CHA
Health Plan

Dear Member:

Welcome to CHA! 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 (1-877-577-9043). You can also go to www.clearhealthalliance.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. 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**.

Your privacy is very important to us. A discreet logo is used on all member materials. In this handbook, the "Plan" means CHA. Welcome to our CHA family.

Sincerely,
CHA

CHA 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.

This information is available for free in other languages. Please contact our customer service number at 1-800-887-6888 *(TTY 711) Monday through Friday from 8 a.m. to 7 p.m. Eastern time.*

Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con nuestro número de servicio al cliente al 1-800-887-6888 *(TTY 711) de lunes a viernes de 8 a.m. a 7 p.m. hora del Este.*

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IMPORTANT PHONE NUMBERS AND WEBSITES

Plan Address

CHA
The Flagler Corporate Center
9250 West Flagler Street, #600
Miami, Florida 33174

Member Services Department

CHA 1-877-577-9043

Florida Relay (TDD/TTY) 711

www.clearhealthalliance.com

Fax Numbers

CHA 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

Enrollment Broker

Main Phone: 1-877-711-3662

TDD: 1-866-467-4970

www.flmedicaidmanagedcare.com

Subscriber 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 Area Offices

Central Region: *407-317-7000*

Hardee, Highlands, Polk 863-534-7100

Brevard, Seminole 321-634-3632

Citrus, Hernando, Lake, Marion, Sumter 352-330-5512

Orange, Osceola 407-317-7000

Northeast Region: *904-723-2000*

Alachua, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Madison, Putnam, Suwannee, Taylor, Union 904-723-2000

Northwest Region: *850-872-7648*

Escambia, Okaloosa, Santa Rosa, Walton 850-595-8200

Bay, Calhoun, Gulf, Holmes, Jackson, Washington 850-872-7648

Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla 850-921-8269

Southeast Region: *561-837-5078*

Palm Beach 561-837-5078

Broward 954-375-6092

Indian River, Martin, Okeechobee, St. Lucie 772-467-4177

Southern Region: *305-377-5055*

Miami-Dade, Monroe 305-377-5055

SunCoast Region: *813-558-5500*

Charlotte, Collier, DeSoto, Glades, Hendry, Hillsborough, Lee, Manatee, Pasco, Pinellas, Sarasota 877-595-0384

www.MyFLFamilies.com

Agency for Healthcare Administration

Medicaid Hearing Unit

P.O. Box 60127 Ft. Myers, FL 33906
Phone: (877)-254-1055 (Toll-Free)

Fax: (239)-338-2642

Email:
MedicaidHearingUnit@ahca.myflorida.com

Agency for Health Care Administration

Medicaid Helpline

1-877-254-1055 or
(toll-free) 1-800-953-0555

Agency for Health Care Administration
Facilities Complaint Line
1-888-419-3456

Behavioral/Mental Health Services
1-800-221-5487

Dental Services
1-800-964-7811

Laboratory Services
1-866-697-8378

Transportation Services
1-866-201-9971

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

CHA is a Medicaid Specialty Plan for people living with HIV/AIDS. We offer Medicaid recipients access to health care. CHA is available in Alachua, Bay, Bradford, Brevard, Broward, Calhoun, Charlotte, Citrus, Collier, Columbia, Desoto, Dixie, Escambia, Franklin, Gadsden, Gilchrist, Glades, Gulf, Hamilton, Hardee, Hendry, Hernando, Highlands, Hillsborough, Holmes, Indian River, Jackson, Jefferson, Lafayette, Lake, Lee, Leon, Levy, Liberty, Madison, Manatee, Marion, Martin, Miami-Dade, Monroe, Okaloosa, Okeechobee, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Saint Lucie, Santa Rosa, Sarasota, Seminole, Sumter, Suwannee, Taylor, Union, Wakulla, Walton and Washington counties.

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)
- SSI (Aged, Blind and Disabled)
- 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)
- Full-Benefit Dual Eligibles (Medicare and Medicaid-FFS)
- Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage plans that are not fully liable for all Medicaid Services covered under the Contract
- The Florida Assertive Community Treatment Team (FACT Team)
- Title XXI MediKids
- Children between 100 – 133% of federal poverty level (FPL) who transfer from the state's Children's Health Insurance Program (CHIP) to Medicaid
- MEDS (SOBRA) for children under one year old and income between 185 - 200% FPL

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 AD - (SOBRA) for aged and disabled enrolled in DD home and community-based waiver
- Recipients with other creditable coverage excluding Medicare

- Recipients age 65and older residing in mental health treatment facilities as defined in F.S. 394.455(32)
- Residents of DD centers including Sunland and Tachacale
- Refugee assistance
- Recipients residing in group homes licensed under Chapter 393, F.S.
- Children receiving services in a prescribed pediatric extended care center (PPEC)

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
- Medically Needy Program
- 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) without other full Medicaid coverage
- Special Low-Income Beneficiaries (SLMB) without other full Medicaid coverage
- Working disabled
- Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Dual Special Needs Plans
- Full-Benefit Dual Eligibles enrolled in Part C – Medicare Advantage Plans that are fully liable for all Medicaid services covered under the Contract
- Recipients in the Health Insurance Premium Payment (HIPP) program

You can also call Enrollment Broker 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 must choose a Plan. If you do not choose a plan, 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, the Plan will assign you to a network PCP. You may change your PCP at anytime (please refer to page 16).

If you are a **mandatory** enrollee required to enroll in a plan, once you are enrolled in CHA or the state enrolls you in a plan, you will have 120 days from the date of your first enrollment to try the Managed Care Plan. During the first 120 days you can change Managed Care Plans for any reason. After the 120 days, if you are still eligible for Medicaid, you may be enrolled in the plan for the next eight months. This is called "lock-in."

Additional Requirements to Enroll in CHA

You must meet the Conditions of Enrollment and general Enrollment. You must also have HIV/AIDS to enroll in the Plan.

Open Enrollment Period

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, without cause.

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 **1-877-577-9043**. One of our Case Managers will help you get the care you need.

It is important that you notify DCF when you are pregnant and when the baby is born. Your doctor and the Plan will also notify the DCF that you are pregnant. The baby can then get a Medicaid ID number.

You must pick a doctor for your baby (Pediatrician), before the baby is born. Do this as soon as you know you are pregnant. We can help you pick the doctor. To pick your baby's PCP- call the Plan's customer service phone number at 1-877-577-9043.

Your baby will have benefits under your Plan. Call your DCF case worker as soon as the baby is born 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 and the Plan at 1-877-577-9043.

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.

If you are a mandatory enrollee and you want to change plans after the initial 120-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 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 may disenroll from the Plan at any time. To disenroll, call **the Enrollment Broker 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 the **the Enrollment Broker 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. If the temporary loss causes you to miss open enrollment period, you will get 120 days to change plans if you choose to do so.

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 Member ID card with you all the time. When you go the doctor or hospital, show your 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 right away 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 DCF Case Worker.

Here is what is on the card:

- **Member Name** – the name of the person covered by the Plan.
- **Member/Medicaid ID 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.
- **Eligibility Date** – the first day your health benefits start with the Plan. Also called the effective date.
- **PCP** – the name of your assigned doctor (PCP).
- **PCP Phone** – the telephone number of your doctor (PCP).
- **Plan** - CHA
- **Behavioral Health** – the telephone number you can call for behavioral healthcare services.
- **Member Services** – the Plan's Member Services Department telephone number.

CULTURAL COMPETENCY REQUIREMENTS - HELPING YOU TO UNDERSTAND YOUR CARE/FOREIGN LANGUAGE INTERPRETATION SERVICES

The Plan and its doctors must make sure you have help in any language. If you do not speak English, we will help you get translation if you need it. This help is free to our members. This service makes sure you can talk to your doctor or the Plan in your preferred language.

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 can also help if you:

(a) have any special needs
(b) cannot see well
(c) cannot hear well
(d) cannot read or understand something, and/or

The Cultural Competency plan can be found at:
http://www.simplyhealthcareplans.com/medicaid/members

To receive these services, call Member Services toll free at **1-877-577-9043** (or Florida Relay Services, **711**). If you are hearing impaired, The Plan will get you the alternative communication free of charge to you in your language.

YOUR DOCTOR OR PRIMARY CARE PHYSICIAN (PCP)

Choosing Your Doctor (PCP)

When you sign up for the Plan you must choose a doctor. This doctor is called your Primary Care Physician or your PCP. If you do not choose a PCP, the Plan will choose 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 30 days of joining the plan. You need to make an appointment with your PCP, even if you are not sick, for a check-up. You should also call your PCP when you are sick, need medicine or need to have tests done. He or she will make sure that you get the care that you need.

For some services you may not need to call your PCP first. Please refer to the Covered Services section in this Member Handbook to find out about those services.

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 get a referral to an OB/GYN. The OB/GYN will oversee your care while you are pregnant.

Medical Release Form

It is important that you sign a Medical Release Form so your PCP can get your medical notes from your last doctor. In your Plan's new member packet, you received a Medical Release Form that you should fill out. Please fill it out and take it to your first appointment or send it to the Plan. 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. This number is on your Member ID card.
- 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. If you are not sick, tell the PCP that you would like a well care visit. This kind of visit is free to you as a member of the Plan.

Cancelling an Appointment

If you cannot go to an appointment, please call your PCP right away. Try to call one day before you cancel your visit.

Changing Your PCP

If you want to change your PCP, call Member Services at 1-877-577-9043. 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.

It is important to tell the Plan and your DCF Case Worker if your address changes. Call Member Services if you are moving to another county. Once your address is updated, you will receive a notice(s) from the Enrollment Broker on changing plans, if applicable.

Participating Doctors

You can always 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. You can also get a directory or search for providers on our website.

The Plan has doctors and other types of licensed providers like nurse practitioners, doctor's assistants and midwives. You can get care from many 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 you to get 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, when needed.

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

CONTINUATION OF CARE/TRANSITION OF CARE

Approvals for Care

You may be getting care 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 you are in the Plan, we will accept these approvals. This also includes prescriptions and care from doctors and providers not with CHA. 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 the Plan's behavioral healthcare provider 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 and treatment began before the doctor left
- Until you select another Plan doctor

ROUTINE/PREVENTIVE CHECK-UPS

Regular check-ups, tests and shots are important. You should see your PCP at least once a year when you are not sick for a well care visit. Children less than two need to see the PCP more often. These small children need to see the doctor when they are 1 to 3 days old, 1 week old, 1 month old, 2 months old, 3 months old, 6 months old, 9 months old, 12 months old 15 months old and 18 months old.

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. Remember these check-ups are free to Plan members. You will not have to pay for these visits.

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 is seen by the PCP.

Children less than two need to see the PCP when they are: 1 to 3 days old, 1 week old, 1 month old, 2 months old, 3 months old, 6 months old, 9 months old, 12 months old 15 months old and 18 months old. Children 2 to 20 years should see the doctor once a year when they are not sick. Also, after age 1, all children should see a dentist for a check-up every year. Call the dental plan or Member Services to learn about free dental services for Plan members.

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 immunizations (shots)
- Nutritional assessments
- Developmental assessments
- Hearing screening
- Dental screening
- Vision screening

Clear must provide all medically necessary services for its members who are under age 21. This is the law. This is true even if Clear does not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

-No dollar limits; or

-No time limits, like hourly or daily limits.

Your provider may need to ask Clear for approval before giving your child the service. Call 1-800-887-6888 if you want to know how to ask for these services.

Preventive Health Guidelines

The Plan follows the healthcare guidelines listed below. They are based on the American Academy of Pediatrics periodicity schedule and 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 your 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

*Frequency should be discussed with your doctor.

Your PCP will work with you to create a schedule to help you prevent or control an illness. This will improve your quality of life.

Healthy Behaviors Reward Program

Our members can earn extra rewards for doing things to get and stay healthy through our Healthy Behaviors Reward Programs. We offer these five programs to our members who want to stop smoking, lose weight, maternity, well child visits or address any drug abuse problems. We will reward members who join and meet certain goals. These programs have been in effect since October 1, 2014.

- Alcohol and Drug Abuse Healthy Behaviors Rewards Program
- Maternity Healthy Behaviors Rewards Program
- Quit Smoking and Using Tobacco Health Behaviors Rewards Program
- Weight Loss Health Behaviors Rewards Program
- Well Child Visits Rewards Program (0-23 Months)
- Well Child Visits Rewards Program (24 Months - 20 Years)

When you join and meet your goals, you will earn reward points. One point is worth $1. Members can earn up to 50 points for completing a program. Points can be used to get home and personal items by mail.

Rewards are non-transferrable, you may lose the rewards if you choose to leave the Plan or lose Medicaid coverage for more than one-hundred eighty (180) days

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

SPECIALTY AND OUT-OF-NETWORK CARE

Specialty Care Doctors and Out-of-Network Care

By joining the Plan you have agreed to go to the Plan's PCPs, hospitals and other doctors. To go to a doctor or hospital that is not on the Plan, you must be approved first. In some cases your PCP will have to make this request for you. 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. The only time you can go to a doctor or hospital not on the Plan is in case of 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.

If you think you need to see a Specialist doctor or need therapy, 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 refer you to one who is in the Plan's network. Before making an appointment to see a Specialist, you must call 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 before we can update the provider directory. Call Member Services for the most up-to-date information on doctors on our Plan.

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 can go to a doctor that belongs to the Plan or a doctor who is not part of the Plan. You do not have to pay for the second opinion. But you must have approval before you setup your visit for a second opinion. Let your PCP know. He or she can help you with the approval for the second opinion. Any tests ordered by the second opinion doctor must be covered by the Plan. Call Member Services for help if you would like a second opinion and to make sure you get all of the needed approvals.

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 CHA and your CHA doctors.

Out-of-Area Emergency (ER) Care

If you have an emergency while you are not in the Plan service area, call 911 or go to the ER closest to you. You can go to any hospital. Please call your doctor right away so he or she 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 CHA, you may get a bill. If you get a bill, the plan will pay it. Send the bill and copies of your hospital medical records to:

CHA
The Flagler Corporate Center
9250 West Flagler Street, #600
Miami, Florida 33174

After-Hours Care

If you need care after regular 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:

- Planned hospital care, including inpatient (overnight stay) and outpatient (one day only) care require your PCP to get prior approval from 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 received prior approval from the Plan
- If you are admitted to stay in the hospital from the Emergency Department, the hospital will notify the Plan to get approval. This will not delay your care.
- Show your Plan member ID card when you go to the hospital for any kind of care

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. If you do not get the help you need or have questions about your behavioral health care benefits, please call Member Services at 1-877-577-9043.

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 Behavioral or Mental Health 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 doctor. The behavioral health doctor will give you an approval number for your records. Make sure to keep a copy of the number. Without an approval, you will have to pay the bill.

What to Do in a Behavioral Health 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 care outside of the Plan's service area:,

- Please tell the Plan by calling the Member Services 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 the Plan's behavioral health services vendor toll free at **1-800-221-5487**.

You will be given the names of several providers in your local community who you can call for an appointment. If you do not like a behavioral health doctor or case manager who is working with you, you can request a change. A change will be made if other Plan providers in your area are available.

Behavioral Health Limitations and Exclusions

Children (under the age of 21) and pregnant women can get up to 365 days of health-related inpatient care a year. All non-pregnant adults can get up to 45 days of inpatient care and up to 365 days of emergency inpatient care a year. This includes behavioral health.

Prescriptions for psychotropic medication for any child (under the age of 13) must also have the written, informed consent of the child's parent or legal guardian. The parent or legal guardian should understand the benefits and risks before giving consent. 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 conditions
- Outpatient hospital services for behavioral health conditions
- Psychiatric physician services for behavioral health conditions and psychiatric specialty codes 42, 43 and 44
- Community behavioral health services for behavioral health conditions
- Community behavioral health services for substance abuse conditions
- Mental Health Targeted Case Management
- Mental Health Intensive Targeted Case Management
- Specialized therapeutic foster care
- Therapeutic group care services
- Behavioral health overlay services
- Residential care
- Sub-acute inpatient psychiatric program (SIPP) services for children

If you or a family member has an alcohol or substance abuse problem, you should;

- Discuss your concerns with your PCP
- Call the Plan's behavioral health provider for help and information

The following behavioral health services are not covered by the Plan:

- Clubhouse services
- Comprehensive behavioral assessments; and
- Florida Assertive Community Treatment services (FACT)

In Lieu of Services-Behavioral Health

In lieu of services are services you receive in different settings. They are used to take the place of ("substitute") other covered services. To receive these services, you need an authorization. The covered in lieu of services for members that are over the age of 21 years are:

In Lieu of Service Covered	**The Service Substitutes**
Crisis Stabilization Units	Hospital Inpatient Psychiatric Service
Substance Abuse Detoxification Facility Service Licensed under Chapter 397, F. S	Hospital Inpatient Detoxification

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 doctor. Say you are with CHA. 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

You may have a behavioral health problem that is not an emergency. Your doctor's office may be closed. In that case, you can go to behavioral health providers with 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, DCF 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.

ACCESS TO DENTAL SERVICES

Children and adults on this plan are covered for many dental services.

Child dental services covered under this plan include:

- Crowns
- Diagnostic evaluations
- Endodontics
- Full and partial dentures (prior approval from the Plan is needed)
- Oral surgery
- Orthodontic treatment (for severe cases; prior approval from the Plan is needed)
- Periodontal services
- Preventive services
- X-rays needed to make a diagnosis
- Restorations
- Any other medically necessary services

Adult dental services include dentures and emergency services, such as:

- A problem-focused evaluation
- X-rays needed to make a diagnosis
- Extraction
- Incision and drainage of an abscess
- Full dentures and removable partial dentures
- Medically necessary extractions and surgery to reduce pain or infection are covered
- Partial dentures require prior approval

Please go to the Expanded Benefits section for more adult dental services.

Pregnant women may get a dental cleaning every six months with no limitations.

To find a dentist on the Plan or if you need help getting dental care, please call Member Services.

CASE AND DISEASE MANAGEMENT

The Plan offers case and disease management programs at no cost. These special programs help members with any of the conditions or needs below.

- Asthma
- Diabetes
- High blood pressure
- Congestive heart failure

- Maternity (pregnancy)
- HIV/AIDS
- Oncology (cancer)
- Complex needs (multiple conditions)
- Behavioral health
- Weight management
- Smoking cessation

These programs can help you meet your health goals. If you join, a case manager will be assigned to you. A case manager is a person who helps you in making a plan to improve your health.

If you have any of the conditions or needs listed above, we would like to invite you to join our program. Once you join you can change your mind and leave the program at any time. If you would like to learn more, please call our Case and Disease Management department toll free at: 1 (855) 459-1566.

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 **1-877-577-9043** (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 **1-877-577-9043** (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.

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 this Member Handbook. You must get covered care from a Plan doctor except in the case of 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.clearhealthalliance.com. You can also call Member Services toll free at **1-877-577-9043**, 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 on where you may obtain the services you need.

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), Medical and Behavioral
- 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
- Nursing Facilities to enrollees under the age of 18
- Optometric and Vision Services
- Oral-maxillofacial surgery
- Pain Management Programs, including evaluations, injections and other services
- Pharmacy 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:

- 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, Medical and Behavioral

Pharmacy Services

A link to the Florida Medicaid Preferred Drug List (PDL) covered by the Plan can be found on our website at: http://www.simplyhealthcareplans.com/medicaid/members you may also find it on the Medicaid site at:
http://ahca.myflorida.com/medicaid/prescribed_drug/pharm_thera/fmpdl.shtml

You may also find the list of drugs that are not on the PDL that need an authorization at:
http://ahca.myflorida.com/medicaid/Prescribed_Drug/pharm_thera/paforms.shtml

TRANSPORTATION SERVICES

The Plan pays for non-emergent and emergency transportation.

Non-emergent

Non-emergent transportation services are for medically necessary services, covered by the Plan. This includes appointments to your doctor and transportation to hospitals, urgent care centers and outpatient facilities. To get non-emergent transportation services you need to contact Access2Care at 1-866-201-9971 or Member Services. To get transportation services you must schedule it 3 business days before your appointment.

The Plan will provide Transportation services if:

- You have no other transportation
- You need help during the transportation service to a Plan covered service

The kind of transport you get will be based on your mental and physical condition.
The transportation services covered includes:

- Mass transit and public transportation systems (Bus and Metrorail)
- Medical vehicles (wheelchair or stretcher vans)
- Multi-load passenger van
- Taxi
- Mileage Reimbursement

If you live close to a bus stop and are physically able to use the bus and/or Metrorail system, we will send you bus /Metro-rail passes for your appointment. To receive your passes before your appointment, you must contact Access2Care 3 business days before your appointment. Please give the address you would like to have your passes sent to. If you travel with a personal care attendant or minor child, an additional pass may be provided upon request.

If public transit is identified as an available level of service but you have a physical/mental condition that does not allow you to use bus services, Access2Care will provide an alternative transport such as taxi, medical vehicle, a van, or private vehicle to your home for pick up until a travel assessment is completed. The type of transportation you get depends on your medical needs.

If your condition does not allow you to use public transportation, you will receive assistance from our Travel Assessment Team. They will send a form to your doctor to determine the correct level of service needed. Once completed the Travel Assessment Team will call you back to confirm the type of transportation that will be provided.

When you call for reservation, you must give the following information:

1. Verification
    - Medicaid Number
    - First and Last Name
    - Date of Birth
    - Home Address

- Telephone Number

2. Type of transportation needed:
   - Regular transportation- no wheelchair /stretcher access
     - Able to stand and walk without assistance
   - Stretcher Van Services
     - Bedbound with no equipment
   - Vehicle with Wheel Chair Access
     - Own your own wheelchair, require ramp with ramp access at home
   - Any additional special needs or escort requests

3. If you will need a return trip or a pharmacy stop on the return trip.

If you are receiving ongoing, regularly scheduled treatments such as dialysis and chemotherapy, you may call Access2Care and ask that they schedule all of your rides for your treatments so that you do not miss any one and make it on time to all of them.

The transportation provider will arrive to pick you up during the one-hour window before your scheduled medical appointment time. The transportation provider has up to one-hour for pick ups.

Please let Access2Care know if your medical appointment changes or if it has been cancelled. Exceptions can be made to the three (3) business day window requirement for scheduling transportation if you become sick or have an urgent issue. You will need to notify the Plan and Access2Care of this.

Emergency Transportation
The Plan covers emergency transportation services without an authorization. For emergency transportation dial 911.

In Lieu of Services

In lieu of services are services you receive in different settings. They are used to take the place of ("substitute") other covered services. To receive these services, you need an authorization. The covered in lieu of services for members that are over the age of 21 years are:

In Lieu of Service Covered	**The Service Substitutes**
Nursing Facilities	Hospital Inpatient Services

Expanded Benefit Services

- **Adult Dental Services**
  - One (1) exam every six (6) months (D0120)
  - One cleaning per six months (D1110)
  - 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 and Community Based Services: Homemaker Services**
  - Homemaker services, available post-discharge, if prescribed by a physician, when no in-home support is available
  - Limited to up to two visits, for up to two hours each visit, within a seven day post-discharge period
  - Authorization required
- **Home Health Visits for Non-Pregnant Adults**
  - Three additional care visits per day
  - Limited to enrollees post hospitalization
    Prior authorization required
- **Influenza Vaccine (Adult)**
  - One vaccine per year
- **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**
    - OTC and/or first aid supplies up to **$25** per household per month; limited to specified provider.
    - No authorization required
- **Physician Home Visit**
    - Expanded - home visit by a primary care specialty provider for medically homebound patients; additional two visits per month limited to one visit per day
    - Authorization required
- **Pneumonia Vaccine (Adult)**
    - Two vaccinations per lifetime
    - Prior authorization required
- **Post Discharge Meals**
    - 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.
    - Prior authorization required
- **Prenatal/Perinatal Visits (in addition to regular prenatal/perinatal benefits)**
    - Four prenatal visits for high-risk pregnancies
    - One postnatal visit within eight weeks of delivery for all pregnancies
    - No prior authorization requirement
- **Primary Care Visits for Non-Pregnant Adults**
    - Primary Care Provider office visit, limited to one per day
    - No prior authorization requirement
- **Shingles Vaccine (Adult)**
    -
    - One vaccination per lifetime
    - Prior authorization required
- **Vision Services**
    - Medically necessary eyeglasses, one additional pair every two calendar years
    - Prior authorization required
- **Waived Copayments, except for denture services**

MEDICAID COVERED SERVICES NOT PROVIDED BY THE PLAN

Below is a listing of services not provided by the plan, but are available through Medicaid fee-for-service.

- Adult Cystic Fibrosis (ACF) Home and Community-Based Services Waiver

- Applied Behavior Analysis (ABA)
- Child Health Service Targeted Case Management
- County Health Department (CHD) Certified Match Program
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver
- Early Intervention Services (EIS) for Recipients Birth to Three Years of Age
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)
- Medicaid Certified School Match (MCSM) Program
- Medical Foster Care
- Model Home and Community-Based Services Waiver
- Newborn Hearing Services
- Nursing Facility Services for Recipients under the Age of 18 Years
- Prescribed Pediatric Extended Care
- Program for All-Inclusive Care for Children
- Project AIDS Care (PAC) Home and Community-Based Services Waiver
- Substance Abuse County Match Program
- Traumatic Brain Injury and Spinal Cord Injury (TBI/SCI) Home and Community-Based Services Waiver

To get more information on the services listed above visit:
http://www.simplyhealthcareplans.com/medicaid/members

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 doctor will take care of any referrals you need. We want you to get the care you need. An authorization shows that the Plan has approved your doctor's service request for you.

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 is an urgent request, we review it in 3 business days or less. Some 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 Notice of Adverse Benefit Determination letter to let you know that we denied it and why. If you or your doctor do not agree with the Plan's decision you can file an appeal. The letter we send 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. You will find more information about appeals in the Grievance and Appeals section of thisMember Handbook.

What Benefits DO NOT Require a Prior Authorization?

- Preventive and screening services, including well child check-ups for children and annual health check-ups for adults
- Family Planning
- Family planning related pharmaceuticals
- Participating Office/free standing laboratory tests at labs consistent with CLIA guidelines
- Emergent transportation services
- Urgent or emergent care at participating Urgent Care Centers or any Emergency Room
- County Health Departments (CHD)
- Federally Qualified Health Centers
- Rural Health Clinics and federally funded migrant health centers when providing:
- Vaccines (with the exception of Pneumonia and Shingles for Adults)
- STD diagnosis/treatment
- Rabies diagnosis/immunization
- School health services and urgent services
- Post-Hospital Stabilization Services for Medical and Behavioral Services

Family Planning Services

Family planning services help you make decisions about having children, family size or how long to wait before having your next child. Services include:

- Education and counseling
- First medical exam
- Follow-up care
- Routine lab studies
- Birth control medicines and supplies
- Diagnostic procedures
- Planning and referrals for other medically necessary services
- Sterilization

Here are some things to know about getting family planning services:

- You're free to choose the Medicaid covered service that works for you.
- You can get these from any Medicaid provider.
- You don't need an authorization (an OK).
- All services are confidential.

Under the age of 18? You can get these services if you're:

- Married

- A parent
- Pregnant
- Have written consent from your authorized representative or if your doctor thinks these services are needed to help with a health problem

It's important for women to go to their postpartum visits to learn about your family planning options.

What Benefits DO Require a Prior Authorization?

- Inpatient and observation admissions
- Admission to any rehabilitation and skilled nursing facility
- All surgical procedures, inpatient or outpatient
- Abortions, Hysterectomies, sterilization procedures
- Cosmetic or Reconstructive Surgery, including but not limited to:
- Breast reconstruction or reduction
- Blepharoplasty
- Venous procedures
- Sclerotherapy
- Services and items:
- Allergy (immunotherapy),
- Ambulance transportation (non-emergent)
- Amniocentesis
- Cardiac and pulmonary rehabilitation programs
- Circumcisions after 12 weeks of age
- Court-ordered services
- Chemotherapy
- Dialysis
- DME, including apnea monitors and bili-blankets
- Upper endoscopies at colonoscopies at hospitals
- Genetic testing
- Gamma Knife, Cyberknife
- Hearing aids
- Home Health Services
- Hospice care
- Hyperbaric Oxygen Therapy (HBO)
- Investigational and experimental procedures and treatments
- IV Infusions
- Laboratory services

- Lithotripsy
- Mental Health
- Nutritional counseling
- MRI's, MRA's
- Oral Surgery
- Oxygen therapy and equipment
- Out-of-Network Services
- Pain Management and or Pain Injections
- PET Scans
- Prenatal care
- Orthotics and Prosthetics, including Cranial Orthotics
- Physical, Occupational and Speech Therapy
- Radiation therapy
- SPECT scans
- Transplants and pre and post-transplant evaluations
- Wound Care and wound vacuums
- Drugs that require pre-authorization

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 to 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 be informed 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 **1-877-577-9043** 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 may file a grievance at any time.

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:

CHA
The Flagler Corporate Center
9250 West Flagler Street, #600
Miami, Florida 33174
Attention: Grievance and Appeals

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:

1-877-577-9043 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 60 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 a request within 10 business days after the Notice of Adverse Benefit Determination 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:

CHA
The Flagler Corporate Center
9250 West Flagler Street, #600
Miami, Florida 33174
Attention: Grievance and Appeals

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:

1-877-577-9043 (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 30 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 30 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 **1-877-577-9043** (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.

Title XXI MediKids enrollees are entitled to file an appeal with the Subscriber Assistance Panel (SAP). Title XXI MediKids enrollees are not eligible to participate in the Medicaid Fair Hearing process.

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 120 days of receipt of the notice of plan appeal resolution (grievance resolution) or within 120 days of the receipt of the notice of Adverse Benefit Determination (denial letter), if you decided to get a Fair Hearing without appealing to the Plan.
MFH Address and contact Info:

Agency for Health Care Administration
Medicaid Hearing Unit
P.O. Box 60127
Ft. Myers, FL 33906
(877) 254-1055 (toll-free)
(239) 338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

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

You cannot file a Medicaid Fair Hearing if you have Medicaid through the MediKids program.

Subscriber Assistance Program

You also have the right to ask for a review by the Subscriber Assistance Program because of problems with the quality of services you got, or matters of contract between you and the Plan. You may only ask for a review by the Subscriber 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 Subscriber Assistance Program will not review your case. To file a request for review by the Subscriber Assistance Program, write or call the Agency for Healthcare Administration (AHCA) at:

Agency for Healthcare Administration
Subscriber Assistance Program
Building 3, MS#45
2727 Mahan Drive
Tallahassee, Florida 32308

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 (CHA), 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 may also call Member Services toll free at **1-800-887-6888** (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.

You can write to us at:

CHA
The Flagler Corporate Center
9250 West Flagler Street, #600
Miami, Florida 33174

To file a complaint about discrimination related issue including access you can call or write:

Non-discrimination Coordinator	Phone: 1-305-921-2630
9250 W. Flagler St. Suite 600	Fax: 1-786-441-8183
Miami, FL 33174	Email: ewilliford@simplyhealthcareplans.com

If you want to file a complaint with the Agency for Healthcare Administration (AHCA) about a health care facility you can call the AHCA Facility Complaint Call Center at l (888) 419-3456 / (800) 955-8771 Florida Relay Service (TDD number).

You may also file a complaint with the Agency for Healthcare Administration's Medicaid Help line by calling 1-877-254-1055. Telecommunications device for the deaf (TDD) 1-866-467-4970 to speak to a Medicaid representative.

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:

CHA
The Flagler Corporate Center
9250 West Flagler Street, #600
Miami, Florida 33174
Attention: Compliance Officer

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. We urge you to talk to your doctor about your wishes. 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**.

HIPAA NOTICE OF PRIVACY PRACTICES

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

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

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

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

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

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

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy paper with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems

- Used or shared by people who work for us, doctors or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

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

- **For your medical care**
  - To help doctors, hospitals and others get you the care you need
- **For payment, health care operations and treatment**
  - To share information with the doctors, clinics and others who bill us for your care
  - When we say we'll pay for health care or services before you get them
  - To find ways to make our programs better, as well as giving your PHI to health information exchanges for payment, health care operations and treatment. If you don't want this, please contact Clear Health's Member Services Department at 1-800-577-9043 for more information.
- **For health care business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your health care, if you tell us it's OK
  - With someone who helps with or pays for your health care, if you can't speak for yourself and it's best for you

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

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

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

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams

- To help coroners, medical examiners or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to worker's compensation if you get sick or hurt at work

What are your rights?

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

What do we have to do?

- The law says we must keep your PHI private except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

We may contact you

You agree that we, along with our affiliates and/or vendors, may call or text any phone numbers you give us, including a wireless phone number, using an automatic telephone dialing system and/or a prerecorded message. Without limit, these calls or texts may be about treatment options, other health-related benefits and services, enrollment, payment, or billing.

What if you have questions?

If you have questions about our privacy rules or want to use your rights, please call Member Services at **1-800-514-4561**. If you're deaf or hard of hearing, call **711**.

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

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

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

Your personal information
We may ask for, use and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.

- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors
  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

DISCRIMINATION

Clear Health Alliance follows Federal civil rights laws. We don't discriminate against people because of their:

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

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

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

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

To get these services, call the Member Services number on your ID card. Or you can call our Grievance Coordinator at 1-305-921-2630 (TTY 711).

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

Grievance Coordinator
9250 W. Flagler St. Suite 600
Miami, FL 33174

Phone: 1-305-921-2630
Fax: 1-786-441-8183
Email: ewilliford@simplyhealthcareplans.com

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

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

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

We can translate this at no cost. Call the Customer Service number on your member ID card.

This information is available for free in other languages. Please contact our customer service number at 1-877-577-9043 (TTY 711) Monday through Friday from 8 a.m. to 7 p.m. Eastern time.

Esta información está disponible gratuitamente en otros idiomas. Póngase en contacto con nuestro número de servicio al cliente al 1-877-577-9043 (TTY 711) de lunes a viernes de 8 a.m. a 7 p.m. hora del Este.

Podemos traducir esto gratuitamente. Llame al número de servicio de atención al cliente que aparece en su tarjeta de identificación (ID Card).	*Spanish*
نستطيع ترجمة هذه المواد مجاناً. اتصل بخدمات الاعضاء، بأستخدام رقم الهاتف المدون على بطاقة الاعضاء لديك.	*Arabic*
Մենք կարող ենք անվճար թարգմանել սա: Զանգահարեք հաճախորդների սպասարկման բաժին ձեր անդամաքարտում (ID card) նշված հեռախոսահամարով:	*Armenian*
ဤအရာကို ကျွန်ုပ်တို့ အခမဲ့ ဘာသာပြန်ပေးနိုင်ပါသည်။ သင့် ID ကတ်ပါ ဝယ်ယူသုံးစွဲသူ ဝန်ဆောင်မှုနံပါတ်ကို ဖုန်းဆက်ပါ။	*Burmese*
我們可以免費為您提供翻譯版本。請撥打您 ID 卡上所列的電話號碼洽詢客戶服務中心。	*Chinese*
ما می توانیم این را به رایگان برایتان ترجمه کنیم. به شماره خدمات مراجعین ما که پشت کارت شناسایی تان (ID) درج شده، تلفن بزنید.	*Farsi*
Nous pouvons traduire ceci gratuitement. Appelez le numéro du service après-vente sur votre carte d'identification.	*French*
Nou ka tradwi sa la pou okenn pri. Pélé nimero sèvis kliyentèl la sou tô kat didantité.	*Fr. Creole*
Wir können das gerne kostenlos übersetzen. Bitte wenden Sie sich an die Kundenservice-Hotline auf Ihrer ID-Karte.	*German*
Μπορούμε να σας μεταφράσουμε το παρακάτω χωρίς χρέωση. Καλέστε τον αριθμό του Τμήματος Εξυπηρέτησης Πελατών που θα βρείτε στην κάρτα ταυτοποίησής σας.	*Greek*
અમે આનું ભાષાંતર કોઈપણ ખર્ચ લીધા વિના કરી શકીએ છીએ. તમારા ID કાર્ડ પર આપેલ ગ્રાહક સેવા નંબર પર ફોન કરો.	*Gujarati*
אנחנו יכולים לתרגם את זה ללא עלות. התקשר למספר של שירות הלקוחות הנמצא על גבי כרטיס הזיהוי שלך.	*Hebrew*

हम इसका अनुवाद निशुल्क कर सकते हैं। अपने ID **कार्ड पर दिए गए ग्राहक सेवा नंबर पर फोन करें।**	*Hindi*
Peb txhais tau qhov ntawm no dawb. Hu rau lub chaw haujlwm pab cov neeg siv peb cov kev pab tus xovtooj uas nyob ntawm koj daim npav ID rau tus tswv cuab.	*Hmong*
Possiamo effettuare la traduzione gratuitamente. Contatti il numero dell'assistenza clienti riportato sulla Sua tessera identificativa.	*Italian*
私たちは、この文章を無料で翻訳することができます。ご自身のIDカードにあるカスタマーサービス番号へお電話ください。	*Japanese*
យើងអាចបកប្រែជូនដោយឥតអស់ថ្លៃអ្វីទេ ។ សូមទូរស័ព្ទទៅផ្នែកសេវាអតិថិជន តាមលេខមាននៅលើប័ណ្ណ ID របស់អ្នក ។	*Khmer*
저희는 이것을 무료로 번역해 드릴 수 있습니다. 가입자 ID 카드에 있는 고객 서비스부 번호로 연락하십시오.	*Korean*
ພວກເຮົາສາມາດແປອັນນີ້ໃຫ້ທ່ານໄດ້ຟຣີ. ໃຫ້ໂທຫາຝ່າຍບໍລິການລູກຄ້າທີ່ມີເບີຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.	*Laotian*
Możemy to przetłumaczyć bez żadnych kosztów. Zadzwoń pod numer obsługi klienta za pomocą karty ID.	*Polish*
Podemos traduzir isto gratuitamente. Ligue para o serviço de atendimento ao cliente que consta no seu cartão de identificação.	*Portuguese*
Мы можем это бесплатно перевести. Позвоните в отдел обслуживания по телефону, приведенному на вашей идентификационной карточке участника плана.	*Russian*
Možemo to prevesti besplatno. Pozovite na broj korisničkog servisa s Vaše identifikacione kartice (ID).	*Serbian*
Maaari namin ito isalin-wika nang walang bayad. Mangyaring tawagan ang numero ng customer service sa inyong ID card na pang miyembro.	*Tagalog*
เราสามารถแปลได้โดยไม่มีค่าใช้จ่ายใดๆ ติดต่อหมายเลขโทรศัพท์ของฝ่ายบริการลูกค้าบนบัตรประจำตัวของคุณ	*Thai*
ہم اس کا ترجمہ مُفت کر سکتے ہیں۔ اپنے ID **کارڈ پر دیے گئے کسٹمر سروس کے نمبر پر کال کریں۔**	*Urdu*
Chúng tôi có thể phiên dịch tài liệu này miễn phí. Xin gọi dịch vụ khách hàng qua số điện thoại ghi trên thẻ ID hội viên của quý vị.	*Vietnamese*
מיר קענען דאס איבערזעצן פריי פון אפצאל. רופט דעם קאסטומער סערוויס נומער אויף אייער אידענטיטעט קארטל.	*Yiddish*