Welcome

Aetna Better Health® of Florida 2026
Medicaid Member Handbook
Learn about your health care benefits

AetnaBetterHealth.com/Florida

aetna®

2947700-FL-EN (Revised 12/2025)

Aetna Better Health® of Florida

Helpful information

Medicaid Member Services 1-800-441-5501
(toll free) 24 hours a day, 7 days a week

Services for Hearing and Speech-Impaired (TTY) Call **711**

24-Hour Nurse Line
1-800-441-5501 (toll free) 24 hours a day, 7 days a week

Behavioral Health 1-844-513-4954
Mailing address
Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202
Miami, FL 33178

Interpreter service
You have the right for someone to help you with any communication issue you might have. There is no cost to you.
Call **1-800-441-5501** (toll-free).

Florida Medicaid Help Line 1-877-711-3662
Department of Children and Families ACCESS Information Line 1-866-762-2237, TTY 711

Emergency (24 hours)
If you have a medical condition which could cause serious health problems or even death if not treated immediately, call **911**.

Website
AetnaBetterHealth.com/Florida

Personal information

My PCP (Primary care provider)

My member ID number

My PCP's phone number

FLORIDA MEDICAID
MEMBER HANDBOOK

Aetna Better Health® of Florida

Effective January 1, 2026

AetnaBetterHealth.com/Florida

ENGLISH: Attention: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call **1-800-385-4104 (TTY: 711)** or speak to your provider.

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios de idiomas gratuitos. También, están disponibles sin cargo ayudas y servicios auxiliares apropiados para brindarle información en formatos accesibles. Llame al **1-800-385-4104 (TTY: 711)** o hable con su proveedor.

FRENCH CREOLE: ATANSYON: Si w pale Kreyòl Ayisyen, gen asistans pou lang gratis ki disponib pou ou. Èd ak sèvis oksilyè pou bay sèvis nan fòma ki aksesib disponib tou gratis. Rele
1-800-385-4104 (TTY: 711) oswa pale ak founisè w la.

VIETNAMESE: CHÚ Ý: Nếu bạn nói tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Bạn cũng sẽ được cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp để nhận thông tin ở các định dạng dễ tiếp cận. Hãy gọi số **1-800-385-4104 (TTY: 711)** hoặc trao đổi với nhà cung cấp dịch vụ của bạn.

PORTUGUESE: Atenção: se você fala português, serviços gratuitos de assistência linguística estão disponíveis para você. Além disso, oferecemos, sem custo adicional, recursos auxiliares adequados para disponibilizar informações em formatos acessíveis. Ligue para **1-800-385-4104 (TTY: 711)** ou fale com o profissional de saúde responsável pelo seu cuidado.

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務，亦可以免費獲得適當的輔助工具和服務，以便您無障礙地使用資訊。請致電 **1-800-385-4104 (TTY: 711)** 或諮詢您的醫療保健提供者。

FRENCH: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Des aides et services auxiliaires adéquats visant à fournir des informations dans des formats accessibles sont également proposés gratuitement. Appelez le **1-800-385-4104 (TTY: 711)** ou adressez-vous à votre prestataire.

TAGALOG: Paunawa: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na pantulong na device at serbisyo para magbigay ng impormasyon sa mga naa-access na format. Tumawag sa **1-800-385-4104 (TTY: 711)** o makipag-usap sa iyong provider.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Кроме того, бесплатно предоставляются соответствующие вспомогательные средства и услуги по передаче информации в доступных форматах. Позвоните по номеру **1-800-385-4104 (TTY: 711)** или обратитесь к своему поставщику услуг.

ARABIC: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. وكما تتوفر أيضًا معينات وخدمات مساعدة مناسبة لتقديم المعلومات بتنسيقات يسهل الوصول إليها مجانًا. اتصل على الرقم **1-800-385-4104 (TTY: 711)** أو تحدث إلى مقدم الخدمة الخاص بك.

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Sono inoltre disponibili gratuitamente adeguati aiuti e servizi ausiliari per fornire informazioni in formati accessibili. Chiamare il numero **1-800-385-4104 (TTY: 711)** o parlare con il proprio fornitore.

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in zugänglicher Form sind ebenfalls kostenlos erhältlich. Rufen Sie **1-800-385-4104 (TTY: 711)** an oder sprechen Sie mit Ihrem Anbieter.

KOREAN: 주의: 한국어를 구사하는 경우, 무료 언어 지원 서비스를 이용할 수 있습니다. 접근 가능한 형식으로 정보를 제공하는적절한 보조 도구와 서비스도 무료로 이용할 수 있습니다. **1-800-385-4104 (TTY: 711)**로 전화하거나 제공업체와 통화하세요.

POLISH: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Dodatkowe środki pomocnicze oraz usługi, zapewniające informacje w dostępnych formatach, są również dostępne nieodpłatnie. Zadzwoń pod numer **1-800-385-4104 (TTY: 711)** albo zwróć się do swojego dostawcy.

GUJARATI: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી મેળવવા માટે યોગ્ય સહાયક સહાયતા અને સેવાઓ પણ નિ:શુલ્ક ઉપલબ્ધ છે. **1-800-385-4104 (TTY: 711)** પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี มีความช่วยเหลือและบริการเสริมจัดไว้ให้เพื่อใช้ตรวจสอบข้อมูลผ่านรูปแบบที่เข้าถึงได้โดยไม่เสียค่าใช้จ่ายใด ๆ ติดต่อหมายเลข
1-800-385-4104 (TTY:711) หรือพูดคุยกับผู้ให้บริการของคุณโดยตรง

Important Contact Information

Member Services Help Line	**1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC)	Available 24 hours
Member Services Help Line TTY	TTY: 711	Available 24 hours
Website	**AetnaBetterHealth.com/Florida**	
Address	Aetna Better Health of Florida PO Box 818043 Cleveland, OH 44181-8043	

Transportation Services: Non- Emergency	ModivCare **1-866-799-4463** Where's my ride? After hours **1-866-799-4464**
Behavioral Health	Contact Member Services **1-800-441-5501**
Dental	Contact your case manager directly or **1-800-441-5501** (MMA-Medicaid) or **1-844-645-7371** (LTC) for help with arranging these services.
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	**1-800-96-ABUSE (1-800-962-2873)** **TTY: 711** or **1-800-955-8771** **https://www.myflfamilies.com/services/abuse/abuse-hotline/how-report-abuse**
For Medicaid Eligibility	**1-866-762-2237 TTY: 711** or **1-800-955-8771** **https://www.myflfamilies.com/medicaid#ME**
To report Medicaid Fraud and/or Abuse	**1-888-419-3456**

	https://apps.ahca.myflorida.com/mpi-complaintform/
To file a complaint about a health care facility	**1-888-419-3456** **http://ahca.myflorida.com/MCHQ/Field_Ops/CAU.shtml**
To request a Medicaid Fair Hearing	**1-877-254-1055** **1-239-338-2642 (fax)** **MedicaidHearingUnit@ahca.myflorida.com**
To file a complaint about Medicaid services	**1-877-254-1055** **TDD: 1-866-467-4970** **http://ahca.myflorida.com/Medicaid/complaints/**
To find information for elders	**1-800-96-ELDER (1-800-963-5337)** **https://elderaffairs.org/**
To find out information about domestic violence	**1-800-799-SAFE (1-800-799-7233)** **TTY: 1-800-787-3224** **http://www.thehotline.org/**
To find information about health facilities in Florida	**https://quality.healthfinder.fl.gov/**
24 Hour Nurse Line	If it can't wait until you see your doctor, call Member Services. Then, choose the option for the Nurse Line. Medicaid Managed Medical Assistance (MMA): **1-800-441-5501 (TTY: 711)** Long-Term Care (LTC): **1-844-645-7371 (TTY: 711)**
Telehealth	**1-866-276-9381**

	https://www.mdlive.com/mobile-app
To find information about urgent care	Call Member Services at **1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**
For an emergency	**9-1-1** or go to the nearest emergency room

Table of Contents

- Important Contact Information....1
- Section 1: Your Plan Identification Card (ID card) 5
- Section 2: Your Privacy 6
- Section 3: Getting Help from Our Member Services 10
- Section 4: Do You Need Help Communicating? 11
- Section 5: When Your Information Changes 11
- Section 6: Changes to your Health Plan 12
- Section 7: Your Medicaid Eligibility 12
- Section 8: Enrollment in Our Plan....13
- Section 9: Leaving Our Plan (Disenrollment)....15
- Section 10: Managing Your Care 16
- Section 11: Accessing Services 17
- Section 12: Helpful Information About Your Benefits....19
- Section 13: Your Plan Benefits: Managed Medical Assistance Services....27
- Section 14: Cost Sharing for Services....47
- Section 15: Long-Term Care (LTC) Program Helpful Information 48
- Section 16: Your Plan Benefits: Long-Term Care Services....49
- Section 17: Member Satisfaction 53
- Section 18: Your Member Rights 56
- Section 19: Your Member Responsibilities....58
- Section 20: Other Important Information....59
- Section 21: Additional Resources 61
- Section 22: Forms 63

Welcome to Aetna Better Health of Florida Statewide Medicaid Managed Care Plan

Aetna Better Health of Florida has a contract with the Florida Agency for Health Care Administration (Agency) to provide health care services to people with Medicaid. This is called the **Statewide Medicaid Managed Care (SMMC) Program**. You are enrolled in our SMMC plan. This means we will offer you Medicaid services. We work with a group of health care providers to help meet your needs.

There are many types of Medicaid services you can receive in the SMMC program. You can receive medical services, like doctor visits, labs, and emergency care, from a **Managed Medical Assistance (MMA)** plan. If you are an elder or adult with disabilities, you can receive nursing facility and home and community-based services in a **Long-Term Care (LTC)** plan. If you have a certain health condition, like HIV/AIDS or a Serious Mental Illness (SMI) you can receive care that is designed to meet your needs in a **Specialty** product.

If your child is enrolled in the Florida KidCare **MediKids** program, most of the information in this handbook applies to you. We will let you know if something does not apply.

If you are a participant in the Intellectual Developmentally Disabled (IDD) Pilot Program, most of the information in this handbook applies to you. We will let you know if something does not apply or if there is information that applies to IDD enrollees.

This handbook will be your guide for all health care services available to you. You can ask us any questions, or get help making appointments. If you need to speak with us, just call us at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC), **(TTY: 711).**

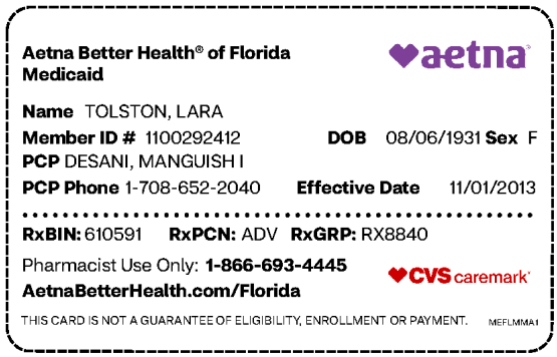
Section 1: Your Plan Identification Card (ID card)

You should have received your ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own ID card.

Always carry your ID card and show it each time you go to a health care appointment or the hospital. Never give your ID card to anyone else to use. If your card is lost or stolen, call us so we can give you a new card.

Your ID card will look like this:

Medicaid – MMA


Aetna Better Health® of Florida
Medicaid

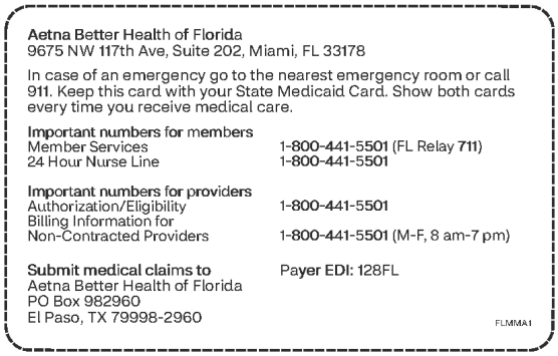
aetna

Name TOLSTON, LARA
Member ID # 1100292412 DOB 08/06/1931 Sex F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 Effective Date 11/01/2013

RxBIN: 610591 RxPCN: ADV RxGRP: RX8840
Pharmacist Use Only: 1-866-693-4445
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLMMA1


Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

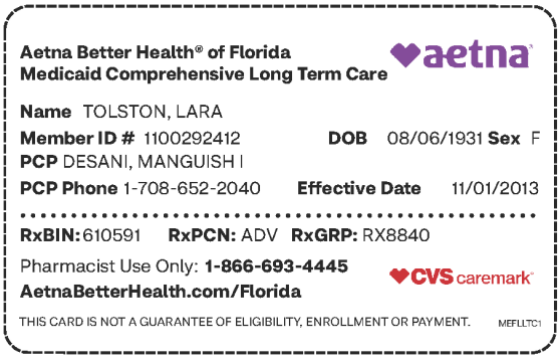
Important numbers for members
Member Services 1-800-441-5501 (FL Relay 711)
24 Hour Nurse Line 1-800-441-5501

Important numbers for providers
Authorization/Eligibility 1-800-441-5501
Billing Information for Non-Contracted Providers 1-800-441-5501 (M-F, 8 am-7 pm)

Submit medical claims to Payer EDI: 128FL
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

FLMMA1

Medicaid – Comprehensive Long-Term Care


Aetna Better Health® of Florida
Medicaid Comprehensive Long Term Care

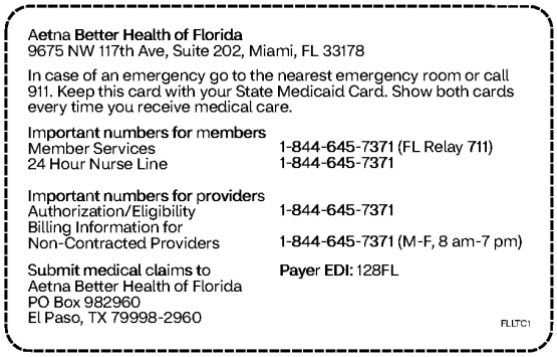
aetna

Name TOLSTON, LARA
Member ID # 1100292412 DOB 08/06/1931 Sex F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 Effective Date 11/01/2013

RxBIN: 610591 RxPCN: ADV RxGRP: RX8840
Pharmacist Use Only: 1-866-693-4445
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLLTC1


Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

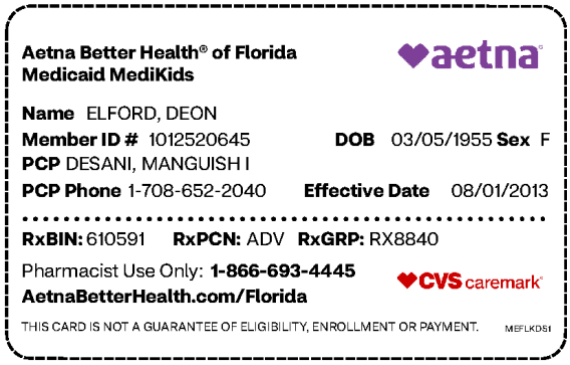
Important numbers for members
Member Services 1-844-645-7371 (FL Relay 711)
24 Hour Nurse Line 1-844-645-7371

Important numbers for providers
Authorization/Eligibility 1-844-645-7371
Billing Information for Non-Contracted Providers 1-844-645-7371 (M-F, 8 am-7 pm)

Submit medical claims to Payer EDI: 128FL
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

FLLTC1

MediKids


Aetna Better Health® of Florida
Medicaid MediKids

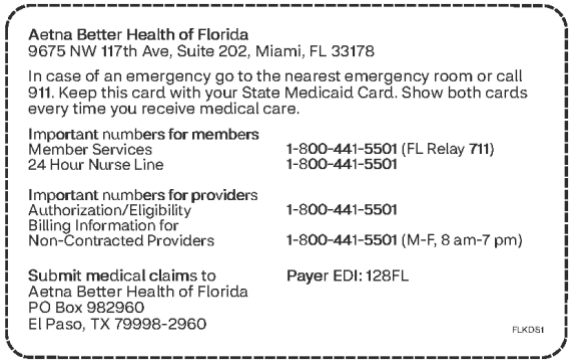
aetna

Name ELFORD, DEON
Member ID # 1012520645 DOB 03/05/1955 Sex F
PCP DESANI, MANGUISH I
PCP Phone 1-708-652-2040 Effective Date 08/01/2013

RxBIN: 610591 RxPCN: ADV RxGRP: RX8840
Pharmacist Use Only: 1-866-693-4445
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLKDS1


Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

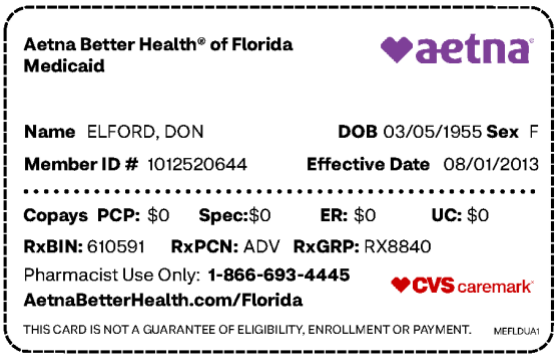
Important numbers for members
Member Services 1-800-441-5501 (FL Relay 711)
24 Hour Nurse Line 1-800-441-5501

Important numbers for providers
Authorization/Eligibility 1-800-441-5501
Billing Information for Non-Contracted Providers 1-800-441-5501 (M-F, 8 am-7 pm)

Submit medical claims to Payer EDI: 128FL
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

FLKDS1

Dual Eligible


Aetna Better Health® of Florida
Medicaid

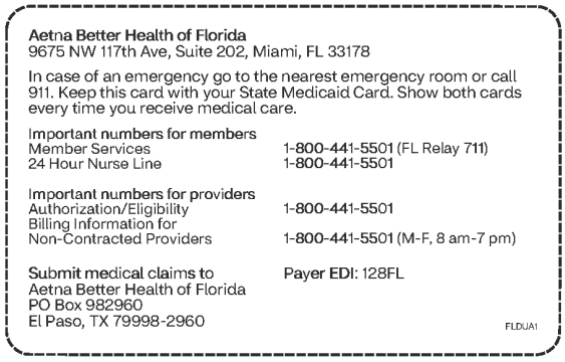
aetna

Name ELFORD, DON DOB 03/05/1955 Sex F
Member ID # 1012520644 Effective Date 08/01/2013

Copays PCP: $0 Spec:$0 ER: $0 UC: $0
RxBIN: 610591 RxPCN: ADV RxGRP: RX8840
Pharmacist Use Only: 1-866-693-4445
AetnaBetterHealth.com/Florida

CVS caremark

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEFLDUA1


Aetna Better Health of Florida
9675 NW 117th Ave, Suite 202, Miami, FL 33178

In case of an emergency go to the nearest emergency room or call 911. Keep this card with your State Medicaid Card. Show both cards every time you receive medical care.

Important numbers for members
Member Services 1-800-441-5501 (FL Relay 711)
24 Hour Nurse Line 1-800-441-5501

Important numbers for providers
Authorization/Eligibility 1-800-441-5501
Billing Information for Non-Contracted Providers 1-800-441-5501 (M-F, 8 am-7 pm)

Submit medical claims to Payer EDI: 128FL
Aetna Better Health of Florida
PO Box 982960
El Paso, TX 79998-2960

FLDUA1

Questions? Call Member Services at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) or **TTY: 711**

Your privacy is important to us. You have rights when it comes to protecting your health information, such as your name, Plan identification number, race, ethnicity, and other things that identify you. We will not share any health information about you that is not allowed by law.

If you have any questions, call Member Services. Our privacy policies and protections are:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. What do we mean when we use the words "health information?"[1]

We use the words "health information" when we mean information that identifies you. Examples include your:

- Name
- Date of birth
- Health care you received
- Amounts paid for your care

How we use and share your health information

Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you are no longer with our plan, with your okay, we will give your health information to your new doctor.

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us.

If you are under eighteen and don't want us to give your health information to your parents, call us. We can help in some cases if allowed by state law.

For payment: We may give your health information to others who pay for your care. Your doctor must give us a claim form that includes your health information. We may also use your health information to look at the care your doctor gives you. We can also check your use of health services.

---

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all the HMO and licensed insurer subsidiaries of Aetna Inc. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

Health care operations: We may use your health information to help us do our job. For example, we may use your health information for:

- Health promotion
- Care management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matter

A case manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. When you call us with questions, we need to look at your health information to give you answers.

Race/Ethnicity, Language, Sexual Orientation and Gender Identity and Other Data
We may get information related to your race, ethnicity, language, sexual orientation, gender identity, food/financial/housing insecurity, access to transportation, interpersonal safety, barriers to achieving health, and any other relevant social needs. We protect this information as described in this notice. We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Create health education information
- Let the doctors know about your language needs
- Address health care disparities
- Let member facing staff and doctors know about your pronouns

We do not use this information to:

- Determine benefits
- Pay claims
- Determine your cost or eligibility for benefits
- Discriminate against members for any reason
- Determine health care or administrative service availability or access

Sharing with other businesses
We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair so they send a van instead of a car to pick you up.

We also may share your health information for these reasons:

- Public safety: To help with things like child abuse and threats to public health.
- Research: To researchers after care is taken to protect your information.

- Business partners: To people that provide services to us. They promise to keep your information safe.
- Industry regulation: To state and federal agencies who check us to make sure we are doing a good job.
- Law enforcement: To federal, state and local enforcement people.
- Legal actions: To courts for a lawsuit or legal matter.

Reasons that we will need your written okay

- Except for what we explained above, we will ask for your okay before using or sharing your health information. For example, we will get your okay:
- For marketing reasons that have nothing to do with your health plan
- Before sharing any psychotherapy notes
- For the sale of your health information
- For other reasons as required by law
- You can cancel your okay at any time. To cancel your okay, write to us. We cannot use or share your genetic information when we make the decision to provide your health care insurance.

What are your rights?

You have the right to look at your health information.

- You can ask us for a copy of it.
- You can ask for your medical records. Call your doctor's office or the place where you were treated.

You have the right to ask us to change your health information.

- You can ask us to change your health information if you think it is not right.
- If we don't agree with the change you asked for, ask us to file a written statement of disagreement.

You have the right to get a list of people or groups that we have shared your health information with.

You have the right to ask for a private way to be in touch with you.

- If you think the way we keep in touch with you is not private enough, call us.
- We will do our best to be in touch with you in a way that is more private.

You have the right to ask for special care in how we use or share your health information.

- We may use or share your health information in the ways we describe in this notice.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.

You have the right to know if your health information was shared without your okay.

- We will tell you if we do this in a letter.

Call us toll free at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)** from 8 AM to 7 PM, Monday through Friday to:

- Ask us to do any of the things above.
- Ask us for a paper copy of this notice.
- Ask us any questions about the notice.

You also have the right to send us a complaint. If you think your rights were violated, write to us at:

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079
FAX: **859-280-1272**

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address. If you are unhappy and tell the Office of Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.

Protecting your information

We protect your health information with specific procedures, such as:

- Administrative. We have rules that tell us how to use your health information no matter what form it is in – written, oral, or electronic.
- Physical. Your health information is locked up and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- Technical. Access to your health information is "role-based." This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

Will we change this notice?

By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. You can get a copy of the most recent notice on our website at **AetnaBetterHealth.com/Florida**.

Section 3: Getting Help from Our Member Services

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

Contacting Member Services

You may call us at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC)

(TTY: 711), Monday to Friday, 8 AM to 7 PM, but not on State approved holidays (like Christmas Day and Thanksgiving Day). When you call, make sure you have your identification card (ID card) with you so we can help you. **(**If you lose your ID card, or if it is stolen, call Member Services.)

Contacting Member Services after Hours

If you call when we are closed, please leave a message. We will call you back the next business day. If you have an urgent question, you may call Member Services at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**.Our nurses are available to help you 24 hours a day, 7 days a week.

Section 4: Do You Need Help Communicating?

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

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

- Telecommunications Relay Service. This helps people who have trouble hearing or talking to make phone calls. Call 711 and give them our Member Services phone number. It is **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711).** They will connect you to us.
  - Information and materials in large print, audio (sound); and braille
  - Help in making or getting to appointments
  - Names and addresses of providers who specialize in your disability

All of these services are provided free to you.

Section 5: When Your Information Changes

If any of your personal information changes, let us know as soon as possible. You can do so by calling Member Services. We need to be able to reach you about your health care needs.

The Department of Children and Families (DCF) needs to know when your name, address, county, or telephone number changes as well. Call DCF toll free at **1-866-762-2237** (**TTY 1-800-955-8771**) Monday through Friday from 8 a.m. to 5:30 p.m. You can also go online and make the changes in your Automated Community Connection to Economic Self Sufficiency (MyACCESS) account at **https://myaccess.myflfamilies.com/**. If you receive Supplemental Security Income (SSI), you must also contact the Social Security

Administration (SSA) to report changes. Call SSA toll free at **1-800-772-1213 (TTY 1-800-325-0778)**, Monday through Friday from 8 a.m. to 7 p.m. You may also contact your local Social Security office or go online and make changes in your Social Security account at **https://secure.ssa.gov/RIL/SiView.do.**

Section 6: Changes to your Health Plan

If your health plan experiences a significant change that affects you as an enrollee, it is the plan's responsibility to inform you (the enrollee) at least 30 days before the intended effective date of the change.

Section 7: Your Medicaid Eligibility

You must be covered by Medicaid and enrolled in our plan for Aetna Better Health of Florida to pay for your health care services and health care appointments. This is called having **Medicaid eligibility**. If you receive SSI, you qualify for Medicaid. If you do not receive SSI, you must apply for Medicaid with DCF.

Sometimes things in your life might change, and these changes can affect whether you can still have Medicaid. It is very important to make sure that you have Medicaid before you go to any appointments. Just because you have a Plan ID Card does not mean you still have Medicaid. Do not worry! If you think your Medicaid has changed or if you have any questions about your Medicaid, call Member Services. We can help you check on your coverage.

If you Lose your Medicaid Eligibility

If you lose your Medicaid and get it back within 180 days, you will be enrolled back into our plan.

If you have Medicare

If you have Medicare, continue to use your Medicare ID card when you need medical services (like going to the doctor or the hospital), but also give the provider your Medicaid Plan ID card too.

If you are having a baby

Aetna Better Health® of Florida and ProgenyHealth® have teamed up to help you and your baby feel your best. We can help you and your family during your pregnancy and after birth. Your case manager can help with:

- Education and support
- Setting up doctor visits
- Making care plans
- Finding free or low-cost items and services

To learn more, call **1-855-231-4730**, Monday to Friday, 8:30 AM to 5:00 PM ET. Your baby will be covered by us on the date of birth. Call Member Services to let us know that your baby has arrived, and we will help make sure your baby is covered and has Medicaid right away.

It is helpful if you let us know you are pregnant **before** your baby is born to make sure your baby has Medicaid. Call DCF toll free at **1-866-762-2237** while you are pregnant. If you need help talking to DCF, call us. DCF will make sure your baby has Medicaid from the day he or she is born. They will give you a Medicaid number for your baby. Let us know the baby's Medicaid number when you get it.

Section 8: Enrollment in Our Plan

Initial Enrollment

When you first join our plan, you have 120 days to try our plan. If you do not like it for any reason, you can enroll in another SMMC plan in the same region. Once those 120 days are over, you are enrolled in our plan for the rest of the year. This is called being **locked-in** to a plan. Every year you have Medicaid and are in the SMMC program, you will have an open enrollment period.

Open Enrollment Period

Each year, you will have 60 days when you can change your plan if you want. This is called your **open enrollment period**. The State's Enrollment Broker will send you a letter to tell you when your open enrollment period is.

You do not have to change plans during your open enrollment period. If you do choose to leave our plan and enroll in a new one, you will start with your new plan at the end of your open enrollment period. Once you are enrolled in the new plan, you are locked-in until your next open enrollment period. You can call the Enrollment Broker at **1-877-711-3662 (TDD 1-866-467-4970).**

Enrollment in the SMMC Long-Term Care Program

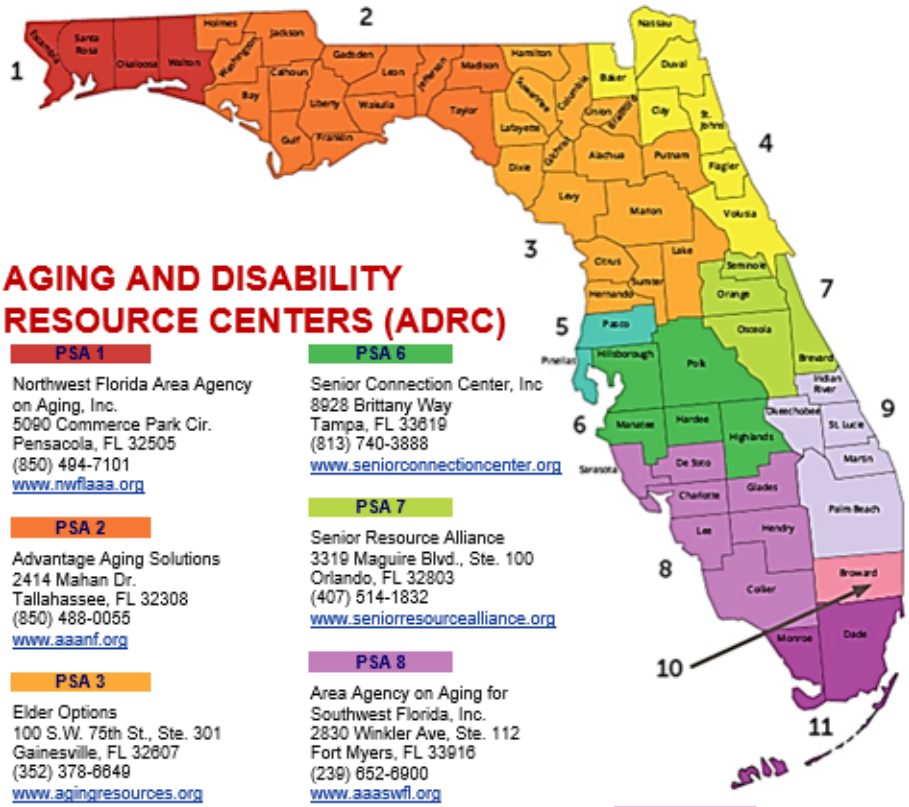
The SMMC Long-Term Care (LTC) program provides nursing facility services and home and community-based care to elders and adults (ages 18 years and older) with disabilities. Home and community-based services help people stay in their homes, with services like help with bathing, dressing, and eating; help with chores; help with shopping; or supervision.

We pay for services that are provided at the nursing facility. If you live in a Medicaid nursing facility full-time, you are probably already in the LTC program. If you don't know, or don't think you are enrolled in the LTC program, call Member Services. We can help you.

The LTC program also provides help for people living in their home. But space is limited for these in-home services, so before you can receive these services, you have to speak to someone who will ask you questions about your health. This is called a screening. The Department of Elder Affairs' Aging and Disability Resource Centers (ADRCs) complete these screenings. Once the screening is complete, the ADRC will notify you about your wait list placement or provide you with a list of resources if you are not placed on the wait list. If you are placed on the wait list and a space becomes available for you in the LTC

program, the Department of Elder Affairs Comprehensive Assessment and Review for Long-Term Care Services (CARES) program will ask you to provide more information about yourself to make sure you meet other medical criteria to receive services from the LTC program. Once you are enrolled in the LTC program, we will make sure you continue to meet requirements for the program each year.

You can find the phone number for your local ADRC using the following map. They can also help answer any other questions that you have about the LTC program. Visit **https://ahca.myflorida.com/Medicaid/statewide_mc/smmc_ltc.shtml** for more information.



AGING AND DISABILITY RESOURCE CENTERS (ADRC)

PSA 1

Northwest Florida Area Agency on Aging, Inc.
5090 Commerce Park Cir.
Pensacola, FL 32505
(850) 494-7101
www.nwflaaa.org

PSA 2

Advantage Aging Solutions
2414 Mahan Dr.
Tallahassee, FL 32308
(850) 488-0055
www.aaanf.org

PSA 3

Elder Options
100 S.W. 75th St., Ste. 301
Gainesville, FL 32607
(352) 378-6649
www.agingresources.org

PSA 4

Elder Source, The Area Agency on Aging of Northeast Florida
10688 Old St. Augustine Rd.
Jacksonville, FL 32257
(904) 391-6600
www.myeldersource.org

PSA 5

Area Agency on Aging of Pasco-Pinellas, Inc.
9549 Koger Blvd., Gadsden Bldg., Ste. 100
St. Petersburg, FL 33702
(727) 570-9696
www.agingcarefl.org

PSA 6

Senior Connection Center, Inc
8928 Brittany Way
Tampa, FL 33619
(813) 740-3888
www.seniorconnectioncenter.org

PSA 7

Senior Resource Alliance
3319 Maguire Blvd., Ste. 100
Orlando, FL 32803
(407) 514-1832
www.seniorresourcealliance.org

PSA 8

Area Agency on Aging for Southwest Florida, Inc.
2830 Winkler Ave, Ste. 112
Fort Myers, FL 33916
(239) 652-6900
www.aaaswfl.org

PSA 9

Area Agency on Aging of Palm Beach/Treasure Coast, Inc.
4400 N. Congress Ave.
West Palm Beach, FL 33407
(561) 684-5885
www.youragingresourcecenter.org

PSA 10

Aging and Disability Resource Center of Broward County, Inc.
5300 Hiatus Rd.
Sunrise, FL 33351
(954) 745-9567
www.adrcbroward.org

PSA 11

Alliance for Aging, Inc.
760 N.W. 107th Ave., Ste. 214,
2nd Floor
Miami, FL 33172
(305) 670-6500
www.allianceforaging.org

Section 9: Leaving Our Plan (Disenrollment)

Leaving a plan is called **disenrolling.** By law, people cannot leave or change plans while they are locked-in except for specific reasons. If you want to leave our plan while you are locked-in, call the State's Enrollment Broker to see if you would be allowed to change plans.

You can leave our plan at any time for the following reasons (also known as **For Cause Disenrollment** reasons[2]):

- We do not cover a service for moral or religious reasons
- You live in and get your Long-Term Care services from an assisted living facility, adult family care home, or nursing facility provider that was in our network but is no longer in our network

You can also leave our plan for the following reasons, if you have completed our grievance and appeal process[3]:

- You receive poor quality of care, and the Agency agrees with you after they have looked at your medical records
- You cannot get the services you need through our plan, but you can get the services you need through another plan
- Your services were delayed without a good reason

If you have any questions about whether you can change plans, call Member Services It is **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC), **(TTY: 711).** or the State's Enrollment Broker at **1-877-711-3662 (TDD 1-866-467-4970)**.

Removal from Our Plan (Involuntary Disenrollment)

The Agency can remove you from our plan (and sometimes the SMMC program entirely) for certain reasons. This is called **involuntary disenrollment**. These reasons include:

- You lose your Medicaid eligibility
- You move outside of where we operate, or outside the State of Florida
- You knowingly use your Plan ID card incorrectly or let someone else use your Plan ID card
- You fake or forge prescriptions

---

[2] For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600: **https://www.flrules.org/gateway/RuleNo.asp?title=MANAGED CARE&ID=59G-8.600**

[3] To learn how to ask for an appeal, please turn to Section 17, Member Satisfaction, on page 55.

- You or your caregivers behave in a way that makes it hard for us to provide you with care
- You are in the LTC program and live in an assisted living facility or adult family care home that is not home-like and you will not move into a facility that is home-like[4]

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

Section 10: Managing Your Care

If you have a medical condition or illness that requires extra support and coordination, we may assign a case manager to work with you. Your case manager will help you get the services you need. The case manager will work with your other providers to manage your health care. If you decide you do not want a case manager, you may opt out at any time by notifying your case manager or calling Member Services. .

If you are in the LTC program, we will assign you a case manager. You must have a case manager if you are in the LTC program. Your case manager is your go-to person and is responsible for **coordinating your care**. This means they are the person who will help you figure out what LTC services you need and how to get them.

If you have a problem with your care, or something in your life changes, let your case manager know and they will help you decide if your services need to change to better support you.

Changing Case Managers

If you want to change case managers, call Member Services. There may be times when we will have to change your case manager. If we need to do this, we will send a letter to let you know and we may give you a call.

Important Things to Tell Your Case Manager

If something changes in your life or you don't like a service or provider, let your case manager know. You should tell your case manager if:

- You don't like a service
- You have concerns about a service provider
- Your services aren't right
- You get new health insurance
- You go to the hospital or emergency room
- Your caregiver can't help you anymore
- Your living situation changes
- Your name, telephone number, address, or county changes

[4] This is for Long-Term Care program enrollees only. If you have questions about your facility's compliance with this federal requirement, please call Member Services or your case manager.

- You want more information about programs you may be eligible for
- You have new health concerns or diagnosis

Health Risk Assessments (HRA)
An HRA needs to be completed by each enrollee within 60 days of enrollment. You may call Member Services or you may receive a call from your health plan to complete the HRA if you have not done so already.

Request to Put Your Services on Hold
If something changes in your life and you need to stop your service(s) for a while, let your case manager know. Your case manager will ask you to fill out and sign a Consent for Voluntary Suspension Form to put your service(s) on hold.

Section 11: Accessing Services

Before you get a service or go to a health care appointment, we have to make sure you need the service and that it is medically right for you. This is called **prior authorization.** To do this, we look at your medical history and information from your doctor or other health care providers. Then we will decide if that service can help you. We use rules from the Agency to make these decisions.

Providers in Our Plan
For the most part, you must use doctors, hospitals, and other health care providers that are in our **provider network**. Our provider network is the group of doctors, therapists, hospitals, facilities, and other health care providers that we work with. You can choose from any provider in our provider network. This is called your **freedom of choice**. If you use a health care provider that is not in our network, you may have to pay for that appointment or service.

You will find a list of providers that are in our network in our provider directory. You can search the online provider directory by provider name, specialty, location, and language and language services. The provider directory gives the provider's name, address, telephone numbers, professional credentials, specialty and board certification status. For more information, you can also visit www.healthgrades.com. This site gives more information about providers, such as which medical school they attended and where they did their residency training. If you want a copy of the provider directory, call **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)** to get a copy or visit our website at **aetnabetterhealth.com/florida/find-provider**.

If you are in the LTC program, your case manager is the person who will help you choose a service provider who is in our network for each of your services. Once you choose a service provider, they will contact them to begin your services. This is how services are **approved** in the LTC program. Your case manager will work with you, your family, your caregivers, your doctors and other providers to make sure that your LTC services work with your medical care and other parts of your life.

Providers Not in Our Plan

There are some services that you may be able to get from providers who are not in our provider network. These services are:

- Family planning services and supplies
- Women's preventative health services, such as breast exams, screenings for cervical cancer, and prenatal care
- Treatment of sexually transmitted diseases
- Emergency care

If we cannot find a provider in our provider network for these services, we will help you find another provider that is not in our network. Remember to check with us first before you use a provider that is not in our provider network. If you have questions, call Member Services.

When We Pay for Your Dental Services

Your dental plan will cover most of your dental services, but some services may be covered by Aetna Better Health of Florida. Contact Member Services at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)** for help with arranging these services.

What Do I Have To Pay For?

You may have to pay for appointments or services that are not covered**.** A **covered service** is a service we must provide in the Medicaid program. All the services listed in this handbook are covered services. Remember, just because a service is covered, does not mean you will need it. You may have to pay for services if we did not approve it first.

If you get a bill from a provider, call Member Services. Do not pay the bill until you have spoken to us. We will help you.

Services for Children[5]

We must provide all medically necessary services for our members who are ages 0 – 20 years old. This is the law. This is true even if we do not cover a service or the service has a limit. As long as your child's services are medically necessary, services have:

- No dollar limits; or
- No time limits, like hourly or daily limits

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

[5] Also known as "Early and Periodic Screening, Diagnosis, and Treatment" or "EPSDT" requirements.

Services Covered by the Medicaid Fee-for-service Delivery System, Not Covered Through Aetna Better Health of Florida.

The Medicaid fee-for-service program is responsible for covering the following services, instead of Aetna Better Health of Florida covering these services:

- County Health Department (CHD) Certified Match Program
- Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver
- Familial Dysautonomia (FD) Home and Community-Based Services Waiver
- Hemophilia Factor-related Drugs
- Intermediate Care Facility Services for Individuals with Intellectual Disabilities (ICF/IID)
- Medicaid Certified School Match (MCSM) Program
- Model Home and Community-Based Services Waiver
- Newborn Hearing Services
- Prescribed Pediatric Extended Care
- Substance Abuse County Match Program

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

Moral or Religious Objections

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

Section 12: Helpful Information About Your Benefits

Choosing a Primary Care Provider (PCP)

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

One of the first things you will need to do when you enroll in our plan is choose a PCP. This can be a doctor, nurse practitioner, or a physician assistant. You will contact your PCP to make an appointment for services such as regular check-ups, shots (immunizations), or when you are sick. Your PCP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PCP by calling Member Services.

You can choose a different PCP for each family member or you can choose one PCP for the entire family. If you do not choose a PCP, we will assign a PCP for you and your family.

You can change your PCP at any time. To change your PCP, call Member Services.

Choosing a PCP for Your Child

You can pick a PCP for your baby before your baby is born. We can help you with this by calling Member Services. If you do not pick a PCP by the time your baby is born, we will pick one for you. If you want to change your baby's PCP, call us.

It is important that you select a PCP for your child to make sure they get their well child visits each year. Well child visits are for children 0 – 20 years old. These visits are regular check-ups that help you and your child's PCP know what is going on with your child and how they are growing. Your child may also receive shots (immunizations) at these visits. These visits can help find problems and keep your child healthy.[6]

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

You do not need a referral for well child visits. Also, there is no charge for well child visits.

Specialist Care and Referrals

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

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

Second Opinions

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

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

Urgent Care

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

---

[6] For more information about the screenings and assessments that are recommended for children, please refer to the "Recommendations for Preventative Pediatric Health Care – Periodicity Schedule" at **Periodicity Schedule (aap.org)**.

If you need Urgent Care after office hours and you cannot reach your PCP, our 24-Hour Nurse Line is available anytime at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)** for your medical questions and when you cannot reach your doctor. You may also find the closest Urgent Care center to you by visiting our website at **aetnabetterhealth.com/florida/find-provider**.

Hospital Care

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

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

Emergency Care

You have an **emergency** medical condition when you are so sick or hurt that your life or health is in danger if you do not get medical help right away. Some examples are:

- Broken bones
- Bleeding that will not stop
- You are pregnant, in labor and/or bleeding
- Trouble breathing
- Suddenly unable to see, move, or talk

Emergency services are those services that you get when you are very ill or injured. These services try to keep you alive or to keep you from getting worse. They are usually delivered in an emergency room.

If your condition is severe, call 911 or go to the closest emergency facility right away. You can go to any hospital or emergency facility. If you are not sure if it is an emergency, call your PCP. Your PCP will tell you what to do.

The hospital or facility does not need to be part of our provider network or in our service area. You also do not need to get approval ahead of time to get emergency care or for the services that you receive in an emergency room to treat your condition.

If you have an emergency when you are away from home, get the medical care you need. Be sure to call Member Services when you are able and let us know.

Pharmacy Benefits

Filling Prescriptions

We cover a full range of prescription medications. We have a list of drugs that we cover. This list is called our **Preferred Drug List**. The drug list is updated regularly. You can find the current list on our Web site at **aetnabetterhealth.com/florida/pharmacy-prescription-drug-benefits.html** or by calling Member Services. The Preferred Drug List

tells you which drugs are covered and if there are any special rules or restrictions such as quantity limits or generic substitutions.

We cover some **brand name** and **generic** drugs. The Florida Medicaid Agency determines if a brand or generic drug is preferred. Generic drugs have the same ingredients as brand name drugs, but they are often cheaper than brand name drugs. They work the same. If a generic drug is covered and you need the brand, your provider may request a Prior Authorization. Your provider will need to submit information such as medical records to support an exception request.

We have pharmacies in our provider network. You can fill your prescription at any pharmacy that is in our provider network. Make sure to bring your Plan ID card with you to the pharmacy.

The list of covered drugs may change from time to time. If the list changes and you are impacted, the health plan will notify you.

Specialty Pharmacy Information

Specialty medicines are used to treat a variety of conditions such as cancer, arthritis, and other diseases. Specialty medicines include injectable medicines that are given by shot at your home or in the doctor's office. You doctor will tell you if you need specialty medicines which need prior approval by Aetna Better Health.

CVS Specialty Pharmacy is our preferred specialty pharmacy for certain drugs. For the list of drugs that should be filled at CVS Specialty Pharmacy, go to our website **aetnabetterhealth.com/florida/pharmacy-prescription-drug-benefits.html**. Please call the phone number on your ID card if you want to opt-out of the CVS Specialty Network and choose among participating providers. Remember to show your ID card to your pharmacist every time you get your prescription filled.

Behavioral Health Services

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

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

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

- Calling Member Services at **1-800-441-5501** (MMA –Medicaid) or

1-844-645-7371 (LTC) **(TTY: 711).**

- Looking at our provider directory.
- Going to our website **aetnabetterhealth.com/florida/find-provider**.

Someone is there to help you 24 hours a day, 7 days a week.

You do not need a referral from your PCP for behavioral health services.

If you are thinking about hurting yourself or someone else, call 911. You can also go to the nearest emergency room or crisis stabilization center, even if it is out of our service area. Once you are in a safe place, call your PCP if you can. Follow up with your provider within 24-48 hours. If you get emergency care outside of the service area, we will make plans to transfer you to a hospital or provider that is in our plan's network once you are stable.

Member Reward Programs

We offer programs to help keep you healthy and to help you live a healthier life (like losing weight or quitting smoking). We call these **healthy behavior programs**. You can earn rewards while participating in these programs. Our plan offers the following programs:

- **Tobacco Cessation Program**
  You can use your health plan benefits to get help to quit smoking. Working with your case manager and many resources in the community, including nicotine replacement therapy, you will be supported while working toward your goal of being tobacco free. As a reward after 3 months of reducing your tobacco use, , you will receive a $20 gift card and another $20 gift card if you continue to make progress towards reducing your tobacco use for 6 months, confirmed by your doctor and claims.
- **Weight Management Program**
  Members who are overweight can receive help with meeting their weight loss goals and become healthier. Our weight management program provides you with support and help from a case manager and nutritional counselor. Members who achieve their weight loss goals after 3 months will receive a wearable Bluetooth fitness tracker that will make it easier to track and meet your fitness goals. After 6 months of continued progress towards your weight loss goals and attending appointments with your nutritionist and doctor, you will receive a $20 gift card.
- **Substance Use**
  If you have a problem with substance use (alcohol or drugs), your health plan is here for you. With the help of your physician, case manager, and behavioral health therapist you will have the support that you need to become and stay sober. After enrolling in our Substance Use program, you will participate in care management, attend AA/NA group meetings, and work with a therapist. After 90 days of making meaningful steps towards recovery, you will receive a $20 gift card. If you continue on your path of recovery for 180 days, attend your meetings and doctor's appointments, you will receive another $20 gift card.

- **Maternity Matters powered by ProgenyHealth**
  Members who are enrolled in Case Management and attend certain maternity appointments during their pregnancy will receive gift card rewards.
  - **Initial Prenatal Visit:** Members enrolled in Case Management who attend their initial prenatal visit during the first trimester of pregnancy will receive a $20 gift card.
  - **Maternity Subsequent Prenatal Visit**: Members enrolled in Case Management who attend subsequent prenatal visits after their initial visit will receive a $10 gift card. Limited to 10 prenatal visits.
  - **Maternity Postpartum Visit**: Members enrolled in Case Management who attend up to 2 visits per pregnancy for postpartum care will receive a $20 gift card. Visits must occur between 7 and 84 days after delivery.
  - **Maternity Dental Visit:** Members enrolled in Case Management who attend up to 2 dental visits per pregnancy will receive a $20 gift card.
  - **Maternity Notification of Pregnancy**: Members can earn $50 per pregnancy when they submit a *Notification of Pregnancy* form to Aetna Better Health of Florida.

Please remember that rewards cannot be transferred. If you leave our Plan for more than 180 days, you may not receive your reward. If you have questions or want to join any of these programs, please call us **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711).**

Chronic Disease Management Programs

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

Cancer and Cancer Prevention: Educates members on ways to prevent cancer (nutrition, exercise, tobacco cessation, sunscreen use). Assists members diagnosed with cancer decrease the emotional burden of their cancer diagnosis and treatment, improve their quality of life and health outcomes, and provides family and community supports to manage the disease.

Diabetes and Diabetes Prevention: Educates members on diabetes health risks, healthy lifestyles (wellness, diet and exercise habits) controlling blood sugar levels, and proper use of medications.

Depression and Depression Prevention (including suicide prevention): Provides prevention education, tools, and support to members. Assists in finding a healthy support system, a provider if needed, and guidance on following a treatment and medication plan.

Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and HIV Prevention: Offers prevention education (diet, exercise, wellness) and teaches members with HIV/AIDS how to self-manage their physical and emotional

symptoms, understand their treatment choices, link to support systems and follow their treatment and medication plan.

Attention Deficit Hyperactivity Disorder (ADHD): Assists pediatric and adult members diagnosed with Attention Deficit Hyperactivity Disorder (ADHD) recognize and manage their symptoms, understand treatment and medication options, and support parents and caregivers.

Substance Use Disorders: Assists members with understanding substance abuse, improving their health, social function, and quality of life. Provides guidance on finding treatment and community-based support systems.

If you are in the LTC program, we also offer the following programs:

Dementia: Provides guidance on services, supports and available resources for members with Alzheimer's Disease, Lewy Body Dementia, Vascular dementia, or Frontotemporal dementia and their caregivers

Chronic Obstructive Pulmonary Disease (COPD): Assists members with improving quality of life symptoms (breathlessness, cough) and physical function. Offers education and support on nutrition, mental health and smoking cessation.

Quality Enhancement Programs

We want you to get quality health care. We offer additional programs that help make the care you receive better. The programs are:

Quality Improvement (QI) strategy

We work hard to improve the service, quality and safety of health care. One way we do this is by measuring how well we and others are doing. We work with groups of doctors and other health professionals to make health care better.

Our clinical activities and programs are based on proven guidelines. We also give you and your doctor information and tools that may help you make decisions.

Program goals

We aim to:

- Meet our members' health care needs.
- Measure, monitor and improve the clinical care and quality of service our members get.
- Institute company-wide initiatives to improve the safety of our members and communities.
- Make sure we obey all the rules, whether they come from plan employers, federal and state regulators or accrediting groups.

Program scope

We work to make your health care better by:

- Developing policies and procedures that reflect current standards of clinical practice.
- Reviewing preventive and behavioral health services, and how care is coordinated.
- Addressing racial and ethnic differences in health care.
- Monitoring the effectiveness of our programs.

- Studying the accessibility and availability of our network providers.
- Performing credentialing and recredentialing activities.
- Assessing member and provider satisfaction.

Program outcomes

Each year we check to see how close we are to meeting our goals. Here's what we did last year:

- We collected data on a set of clinical measures called the Healthcare Effectiveness Data and Information Set (HEDIS®[6]), as applicable. We shared the results with the National Committee for Quality Assurance (NCQA) Quality Compass®[7]. The NCQA makes the results public. Each year, we use the results to set new goals and improve selected measures. As a result, performance has improved on many measures.
- We asked members how satisfied they are with Aetna Better Health of Florida. We improved in rating of health care, personal doctor and specialist, and how well doctors communicate. We met the cultural and language needs of our members.
- We surveyed members in the Disease Management Program. They told us they were satisfied with the program overall. The program helped them understand and improve their health. It also helped them follow their treatment plans and reach their health goals.
- We also:
  - Continued with our patient safety program.
  - Improved access to providers.
  - Improved communication between members' Primary Care and Behavioral Health Physicians.

Accreditation

We take our accreditation by the NCQA seriously. It's how we show our commitment to improving your quality of care, access to care and member satisfaction. Get more information about our NCQA accreditation go to **www.ncqa.org/**.

To learn more about our QI Program and how we measure quality, call Member Services. You also have a right to tell us about changes you think we should make.

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

You also have a right to tell us about changes you think we should make. To get more information about our quality enhancement program or to give us your ideas, call Member Services.

[6]HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[7] Quality Compass is a registered trademark of NCQA

Section 13: Your Plan Benefits: Managed Medical Assistance Services

The table below lists the medical services that are covered by our Plan. Remember, you may need a referral from your PCP or approval from us before you go to an appointment or use a service. Services must be medically necessary for us to pay for them[7].

There may be some services we do not cover but might be covered by Medicaid. There are some services your State has determined are medically appropriate and can be provided in place of a covered service or setting under the State plan. These are called "In Lieu of Services (ILOS)." To find out about these benefits, call the Agency Medicaid Help Line at **1-877-254-1055**. If you need a ride to any of these services, we can help you. You can call **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)** to schedule a ride.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the date the change takes place.

If you have questions about any of the covered medical services, please call Member Services.

Service	Description	Coverage/Limitations	Prior Authorization Required
Addictions Receiving Facility Services	Services used to help people who are struggling with drug or alcohol addiction	As medically necessary and recommended by us	Yes
Allergy Services	Services to treat conditions such as sneezing or rashes that are not caused by an illness	We cover medically necessary blood or skin allergy testing and up to 156 doses per year of allergy shots	No
Ambulance Transportation Services	Ambulance services are for when you need emergency care while being transported to the hospital or special support when being transported between facilities	Covered as medically necessary.	Yes; authorization required for hospital-to-hospital transfers only.
Ambulatory	Services provided to	As medically necessary and	Yes

[7] You can find the definition for Medical Necessity in the Definitions Policy at **https://ahca.myflorida.com/medicaid/rules/adopted-rules-general-policies**

Service	Description	Coverage/Limitations	Prior Authorization Required
Detoxification Services	people who are withdrawing from drugs or alcohol	recommended by us	
Ambulatory Surgical Center Services	Surgery and other procedures, including dental sedation and anesthesia that are performed in a facility that is not the hospital (outpatient)	Covered as medically necessary.	Yes; authorization required for some procedures.
Anesthesia Services	Services to keep you from feeling pain during surgery or other medical procedures	Covered as medically necessary.	No
Assistive Care Services	Services provided to adults (ages 18 and older) help with activities of daily living and taking medication	We cover 365/366 days of services per year, as medically necessary.	Yes
Behavior Analysis (BA)	Structured interventions, strategies, and approaches provided to decrease maladaptive behaviors and increase or reinforce appropriate behaviors.	We cover recipients under the age of 21 years requiring medically necessary services.	Yes
Behavioral Health Assessment Services	Services used to detect or diagnose mental illnesses and behavioral health disorders	We cover, as medically necessary: One initial assessment per year One reassessment per year Up to 150 minutes of brief behavioral health status assessments (no more than 30 minutes in a single day)	No
Behavioral Health Overlay Services	Behavioral health services provided to children (ages 0 – 18) enrolled in a DCF	We cover 365/366 days of medically necessary services per year, including therapy, support services and aftercare	Yes

Service	Description	Coverage/Limitations	Prior Authorization Required
	program	planning	
Behavioral Health Services – Child Welfare	A special mental health program for children enrolled in a DCF program	As medically necessary and recommended by us	Yes
Cardiovascular Services	Services that treat the heart and circulatory (blood vessels) system	We cover the following as prescribed by your doctor, when medically necessary: Cardiac testing Cardiac surgical procedures Cardiac devices	Yes; prior authorization required for some tests and procedures.
Child Health Services Targeted Case Management	Services provided to children (ages 0 - 3) to help them get health care and other services OR Services provided to children (ages 0 – 20) who use medical foster care services	Your child must be enrolled in the DOH Early Steps program OR Your child must be receiving medical foster care services	No
Chiropractic Services	Diagnosis and manipulative treatment of misalignments of the joints, especially the spinal column, which may cause other disorders by affecting the nerves, muscles, and organs	We cover, as medically necessary: 24 patient visits per year, per member X-rays	No
Clinic Services	Health care services provided in a county health department, federally qualified health center, or a rural health clinic	Visits to a federally qualified health center or rural health clinic visit, medically necessary	No
Community-Based Wrap-Around Services	Services provided by a mental health team to children who are at risk of going into a	As medically necessary and recommended by us	Yes

Service	Description	Coverage/Limitations	Prior Authorization Required
	mental health treatment facility		
Crisis Stabilization Unit Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	Notification is required within 24 hours of admission. Authorization is provided for the first 3 days of an emergency involuntary (Baker Act) admission. Prior authorization is required for continued stay
Dialysis Services	Medical care, tests, and other treatments for the kidneys. This service also includes dialysis supplies, and other supplies that help treat the kidneys	We cover the following as prescribed by your treating doctor, when medically necessary: Hemodialysis treatments Peritoneal dialysis treatments	Yes
Drop-In Center Services	Services provided in a center that helps homeless people get treatment or housing	As medically necessary and recommended by us	No
Durable Medical Equipment and Medical Supplies Services	Medical equipment is used to manage and treat a condition, illness, or injury. Durable medical equipment is used over and over again, and includes things like wheelchairs, braces, crutches, and other items. Medical supplies are items meant for one-time use and then thrown away	As medically necessary, some service and age limits apply. Call Member Services at **1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC) or **TTY: 711** for more information.	Yes; prior authorization required for certain equipment and supplies.

Service	Description	Coverage/Limitations	Prior Authorization Required
Early Intervention Services	Services to children ages 0 - 3 who have developmental delays and other conditions	We cover medically necessary: One initial evaluation per lifetime, completed by a team Up to 3 screenings per year Up to 3 follow-up evaluations per year Up to 2 training or support sessions per week	No
Emergency Transportation Services	Transportation provided by ambulances or air ambulances (helicopter or airplane) to get you to a hospital because of an emergency	Covered as medically necessary.	No
Evaluation and Management Services	Services for doctor's visits to stay healthy and prevent or treat illness	We cover medically necessary: One adult health screening (check-up) per year Well child visits are provided based on age and developmental needs One visit per month for people living in nursing facilities Up to two office visits per month for adults to treat illnesses or conditions	No
Family Therapy Services	Services for families to have therapy sessions with a mental health professional	We cover medically necessary: Up to 26 hours per year	No
Family Training and Counseling for Child Development	Services to support a family during their child's mental health treatment	As medically necessary and recommended by us	No
Gastrointestinal Services	Services to treat conditions, illnesses, or diseases of the stomach or digestion system	We cover: Covered as medically necessary	Yes; prior authorization required for certain tests and procedures.

Service	Description	Coverage/Limitations	Prior Authorization Required
Genitourinary Services	Services to treat conditions, illnesses, or diseases of the genitals or urinary system	We cover: Covered as medically necessary	Yes; prior authorization required for certain tests and procedures.
Group Therapy Services	Services for a group of people to have therapy sessions with a mental health professional	We cover medically necessary: Up to 39 hours per year	No
Hearing Services	Hearing tests, treatments and supplies that help diagnose or treat problems with your hearing. This includes hearing aids and repairs	We cover hearing tests and the following as prescribed by your doctor, when medically necessary: Cochlear implants One new hearing aid per ear, once every 3 years Repairs	No
Home Health Services	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness or injury	We cover, when medically necessary: Up to 4 visits per day for pregnant recipients and recipients ages 0-20 Up to 3 visits per day for all other recipients	Yes
Hospice Services	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers	Covered as medically necessary Copayment: See information on Patient Responsibility for copayment information; you may have Patient Responsibility for hospice services whether living at home, in a facility, or in a nursing facility	Yes
Individual Therapy Services	Services for people to have one-to-one therapy sessions with	We cover medically necessary: Up to 26 hours per year	No

Service	Description	Coverage/Limitations	Prior Authorization Required
	a mental health professional		
Infant Mental Health Pre and Post Testing Services	Testing services by a mental health professional with special training in infants and young children	As medically necessary and recommended by us	Yes
Inpatient Hospital Services	Medical care that you get while you are in the hospital. This can include any tests, medicines, therapies and treatments, visits from doctors and equipment that is used to treat you	We cover the following inpatient hospital services based on age and situation, when medically necessary: Up to 365/366 days for recipients ages 0-20 Up to 45 days for all other recipients (extra days are covered for emergencies)	Yes
Integumentary Services	Services to diagnose or treat skin conditions, illnesses or diseases	Covered as medically necessary	Yes, prior authorization required for certain tests and procedures.
Laboratory Services	Services that test blood, urine, saliva or other items from the body for conditions, illnesses or diseases	Covered as medically necessary	Yes, prior authorization required for genetic testing.
Medical Foster Care Services	Services that help children with health problems who live in foster care homes	Must be in the custody of the Department of Children and Families	No
Medication Assisted Treatment Services	Services used to help people who are struggling with drug addiction	Covered as medically necessary	No
Medication Management Services	Services to help people understand and make the best choices for taking medication	Covered as medically necessary	No
Mental Health	Treatment provided	As medically necessary and	Yes

Service	Description	Coverage/Limitations	Prior Authorization Required
Partial Hospitalization Program Services	for more than 3 hours per day, several days per week, for people who are recovering from mental illness	recommended by us	
Mental Health Targeted Case Management	Services to help get medical and behavioral health care for people with mental illnesses	Covered as medically necessary	Yes
Mobile Crisis Assessment and Intervention Services	A team of health care professionals who provide emergency mental health services, usually in people's homes	As medically necessary and recommended by us	No
MultiSystemic Therapy Services	An intensive service focused on the family for children at risk of residential mental health treatment	As medically necessary and recommended by us	Initial prior authorization not required. If the service exceeds 104 units, prior authorization is required
Neurology Services	Services to diagnose or treat conditions, illnesses or diseases of the brain, spinal cord or nervous system	Covered as medically necessary	Yes, prior authorization required for certain tests and procedures.
Non-Emergency Transportation Services	Transportation to and from all of your medical appointments. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles	We cover the following services for recipients who have no transportation: Out-of-state travel Transfers between hospitals or facilities Escorts when medically necessary	Yes, prior authorization is needed for travel over 50 miles.
Nursing Facility Services	Medical care or nursing care that you get while living full-	We cover 365/366 days of services in nursing facilities as medically necessary	Yes

Service	Description	Coverage/Limitations	Prior Authorization Required
	time in a nursing facility. This can be a short-term rehabilitation stay or long-term	Copayment: See information on Patient Responsibility for room & board copayment information	
Occupational Therapy Services	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: One initial evaluation per year Up to 210 minutes of treatment per week One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Oral Surgery Services	Services that provide teeth extractions (removals) and to treat other conditions, illnesses or diseases of the mouth and oral cavity	Covered as medically necessary	Yes
Orthopedic Services	Services to diagnose or treat conditions, illnesses or diseases of the bones or joints	Covered as medically necessary	Yes, prior authorization required for certain tests and procedures.
Outpatient Hospital Services	Medical care that you get while you are in the hospital but are not staying overnight. This can include any tests, medicines, therapies and treatments, including dental sedation and anesthesia, and visits	Emergency services are covered as medically necessary Non-emergency services cannot cost more than $1,500 per year for recipients ages 21 and over	Yes, prior authorization required for certain tests and procedures

Service	Description	Coverage/Limitations	Prior Authorization Required
	from doctors and equipment that is used to treat you		
Pain Management Services	Treatments for long-lasting pain that does not get better after other services have been provided	Covered as medically necessary. Some service limits may apply	Yes
Partial Hospitalization Services	Services for people leaving a hospital for mental health treatment	As medically necessary and recommended by us	Yes
Physical Therapy Services	Physical therapy includes exercises , stretching and other treatments to help your body get stronger and feel better after an injury, illness or because of a medical condition	We cover for children ages 0-20 and for adults under the $1,500 outpatient services cap, as medically necessary: One initial evaluation per year Up to 210 minutes of treatment per week One initial wheelchair evaluation per 5 years We cover for people of all ages, as medically necessary: Follow-up wheelchair evaluations, one at delivery and one 6-months later	Yes
Podiatry Services	Medical care and other treatments for the feet	We cover, as medically necessary: Up to 24 office visits per year Foot and nail care X-rays and other imaging for the foot, ankle and lower leg Surgery on the foot, ankle or lower leg	Yes, prior authorization required for certain tests and procedures.
Prescribed Drug Services	This service is for drugs that are prescribed to you by a doctor or other health care provider	We cover, as medically necessary: Up to a 34-day supply of drugs, per prescription Refills, as prescribed	Yes, prior authorization required for some drugs.
Private Duty Nursing Services	Nursing services provided in the home	We cover, as medically necessary:	Yes

Service	Description	Coverage/Limitations	Prior Authorization Required
	to people ages 0 to 20 who need constant care	Up to 24 hours per day	
Psychiatric Specialty Hospital Services	Emergency mental health services that are performed in a facility that is not a regular hospital	As medically necessary and recommended by us	No
Psychological Testing Services	Tests used to detect or diagnose problems with memory, IQ or other areas	We cover, as medically necessary: 10 hours of psychological testing per year	Yes
Psychosocial Rehabilitation Services	Services to assist people re-enter everyday life. They include help with basic activities such as cooking, managing money and performing household chores	We cover, as medically necessary: Up to 480 hours per year	Yes
Radiology and Nuclear Medicine Services	Services that include imaging such as x-rays, MRIs or CAT scans. They also include portable x-rays	Covered as medically necessary	Yes, prior authorization required for some studies.
Regional Perinatal Intensive Care Center Services	Services provided to pregnant women and newborns in hospitals that have special care centers to handle serious conditions	Covered as medically necessary	No
Reproductive Services	Services for women who are pregnant or want to become pregnant. They also include family planning services that provide birth control drugs and supplies to	We cover medically necessary family planning services. You can get these services and supplies from any Medicaid provider; they do not have to be a part of our Plan. You do not need prior approval for these services. These services are	No

Service	Description	Coverage/Limitations	Prior Authorization Required
	help you plan the size of your family	free. These services are voluntary and confidential, even if you are under 18 years old.	
Respiratory Services	Services that treat conditions, illnesses or diseases of the lungs or respiratory system	We cover medically necessary: Respiratory testing Respiratory surgical procedures Respiratory device management	Yes, prior authorization required for certain tests and procedures.
Respiratory Therapy Services	Services for recipients ages 0-20 to help you breathe better while being treated for a respiratory condition, illness or disease	We cover medically necessary: One initial evaluation per year One therapy re-evaluation per 6 months Up to 210 minutes of therapy treatments per week (maximum of 60 minutes per day)	Yes
Self-Help/Peer Services	Services to help people who are in recovery from an addiction or mental illness	As medically necessary and recommended by us	No
Specialized Therapeutic Services	Services provided to children ages 0-20 with mental illnesses or substance use disorders	We cover the following medically necessary: Assessments Foster care services Group home services	No
Speech-Language Pathology Services	Services that include tests and treatments help you talk or swallow better	We cover the following medically necessary services for children ages 0-20: Communication devices and services Up to 210 minutes of treatment per week One initial evaluation per year We cover the following medically necessary services for adults: One communication evaluation per 5 years	Yes
Statewide Inpatient Psychiatric	Services for children with severe mental illnesses that need	Covered as medically necessary for children ages 0-20	Yes

Service	Description	Coverage/Limitations	Prior Authorization Required
Program Services	treatment in the hospital		
Substance Abuse Intensive Outpatient Program Services	Treatment provided for more than 3 hours per day, several days per week, for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Substance Abuse Short-term Residential Treatment Services	Treatment for people who are recovering from substance use disorders	As medically necessary and recommended by us	Yes
Therapeutic Behavioral On-Site Services	Services provided by a team to prevent children ages 0-20 with mental illnesses or behavioral health issues from being placed in a hospital or other facility	We cover medically necessary services: Up to 9 hours per month	No
Transplant Services	Services that include all surgery and pre and post-surgical care	Covered as medically necessary	Yes
Visual Aid Services	Visual Aids are items such as glasses, contact lenses and prosthetic (fake) eyes	We cover the following medically necessary services when prescribed by your doctor: Two pairs of eyeglasses for children ages 0-20 One frame every two years and two lenses every 365 days for adults ages 21 and older Contact lenses Prosthetic eyes	No
Visual Care Services	Services that test and treat conditions, illnesses and diseases of the eyes	Covered as medically necessary	Yes

Your Plan Benefits: Expanded Benefits

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

Service	Description	Coverage/Limitations	Prior Authorization
After School Activities	Members ages 5-18 have access to a $50 stipend per year for after-school activities. No prior authorization required.	Ages 5-18, $50 per year	No
Asthma Home Care	Members with an asthma diagnosis have access to hypoallergenic bedding and a $150 stipend for carpet cleaning and pest control. Prior authorization required.	One set of bedding per year, $150 per year for carpet cleaning and pest control	Yes
Baby Item Stipend	Members may get $150 stipend per pregnancy for baby items such as crib, stroller and car seat. Prior authorization required.	$150 per pregnancy after completing a prenatal visit within the first trimester or within 30 days of joining plan.	Yes
Behavioral Health Integration Services	Care management services provided by doctors	As medically necessary	No
Blue Jeans for Teens	Members ages 13-21 may get a $150 stipend per year for clothing with a qualifying well-visit with their primary care doctor. Prior authorization required.	Ages 13-21, $150 per year	Yes
Calming Comfort Collection	Members may get one calming box per year that includes items to support mental health concerns and trauma. Prior authorization required.	One box per year	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Career Closet	Members 18+ may get a $100 clothing stipend to support workforce development after completing 5 life skill courses through the online program. One time only. Prior authorization required.	Members 18+, $100 per lifetime	Yes
Childcare Support	Members may get $150 one time to pay for childcare during pregnancy or postpartum. Prior authorization required.	$150 one time	Yes
Developmentally Delayed Stipend	Members 18+ may get a $500 stipend to cover expenses related to the following: Education/job training Pursuing volunteer opportunities or faith-based activities Services that provide improvements for the home Supports that address barriers to access to care (transportation or provider consultations not otherwise covered by Medicaid). Prior authorization required.	Members 18+, $500 per year	Yes
Diaper Club	Pregnant members and babies up to 30 months may earn a $35 diaper stipend after completing well visits. Prior authorization required.	$35 for pregnant members in their 3rd trimester $35 every 2 months (up to 6 times) for each child from 0 to 15 months $35 every 6 months (up to 2 times) for each child from 16 to 30 months	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Doula Services	Members may get unlimited doula services to support prenatal and postpartum care. No prior authorization required.	No limit for pregnant female members 14 to 55 years of age	No
Durable Medical Equipment	Members ages 10+ may get one blood pressure monitor per year. Prior authorization required.	Members ages 10+, one per year	Yes
Financial Literacy Book	Members ages 6-18 may get one financial literacy book. No prior authorization required.	Members ages 6-18, one book per lifetime	No
Food Assistance: Food as Medicine	Members with certain chronic conditions may get a $50 food stipend per month (up to 3 months). Prior authorization is required.	Members new to case management or newly diagnosed with certain chronic conditions; $50 per month (up to 3 months)	Yes
Food Assistance: Home Delivered Meals Post-Discharge	Members may get up to 14 meals after discharge from a hospital or nursing facility. Prior authorization is required.	14 meals after minimum 3-day inpatient hospital stay or nursing facility and within the first 30 days of discharge	Yes
GED Support and Job Skills Training	Members ages 18+ (16-17 with parental, custodial or legal guardian consent and school district permission) may access a job skills training platform. The platform has GED preparation courses, preparation materials, and practice tests to help members with a GED. The costs of GED tests may be covered. No prior authorization required.	Members ages 18+ (16-17 with parental, custodial or legal guardian consent and school district permission). One per year	No

Service	Description	Coverage/Limitations	Prior Authorization
Grooming and Hygiene Stipend	Members ages 18+ with a qualifying well visit with their primary care doctor will receive a $50 stipend per quarter to support workforce activities. Prior authorization required.	Members ages 18+ with a qualifying well visit with their primary care doctor, $50 per quarter	Yes
Hearing Benefits for Adults	Members ages 21+ get one annual hearing exam and a set of hearing aids every two years. No prior authorization required.	Members ages 21+, one annual hearing exam and a set of hearing aids every two year	No
Home Delivered Meals – Hurricane Preparedness	Home and Community-Based members may request three home-delivered, shelf-stable meals per day for up to 2 weeks to prepare for hurricane season. Prior authorization required.	Home and Community-Based members, three meals per day for 2 weeks, may be requested May through November	Yes
Housing Assistance: Transition Funds	LTC members who live in a nursing facility and would like to transition home are eligible to get assistance with moving expenses. Funds can be used towards housing, furnishings, supplies and other related moving expenses. Prior authorization required.	LTC members transitioning from nursing facility to assisted living facility or home	Yes
Housing Assistance: LTSS Housing/Utility Stipend	Members 18+ needing help may get a $500 stipend per year for housing issues such as utility payments. Prior authorization required.	Members 18+, $500 per year	Yes
Housing Assistance: Legal Services	Members 18+ who are tenants may get $500 to use toward legal services related to housing issues such as eviction or repairs. No prior authorization	Members 18+, one per year	No

Service	Description	Coverage/Limitations	Prior Authorization
	required.		
Laundromat Stipend	Members 18+ with a qualifying well visit with their primary care doctor may get a $25 stipend per quarter for laundromat services. Prior authorization required.	Members 18+ with a qualifying well visit with their primary care doctor, $25 per quarter	Yes
Medication Lockbox	Members ages 18+ who are prescribed a medication and have children in their home may get one lockbox per year to secure medications. No prior authorization required.	Members ages 18+ who are prescribed a medication and have children in their home, one lockbox per year	No
Newborn Circumcision	Infants up to 28 days old may get newborn circumcision. No prior authorization required.	Infants up to 28 days old, one per lifetime	No
Non-Emergency Transportation	Members ages 18+ may get ten one-way trips per month to access resources such as food banks, local organizations, faith-based groups, and other activities. No prior authorization required.	Members ages 18+, ten one-way trips per month	No
Occupational Therapy for Adults	Members ages 21+ may get occupational therapy, including: Evaluation and re-evaluation every year Up to seven therapy treatment units per week Wheelchair fitting once every two years Prior authorization required.	Members ages 21+ One evaluation and one re- evaluation per year Up to seven therapy treatment units per week Wheelchair fitting once every two years	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Over-the- Counter (OTC) Benefit	Members may get $65 per household per month for OTC products. No prior authorization required.	$65 limit per household per month on select OTC items	No
Over-the-Counter Period Stipend	Female members ages 11+ may get $20 per quarter for menstrual products. No prior authorization required.	Female members ages 11+, $20 per member per quarter on select OTC items	No
Physical Therapy for Adults	Members ages 21+ may get physical therapy, including: Evaluation and re-evaluation every year Up to seven therapy treatment units per week Wheelchair fitting once every two years. Prior authorization required.	Members ages 21+ One evaluation and one re- evaluation per year Up to seven therapy treatment units per week Wheelchair fitting once every two years	Yes
Prenatal/ Postpartum Services – Breast Pump	Members may get a breast pump.	One hospital grade breast pump per year for rent, one non-hospital grade breast pump every two years.	Yes, prior authorization required for hospital-grade pump.
Prenatal/ Postpartum Services – Visits	Members may get expanded prenatal and postpartum visits. No prior authorization required.	Up to 14 prenatal visits for low-risk pregnancy and 18 visits for high-risk pregnancy before baby is born. After baby is born, three visits within 90 days of delivery.	No
Primary Care Visits for Adults	Members 21+ have access to unlimited primary care visits. No prior authorization required.	Members 21+	No
Tutoring for Children and Teens	Members ages 6-18 may get individualized tutoring and mentoring sessions. Prior authorization required.	Members ages 6-18	Yes
Vision and Hearing Flex Card	Members ages 21+ may get a $100 stipend every two years for extra vision and hearing services after using up expanded benefits. Prior authorization required.	Members ages 21+, $100 every two years after using up expanded benefits	Yes

Service	Description	Coverage/Limitations	Prior Authorization
Vision Services for Adults	Members ages 21+ may get a six-month supply of contact lenses with prescription, eyeglasses with prescription, and one eye exam per year. No prior authorization required.	Members ages 21+, six-month supply of contact lenses with prescription, eyeglasses with prescription, and one eye exam per year.	No
Waived Copayments	Members have access to unlimited waived copayments on all Medicaid covered services. Prior authorization required for non-participating providers.	limit	No prior authorization required for participating providers. Prior authorization required for non-participating providers.
Young Adult Life Coaching Services	Members ages 16-30 may have access to online education for support with developing life skills. No prior authorization required.	Members ages 16-30	No

Your Plan Benefits: Nursing Facility Transition Assistance Benefit

Aetna Better Health of Florida provides a Nursing Facility Transition Assistance benefit for families who are preparing to transition a child home from a nursing facility. You can use this benefit to address housing-related barriers, including but not limited to:

- Renovations to a home, such as improving the electrical system in the home to be able to support the power needs of a ventilator or other medical equipment with substantial power needs
- Purchase of a generator to address equipment needs during power outages
- An addition to the home to provide the child with their own bedroom large enough to accommodate required medical equipment
- An addition to allow a family member such as a grandparent to move in with the family to assist with the child's care or to provide space for private duty nursing in the home.
- The addition of an accessible bathroom if the current bathrooms could not be successfully renovated with home modification funding
- Adaptations to or purchase of an equipped vehicle to meet the child's transportation needs
- Deposits to facilitate transition, including rental security deposits and move-in fees

- Renovations to address the needs of other children in the home and pets so that bringing the child home from a nursing facility does not negatively impact the well-being of other family members
- Repairs or services to a home to ensure a healthy environment, such as mold mitigation, carpet cleaning, HVAC system repairs, or pest control Funding to facilitate moving the child to family that resides out-of-state or to assist families living out-of-state to move back to Florida

Prior authorization is required. Limit of **$75,000** per lifetime.

Questions?

Talk to your child's care manager or call Member Services at **1-800-441-5501** (MMA – Medicaid) or **TTY: 711.**

Your Plan Benefits: Pathways to Prosperity

The Plan shall assess members who may be experiencing barriers to employment, economic self-sufficiency, and independence gain access to care coordination/case management services and health-related social needs, such as housing assistance, food sustainability, vocational training, and educational support services.

New medical treatments

We are always considering new medical treatments. We want you to get safe, up-to-date, and high-quality medical care. A team of providers reviews new health care methods. They decide if they should become covered services. Services and treatments that are being researched and studied are not covered services. We take these steps to decide if new treatments will be a covered benefit or service:

• Study the purpose of each new treatment

• Review medical studies and reports

• Determine the impact of a new treatment

• Develop guidelines on how and when to use the new treatment

Section 14: Cost Sharing for Services

Cost sharing means the portion of costs for certain covered services that is your responsibility to pay. Cost sharing can include coinsurance, copayments, and deductibles. If you have questions about your cost sharing requirements, please contact Member Services.

Section 15: Long-Term Care (LTC) Program Helpful Information

(Read this section if you are in the LTC program. If you are not in the LTC program, skip to Section 17)

Starting Services

It is important that we learn about you so we can make sure you get the care that you need. Your case manager will set up a time to come to your home or nursing facility to meet you.

At this first visit, your case manager will tell you about the LTC program and our Plan. She or he will also ask you questions about:

- Your health.;
- How you take care of yourself.;
- How you spend your time.;
- Who helps takes care of you; and
- Other things.

These questions make up your **initial assessment.** The initial assessment helps us learn about what you need to live safely in your home. It also helps us decide what services will help you the most.

Developing a Plan of Care

Before you can begin to get services under the LTC program, you must have a **person-centered plan of care (plan of care)**. Your case manager makes your plan of care with you. Your plan of care is the document that tells you all about the services you get from our LTC program. Your case manager will talk to you and any family members or caregivers you want to include to decide what LTC services will help. They will use the initial assessment and other information to make a plan that is just for you. Your plan of care will tell you:

- What services you are getting
- Who is providing your service (your service providers)
- How often you get a service
- When a service starts and when it ends (if it has an end date)
- What your services are trying to help you do. For example, if you need help doing light housekeeping tasks around your house, your plan of care will tell you that an adult companion care provider comes 2 days a week to help with your light housekeeping tasks.
- How your LTC services work with other services you get from outside our Plan, such as from Medicare, your church or other federal programs
- Your **personal goals**

  We don't just want to make sure that you are living safely. We also want to make sure that you are happy and feel connected to your community and other people. When your case manager is making your plan of care, they will ask you about any **personal goals** you might have. These can be anything, really, but we want to make sure that

your LTC services help you accomplish your goals. Some examples of personal goals include:

- Walking for 10 minutes every day
- Calling a loved one once a week
- Going to the senior center once a week
- Moving from a nursing facility to an assisted living facility

You or your **authorized representative** (someone you trust who is allowed to talk to us about your care) must sign your plan of care. This is how you show you agree with the **services** on **your plan of care**.

Your case manager will send your PCP a copy of your plan of care. They will also share it with your other health care providers.

Updating your Plan of Care

Every month your case manager will call you to see how your services are going and how you are doing. If any changes are made, she or he will update your plan of care and get you a new copy.

Your case manager will come to see you in person to review your plan of care every 90 days (or about 3 months). This is a good time to talk to them about your services, what is working and isn't working for you, and how your goals are going. They will update your plan of care with any changes. Every time your plan of care changes, you or your authorized representative must sign it.

Remember, you can call your case manager any time to talk about problems you have, changes in your life, or other things. Your case manager or a health plan representative is available to you when you need them.

Your Back-Up Plan

Your case manager will help you make a **back-up plan**. A back-up plan tells you what to do if a service provider does not show up to give a service. For example, your home health aide did not come to give you a bath.

Remember, if you have any problems getting your services, call your case manager.

Section 16: Your Plan Benefits: Long-Term Care Services

The table below lists the Long-Term care services covered by our Plan. Remember, services must be medically necessary in order for us to pay for them[8].

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the effective date of the change.

[8] You can find a copy of the Statewide Medicaid Managed Care Long-Term Care Program Coverage Policy at **https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies**.

If you have any questions about any of the covered Long-Term care services, please call your case manager or Member Services.

Service	Description	Prior Authorization
Adult Companion Care	This service helps you fix meals, do laundry and light housekeeping.	Yes
Adult Day Health Care	Supervision, social programs, and activities provided at an adult day care center during the day. If you are there during meal times, you can eat there.	Yes
Assistive Care Services	These are 24-hour services if you live in an adult family care home.	Yes
Assisted Living	These are services that are usually provided in an assisted living facility. Services can include housekeeping, help with bathing, dressing, and eating, medication assistance, and social programs.	Yes
Attendant Nursing Care	Nursing services and medical assistance provided in your home to help you manage or recover from a medical condition, illness, or injury	Yes
Behavioral Management	Services for mental health or substance abuse needs	Yes
Caregiver Training	Training and counseling for the people who help take care of you	Yes
Care Coordination/ Case Management	Services that help you get the services and support you need to live safely and independently. This includes having a case manager and making a plan of care that lists all the services you need and receive.	Yes
Home Accessibility/ Adaptation Services	This service makes changes to your home to help you live and move in your home safely and more easily. It can include changes like installing grab bars in your bathroom or a special toilet seat. It does not include major changes like new carpeting, roof repairs, plumbing systems, etc.	Yes
Home Delivered Meals	This service delivers healthy meals to your home.	Yes

Service	Description	Prior Authorization
Homemaker Services	This service helps you with general household activities, like meal preparation and routine home chores.	Yes
Hospice	Medical care, treatment, and emotional support services for people with terminal illnesses or who are at the end of their lives to help keep them comfortable and pain free. Support services are also available for family members or caregivers.	Yes
Intermittent and Skilled Nursing	Extra nursing help if you do not need nursing supervision all the time or need it at a regular time	Yes
Medical Equipment and Supplies	Medical equipment is used to help manage and treat a condition, illness, or injury. Medical equipment is used over and over again, and includes things like wheelchairs, braces, walkers, and other items. Medical supplies are used to treat and manage conditions, illnesses, or injury. Medical supplies include things that are used and then thrown away, like bandages, gloves, and other items.	Yes
Medication Administration	Help taking medications if you can't take medication by yourself	Yes
Medication Management	A review of all the prescription and over-the-counter medications you are taking	Yes
Nutritional Assessment/Risk Reduction Services	Education and support for you and your family or caregiver about your diet and the foods you need to eat to stay healthy	Yes
Nursing Facility Services	Nursing facility services include medical supervision, 24-hour nursing care, help with day-to-day activities, physical therapy, occupational therapy, and speech-language pathology	Yes
Personal Care	These are in-home services to help you with: • Bathing • Dressing • Eating • Personal Hygiene	Yes

Service	Description	Prior Authorization
Personal Emergency Response Systems (PERS)	An electronic device that you can wear or keep near you that lets you call for emergency help anytime	Yes
Respite Care	This service lets your caregivers take a short break. You can use this service in your home, an Assisted Living Facility or a Nursing Facility.	Yes
Occupational Therapy	Occupational therapy includes treatments that help you do things in your daily life, like writing, feeding yourself, and using items around the house.	Yes
Physical Therapy	Physical therapy includes exercises, stretching, and other treatments to help your body get stronger and feel better after an injury, illness, or because of a medical condition.	Yes
Respiratory Therapy	Respiratory therapy includes treatments that help you breathe better.	Yes
Speech Therapy	Speech therapy includes tests and treatments that help you talk or swallow.	Yes
Structured Family Caregiving	Services provided in your home to help you live at home instead of in a nursing facility	We may offer the choice to use this service instead of nursing facility services.
Transportation	Transportation to and from all of your LTC program services. This could be on the bus, a van that can transport disabled people, a taxi, or other kinds of vehicles.	Yes

Long-Term Care Participant Direction Option (PDO)*

You may be offered the Participant Direction Option (PDO). You can use PDO if you use any of these services and live in your home:

- Attendant care services
- Homemaker services
- Personal Care services
- Adult companion care services
- Intermittent and skilled nursing care services

PDO lets you **self-direct** your services. This means you get to choose your service provider and how and when you get your service. You have to hire, train, and supervise the people who work for you (your direct service workers).

You can hire family members, neighbors, or friends. You will work with a case manager who can help you with PDO.

If you are interested in PDO, ask your case manager for more details. You can also ask for a copy of the PDO Guidelines to read and help you decide if this option is the right choice for you.

**PDO is not an available option for Intellectual and Developmental Disabilities Waiver program participants. See Exhibit C*

Your Plan Benefits: LTC Expanded Benefits

Expanded benefits are extra services we provide to you at no cost. Talk to your case manager about getting expanded benefits.

Service	Description	Coverage/ Limitations	Prior Authorization
Calming Comfort Collection	Members may get one calming box per year that includes items to support mental health concerns and trauma. Prior authorization required.	One box per year	Yes

Section 17: Member Satisfaction

Complaints, Grievances, and Plan Appeals

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

	What You Can Do:	What We Will Do:
If you are not happy with us or our providers, you can file a **Complaint**	You can: • Call us at any time. **1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**	We will: • Try to solve your issue within 1 business day.
If you are not happy with us or our providers, you can file a **Grievance**	You can: • Write us or call us at any time. • Call us to ask for more time to solve your grievance if you think more time will help.	We will: • Review your grievance and send you a letter with our decision within 30 days.

	What You Can Do:	What We Will Do:
	Grievance and Appeals PO Box 81139 5801 Postal Road Cleveland, OH 44181 **1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**	If we need more time to solve your grievance, we will: • Send you a letter with our reason and tell you about your rights if you disagree.
If you do not agree with a decision we made about your services, you can ask for an **Appeal**	You can: • Write us, or call us and follow up in writing, within 60 days of our decision about your services. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. Aetna Better Health of Florida Grievance and Appeals PO Box 81139 5801 Postal Road Cleveland, OH 44181 **1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**	We will: • Send you a letter within 5 business days to tell you we received your appeal. • Help you complete any forms. • Review your appeal and send you a letter within 30 days to answer you.
If you think waiting for 30 days will put your health in danger, you can ask for an **Expedited or "Fast" Appeal**	You can: • Write us or call us within 60 days of our decision about your services. Aetna Better Health of Florida Grievance and Appeals PO Box 81139 5801 Postal Road Cleveland, OH 44181 **1-800-441-5501** (MMA – Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**	We will: • Give you an answer within 48 hours after we receive your request. • Call you the same day if we do not agree that you need a fast appeal and send you a letter within 2 days.
If you do not agree with our appeal decision, you can ask for a **Medicaid Fair Hearing****	You can: • Write to the Agency for Health Care Administration Office of Fair Hearings.	We will: • Provide you with transportation to the Medicaid Fair Hearing, if needed.

	What You Can Do:	What We Will Do:
	• Ask us for a copy of your medical record. • Ask for your services to continue within 10 days of receiving our letter, if needed. Some rules may apply. ********You must finish the appeal process before you can have a Medicaid Fair Hearing.*	• Restart your services if the State agrees with you. If you continued your services, we may ask you to pay for the services if the final decision is not in your favor.

Fast Plan Appeal
If we deny your request for a fast appeal, we will transfer your appeal into the regular appeal time frame of 30 days. If you disagree with our decision not to give you a fast appeal, you can call us to file a grievance.

Medicaid Fair Hearings (for Medicaid Members)
You may ask for a fair hearing at any time up to 120 days after you get a Notice of Plan Appeal Resolution by calling or writing to:

Agency for Health Care Administration
Medicaid Fair Hearing Unit
PO Box 7237
Tallahassee, FL 32314-7237
1-877-254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidFairHearingUnit@ahca.myflorida.com

If you request a fair hearing in writing, please include the following information:

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

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

- Why you think the decision should be changed
- The service(s) you think you need
- Any medical information to support the request
- Who you would like to help with your fair hearing

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

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

Review by the State (for MediKids Members)

When you ask for a review, a hearing officer who works for the State reviews the decision made during the Plan appeal. You may ask for a review by the State any time up to 120 days after you get the notice.

You must finish your appeal process first.

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

Agency for Health Care Administration
P.O. Box 7237
Tallahassee, FL 32314-7237
1-877 254-1055 (toll-free)
1-239-338-2642 (fax)
MedicaidHearingUnit@ahca.myflorida.com

After getting your request, the Agency will tell you in writing that they got your request.

Continuation of Benefits for Medicaid Members

If you are now getting a service that is going to be reduced, suspended or terminated, you have the right to keep getting those services until a final decision is made for your **Plan appeal or Medicaid fair hearing**. If your services are continued, there will be no change in your services until a final decision is made.

If your services are continued, and our decision is not in your favor, we may ask you to pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

To have your services continue during your appeal or fair hearing, you must file your appeal and ask to continue services within this timeframe, whichever is later:

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

Section 18: Your Member Rights

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

- Be treated with courtesy and respect
- Always have your dignity and privacy considered and respected

- Receive a quick and useful response to your questions and requests
- Know who is providing medical services and who is responsible for your care
- Know what member services are available, including whether an interpreter is available if you do not speak English
- Know what rules and laws apply to your conduct
- A right to receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Be given easy to follow information about your diagnosis, and openly discuss the treatment you need, choices of treatments and alternatives, risks, and how these treatments will help you
- Participate in making choices with your provider about your health care, including the right to say no to any treatment, except as otherwise provided by law
- Be given full information about other ways to help pay for your health care
- A right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Know if the provider or facility accepts the Medicare assignment rate
- To be told prior to getting a service how much it may cost you
- Get a copy of a bill and have the charges explained to you
- Get medical treatment or special help for people with disabilities, regardless of race, national origin, religion, handicap, or source of payment
- Receive treatment for any health emergency that will get worse if you do not get treatment
- Know if medical treatment is for experimental research and to say yes or no to participating in such research
- Make a complaint when your rights are not respected
- Ask for another doctor when you do not agree with your doctor (second medical opinion)
- Get a copy of your medical record and ask to have information added or corrected in your record, if needed
- Have your medical records kept private and shared only when required by law or with your approval
- Decide how you want medical decisions made if you can't make them yourself (advanced directive)
- To file a complaint or grievance about any matter other than a Plan's decision about your services.
- To appeal a Plan's decision about your services
- Receive services from a provider that is not part of our Plan (out-of-network) if we cannot find a provider for you that is part of our Plan
- Speak freely about your health care and concerns without any bad results
- Freely exercise your rights without the Plan or its network providers treating you badly

- Get care without fear of any form of restraint or seclusion being used as a means of coercion, discipline, convenience or retaliation
- Receive information on beneficiary and plan information
- Obtain available and accessible services covered under the Plan (includes In Lieu of Services (ILOS))
- A right to make recommendations regarding the organization's member rights and responsibilities policy.

LTC Members have the right to:

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Receive services in a home-like environment regardless where you live
- Receive information about being involved in your community, setting personal goals and how you can participate in that process
- Be told where, when and how to get the services you need
- To be able to take part in decisions about your health care
- To talk openly about the treatment options for your conditions, regardless of cost or benefit
- To choose the programs you participate in and the providers that give you care

Section 19: Your Member Responsibilities

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

- Give accurate information about your health to your Plan and providers
- Tell your provider about unexpected changes in your health condition
- Talk to your provider to make sure you understand a course of action and what is expected of you
- Listen to your provider, follow instructions for care, and ask questions
- Keep your appointments, and notify your provider if you will not be able to keep an appointment
- A responsibility to follow plans and instructions for care that they have agreed to with their practitioners.
- Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
- A responsibility to understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.
- Make sure payment is made for non-covered services you receive
- Follow health care facility conduct rules and regulations
- Treat health care staff and case manager with respect
- Tell us if you have problems with any health care staff

- Use the emergency room only for real emergencies
- Notify your case manager if you have a change in information (address, phone number, etc.)
- Have a plan for emergencies and access this plan if necessary for your safety
- Report fraud, abuse and overpayment

LTC Members have the responsibility to:

- Tell your case manager if you want to disenroll from the Long-Term Care program
- Agree to and participate in the annual face-to-face assessment, quarterly face-to-face visits and monthly telephone contact with your case manager

Section 20: Other Important Information

Patient Responsibility for Long-Term Care (LTC) or Hospice Services

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

To learn more about patient responsibility, you can talk to your LTC case manager, contact the DCF by calling **1-866-762-2237** toll-free, or visit the DCF Web page at **https://www.myflfamilies.com/medicaid** (scroll down, review the links on the left side of the webpage and select the document entitled 'SSI-Related Medicaid Program Fact Sheet').

Indian Health Care Provider (IHCP) Protection

Indians are exempt from all cost sharing for services furnished or received by an IHCP or referral under contract health services.

Emergency Disaster Plan

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

For LTC members, your case manager will assist you in creating a disaster plan.

Tips on How to Prevent Medicaid Fraud and Abuse:

- DO NOT share personal information, including your Medicaid number, with anyone other than your trusted providers.

- Be cautious of anyone offering you money, free or low-cost medical services, or gifts in exchange for your Medicaid information.
- Be careful with door-to-door visits or calls you did not ask for.
- Be careful with links included in texts or emails you did not ask for, or on social media platforms.

Fraud/Abuse/Overpayment in the Medicaid Program

To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at **1-888-419-3456** or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at:

https://apps.ahca.myflorida.com/mpi-complaintform/

You can also report fraud and abuse to us directly by contacting Member Services at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) **(TTY: 711)**. Or you can call our Special Investigative Unit (SIU) at **1-866-806-7020** or fax to **724-778-6827.**

Abuse/Neglect/Exploitation of People

You should never be treated badly. It is never okay for someone to hit you or make you feel afraid. You can talk to your PCP or case manager about your feelings.

If you feel that you are being mistreated or neglected, you can call the Abuse Hotline at **1-800-96-ABUSE** (**1-800-962-2873**) or for TTY/TDD at **1-800-955-8771**.

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

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

- If you are hurt, call your PCP
- If you need emergency care, call 911 or go to the nearest hospital. For more information, see the section called EMERGENCY CARE
- Have a plan to get to a safe place (a friend's or relative's home)
- Pack a small bag, give it to a friend to keep for you

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

Advance Directives

An **advance directive** is a written or spoken statement about how you want medical decisions made if you can't make them yourself. Some people make advance directives when they get very sick or are at the end of their lives. Other people make advance directives when they are healthy. You can change your mind and these documents at any time. We can help you get and understand these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

1. A Living Will

2. Health Care Surrogate Designation
3. An Anatomical (organ or tissue) Donation

You can download an advanced directive form from this website: **https://quality.healthfinder.fl.gov/report-guides/advance-directives**.

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

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

If your provider is not following your advance directive, you can file a complaint with Member Services at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) or the Agency by calling **1-888-419-3456**.

Getting More Information

You have a right to ask for information. Call Member Services or talk to your case manager about what kinds of information you can receive for free. Some examples are:

- Your member record
- A description of how we operate
- Your Medicaid (MMA) or Long-Term Care benefits
- The many programs available to you
- Our quality improvement (QI) program
  - How we measure what we do and how well we do. This includes:
  - Member satisfaction surveys
  - HEDIS scores and Performance Measures
  - Quality improvement activities

Section 21: Additional Resources

Floridahealthfinder.gov

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

- Up-to-date licensure information
- Inspection reports
- Legal actions
- Health outcomes
- Pricing
- Performance measures
- Consumer education brochures

- Living wills
- Quality performance ratings, including member satisfaction survey results

The Agency collects information from all Plans on different performance measures about the quality of care provided by the Plans. The measures allow the public to understand how well Plans meet the needs of their members. To see the Plan report cards, please visit **https://quality.healthfinder.fl.gov/Facility-Provider/Medicaid-ReportCard?&type=-13**.

Elder Housing Unit

The Elder Housing Unit provides information and technical assistance to elders and community leaders about affordable housing and assisted living choices. The Florida Department of Elder Affairs maintains a website for information about assisted living facilities, adult family care homes, adult day care centers and nursing facilities at **https://elderaffairs.org/programs-services/housing-options/** as well as links to additional Federal and State resources.

MediKids Information

For information on MediKids coverage please visit:
http://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/program_policy/FLKidCare/MediKids.shtml

Aging and Disability Resource Center

You can also find additional information and assistance on State and federal benefits, local programs and services, legal and crime prevention services, income planning or educational opportunities by contacting the Aging and Disability Resource Center.

Independent Consumer Support Program

The Florida Department of Elder Affairs also offers an Independent Consumer Support Program (ICSP). The ICSP works with the Statewide Long-Term Care Ombudsman Program, the ADRC and the Agency to ensure that LTC members have many ways to get information and help when needed. For more information, please call the Elder Helpline at **1-800-96-ELDER** (**1-800-963-5337**) or visit **https://elderaffairs.org/programs-services/medicaid-long-term-care-services/statewide-medicaid-managed-care-long-term-care-program/**.

Section 22: Forms

Living Will

Designation of Health Care Surrogate

Donor Form (Anatomical Donation)

Advance Directive Wallet Card

Living Will

Declaration made this_____day of 2____, I,_____willfully and voluntary make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____ (initial) I have a terminal condition, or

_____ (initial) I have an end-stage condition, or

_____ (initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of Medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do_____, I do not_____desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

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

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

Name

Street Address_____

City _____ State___ Zip_____Phone _____

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

Additional instructions:

Signed: _____

Witness:_____

Address_____

City_____State_____Zip_____

Phone _____

Witness:_____

Address_____

City_____State_____Zip_____

Phone _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Questions? Call Member Services at **1-800-441-5501** (MMA –Medicaid) or **1-844-645-7371** (LTC) or **TTY: 711**

Designation of Health Care Surrogate

Name:

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

Name_____

Address_____ City

_____State____ Zip_____Phone_____

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

Name_____

Address _____

City_____State_____ Zip_____Phone_____

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

Additional instructions (optional):

_____

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

Name _____

Signature_____Date_____

Witnesses: 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Uniform Donor Form

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

I give:

(a) _____ any needed organs or parts;

(b) _____ only the following organs or parts [specify the organ(s) or part(s)]:

_____

_____

_____

for the purpose of transplantation, therapy, medical research, or education;

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

_____

_____

_____

[If applicable, list specific done]

Signed by the donor and the following witnesses in the presence of each other:
Donor's Signature_____
Date of Birth _____
Date Signed _____ City and State_____

Witness 1: _____ Witness 2: _____
Address _____ Address _____

City_____State_____Zip_____City_____State____Zip _____

Phone_____ Phone _____

Questions? Call Member Services at **1-800-441-5501** (MMA –Medicaid) or
1-844-645-7371 (LTC) or **TTY: 711**

Advance Directives Wallet Card

You can use the card below to tell others about your advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Health Care Advance Directives

I, _____

have created the following Advance Directives:

Living Will

Health Care Surrogate Designation

Anatomical Donation

Other (specify)

---------- **FOLD** ---------- -

Contact:

Name _____

Address _____

_____

_____

Phone _____

Signature _____

Date _____

Produced and distributed by the Florida Agency for Health Care Administration (AHCA). This publication can be copied for public use or call AHCA toll-free number **1-888-419-3456** for additional copies.

AetnaBetterHealth.com/Florida

2947700-FL-EN (Revised 12/2025)

aetna®

Aetna Better Health® of Florida