1484**. Se tiver uma deficiência auditiva ou verbal, ligue para **TTY/TDD 1-800-255-0056**.

Deutsch (German):
Sie können kostenlose Hilfe in Ihrer Sprache in Anspruch nehmen. Der Peach State-Krankenversicherungsplan bietet Sprachunterstützung an, einschließlich geschriebener und gesprochener Sprachunterstützung, ebenso wie zusätzliche Hilfsangebote und Dienste. Große Schrift und andere alternative Formate stehen Ihnen ebenfalls ohne Zusatzkosten zur Verfügung. Benötigen Sie Hilfe? Rufen Sie den Mitgliederservice unter **1-800-704-1484** an. Wenn Sie an einem Gehörschaden oder einer Sprechstörung leiden, rufen Sie an unter **TTY/TDD 1-800-255-0056**.

ఇంగ్లిష్ (Telegu):
మీరు మాట్లాడే భాషలో ఉచితంగా సహకారం పొందుతారు. Peach State హెల్త్ ప్లాన్ భాషా సాయాన్ని అందిస్తుంది, ఇందులో రాతపూర్వక మరియు మౌఖిక భాషా మద్ధతు, అలాగే సహకారం మరియు సేవలు అందించబడతాయి. పెద్ద ఫాంట్ మరియు ఇతర ప్రత్యామ్నాయ ఫార్మెట్‌లు కూడా మీకు ఉచితంగా లభ్యమవుతాయి. మీకు సహాయం కావాలా? సభ్యుల సేవల నిమిత్తం **1-800-704-1484**కు కాల్ చేయండి. మీకు వినికిడి లేదా మాట్లాడటంలో లోపం ఉంటే, **TTY/TDD 1-800-255-0056** కు కాల్ చేయండి.

Anglè (Haitan-Creole):
Ou ka jwenn èd gratis nan lang ou. Plan Sante Peach State la ofri asistans lang, ki enkli sipò lang alekri ak oral, e tou asistans ak sèvis oksilyè. Tèks an gwo karaktè ak lòt fòma disponib pou ou tou gratis. Bezwen èd? Rele Sèvis Kliyantèl la nan 1-800-704-1484. Si ou genyen yon andikap tande oswa langaj, rele TTY/TDD nan 1-800-255-0056.

العربية اللغة **(Arabic):**
يمكنك الحصول على مساعدة مجانية بلغتك. يقدم لك برنامج Peach State Health Plan خدمات المساعدة اللغوية، بما في ذلك الدعم اللغوي المكتوب والمنطوق، بالإضافة إلى الوسائل والخدمات المساعدة. كما يُوفر لك الطباعة بخط كبير وتنسيقات بديلة أخرى بدون . إذا كنت تعاني من إعاقة في السمع أو **1-800-704-1484**أي تكلفة. هل تحتاج إلى المساعدة؟ اتصل بخدمات الأعضاء على النطق، فاتصل بخدمةTTY/TDD الرقم: . **1-800-255-0056**:على الرقم

Kiswahili (Swahili):
Unaweza kupata msaada bila malipo katika lugha yako. Mpango wa Afya wa Jimbo la (Peach Peach State Health Plan) unatoa msaada wa lugha, ikiwemo msaada wa lugha ya maandishi na ya mazungumzo, pamoja na huduma saidizi na za ziada. Fonti kubwa, na miundo mingine mbadala pia unaipata bila gharama yoyote. Je, unahitaji msaada? Piga simu ya Huduma za Wanachama kwa **1-800-704-1484**. Ikiwa una ulemavu wa kusikia au kuzungumza, piga simu kwa **TTY/TDD 1-800-255-0056**.

NOTES

1100 Circle 75 Parkway
Suite 1100
Atlanta, GA 30339

www.pshp.com

¿Necesita ayuda para entender esto? Si la necesita, llame a la línea de Servicios para los miembros de Peach State Health Plan al 1-800-704-1484. Si es una persona con problemas de audición, llame a nuestro TTY 1-800-255-0056. Para obtener esta información en letra más grande o que se la lean por teléfono, llame a Servicios para los Miembros.

PSHP_040626_0130, GA_11705