Medicaid Member Handbook
Dear Member:

Welcome to Better Health! We are glad to have you as a member of our family.

This is your Member Handbook. It will help you answer any questions you may have about your health plan. Please take the time to learn about your benefits and how to use the Plan services. This will help you to make better choices.

If you need anything please call us. Use the Member Services phone number on the back of your ID card (1-800-514-4561). You can also go to www.betterhealthflorida.com. Representatives are here to help, 8 a.m. to 7 p.m., Monday through Friday. If you need help after hours, leave a voice message. A representative will call you back the next business day. You may have an emergency or cannot talk to your doctor. Please call 911 or go to the emergency room.

Always go to the Department of Children and Family Services (DCF) when it’s time to recertify your Medicaid plan. This is important for you and your family. You need your Medicaid plan to get your healthcare. If your Medicaid coverage is about to end, please call Access Florida toll free at 1-866-762-2237.

In this handbook, the “Plan” or “BET” means Better Health.

Welcome to our Better Health family.

Better Health

Better Health, Inc. is a Managed Care Plan with a Florida Medicaid contract.

The benefit information provided is a brief summary, not a complete description of benefits. For more information contact the Managed Care Plan. Limitations, copayments, and restrictions may apply. Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change.
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Member Handbook Information
This handbook is available in Spanish, large print, or audio recording. Please call Member Services if you need a special format. We want to make sure you understand your benefits.

Información Del Manual Del Cliente
Esta Guía está disponible en Español, en forma impresa grande o una grabación de audio. Por favor llamar al departamento de Servicio al Cliente si usted necesita un formato especial. Queremos asegurarnos que usted entiende sus beneficios.
IMPORTANT PHONE NUMBERS AND WEBSITES

Plan Address
Better Health
1701 Ponce de Leon Boulevard
Coral Gables, Florida 33134

Member Services Department
Better Health 1-800-514-4561
Florida Relay (TDD/TTY) 711
www.betterhealthflorida.com

Fax Numbers
Better Health 1-877-915-0553

Access Florida
Recertify Medicaid coverage or locate your local offices 1-866-762-2237
Florida Relay 711 or TTY 1-800-955-8771
www.myflorida.com/accessflorida

Choice Counseling
Main Phone: 1-877-711-3662
TDD: 1-866-467-4970
www.flmedicaidmanagedcare.com

Beneficiary Assistance Program
1-850-412-4502

Agency Consumer Complaint Hotline
1-888-419-3456

Fraud and Abuse Hotline
1-888-419-3456
www.floridaoig.com/reportfraud.htm

24-Hour Mental Health Crisis Line
305-630-1400
1-800-221-5487

Department of Children and Families (DCF) Area Offices
Central Region: 407-317-7000
Hardee, Highlands, Polk 863-534-7100
Southeast Region: 561-837-5078
Broward 954-375-6092
SunCoast Region: 813-558-5500
Hillsborough, Manatee 877-595-0384
www.MyFLFamilies.com

Medicaid Fair Hearing Office
Department of Children and Families
Office of Appeal Hearings
Building 5, Room 255
1317 Winewood Boulevard
Tallahassee, FL 32399-0700
Phone: (850) 488-1429
Fax: (850) 487-0662
Email: Appeal_Hearings@DCF.state.fl.us

Medicaid Area Offices
Area 6 - Hillsborough, Highlands, Hardee, Polk, Manatee 813-350-4800
1-800-226-2316
Fax 813-673-4588
Area 10 - Broward 954-958-6500
Fax 954-202-3220

Dental Services
1-800-964-7811

Laboratory Services
1-866-697-8378

Transportation Services
1-866-201-9970

National Domestic Violence Hotline
1-800-799-7233

Poison Control
1-800-222-1222

Aging and Disabilities Resource Centers
1-800-96 ELDER (1-800-963-5337)
http://elderaffairs.state.fl.us/doea/arc.php
ENROLLMENT INFORMATION

Better Health (BET) is a Provider Service Network (PSN). A PSN is a Plan made up of a group of healthcare providers. Better Health is in Broward, Hardee, Highlands, Hillsborough, Manatee, and Polk Counties. We give access to healthcare to Medicaid recipients.

Conditions of Enrollment

If you get Medicaid from one of the following programs, you MUST enroll with a Managed Care Plan:

- Temporary Assistance for Needy Families (TANF)
- Supplemental Security Income (SSI)
- Hospice
- Low Income Families and Children
- Institutional Care
- Medicaid (MEDS) – Sixth Omnibus Budget Reconciliation Act (SOBRA) for children born after September 30, 1983 (age 18 to 19)
- MEDS AD (SOBRA) for aged and disabled
- Protected Medicaid (aged and disabled)
- Dual Eligibles (Medicare and Medicaid-FFS)
- Dual Eligibles – Part C – Medicare Advantage plans only
- The Florida Assertive Community Treatment Team (FACT Team)

If you are enrolled in any of the following programs, you may VOLUNTARILY enroll in a Managed Care Plan:

- SSI (enrolled in developmental disabilities home and community-based waiver)
- MEDS (SOBRA) for children under one year old and income between 185% and 200% Federal Poverty Level (FPL)
- MEDS AD (SOBRA) (for aged and disabled) enrolled in DD home and community-based waiver
- Recipients with other creditable coverage excluding Medicare
- Recipients residing in residential community facilities operated through DJJ or mental health treatment facilities defined in FS 394.455(32)
- Residents of DD centers including Sunland and Tachacale
- Refugee assistance
If you receive Medicaid coverage through one of the following programs, you are NOT ALLOWED to enroll in a Managed Care Plan:

- Presumptively eligible pregnant women
- Family planning waiver
- Women enrolled through the Breast and Cervical Cancer program
- Emergency shelter/Department of Juvenile Justice (DJJ) residential
- Emergency assistance for aliens
- Qualified Individual (QI) 1
- Qualified Medicare Beneficiary (QMB)
- Special Low-Income Beneficiaries (SLMB)
- Working disabled
- Children receiving services in a Prescribed Pediatric Extended-Care Center (PPEC)
- Recipients in the Health Insurance Premium Payment (HIPP) program

You can also call Choice Counseling toll free at 1-877-711-3662. They can let you know if you are required or allowed to enroll in a Managed Care Plan.

**Enrollment**

You must live in our service area to join our Plan. You have 30 days to choose a Plan. If you do not choose a plan in 30 days, the state will choose one for you. You must also choose a Primary Care Physician (PCP) when you choose a Plan. If you do not choose a PCP, a PCP will be assigned to you.

If you are a mandatory enrollee required to enroll in a plan, once you are enrolled in Better Health or the state enrolls you in a plan, you will have 90 days from the date of your first enrollment to try the Managed Care Plan. During the first 90 days you can change Managed Care Plans for any reason. After the 90 days, if you are still eligible for Medicaid, you will be enrolled in the Plan for the next nine months. This is called “lock-in.”

If you choose a Plan at the end of a month, your Plan may not start until the first day of the second month after you make your choice. Medicaid will tell you your start date.

**Open Enrollment Period**

Once a year you will have the chance to change plans. We hope you stay with us!

If you are a mandatory enrollee, the state will send you a letter 60 days before the end of your enrollment year telling you that you can change plans if you want to. This is called “open enrollment.” You do not have to change Managed Care Plans. If you choose to change plans during open enrollment, you will begin in the new plan at the end of your current enrollment
year. Whether you pick a new plan or stay in the same plan, you will be locked into that plan for the next 12 months. Every year you may change Managed Care Plans during your 60-day open enrollment period.

**Newborn Enrollment**

If you think you are pregnant, call your doctor. He or she will refer you to an Obstetrician/Gynecologist (OB/GYN). You should also call the Plan toll free at **1-800-514-4561**. One of our Case Managers will help you get the care you need.

Your doctor and the Plan will notify the Department of Children and Families (DCF) that you are pregnant. The baby can then get a Medicaid ID number.

You can pick a doctor for your baby (Pediatrician). Do this as soon as you know you are pregnant. If you have not selected a doctor, we can help you pick one.

Call us when you have your baby. We will advise DCF. DCF will review your baby’s Medicaid eligibility. They will start the baby’s Medicaid ID number.

Your baby will have benefits under your Plan. Call your DCF case worker to get benefits for your baby.

Your baby will stay on your Plan until:

- he or she is no longer eligible, or
- you disenroll the child.

To start or stop Medicaid coverage for your baby, call your DCF Case Worker at 1-866-762-2237 or the Plan at 1-800-514-4561.

**Prenatal Care and the Unborn Baby’s Medicaid ID Number**

When pregnant, it is important to have regular visits to a doctor. Seeing a doctor early helps to make sure you and your baby are doing well. The Plan covers care for all pregnant women. See your doctor right away if you are pregnant or think you are pregnant. Also tell DCF and the Plan. Letting DCF know you are pregnant will help you get your unborn baby a Medicaid ID number to use when the baby is born.

**Newborn Baby’s Medicaid ID Number Activation Process**

Tell the Plan when your baby is born. Please call the Member Services number on the back of your ID card. Also tell your DCF Case Worker. The DCF Case Worker will enter your baby’s birth in the system. Then you can use your new baby’s ID card for his or her care.
Women, Infants and Children (WIC) Program

The Women, Infants and Children (WIC) Program gives help for:

- All pregnant women
- Breast-feeding women
- Postpartum women
- Infants
- Children up to 5 years of age

You can ask your doctor for a referral to the WIC Program.

Disenrollment

As your Plan it is important for us to know when you are having problems, with care or our doctors. Please call Member Services quickly and let the representative know about the problem you are having. The representative will help you.

You can ask to leave the Plan any time. Medicaid will make the final decision on requests to leave the Plan. Medicaid will send you a letter with your rights and their decision. If you do not like the decision, you can request a Medicaid Fair Hearing. If your request is approved, your end date will be the last day of the month in which your request was received.

If you are a mandatory enrollee and you want to change plans after the initial 90-day period ends or after your open enrollment period ends, you must have a state-approved good cause reason to change plans. The following are state-approved good cause reasons to change Managed Care Plans:

- The enrollee does not live in a region where the Managed Care Plan is authorized to provide services, as indicated in FMMIS.
- The provider is no longer with the Managed Care Plan.
- The enrollee is excluded from enrollment.
- A substantiated marketing or community outreach violation has occurred.
- The enrollee is prevented from participating in the development of his/her treatment plan/plan of care.
- The enrollee has an active relationship with a provider who is not on the Managed Care Plan’s panel, but is on the panel of another Managed Care Plan. “Active relationship” is defined as having received services from the provider within the six months preceding the disenrollment request.
- The enrollee is in the wrong Managed Care Plan as determined by the Agency.
- The Managed Care Plan no longer participates in the region.
- The state has imposed intermediate sanctions upon the Managed Care Plan, as specified in 42 CFR 438.702(a)(3).
• The enrollee needs related services to be performed concurrently, but not all related services are available within the Managed Care Plan network, or the enrollee’s PCP has determined that receiving the services separately would subject the enrollee to unnecessary risk.

• The Managed Care Plan does not, because of moral or religious objections, cover the service the enrollee seeks.

• The enrollee missed open enrollment due to a temporary loss of eligibility.

• Other reasons per 42 CFR 438.56(d)(2) and s. 409.969(2), F.S., including, but not limited to: poor quality of care; lack of access to services covered under the Contract; inordinate or inappropriate changes of PCPs; service access impairments due to significant changes in the geographic location of services; an unreasonable delay or denial of service; lack of access to providers experienced in dealing with the enrollee’s health care needs; or fraudulent enrollment.

If you are a voluntary member you can disenroll from the Plan at any time. To disenroll, you should call Choice Counseling toll free at 1-877-711-3662.

Some Medicaid recipients may change Managed Care Plans whenever they choose, for any reason. To find out if you may change plans, call Choice Counseling at 1-877-711-3662.

You cannot file an appeal of a disenrollment decision if you were disenrolled for any of the following reasons:

• You moved out of the service area
• You lost Medicaid eligibility
• Medicaid determined that you are in an excluded population
• Enrollee death

Loss of Medicaid Eligibility – Reinstatement Process

If you are no longer with Medicaid, you will have to leave the Plan. If you get your Medicaid back within 180 days from the day that you stopped getting Medicaid you will become a Plan member again. This is called a “temporary loss.” You will be given to the same Doctor you had with the Plan. If the Doctor is not available, you will have to pick another Doctor.

If you have a temporary loss of Medicaid eligibility, you will be put back into the Plan you chose. The Plan will send you a letter to remind you to renew your benefits.

Please call Access Florida at 1-866-762-2237. It is important that you get information on when your Medicaid coverage ends. That way you can continue getting your medical services.
MEMBER IDENTIFICATION (ID) CARD

Carry your ID card with you all the time. When you go the doctor or hospital, show your card. Also show your Plan member ID card. DO NOT let anyone use your card or you may be removed from the Plan.

Lost or Stolen Cards, Changes or Corrections

If your ID card is lost or stolen, you can still receive care from your doctors. You will need to call the Member Services department fast to get a new ID card.

Also call Member Services when you need to make changes to the ID card like a name or address change. You also have to report these changes to your Case Worker.

Here’s what’s on the card:

- **Member Name** – the name of the person covered by the Plan.
- **Member Number** – your personal Plan ID number. Your member number is your state-assigned Medicaid ID Number. Please have this number when you call your doctor or call or write to the Plan.
- **Effective Date** – the first day your health benefits start with the Plan.
- **Doctor (PCP) Name** – the name of your Doctor (PCP).
- **Doctor (PCP) Phone Number** – the telephone number of your Doctor (PCP).
- **Behavioral Health Phone Number** – telephone number for behavioral healthcare services.
CULTURAL COMPETENCY REQUIREMENTS -
HELPING YOU TO UNDERSTAND YOUR CARE/FOREIGN LANGUAGE
INTERPRETATION SERVICES

The Plan and its Doctors have to make sure that you have help talking in any language. Your
doctors will help you get translation. This help is free to our members. This service makes sure
you know what need to know about your health and what you need to do.

All doctors follow the Plan’s Cultural Competency plan. This means that your doctor should:
- understand what you believe
- help you understand everything you need to know about your health and what you need
to do.

The Plan will help you if you if:
(a) have any special needs
(b) cannot see well
(c) cannot hear well
(d) cannot read or understand something, and/or
(e) do not speak English

The Plan has a foreign language interpretation service and other systems that can help you for
free. To receive these services, call Member Services toll free at 1-800-514-4561 (or Florida
Relay Services, 711).

YOUR DOCTOR OR PRIMARY CARE PHYSICIAN (PCP)

Choosing Your Doctor (PCP)

When you sign up for the Plan you must pick a doctor. If you do not pick one, the Plan will pick
one for you. You can ask to change your PCP by calling us. You can ask that all your family
members who are on the Plan get care from the same PCP. You may pick a different PCP for
each member of your family.

IMPORTANT! Visit your PCP within the first 3 months of joining the plan. You need to
make an appointment with your PCP, even if you are not sick, for a check-up. You also have to
call your PCP every time you are sick, need medicine and/or need to have tests done. He or she
will make sure that you get the care that you need. Medicaid and the Plan will not pay for any
care or supplies if you go to a doctor that is not on the Plan, or if you don’t call your PCP first;
extcept if you have an emergency or during your continuity of care period. Please see the
Continuation of Care/Transition of Care section in this handbook for more information.
There are some services where you do not have to call your PCP before you get the services. Please refer to the Covered Services section in this Member Handbook to find out what those services are.

If you are pregnant, you may pick a doctor on the Plan as your PCP. He or she will help you get all your medical care while you are pregnant. See your PCP right away if you are pregnant or think you are pregnant to make sure you see an doctor for care while you are pregnant.

**Medical Release Form**

When you go to your PCP, it is important that you sign a Medical Release Form so that he or she can get your medical notes from your last doctor. In your Plan’s new member packet, you will receive a Medical Release Form that you need to fill out. Please fill it out and take it to your first appointment. With this form, your PCP can get your medical information from your last PCP.

**First PCP Appointment**

- Call your PCP’s office and have your member ID number ready.
- Let the PCP’s office know that you are a new member of the Plan.
- When you make an appointment with your PCP tell them what the appointment is for.

**Cancelling an Appointment**

If you cannot go to an appointment, please call your PCP fast. Try to call one day before your appointment.

**Changing Your PCP**

If you want to change your PCP, call Member Services at 1-800-514-4561. Someone will help you find a new PCP or help you change to the PCP you want. They will tell you the date of the change. A new member ID card will be mailed to you. It will have the name and phone number of your new PCP. Please use the new card when seeing your PCP or doctor.

**Notice of Changes**

The Plan will let you know if anything changes with your plan or benefits. We will send you a letter. We will also let you know about your choices.

Tell us if your address changes. Call Member Services if you are moving to another county. We can tell you if you can stay on our Plan or if you need to choose a new Plan. If you can stay on our Plan after your move, we will help you find a new PCP.
Participating Doctors

As a member, you can get information about the doctors that are on our Plan. If you want to find out about your doctor(s), please call the Member Services department.

The Plan has doctors and other types of licensed providers like nurse practitioners, doctor’s assistants and midwives. You can sometimes get care from any of these providers. In some areas when you join the Plan, you can pick a PCP who is in a group or a clinic.

The doctor you pick will help to get you all of your healthcare services. He or she will make sure that you get the care you need. He or she will also send you to other Specialist doctors that belong to the Plan, if you need it.

The Plan will not pay for any care you get from doctors who are not on the Plan; except for emergencies and urgent care or during your continuity of care period. Please see the Continuation of Care/Transition of Care section in this handbook for more information. If a doctor you want to see is not on the Plan, you will need to call our Member Services department to change your doctor to one that does participate with the Plan.

Access and Availability

The Plan’s doctors have to see our members for care as follows:

- Emergency Medical Care – 24 hours a day/7 days a week
- Urgent Care - within one day of a request
- Routine Sick Care - within one week of a request
- Preventive Care - within 30 days of a request
- Routine Specialty Care – within 14 days of a request

CONTINUATION OF CARE/TRANSITION OF CARE

Approvals for Care

You may be getting treatment now. You may have approvals for care made by another plan or by Medicaid. You may have a visit scheduled with your doctor. For the first 60 days, we will accept these approvals. This also includes prescriptions and care from doctors and providers not with Better Health. We will accept the approval until your Better Health PCP looks at the services and decides when we can safely transfer you to a Plan doctor/provider. This may happen before the 60 days. We will need to speak with you to arrange and pay for your care.
Call us right away if you:
- Have an approved authorization
- Are taking medications
- Have an appointment to see a doctor
- Have a test or procedure scheduled

You may be getting behavioral health services now. This may include hospital, mental health, case management services or more. Please call Psychcare toll free at 1-800-221-5487 if you are getting behavioral health services now.

**What Happens When a Doctor Leaves the Plan?**

If your doctor leaves the Plan while you are in active care, you can keep seeing your doctor:
- Until your treatment ends as long as the care or treatment began before the doctor left
- Until you select another Plan doctor

**ROUTINE/PREVENTIVE CHECK-UPS**

Regular check-ups, tests and shots are important. Regular check-ups can help find health problems before they get worse. Learn what you can do to stay healthy. Ask your doctor about health questions you have. Please see the Preventive Health Guidelines section of this handbook. It will show you what tests you need and when to have them.

**The Child Health Check-Up Program**

Your child needs to have check-ups. Please see the Preventive Health Guidelines section of this handbook. As the parent, representative or caregiver of a child, it is up to you to make sure that your child(ren) are seen regularly by their PCP.

The Plan covers the healthcare services and needs of your child. The Plan covers the following Child Health Check-up Program healthcare services needed to prevent diseases:
- Lab tests (including lead screening)
- Unclothed physical exams
- Health and development history
- Routine immunization update
- Nutritional assessments
- Developmental assessments
- Hearing screening
- Dental screening
- Vision screening
Preventive Health Guidelines

The Plan follows the healthcare guidelines listed below. They are based on the U.S. Preventive Services Task Force. Your doctor, the law or other factors may cause the way the Plan covers and pays for some of the screenings, lab work, and shots to change. Please contact the Plan with questions about benefits. Persons at high risk for disease may need more care.

CHILDREN YOUNGER THAN 10 YEARS

Screenings

- **Height/Weight** - Regularly throughout infancy and childhood
- **Blood Pressure** - Periodically* throughout childhood
- **Vision Screening** - Once between ages 3-4
- **T4 and/or TSH** - Optimally between day 2 and 6, but in all cases before discharge from the hospital
- **PKU level** - At birth
- **Lead Test Screening** - Done at 12 and 24 months old; between 24 and 72 months if not previously screened

Immunizations (Shots)

- **DTaP or DTP** - Five immunizations at 2, 4, and 6 months; and between 15-18 months; and once between ages 4-6
- **Polio** - Four immunizations at 2 and 4 months; and between 6-18 months and between ages 4-6
- **MMR** - Two immunizations between 12-15 months; and between ages 4-6. If missed, given by ages 11-12.
- **H. influenza type B (Hib)** - Three or four immunizations, depending on the vaccine, at 2, 4, and 6 months; and between 12-15 months
- **Hepatitis B** - Three immunizations: beginning at age 2 months or at age 6 months (depending on whether or not the vaccine used contains thimerosal). All three immunizations should be completed by age 18 months. If not immunized by age 11, three immunizations given according to your doctor’s recommendations.
- **Pneumococcal Conjugate Vaccine** – Four immunizations done at 2, 4, and 6 months; and between 12-15 months old
- **Varicella** - One immunization between 12-18 months; for older children, if missed, and no history of chicken pox, frequency should be discussed with your doctor.*
Things to Talk to Your Child’s Doctor About:

**Diet and Exercise**
- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity

**Substance Use**
- Effects of passive smoking
- Anti-tobacco message

**Dental Health**
- Baby bottle tooth decay
- Regular dental visits
- Floss, brush and fluoride

**Injury Prevention**
- Child safety car seats
- Bicycle helmet; avoid bicycling near traffic
- Lap and shoulder seat belts
- Smoke detector, flame retardant sleepwear
- Set hot water heater temperature lower than 120°-130°F
- Window and stair guards, swimming pool fence
- Safe storage of drugs, cleaning supplies, toxins, firearms and matches
- Poison control phone number
- CPR training for parents/caregivers

*How often should be discussed with your doctor.

**YOUNG ADULTS 11-24 YEARS**

**Screenings**

- **Height/Weight** - Periodically*
- **Blood Pressure** - Periodically*
- **Papanicolaou (Pap) test** - Every one to three years for sexually active females; or beginning at age 18
- **Chlamydia screening** - Routine screenings recommended for all sexually active females*
- **Rubella serology or vaccination history** - Recommended for all females of child-bearing age
**Immunizations**

- **Tetanus-diphtheria (Td)** - Boosters between ages 11-16; and then every 10 years*
- **HPV (Human Papillomavirus)** – Between ages of 12-26
- **Hepatitis B** - If not previously immunized, one immunization at current (next) visit, one month later, and six months later
- **MMR** - Between ages 11-12 if second dose was not received
- **Varicella** - Between ages 11-12 if susceptible to chicken pox
- **Rubella** - Administered after age 12 females who are not pregnant

**Other Preventions**

**Multivitamins with folic acid** - Females (Planning/capable of pregnancy)

**Diet and Exercise**
- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity
- Adequate calcium intake

**Substance Abuse**
- Avoid underage drinking/illicit drug use
- Avoid tobacco use

**Sexual Behavior**
- Sexually transmitted disease (STD) prevention/abstinence
- Avoid high-risk behavior
- Unintended pregnancy

**Injury Prevention**
- Bicycle/motorcycle/ATV helmets-safety
- Lap and shoulder seat belts
- Smoke detectors
- Safe firearm handling
- Set hot water heater temperature lower than 120°-130°
- CPR training for parents/caregivers

**Dental Health**
- Regular dental visits
- Floss, brush and fluoride

*How often should be discussed with your doctor.
ADULTS 25-64 YEARS

Screenings

- **Height/Weight** - Periodically*
- **Blood Pressure** - Periodically*
- **Total Blood Cholesterol** - Periodically* males between ages 35-64, females between ages 45-64
- **Fecal Occult blood test** - Annually* beginning at age 50
- **Sigmoidoscopy** - Every 3 to 5 years beginning at age 50
- **Clinical breast exam** – Annually, females between ages 50-69
- **Mammogram** - Every one to two years females between ages 50-69*
- **Papanicolaou (Pap) test** - Every one to three years; sexually active females who have not had a hysterectomy

Other Preventions

- **Discuss hormone replacement therapy**-Periodically, peri- and post-menopausal females*
- **Multivitamins with folic acid** – Females (Planning/capable of pregnancy)

Provider Discussion Topics

Diet and Exercise

- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity
- Adequate calcium intake

Substance Abuse

- Avoid alcohol/drug use
- Avoid tobacco use

Sexual Behavior

- Unintended pregnancy
- Sexually transmitted disease (STD) prevention
- Avoid high-risk behavior
**Injury Prevention**
- Bicycle/motorcycle/ATV helmets-safety
- Lap and shoulder seat belts
- Smoke detectors
- Safe firearm handling
- CPR training for parents/caregivers

**Dental Health**
- Regular dental visits
- Floss, brush and fluoride

*How often should be discussed with your doctor.

**ADULTS 65 YEARS AND OLDER**

**Screenings**

- **Height/Weight** - Periodically*
- **Blood Pressure** - Periodically*
- **Papanicolaou (Pap) test** - Every one to three years; sexually active females who have not had a hysterectomy; consider discontinuing if previous regular screenings were normal*
- **Fecal Occult blood test** - Annually
- **Sigmoidoscopy** - Every 3 to 5 years
- **Clinical breast exam** – Annually - females between ages 65-69
- **Mammogram** - Every one to two years - females between ages 65-69*
- **Vision Screening** - Annually
- **Hearing Screening** - Periodically*

**Other Preventions**

- **Discuss hormone replacement therapy** - Periodically*, peri- and post-menopausal females

**Provider Discussion Topics**

**Diet and Exercise**
- Limit fat and cholesterol intake, maintain caloric balance and emphasize grains, fruits and vegetables
- Regular physical activity
Substance Abuse
- Avoid alcohol/drug use
- Avoid tobacco use

Sexual Behavior
- Sexually transmitted disease (STD) prevention
- Avoid high-risk behavior

Dental Health
- Regular dental visits
- Floss, brush, and fluoride
- Injury Prevention
- Lap and shoulder seat belts
- Bicycle and motorcycle helmets-safety
- Safe firearm handling
- Smoke detectors
- Set hot water heater temperature lower than 120°-130°
- CPR training for household members/caregivers

*How often should be discussed with your doctor.

Your PCP and a Plan Case Manager will work with you. We will create a schedule to help you prevent or control an illness. This will improve your quality of life. The Plan will contact you if you qualify for these programs.

Healthy Behaviors Program

We will offer programs to our members who want to stop smoking, lose weight, or address any drug abuse problems. We will reward members who join and meet certain goals. These programs will be ready October 1, 2014. We will send more information to you later.

SPECIALTY AND OUT-OF-NETWORK CARE

Specialty Care Doctors and Out-of-Network Care

If you think you need to see a Specialist doctor, tell your PCP first. Many times your PCP will be able to help you. If your PCP thinks you need to see a Specialist, he or she will recommend one for you. Before making an appointment to see a Specialist, call the Member Services. They will help you make sure that the Specialist is on the Plan. Sometimes during the month new doctors join the Plan and some leave the Plan. These changes may happen after we send you our
directory but before we can update it. You can call Member Services for the most up-to-date information on doctors on our Plan.

By joining the Plan you have agreed to go to the Plan’s PCPs, hospitals and other doctors. If you use a doctor that is not on the Plan without your PCP or the Plan telling you, you will have to pay that medical bill yourself; except for emergencies and urgent care or during your continuity of care period. Please see the Continuation of Care/Transition of Care section in this handbook for more information.

If you need a Specialist and the Plan does not have a doctor in that specialty, you can select an out-of-network doctor you want to see, as long as the Plan knows this in advance and approves it. Please contact Member Services for more information.

**Second Medical Opinion**

As a member of the Plan you can get a second medical opinion if you need surgery, or if you have a serious injury or illness. You have to go to either a doctor that belongs to the Plan, or you can go to a doctor that is not part of the Plan. You first have to let your PCP know so he or she can help you with the approval for the second medical opinion. Contact the Plan for help if you would like a second opinion. You do not have to pay for the second opinion. Your PCP must be told about all the tests that the second medical opinion doctor orders before you have them done. Please, always call the Member Services department to make sure that the test or treatment ordered by the second medical opinion doctor is covered.

**DIFFERENT TYPES OF MEDICAL CARE**

**Emergency Room Care (ER)**

A medical emergency is a serious medical injury or illness. It is something you do not expect. It is something that needs to be taken care of quickly so that it does not get worse and become a permanent or long-lasting disease or injury.

Here are some examples of emergencies:

- Miscarriage or pregnancy problems
- Rape
- Unusual or excessive bleeding
- Overdose/Poison
- Severe body pain
- Severe burns
- Severe shortness of breath
- Chest pain
If you require emergency care:

- Go to the closest emergency room (ER) or call 911
- Show your Plan member ID card wherever you go to get care
- Ask the facility to call your doctor after you have gotten care
- Call your doctor for a follow-up visit after the emergency is over, or you leave the hospital

If the ER doctor thinks that you do not have a medical emergency but you still want to get care at the hospital, you can do so, but you will have to pay the hospital and all other related bills.

In the case of an emergency, you do not have to call the Plan. Call 911 or go to the ER closest to you. Please give the ER your Plan ID card.

If you are not sure if you need to go to the emergency room, call your PCP.

If you have to stay at the hospital because of an emergency, please tell the hospital to call the Plan within 24 hours of when you get there. If during the emergency you stay in a hospital that is not on the Plan, you can stay there until the hospital doctor tells us that it is safe to move you and take you to another hospital. You will be taken to another hospital that is on the Plan only when you are stable and it is safe to move you. The doctors in the hospital will talk to and work with Better Health and your Better Health doctors.

**Out-of-Area Emergency (ER) Care**

If you have an emergency while you are not in the Plan service area, go to the ER closest to you. You can go to any hospital. Please call your doctor right away so they can help you get the care you need.

Emergency care does not need to be approved. If the hospital or outpatient ER does not take Better Health, you may get a bill. If you get a bill, send the bill and copies of your hospital medical records to:

Better Health  
Member Services Department  
1701 Ponce de Leon Boulevard  
Coral Gables, Florida 33134

**After-Hours Care**

If you need care after regular office hours (except for emergencies) you must call your doctor. Doctors must have coverage for patients 24 hours a day, seven days a week.
Your PCP can:

- Give you directions by telephone
- Prescribe medication
- Ask you to come to his or her office
- Refer you to an emergency room or another doctor for care
- Ask that you make an appointment during regular office hours

You also can get after hours care at an in-network urgent care facility for urgent needs or emergencies.

**Urgent Care Facilities**

If your doctor’s office is closed, you can go to a health doctor who has later office hours. You also can use urgent care centers.

**Hospital Care**

You can get care at other hospitals with approval from the Plan, except in the case of a medical emergency. If you need to go to the hospital, keep the following in mind:

- Hospital care, including inpatient (overnight stay) and outpatient (one day only) care require your PCP to notify the Plan
- Hospital care is required to be provided within the service area; your PCP will arrange for admission to a Plan participating hospital
- The Plan will pay claims for covered care at participating hospitals when your PCP has notified the Plan
- Show your Plan member ID card when you are admitted to the hospital

Please call the Plan if you have any questions.

**ACCESS TO BEHAVIORAL HEALTH SERVICES**

Behavioral health services you can get include inpatient and outpatient hospital services and psychiatric services. You and your children can also get many mental health and case management services. You can get these services near your home, in your home and in schools. Some of the services include:

- Individual, family, and group therapy
- Social rehabilitation
- Day treatment for adults and children
- Evaluations
- Treatment planning
Call toll free at **1-800-221-5487** if you want to know more. The staff will be happy to help you.

Access to behavioral health services and referrals is available for:

- Urgent Care – within one (1) day
- Routine Patient Care – within one (1) week
- Well Care Visit – within one (1) month

**What to Do If You Are Having a Problem**

If you are having any of the following feelings or problems, you should contact a behavioral health doctor:

- Constantly feeling sad
- Feeling hopeless and/or helpless
- Feelings of guilt
- Feelings of worthlessness
- Difficulty sleeping
- Poor appetite
- Weight loss
- Loss of interest
- Difficulty concentrating
- Irritability
- Constant pain such as headaches, stomachaches and backaches

You do not need to call your doctor for a referral to a behavioral health provider. An approval will be given at the time you call the behavioral health provider. Without getting an approval, you will have to pay the bill.

**What to Do in an Emergency, or If You Are Out of the Plan Service Area**

First, decide if you are having a true behavioral health emergency. Do you think that you are a danger to yourself or others? Call 911 or go the nearest emergency room for attention if you think you are in danger of harming yourself or others. You do not need to get approval first for these services. Follow these steps even if the ER is not in the Plan’s service area.

If you need emergency behavioral health help outside of the Plan’s service area:

- Please tell the Plan by calling the number on your ID card
- Call your PCP if you can and follow-up with your doctor within 24 to 48 hours

For out-of-area emergency care, when you are stable, plans will be made to move you to an in-network facility.

**Behavioral Health Services**

If you need help finding a behavioral health provider in your area, you can call Psychcare behavioral health services toll free at **1-800-221-5487**.
You will be given the names of several providers in your local community from which you can choose to call for an appointment. You can also choose a different behavioral health case manager or direct service provider within the Plan if available.

**Behavioral Health Limitations and Exclusions**

Adults and children can get up to 45 inpatient days a year of inpatient care, including behavioral health. Pregnant substance abusers can get up to 28 days of inpatient substance abuse treatment.

Any child (0-13 years old) prescribed a psychotropic medication must obtain an informed consent by their parent or legal guardian. Psychotropic medications include antipsychotics, antidepressants, anti-anxiety medications, and mood stabilizers.

The Managed Care Plan will provide the following services in accordance with Medicaid guidelines and the Behavioral Health Services Coverage and Limitations Handbook:

- Inpatient hospital services for behavioral health and substance abuse conditions
- Outpatient hospital services for behavioral health and substance abuse conditions
- Mental health physician services
- Community mental health services
- Mental health targeted case management
- Mental health intensive targeted case management

If you or a family member has a substance abuse problem, you should:

- Call your doctor
- Ask our behavioral health staff to help you with a referral

The following services are not covered by the Plan:

- Specialized therapeutic foster care
- Therapeutic group care services
- Behavioral health overlay services
- Residential care
- Community substance abuse services
- Sub-acute inpatient psychiatric program (SIPP) services
- Clubhouse services
- Comprehensive behavioral assessments; and
- Florida Assertive Community Treatment services (FACT)

**After-Hours Care for Behavioral Health Services**

If you need care after regular hours (except for emergencies), call your behavioral health doctor. Doctors are required to have coverage for patients 24 hours a day, seven days a week.
Always call your behavioral health provider. Say you are with Better Health. Your doctor or mental health provider can:

- Give you directions by telephone
- Prescribe medication
- Ask you to come to his or her office
- Refer to an emergency facility or another provider for care
- Ask you to make an appointment during regular office hours.

You may also go to a network urgent care center.

**Urgent Care Facilities for Behavioral Health Services**

Sometimes you may have a behavioral health problem that is not an emergency, but your provider’s office is closed. If your PCP’s office is closed, you can use select behavioral health providers who have later office hours. You can also use urgent care centers.

**Hospital Care for Behavioral Health Services**

You may get behavioral health care at in-network hospitals. If you need to go to the hospital, keep the following in mind:

- You must go to a hospital in the service area. Your PCP will help to admit you to a Plan hospital.
- Make sure the hospital is with the Plan.
- Hospital services, including inpatient (overnight stay) and outpatient (one day only) services require your PCP to tell the Plan.
- The Plan will pay claims for covered services at network hospitals when your PCP has notified the Plan.
- Please call the Plan if you have any questions about prior approvals.
- The Plan will pay for emergency behavioral health care. (Please read the section above on ER care for more information.)
- Show your Plan ID card when you go to the hospital for any reason.

**Reporting Abuse, Neglect and Exploitation**

If you feel you or your family members are the victim of abuse, neglect or exploitation, you have the right to report this to your local police, protective services, your doctor, the Plan, or to the abuse hotline at **1-800-96-ABUSE**.

The Plan must report any suspected abuse, neglect or exploitation of members immediately. DCF looks into reports of abuse, neglect or exploitation of children. The Florida Adult Protective
Services looks into reports of abuse, neglect or exploitation of elders or those with disabilities. All reports are confidential.

**MEMBER SERVICES**

The Plan Member Services representatives are here to help you and to answer questions you may have from 8 a.m. to 7 p.m., Monday through Friday. Please call Member Services toll free at **1-800-514-4561** (or call Florida Relay Services **711**).

Our representatives can:
- Help you get your covered healthcare services
- Change member ID cards
- Make changes to your address and telephone numbers
- Change your PCP
- Send you a doctor list
- Give you information on our corporate structure and operations, including physician incentive plans
- Help you with claims or billing issues
- Describe our quality benefit enhancements
- Help you when you become pregnant and when your baby is born
- Listen and help you with a problem
- Give you a copy of information on Clinical Practice Guidelines
- Give you information about our Quality and Performance ratings and measures
- Give you free interpreter services for all foreign languages
- Help with complaints, grievances and appeals questions

**Plan Performance and Quality Improvement**

Please call Member Services toll free at **1-800-514-4561** (or call Florida Relay Services **711**) to get a copy of our plan performance measures, and other information about our quality improvement and disease management programs.

**Copies of This Notice**

You have the right to get an additional copy of this notice any time. Please call Member Services or write to us at the address below to ask for a copy.

Better Health  
Compliance Officer  
1701 Ponce de Leon Boulevard  
Coral Gables, Florida 33134

Call Member Services toll free at **1-800-514-4561**, Monday through Friday, 8 a.m. to 7 p.m.
COVERED SERVICES

The Plan gives you the right to get care for medical, dental and behavioral health services. The list of services and coverage can be found in your Member Handbook. You must get covered care from a Plan doctor except in the case of an emergency or urgent care.

Please remember that our list of Plan doctors changes from time to time. It is up to you to make sure that your PCP or healthcare doctor is on the Plan. You can look in the doctor list we send you or use the most up-to-date doctor list that is on our website at www.betterhealthflorida.com. You can also call Member Services toll free at 1-800-514-4561, or for the hearing impaired call Florida Relay Services at 711.

If one of the doctors on the Plan does not want to do a service or send you for a service because of moral or religious objections, please call Member Services for assistance.

Below is a list of services that are covered under Florida Medicaid and by the Plan:

- Advanced Registered Nurse Practitioner
- Ambulatory Surgical Center Services
- Assistive Care Services
- Behavioral Health Services
- Birth Center and Licensed Midwife Service
- Chiropractic Services
- Clinic Services
- Dental Services
- Diabetic Supplies and Education
- Emergency Behavioral Health Services
- Emergency Services (including post-stabilization services)
- Family Planning Services and Supplies
- Federally Qualified Health Center (FQHC) Services
- Healthy Start Services
- Hearing Services
- Home Health Services and Nursing Care
- Hospice Services
- Hospital Services, Inpatient
  - Children/Adolescents/Pregnant Women = up to 365 days
  - Non-Pregnant Adults = up to 45 days and up to 365 days of ER inpatient care
- Hospital Services, Outpatient
- Immunizations
- Interpreter services
- Laboratory and Imaging Services
- Mammograms, Pap and Pelvic Exams
- Medical Supplies, Equipment, Prostheses and Orthoses
- Neurology and Neuromuscular Testing
- Optometric and Vision Services
- Oral-maxillofacial surgery
- Pain Management Programs, including evaluations, injections and other services
- Physician Assistant Services
- Physician Services (Primary Care Physician (PCP), Specialist, ARNP)
- Podiatric Services
- Pregnancy Care (prenatal and postpartum, including at-risk pregnancy services and women’s health services)
- Prescribed Drug Services
- Radiology such as CT, MRI, MRA, PET and SPECT scans
- Renal Dialysis Services
- Rural Health Clinic (RHC) Services
- Skilled Nursing Facility
- Sleep studies
- Therapy Services (Occupational, Physical, Respiratory, Speech/Language Pathology)
- Transplant Services (including evaluation and pre- and post-transplant care)
- Transportation Services
- Well Adult Exams each year
- Well Child Exams for children under age 21

Physician care includes services done by a doctor, Advanced Registered Nurse Practitioner (ARNP), or doctor’s assistant.

Members do not need to get an approval for these services only:
- PCP visits
- Family Planning
- Federally Qualified Health Center (FQHC)
- Chiropractic Services (10 visits per calendar year)
- Dermatology (5 visits per calendar year)
- Immunizations given by the County Health Department
- Podiatry Services (5 visits per calendar year)
- School-Based services
- Well-Woman Exam with an OB/GYN (1 per calendar year)
- Emergency or post-stabilization services

All other services must have a referral from your PCP.
**Expanded Benefit Services**

- **Adult Dental Services**
  - One cleaning per six months (D1110)
  - Two preventive exams or oral evaluations every 12 months (D0120)
  - One preventive exam or oral evaluation every 36 months (D0150)
  - Two simple extractions per year by a general dentist (D7140)
  - One comprehensive x-ray every 36 months
  - Two preventive x-rays every 12 months (D0220, D0230, D0270, D0272-D0274)
  - No authorization required

- **Hearing Services**
  - One preventive adult hearing screening per calendar year
  - No authorization required

- **Home Health Visits for Non-Pregnant Adults**
  - Three additional personal care visits
  - Limited to enrollees post hospitalization
  - Prior authorization required

- **Influenza Vaccine (Adult)**
  - One vaccination per lifetime
  - Prior authorization required

- **Medically-Related Lodging and Food**
  - $70 per day (per diem) for enrollee’s parent or caregiver
  - Limited to child enrollees
  - Only available if enrollee is required to travel more than 120 miles from home for medically necessary covered care
  - Limit of $25 per day for food included in per diem
  - Not available for days enrollee is receiving inpatient treatment
  - Not available if staying overnight in a private home
  - Prior authorization required

- **Newborn Circumcisions**
  - Circumcisions for newborns up to 12 weeks after birth
  - No authorization required

- **Nutritional Counseling**
  - Adult nutritional counseling with a licensed nutritionist, limited to 15 visits per year
  - Referral required

- **Outpatient Hospital Services**
  - One speech therapy evaluation, maximum three speech therapy visits per week for three weeks (9 visits total)
  - Limited to adult enrollees
  - Prior authorization required
• **Over-the-Counter Items**
  o OTC and/or first aid supplies up to **$25** per household per month
  o No authorization required

• **Physician Home Visit**
  o Expanded - home visit by a primary care specialty provider for medically homebound patients; additional two visits per month limited to one visit per day
  o Authorization required

• **Pneumonia Vaccine (Adult)**
  o Two vaccinations per lifetime
  o Prior authorization required

• **Post Discharge Meals**
  o Two home delivered meals per day after a hospital discharge, limited to up to five calendar days for enrollees with no in-home support present and when requested by a physician.
  o Prior authorization required

• **Prenatal/Perinatal Visits**
  o Four prenatal visits for high-risk pregnancies
  o One postnatal visit within eight weeks of delivery for all pregnancies.
  o No prior authorization requirement

• **Primary Care Visits for Non-Pregnant Adults**
  o Primary Care Provider office visit, limited to one per day
  o No prior authorization requirement

• **Shingles Vaccine (Adult)**
  o One vaccination per lifetime
  o Prior authorization required

• **Vision Services**
  o Medically necessary eyeglasses, one additional pair every two calendar years
  o Prior authorization required

• **Waived Copayments, except for denture services**

**REFERRAL OR AUTHORIZATION**

*What is a Referral or Authorization?*

A referral means you need your doctor’s approval to get a service. Referrals may be written or by phone.

Your PCP will take care of any referrals you need. We want you to go get the care you need.

Some things that can happen are:

• **Prior authorization:** Also called an approval. This means your PCP calls the Plan first. Then you can go to a Specialist or hospital.
• **Concurrent Review:** This means the Plan reviews your care as you get it.

• **Retrospective Review:** This means the Plan checks your medical notes after you have gotten care.

• **Case Management:** This is when a trained clinical person works with you to teach you how to take care of your disease or illness; and works with your PCP to make sure you get the care that you need. Case Managers help to make it easier to get the care you need.

Prior authorizations or approvals can take up to fourteen (14) days from the time we receive the request at the Plan. Most of the time it is faster. This is for non-emergency problems.

If it’s an urgent request, we review it in (72) hours or less. Some kinds of emergency referrals are done over the phone.

If your doctor asks the Plan for an approval and it is denied, we will send you a letter to let you know that we denied it. If you or your PCP do not agree with the Plan’s decision you can file an appeal. The letter will tell you how to file an appeal. In an appeal, someone different from the person who denied the authorization looks at your case and the decision made. Go to the Grievance and Appeals section of this handbook for next steps.

**MEMBER RIGHTS AND RESPONSIBILITIES**

As a Plan member, you have rights and responsibilities that are important for you to know.

**You Have the Right to:**

• Be treated with respect and with due consideration for your dignity and privacy.

• You have the right to ask for and get a copy of your medical records and to ask that they be changed and corrected, as required by the law.

• You have the right to a prompt and reasonable response to questions and requests.

• You have the right to know who is providing medical services and who is responsible for your care. You have the right to know his or her qualifications.

• You have the right to know what rules and regulations apply to your conduct.

• You have the right to be furnished healthcare services in accordance with Federal and State regulations.

• You have the right to be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.

• You have the right to receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and ability to understand. You are to be given the opportunity to participate in decisions involving your healthcare, except when such participation is contraindicated for medical reasons. (If written permission is required for procedures, such as surgery, be sure you understand the related risks and why the procedure or treatment is needed.)
• You have the right to impartial access to medical treatment or accommodations, regardless of race, national origin, religion, physical handicap, or source of payment.
• You have the right to receive information about the Primary Care Physicians (PCPs) or other Specialists in your Plan.
• You have the right to receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
• You have the right to receive a copy of a reasonably clear and understandable itemized bill and, upon request, to have the charges explained.
• You have the right to know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
• You have the right to know what member support services are available, including whether an interpreter is available if you do not speak English.
• You have the right to know about access to after-hours, 24-hour and emergency care.
• You have the right to treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
• You have the right to participate in decisions regarding your healthcare, including the right to refuse treatment and be advised of the probable results of your decision. The Plan encourages you to discuss your objections with your healthcare professional.
• You have the right to choose a PCP from the Plan network of doctors. If you need information on how to change your PCP, you may call the Plan.
• You have the right to express grievances regarding any violation of your rights, as stated in Florida law, through the grievance procedure to the healthcare provider or healthcare facility which served you and to the appropriate state licensing agency.
• You have the right to know about and be allowed to have a written Advance Directive.
• You have the right to your medical records and information to be kept in private and confidential, except as required by law. This includes any information you have shared with your provider or the staff.
• If you are eligible for Medicare, you have the right to know, upon request and in advance of treatment, whether the healthcare provider or the healthcare facility accepts the Medicare assignment rate.
• You have the right to know if your doctor has malpractice insurance coverage.
• You have the right to be free from any form of restraints or seclusion as a means of coercion, discipline, convenience or retaliation.

Additionally, the state must ensure that you are free to exercise your rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat you.
You Have the Responsibility to:

- Be informed about the Plan’s covered services by reading the Member Handbook. Please call the Plan when you have questions or concerns about your coverage toll free at 1-800-514-4561 or call Florida Relay Services at 711.
- You are responsible to know how to use the Plan’s services and know the Plan’s processes.
- You are responsible for providing to the healthcare provider, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications (including over-the-counter products), dietary supplements, any allergies or sensitivities, and other matters relating to your health.
- You are responsible to report unexpected changes in your medical condition to your healthcare provider.
- You are responsible to inform the Plan and your doctors if you change your address.
- You are responsible to show your Plan member ID card when getting services and not allow the illegal use of your member ID card.
- You are responsible to inform your doctor and the Plan about any other insurance that you have.
- You are responsible to conduct yourself in a manner that is respectful of all healthcare providers and staff, as well as other members.
- You are responsible to follow healthcare facility rules and regulations affecting your care and conduct.
- You are responsible to follow the treatment Plan recommended by your healthcare provider.
- You are responsible for reporting to your healthcare provider if you are contemplating a course of action and you what expect from him or her.
- You are responsible to consult with your PCP for his or her advice before getting care, unless it is an emergency and your life and health are in serious danger.
- You are responsible for keeping appointments with your provider, and when you are unable to do so, you are responsible to notify him or her.
- You are responsible for assuring that the financial obligations related to non-covered services are fulfilled as soon as possible.
- You are responsible to establish and maintain a relationship with your PCP.
- You are responsible for your actions if you refuse treatment or you do not follow your healthcare provider’s recommendations.
- You are responsible for informing your provider about any Living Will, Medical Power of Attorney, or Advance Directives that could affect your care.
- You are responsible to provide the name of a responsible adult to go with you and stay with you at the hospital for 24 hours, if your provider requests that you do so.
GRIEVANCES AND APPEALS

As a member of the Plan, you have the right to file a grievance or appeal.

**Grievance Process**

A grievance is a feeling of dissatisfaction. An example could be how your PCP or another healthcare doctor of the Plan treated you, or how you are unhappy with the quality of care given.

You have one year from the date the event happened to file a grievance.

You can file a written or oral grievance. Another person you choose – for example, your PCP, a friend or relative – can also send your grievance and act on your behalf.

Mail a grievance letter or the Grievance Form in writing to:

Better Health
Grievance and Appeals
1701 Ponce de Leon Boulevard
Coral Gables, Florida 33134

A Member Services representative can give you a Grievance Form and help you fill it in. You can also call toll free to file a grievance over the phone:

1-800-514-4561 or Florida Relay Services at 711
Monday through Friday, 8 a.m. to 7 p.m.

We will need your name, member ID number, telephone number and address, and the reason for your grievance. We will start processing your grievance the day you call or we get your letter. We will not take any negative action against you or your approved representative for filing a grievance.

Staff from other areas can get complaints, grievances and appeals by phone. Upon receipt they forward them right away to the Plan’s Grievance Coordinator. He or she will send you a letter within 5 business days of the Plan’s receipt of your call or letter to let you know your grievance was received. The coordinator may need to get more information and your medical records.

Your grievance will be reviewed and a decision will be made. You will get an answer from us within 90 days from the day the Plan receives your grievance, or sooner if your health condition requires it. It will be in writing. We will let you know if we need more time to resolve your
grievance. We will notify you in writing within 5 business days to explain the reason for the delay. You can also ask for more time to resolve your grievance – up to 14 calendar days.

**Filing an Appeal**

An appeal can be filed when you are not happy with a decision that the Plan has made and you ask us to review the decision. You can appeal when one of the following occurs:

- We issue a denial or limitation of a requested service, type of service or level of service
- We reduce, suspend or terminate a previously authorized service
- We deny a whole or partial payment of a service (claims are denied)
- We fail to provide a service in a timely manner as defined by regulations
- We deny the right to access services outside of the network if you live in a rural area with only one managed care organization
- We deny services that were ordered by an authorized doctor
- The filing period has not expired

You have 30 days from the date of our decision to file an appeal.

If you want your services to continue while the appeal is reviewed, you or your authorized representative must file an appeal within 10 business days after the denial letter was mailed or within 10 business days after the effective date of the denial, whichever is later. Also at this time call our Member Services Department and tell them that you want your benefits to continue during the appeal process.

You can file an appeal in writing, by letter or using the Appeal Form and mail to:

**Better Health**

**Grievance and Appeals**

**1701 Ponce de Leon Boulevard**

**Coral Gables, Florida 33134**

You can get an Appeal Form by calling Member Services. A representative help you fill it in.

You can also file an appeal by calling the Plan toll free at:

**1-800-514-4561 (or Florida Relay Services at 711)**

*Monday through Friday, 8 a.m. to 7 p.m.*

Another person – for example, your PCP, a friend or relative – can also send your appeal and act on your behalf as long as you approve it in writing.

We will need your name, member ID number, telephone number and address, and the reason for your appeal. We will start processing your appeal the day you call or we receive your letter,
whichever is first. We will not take any negative action against you or your approved representative for filing an appeal.

You will be able to provide the information necessary to support your appeal case. You can do this in writing or in person. We will resolve the appeal within 45 days from the day we get the appeal, or sooner if your health requires it. Services will continue upon appeal of a suspended authorization but you, the member, may have to pay for continued services in case of an adverse ruling. We will let you know if we need more time to resolve your appeal and will notify you in writing within 5 business days to explain the reason for the delay. You can also ask for more time to address your appeal – up to 14 calendar days.

When a request is made for benefits to continue during the appeal process, the benefits will continue until one of the following occurs: (1) The appeal is withdrawn; (2) 10 business days pass after the Plan sent the denial letter, unless a Medicaid Fair hearing is requested during these 10 days; (3) the Medicaid Fair Hearing office makes an adverse hearing decision; or (4) the time period or limit of the authorized service has been met. If the Medicaid Fair Hearing Officer agrees with our decision, you may have to pay for the cost of any continued benefits.

**Filing an Expedited Appeal**

If we make a decision that you are not happy with and you want to file an appeal, but feel that the time for this appeal could be a danger to your life or health, or cause you to be injured, you or your doctor may ask for a fast review. Fast reviews also are called expedited appeals. Expedited appeals can be done by phone or in writing.

When we get your request for an expedited appeal, we will decide if your appeal needs a fast review. If we decide that your appeal does not need a fast review, we will let you know in writing and then process your appeal as a regular appeal (within 45 days).

If it is processed as an expedited review, you or your doctor will get a verbal response by close of business within 72 hours. A written notice will be sent within 2 days of the decision.

For fast reviews, call Member Services toll free at **1-800-514-4561** (or Florida Relay Services at **711**), Monday through Friday, 8 a.m. to 7 p.m. Call the Plan if you need more information on expedited appeals.

**Medicaid Fair Hearing**

If you are not happy with our decision you have the right to ask for a Medicaid Fair Hearing. If you ask for a hearing, you may continue to get your benefits from us until a decision is made at the hearing. If the Medicaid Fair Hearing determines that our decision was right, you may have to pay for the cost of the ongoing care.
You or your doctor may ask for a Medicaid Fair Hearing. You must do so within 90 days of receipt of the notice of resolution (grievance resolution) or within 90 days of the receipt of the notice of action (denial letter), if you decided to get a Fair Hearing without appealing to the Plan. The Medicaid Fair Hearing Office may be contacted by telephone at (850) 488-1429, by Fax at (850) 487-0662, in writing at Department of Children and Families, Office of Appeal Hearings, Building 5, Room 255, 1317 Winewood Boulevard, Tallahassee, FL 32399-0700, and by email at Appeal_Hearings@dcf.state.fl.us.

Please include in your letter the following information: the Plan name (Better Health), your name, your member ID number, contact information and the reason for your appeal.

**Beneficiary Assistance Program**

You also have the right to ask for a review because of problems with the quality of services you got, or matters of contract between you and the Plan, by the Beneficiary Assistance Program. You may only ask for a review by the Beneficiary Assistance Program, after you have followed the grievance and appeal process with the Plan. You must ask for this review within one year from the receipt of our decision letter. If you ask for a Medicaid Fair Hearing review, the Beneficiary Assistance Program will not review your case. To file a request for review by the Beneficiary Assistance Program, write or call the Agency for Healthcare Administration (AHCA) at:

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Agency for Healthcare Administration
Beneficiary Assistance Program
Building 1, MS#26
2727 Mahan Drive
Tallahassee, Florida 32308
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Phone: 1-850-412-4502
Toll-free: 1-888-419-3456 (toll free)

Please be sure your letter has the following information: the Plan name (Better Health), your name, your member ID number, contact information and the reason for your grievance or appeal.

**COMPLAINTS**

**Complaints and Communications to the Plan**

If you want to communicate with us about privacy issues or file a complaint with us, you can call or write to the Plan. You will not be penalized for filing a complaint.
You can write to us at:

Better Health
Compliance Officer
1701 Ponce de Leon Boulevard
Coral Gables, Florida 33134

You may also call Member Services toll free at 1-800-514-4561 (or Florida Relay Services at 711), Monday through Friday, 8 a.m. to 7 p.m. If you call, a Plan representative will try to help and resolve your complaint during the phone call. If the issue is not resolved within 24 hours, the complaint becomes a grievance.

Complaints to the Federal Government

If you believe that your privacy rights have been violated, you have the right to file a complaint with the Federal Government. You may contact the:

Office of Civil Rights
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Phone: 1-866-627-7748
TDD: 1-866-788-4989
E-mail: ocrprivacy@hhs.gov

You will not be penalized for filing a complaint with the Federal Government.

MEMBER PRIVACY AND HIPAA

HIPAA is a law that protects your information and governs the way the Plan can use your medical records and other healthcare information. The way we use and protect your personal health information (PHI) and records is important to the Plan. Here are some ways we protect your records:

- You sign a release for medical notes. This means you give us approval to get your medical notes when looking at a quality matter or medical care question.
- The Plan has on paper and has put into place rules and ways that keep the privacy of your data file. This type of file can only be given to a person or company that has been given the form that you signed allowing the release. A signed medical release form lets the Plan give medical notes to the Federal and State government.
- Contracts between the Plan and its doctors or other providers include information about the privacy of your records.
The Plan is committed to keeping the privacy of your records and data. If you have any questions about this, please contact the Member Services department.

REPORTING FRAUD, ABUSE OR OVERPAYMENT

Members may call the Florida Office of the Inspector General.

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

If you report suspected fraud and your report results in a fine, penalty or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General’s Fraud Rewards Program (toll free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of $500,000 per case (Section 409.9203, Florida Statutes). You can talk to the Attorney General’s Office about keeping your identity confidential and protected.

Your Identity Will Be Protected

The Plan reports fraud, abuse or overpayment to the Bureau of Managed Healthcare, Medicaid Program Integrity and the Medicaid Fraud Control Unit.

The Plan has a Compliance Officer who is accountable for all fraud and abuse complaints.

The Plan’s Compliance Officer can be contacted at:

Better Health
Compliance Officer
1701 Ponce de Leon Boulevard
Coral Gables, Florida 33134

Toll Free 1-877-253-9251
Florida Relay Services 711
Fax (786) 441-8218 or (786) 441-4625
SIU@simplyhealthcareplans.com

The Plan will investigate any unusual things such as:

- Incorrect and false reporting of services
- Providers who provide wrong information (overstatements) on reports or code claims wrong (up-coded levels of service) to get more money
• Providers who give false information in medical records or destroy medical records
• Providers who write and give wrong information to get authorizations/referrals approved
• Providers who give information which is not true in their credentialing/re-credentialing information
• Providers who ask members to pay for services the Plan pays for

ADVANCE DIRECTIVES

You Have the Right to Decide

All members have rights under state law to accept or refuse medical or surgical treatment and the right to have Advance Directives.

An Advance Directive is a paper that says what kind of care you want or do not want when you get sick and have a serious medical condition(s) that would stop you from speaking and telling your doctors how you want to be treated. An Advance Directive will let the doctors know how you want to receive your care.

What is an Advance Directive?

An Advance Directive is written or oral instructions that are to be used in case you have a serious illness or injury. It tells others how you want your care to be handled (including mental health) when you are not able to make choices yourself. There are two types of Advance Directives: (1) a Living Will and (2) a Healthcare Surrogate Designation.

An Advance Directive lets you tell others about your care choices, or lets you pick someone to make those choices for you if and when you cannot make choices about your healthcare treatment for yourself. An Advance Directive lets you make choices about your future healthcare treatment.

The Plan has policies for Advance Directives that tell you about your rights under Florida law. This policy includes your right to accept or not accept medical or surgical treatment and the right to write and have Advance Directives. These policies, which respect these rights, have information about any limits on your care and are given to all Plan members age 18 and older. The policy is explained below.

What is a Living Will?

A Living Will tells others about the kind of care you want or do not want if you are unable to make your own choices. It is called a Living Will because it is put in place while you are still living. Florida’s law has a form to use for a Living Will. You may use it or some other form.
You may want to talk to a lawyer/attorney or doctor to be sure that you have completed the form correctly so that your wishes will be understood.

**What is a Healthcare Surrogate Designation?**

A Healthcare Surrogate Designation is a signed and dated paper naming another person – such as a husband, wife, daughter, son or close friend – as your agent. This person will be the one who will make healthcare choices for you if cannot make them for yourself.

You can write the orders about any treatment you want, or wish not to get. Florida law has a form that you can use to write who you want to be your healthcare surrogate. You may use it or some other form. You may want to pick a second person too, in case your first choice is not available.

You may wish to have both a Living Will and a Healthcare Surrogate Designation, or you may want to have both in a single paper that lets everyone know your treatment choices in different situations and says who the person is that can make healthcare choices for you if and when you become unable to make these choices for yourself.

**Do I Have to Write an Advance Directive Under Florida Law?**

No, there is no legal requirement to have an Advance Directive. But if you have not made an Advance Directive or picked a healthcare surrogate, healthcare choices may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative or a close friend, in that order. This person would be called a “proxy.”

**Can I Change My Mind After I Write a Living Will or Designate a Healthcare Surrogate?**

Yes, you can change or cancel these papers anytime. Any change has to be in writing, and signed and dated by you. You can change an Advance Directive verbally if you are unable to write it.

**What If I Filled Out an Advance Directive in Another State and Need Treatment in a Healthcare Facility in Florida?**

An Advance Directive completed in another state, in compliance with the other state’s law, can be honored in Florida.
What Should I Do With My Advance Directive If I Want to Have One?

Make sure that someone, such as your doctor, lawyer, or family member knows that you have an Advance Directive and where it is. Think about the following:

- If you have picked a Healthcare Surrogate, give a copy of the written form or the original to that person.
- Give a copy of your Advance Directive to your doctor for your medical files.
- Keep a copy of your Advance Directive in a place where you can find it.
- Keep a card or note in your purse or wallet saying that you have an Advance Directive and where it is located.

If you change your Advance Directive, make sure your doctor, lawyer and/or family member has the latest copy.

You can pick a new healthcare doctor in cases when the doctor cannot follow the Advance Directive wishes because of objections of conscience. For more information, ask those in charge of your care or contact the Plan.

If for any reason the Advance Directive law changes, the Plan will tell you about those changes within 90 days after the changes happen.

For information about Advance Directives you can ask your PCP or you can call the Member Services department and they will help you.

If you want to file a complaint about someone not following the Advance Directive rules and laws, you can call the Florida Agency for Healthcare Administration’s Consumer Complaint Line toll free at 1-888-419-3456.