



# CHOICES

## Health Services

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Community Health Offering Innovative Care  
& Educational Services

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# PROVIDER MANUAL

*Revised December 2008*

**CHOICES Health Services  
Provider Manual**

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## Contact Information

Provider Information

Please see Provider Manual

### **Administrative Office**

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- Questions about eligibility
- Program services or policy inquiries
- Refer Patients to CHOICES
- To update information on your practice

**CHOICES Health Services**  
Alachua County Department of  
Community Support Services  
218 SE 24<sup>th</sup> Street  
Gainesville, FL 32641

Phone: (352) 264-6772  
Fax: (352) 264-6894  
[www.acCHOICES.com](http://www.acCHOICES.com)

- 
- Enrollee eligibility verification
  - Claims and Billing Inquires
  - Billing information and inquiries
  - Questions about Covered Services
  - **Electronic Billing:** Claims Net

**MCA Administrators, Inc.**  
Manor Oak Two, Suite 605  
Pittsburgh, PA 15220  
Phone: (800) 922-4966  
Fax: (412) 922-3071

- 
- Covered Prescriptions
  - Drug Information
  - Prior Authorizations

**Catalyst Rx**  
800 King Farm Blvd.,  
4<sup>th</sup> Floor  
Rockville, MD 20850  
Phone: (800) 688-0438  
Fax:(301) 548-2988  
[www.catalystrx.com](http://www.catalystrx.com)

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## **CHOICES Health Services**

Thank you for partnering with Alachua County's CHOICES Health Services. Your participation is integral to the program's success. With your support we are able to extend quality health care to many residents of Alachua County; improving and enhancing the quality of life experienced by a significant number of people in our community.

### **Our Mission**

CHOICES, Community Health Offering Innovative Care and Educational Services, Health Services is a program offered by the Alachua County Board of County Commissioners (BOCC). The mission of CHOICES is to improve health care access for residents of Alachua County through the administration of innovative and cost-effective programs.

It is well documented that individuals who do not have access to health coverage are more likely to delay receipt of services and seek care when conditions are more advanced, thus more difficult and expensive to treat. Therefore, individuals without access to care are more likely to suffer poor health and disabling conditions. Since, for many, the affordability of health coverage is a deterrent to seeking care, medically underserved communities disproportionately experience declines in health status. CHOICES Health Services aims to decrease the occurrence of such health conditions among county residents by offering affordable health care to those who cannot afford it.

CHOICES Health Services is pioneering a new concept in financing health care. The program covers prevention in addition to other health services with the expectation that preventive care will prove to be the best investment of public funds. The services provided to CHOICES Enrollees will emphasize evidence based primary care, which includes both medical and oral health services.

Enrollees diagnosed with asthma, congestive heart failure, diabetes and hypertension will also be eligible for disease management services. In addition, low income Senior Citizens, age 65 and older, may qualify for oral health services.

CHOICES also offers a Health Education and Wellness program as well as a Disease Management program. These programs provide county residents with information concerning the maintenance of healthy lifestyles and the impact of lifestyle choices on long-term health and disease prevention. CHOICES Health Education and Wellness program and the Disease Management program are open to all Alachua County residents.

## **CHOICES Goals**

The primary goal of the CHOICES Health Services program is to increase the quality and quantity of preventive care and disease management services available to medically poor residents of Alachua County. Secondly, the program aims to increase public awareness, knowledge and adoption of healthy lifestyle behaviors.

## **CHOICES Objectives**

In order to meet its goals, CHOICES has established the following objectives:

1. Increase public access to and utilization of preventive care services
2. Increase early identification of health-related problems among the medically underserved population in Alachua County.
3. Improve management of chronic conditions such as asthma, diabetes, congestive heart failure and hypertension for the medically underserved population in Alachua County.
4. Increase public knowledge concerning healthy lifestyle behaviors.

It is expected that achievement of these objectives will result in improved health for program participants as well as decreased sick days; decreased use of the emergency department services; and less hospitalizations.

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## **PROGRAM ADMINISTRATION**

### **Program Funding**

The enabling state legislation, Florida Statutes Chapter 212, allows counties to levy a special sales tax to fund health care. CHOICES is funded by a 0.25% sales tax that was approved by Alachua County voters in August 2004. The tax was approved for seven years. Collection began in January of 2005.

The voter approved Ordinance and s BoCC approved Surtax Use Plan describes the criteria for participant eligibility and program services to be included and excluded. Administrative expenses are capped at 15% of annual revenues. The remaining funds are contracted for providing direct health care services, health education and disease management programs.

## **ORGANIZATIONAL STRUCTURE**

### The Department of Community Support Services

The Alachua County Board of County Commissioners (BOCC) has delegated the administrative responsibility for program operations to the Alachua County Community Support Services Department (CSS). In addition to CHOICES Health Services, CSS manages several community service programs and divisions dedicated to serving the needs of Alachua County residents. The programs and divisions comprising CSS include the following: Partners for a Productive Community, Senior Services, Social Services, Veterans Services, Victim Services, Crisis Center, Poverty Reduction, CAPP and Cooperative Extension. For additional information visit [www.alachua.fl.us](http://www.alachua.fl.us)

### CHOICES Staff

CHOICES Staff is responsible for all administration program functions, including; provider, enrollee and community relations as well as the administration of CHOICES Health Education and Wellness Program and CHOICES Disease Management Program.

### Third Party Administrator (TPA)

MCA Administrators, Inc. has been selected as the CHOICES Third Party Administrator (TPA). MCA has been contracted to manage Enrollee information, pay claims, respond to claim inquiries, and the utilization of data .MCA also provides enrollee ID cards to Enrollees and makes eligibility information available to providers.

### Advisory Board

A citizen advisory board has been established to advise the BOCC and CHOICES staff on program implementation and administration. The CHOICES Advisory Board is composed of a wide variety of professionals and one CHOICES consumer. The Advisory Board organizes committees, composed of its members and additional professionals, to provide expert advice in areas of key policy and program activities. The subcommittees are: Medical Services, Oral Health Services, Budget & Finance, Outreach and Evaluation.

All Advisory Board and subcommittee meetings are open to the public and advertised according to Alachua County rules. Information regarding County boards and meetings is available on the Alachua County website at [www.alachuacounty.us](http://www.alachuacounty.us)

## **PROGRAM SERVICES**

### Health Care Services

CHOICES contracts with local health care professionals to provide medical and dental care services to enrollees. The contracted providers are listed in the CHOICES Provider Directory. The most current Provider Directory can be provided to you upon request. It may also be found on the CHOICES website: [www.acCHOICES.com](http://www.acCHOICES.com).

### Disease Management Program

In order to strengthen our effort to provide quality preventive care, we have added the CHOICES Disease Management Program. This program helps CHOICES participants identify health risks or conditions early, before they seriously progress. CHOICES has partnered with experienced health clinicians who will work with members and their primary care providers. Enrollees who suffer from chronic health conditions, such as diabetes, asthma and high blood pressure, will be given information and services that will help them manage these conditions.

Through teamwork and individual initiative, members should experience improvements to their health over time. Most importantly, enrollee participation in CHOICES Disease Management Program will help reduce unnecessary emergency room visits and hospital stays related to chronic conditions.

### Health Education and Wellness Program

CHOICES Health Services is committed to helping Alachua County become a healthier community. In partnership with community health educators, CHOICES Health Education and Wellness Program provides information and resources on a wide variety of health-related topics. Nutrition, exercise, heart health, and weight management are just a few of the focus areas of this program. The program is offered to all Alachua County residents.

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## **Health Care Services**

Enrollees select a Primary Care Provider (PCP) from provider groups that have agreed to participate in CHOICES. The agreement between CHOICES and providers requires that any professional providing primary care services to CHOICES Enrollees be properly licensed and

appropriately qualified. An individual provider may be a licensed MD, DO, ARNP or PA. We request that, to the extent possible, Enrollees see the same individual health care provider, within their chosen provider group, at each visit. The Enrollee may change Primary Care Provider Groups once per calendar year after their initial selection. Exceptions may be made for extenuating circumstances. Enrollees must contact the office to make a request for change.

It is important that health care providers and Enrollees work together to coordinate care. Providers should have a system in place to remind Enrollees in advance of their appointments and contact Enrollees who have missed appointments to recommend that they reschedule.

CHOICES endeavors to reduce barriers to access in care. CHOICES should be contacted if there are any Enrollee problems or concerns so they do not escalate to the point of patient discharge. If a provider wants to discharge the Enrollee from their practice, they should contact the CHOICES Provider Relations Program Manager. The Enrollee and CHOICES must be notified of the discharge in writing. CHOICES will work with the provider and Enrollee to facilitate a smooth transition. Except in extraordinary circumstances, the provider is obligated to provide services to Enrollees for up to 30 days or until the patient transfer is complete, whichever is less.

Specific primary care services will be covered by CHOICES (please see *Summary of Healthcare Plan Benefits*). Non-covered services will be the financial responsibility of the Enrollee.

### **Role of the Primary Care Provider**

The Primary Care Provider will provide Enrollees a medical home and offer primary care which includes:

- Routine and preventive care to ensure good health, disease prevention and early detection
- Treatment of acute illnesses and minor injuries
- Chronic disease diagnosis and management
- Referral to CHOICES Health Services Disease Management Program for those Enrollees with asthma, diabetes, congestive heart failure and hypertension
- Immunizations and flu shots as needed
- Family planning consultation
- Prescribing medications
- Referrals for specialty consultations, diagnostic services and hospitalization when necessary
- Providing or arranging for health education

The PCP will coordinate medical services needed by the Enrollee, including those for which the Enrollee will be financially responsible. The PCP may follow their own guidelines for adults, but the routine screenings for which CHOICES will pay are listed in the scope of services.

The PCP is expected to offer consultative services to Enrollees 24 hours a day, 7 days a week, and 365 days a year. This service includes after hours telephone access to a professional who is qualified to make any of the following recommendations to an Enrollee who is experiencing pain or other unusual symptoms:

- treat pain or symptoms at home and come in to see the PCP on the next day
- go to an urgent care center
- go to an emergency department

PCPs should be able to accommodate urgent care visits when needed for unplanned events and minor injuries. Work-related injuries are not covered by CHOICES.

### **Role of the Oral Healthcare Provider**

CHOICES Health Services covers basic oral health services because it is recognized that oral health is integral to overall health. The oral health service provider is expected to provide basic comprehensive and urgent care. Basic comprehensive care is defined as diagnosis, cleaning, oral health education, fillings, scaling and root planing. Urgent care is defined as care provided for pain, uncontrolled bleeding, serious swelling or severe infection. The oral health provider will coordinate dental services needed by the Enrollee, including those for which the Enrollee will be financially responsible.

The oral health provider is expected to offer consultative services to Enrollees 24 hours a day, 7 days a week, and 365 days a year. This service includes after hours telephone access to a professional qualified to make any of the following recommendations to an Enrollee experiencing pain or unusual symptoms:

- treat pain or symptoms at home and come in to see the oral health provider the next day
- go to an urgent care center
- go to an emergency department

### **Professional Qualifications**

Health care practitioners must practice according to the constraints of their individual practice acts and protocols. Professional personnel

records should document training as appropriate to individual practice. Health care professionals who are required by Florida law to have a license to practice must have proof of a current Florida license. Other health care professionals assisting with health care services must have demonstrated knowledge and skills in the area of health care in which they will be assisting.

### **Evaluation and Quality Assurance**

Providers are expected to have their own quality assurance programs in place. These programs should include ongoing monitoring of quality of care, documentation, qualifications for professional staff and requirements for ongoing training of professional and support staff. The quality improvement process is expected to include annual satisfaction surveys of adults receiving primary care or oral health services.

*CHOICES will conduct ongoing process evaluation activities for the program. CHOICES may visit providers to conduct chart reviews to ensure that performance specifications included in written agreements are met. Researchers will also obtain data from the TPA, interview Enrollees and providers and review charts. They may request to schedule on-site activities in advance and at the convenience of the provider to support evaluation efforts.*

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### **Administrative Updates**

Providers should notify CHOICES in writing of changes in their practice at least 30 days prior to the change. CHOICES should be notified if the practice changes:

- Location, mailing address, phone or fax number
- Tax identification number
- Practice name
- Addition or deletion of practice site or health care practitioner
- Change in hours of practice

### **CHOICES Enrollees**

#### **Eligibility**

Members are enrolled until determined to be ineligible or if they fail to provide updated information to determine continuing eligibility as requested. Reviews will be conducted no less than 12 months after initial eligibility determination. In order to facilitate access to care, the initial period of enrollment will begin within 5 days of eligibility determination.

If an Enrollee no longer meets the eligibility criteria due to changes in job status, income, residency, etc., he or she will no longer be eligible for coverage through CHOICES Health Services. Failure to submit requested documentation to determine continued eligibility will cause a gap in coverage or disenrollment.

The current criteria for eligibility in the CHOICES Program include:

- Adult between age 18-64
- U.S. citizen or permanent resident
- Alachua County resident
- Household income at or below 200% of Federal Poverty Level
- Employment of an average of 100 hours or more each month (including self-employment) and has been employed for at least 30 days
- Employee is not eligible for group health care coverage or public programs such as Medicaid or Veterans Administration.
- Employer offered health benefits are not affordable (*affordability criteria applies*)
- Seniors 65 and older with limited income may be eligible to receive oral health services.

### **Identification**

Once enrolled in CHOICES, Enrollees are given an Enrollee Handbook and are included in MCA's eligibility database. Identification cards are sent to Enrollees within three weeks of completing all enrollment forms.

Enrollment in CHOICES should be verified at each visit. In addition to verifying enrollment, providers should contact MCA to ask if an Enrollee's dental service limits have been reached prior to providing services. To verify enrollment and dental benefits status call MCA Administrators, Inc. at (800) 922-4966.

### **Referral**

Providers are encouraged to refer adults who may be eligible for enrollment in CHOICES Health Services. Applications are available to providers and should be distributed to potential Enrollees. If you need more application packets or brochures, call CHOICES at (352) 264-6772. We will mail or deliver them to your office. Applications are also available online at [www.acCHOICES.com](http://www.acCHOICES.com) and at various outreach sites located throughout the County. Once completed, applications may be:

**Mailed or Delivered to:** CHOICES Health Services  
218 SE 24<sup>th</sup> Street  
Gainesville, FL 32641

**Faxed to:** 352-264-6894  
**or Emailed to:** [CHOICES@alachuacounty.us](mailto:CHOICES@alachuacounty.us)

In order to apply in person, applicants may call (352) 264-6772 to schedule an appointment. They may also attend open enrollment at the Community Support Services office (located in the Community Support Services and Alachua County Health Department building, 218 SE 24<sup>th</sup> Street, Gainesville co-located with the Alachua County Health Department). No appointment is required. Please call for a current open enrollment schedule or visit [www.acCHOICES.com](http://www.acCHOICES.com).

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### **Covered Services**

Please see the summary of services for an overview. CHOICES will be financially responsible for covered services (both medical and oral health services) and Enrollees will be responsible for co-pays and all health services not covered by CHOICES.

Covered services are defined as those services for which CHOICES will pay when they are offered by an approved and assigned provider and meet the criteria set by CHOICES. Providers will assist Enrollees in understanding the need for services beyond those paid by CHOICES and will make appropriate referrals as available in order to assist them in obtaining needed services.

CHOICES does not cover any worker's compensation related services. Services received for the care and treatment of an injury or sickness related to the Enrollee's occupation, that is, an injury or sickness that arises from work for wages or profit, including self-employment, will not be covered.

**\*Services exceeding the benefits or not meeting the specified criteria are not covered and will be the responsibility of the Enrollee who should be notified of his/her financial obligation prior to receiving the service.**

To verify covered services and covered service annual limits, contact MCA Administrators, Inc. (800) 922-4966.

## **Prevention and Screening**

*The prevention services covered by CHOICES include a comprehensive examination once every 5 years for Enrollees between ages 18 and 30, once every 3 years between ages 30-50 and once every year after age 50.*

- *Follow up visits for management of identified problems or conditions are to be scheduled at the discretion of the PCP. Urgent and episodic care of illness and problems provided in the primary care office, as requested by the Enrollee, are included as primary care.*

*CLIA waived lab tests may be done by the PCP in their office or specimens may be collected and sent to the CHOICES participating laboratories. We encourage providers who order lab tests that are not covered by CHOICES to pay for the service at their contracted rate and bill the Enrollee at cost. If the Enrollee pays the laboratory directly they will receive a bill for more than the contract rate of most providers.*

*Approved screenings to be offered as part of ongoing primary care include:*

- *Mammography*
- *Pap smear*
- *Fecal occult blood*
- *Flexible sigmoidoscopy*
- *Colonoscopy*
- *Cholesterol Screen*
- *Bone Density*
- *PSA*

*\*See Summary of Healthcare Plan Benefits for more information.*

## **Disease Management**

The PCP is encouraged to manage chronic conditions within their scope of practice and the status of the condition. The PCP may need to refer the Enrollee to a specialist to establish good management of the condition, then work with the specialist to assume care once the condition is under control.

Enrollees diagnosed with Diabetes, Asthma, Hypertension, and Congestive Heart Failure:

- will be referred by the PCP to CHOICES Disease Management programs
- are approved for a broader range of tests and services to support management of these conditions
- have a higher annual dollar limit for oral health services

The PCP should refer Enrollees with other chronic diseases to the appropriate specialists. PCP's must remind Enrollees that consultation and medical services rendered by these specialists may not be covered by CHOICES.

## **Pharmacy**

Pharmacy services will be limited to direct payment for short term needs (e.g. antibiotics, pain medication) and long term needs related to chronic conditions. These services will be provided by the pharmacy benefits manager, Catalyst Rx. For questions regarding prescription benefits, contact Catalyst Rx at 1-800-688-0438 or visit [CatalystRx.com](http://CatalystRx.com).

Enrollees can fill their prescriptions at most retail pharmacies. Enrollees have a \$5.00 co-pay per covered medication, with an upper limit of ten medications per month. There is a limit of 10 covered prescriptions per month.

CHOICES primarily covers generic medications. Brand name medications may be covered when approved as medically necessary. Enrollees who fail all available generic medications in a certain class may be able to receive authorization for a brand name medication.

## **Covered Oral Health Services**

Oral health services provided include diagnosis, cleaning, oral health education, fillings, scaling, root planing, sealants, root canals and urgent care. A maximum annual limit per enrollee has been established for oral health services paid for by CHOICES. For those enrolled in the CHOICES Disease Management program, the limit is \$1200 per year. For all other Enrollees the limit will be \$1000 per year. Providers should verify financial eligibility prior to providing services.

## **Enrollee Rights and Responsibilities**

The CHOICES Program has developed a set of Enrollees rights and responsibilities. They are discussed with Enrollees at enrollment and are included in the Enrollee Handbook.

### **CHOICES Enrollees have the right to:**

- Be treated with courtesy, respect, and dignity, and have privacy concerning their medical care.
- Receive a prompt and reasonable response to their questions and requests.
- Know the names of the practitioners providing medical services and other health care team members responsible for their care.
- Know what patient support services are available (including help with a hearing impairment, or an interpreter in their language if they do not speak English).
- Know what rules and regulations apply to their conduct as patients.
- Receive information about diagnoses, planned course of treatment, alternatives, risks and prognosis.
- Accept or refuse treatment as allowed by law.
- Be given, upon request, full information and necessary counseling on the availability of known financial resources for their care.
- Upon request, receive a reasonable estimate of charges for medical care before receiving any treatments. The actual costs may be higher based on changes in medical condition or treatment needs.
- Receive a copy of a clear and understandable itemized bill, and, upon request, have the charges explained.
- Have impartial access to medical treatment or accommodations, regardless of race, national origin, religion, disability and source of payment.
- Treatment or referral for any emergency medical condition that will deteriorate from failure to provide treatment.
- Know if medical treatment is for research purposes. Enrollees may consent or refuse to participate in such research; their refusal will not compromise access to any other services.
- View their medical records in accordance with Florida law.
- Participate in decisions that involve their care, including consideration of ethical issues.
- Express grievances about any violation of rights as stated in Florida law.

### **Enrollees are responsible for:**

- Giving their health care team accurate and complete information about their present complaints, past illnesses, hospitalizations, medications and other health matters.
- Reporting unexpected changes in medical condition to their health care team.
- Telling their health care team when they don't understand a planned course of treatment or what is expected of them.
- Following recommended treatment plans.
- Accepting the consequences of refusing treatment or failing to follow their health care team's instructions.
- Keeping appointments and notifying providers in advance when unable to do so.
- Paying co-pays and any additional charges required for their treatment by the health care providers.
- Following health care facility rules and regulations affecting patient care and conduct.
- Making their health care team aware that they have an Advance Directive, such as a Living Will.
- Respecting the property of others, and the property of the health care providers.

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## **Payment for Services**

### **Billing and Claims**

CHOICES pays claims through a Third Party Administrator, Managed Care of America Administrators, Inc. (MCA). Billing may be submitted through paper claims or electronically. CHOICES encourages providers to bill electronically (see below).

CHOICES will only pay for covered services rendered to Enrollees during periods of established eligibility. In order to receive payment for claims, the provider must:

- Have a written agreement with CHOICES to provide services
- Have provided a covered service within the benefit limits
- Use HIPAA compliant format for claims
- Submit a complete and accurate claim

- Provide a procedure which is consistent with the diagnosis (medically necessary)
- Submit claims within 180 days of providing the service

Send paper claims to:

**MCA Administrators, Inc.  
Manor Oak Two, Suite 605  
1910 Cochran Road  
Pittsburgh, PA 15220**

Send electronic claims to:

**Claims Net**

If you have questions about submitting claims, payments or Explanation of Benefits please contact MCA customer service at 1-800-922-4966.

### **Co-payments**

CHOICES requires the Enrollee to pay a co-pay for certain healthcare services. (Please see the Summary of Healthcare Plan Benefits.) The Provider is responsible for collecting the co-pay. Each provider should follow their normal policies regarding collection of the co-pay. **Please ensure the total costs of services are reflected on all claims when submitting to MCA for payment.** CHOICES asks that all facilities make an effort to collect this co-pay and notify CHOICES of any difficulties with collection.

Claims paid by the TPA will assume that the co-pay is collected and the Enrollee will receive an Explanation of Benefits statement (EOB) that shows the amount of the co-pay. The policy regarding co-pay for service has also been described in the Enrollee Handbook.

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## **Provider Issues, Concerns and Appeals**

### **Claims and Payment Issues**

The response to all claims submitted by providers will be documented on the Explanation of Benefits or EOB sent by MCA Administrators, Inc. Each claim submitted will be noted as paid or will include the reason for non-payment. At least 97 % of “clean claims” will be paid or denied within 10 days of receipt from the provider. All claims will be paid within 30 days of receipt of complete information from provider. If the Provider thinks there is an error or has any questions about the interpretation or disagreement with the adjudication, they should contact MCA customer

service at 1-800-922-4966. MCA staff will attempt to clarify or resolve any issues with the claims payment process.

If not satisfied with this initial response, the provider may submit an appeal. This should be done in writing within 30 calendar days of receipt of the EOB. Providers must use the form included in this section of the manual. The appeal is faxed to MCA at 412-922-3071. The appeal will be reviewed within 15 business days of receipt by a committee that includes representation from MCA and the CHOICES Provider Relations Manager. If payment is denied by the committee, the provider will receive a written response of the decision within 15 business days.

If the appeal is denied, the provider may file a second level appeal that will be submitted in writing to CHOICES Provider Relations Program Manager using an approved form provided by CHOICES. The second level appeal must be submitted within 30 calendar days of receipt of the denial of the first appeal. The second level appeal shall be faxed to CHOICES Attn: Provider Relations at (352) 264-6894. It will be reviewed within 15 business days by a committee consisting of staff from the Department of Community Support Services. If the claim is denied, the provider will be mailed a denial letter within 15 business days. If the provider is not satisfied with the response to the second appeal, the provider may file a request for a formal hearing.

### **Compliments and Concerns**

Other issues and concerns should be directed to the CHOICES Provider Relations Program Manager at (352) 264-6772. If providers wish to submit comments or concerns in writing, they may be sent to the CHOICES Provider Relations Program Manager. Please let us hear your compliments and complaints so we can use your input in our ongoing program review and improvement.

**Alachua County's  
CHOICES HEALTH SERVICES  
SUMMARY OF SERVICES AND BENEFITS**

**GENERAL PLAN INFORMATION**

**PLAN DESCRIPTION:** CHOICES Health Services covers Ambulatory and Outpatient Services which are covered by Medicare unless explicitly stated as excluded by the Plan. Ambulatory and Outpatient Services are those services provided in a physician or other healthcare provider's office or outpatient facility and does not include confinement.

<b>PLAN NAME:</b>	CHOICES Health Services
<b>PLAN ADDRESS:</b>	Alachua County Department of Community Support Services 218 SE 24 <sup>th</sup> Street Gainesville, FL 32641
<b>APPROVED BY BOCC:</b>	November 25, 2008
<b>PLAN EFFECTIVE DATE:</b>	December 1, 2008
<b>PLAN ADMINISTRATOR:</b>	Alachua County Board of County Commissioners
<b>PROGRAM ADMINISTRATOR:</b>	Community Support Services Department Director
<b>CLAIMS ADMINISTRATOR:</b>	MCA Administrators Managed Care of America Manor Oak Two Suite 605 1910 Cochran Road Pittsburgh, PA 15220 800-922-4966
<b>PHARMACY BENEFITS MANAGER:</b>	Catalyst Rx A Health Extras Company 800 King Farm Blvd 4 <sup>th</sup> Floor Rockville, MD 20850

## DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

**Ambulatory Surgery Center** is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

**Brand Name** means a trade name medication.

**CHOICES Health Services (CHOICES)**. Community Health Offering Innovative Care and Educational Services. Alachua County's Indigent Healthcare program which is administered through the County's Community Support Services Department.

**CHOICES Disease Management Program**. A program component of CHOICES which provides chronic disease management services for CHOICES Enrollees.

**Covered Charge(s)** means those Medically Necessary services or supplies that are covered under this Plan.

**Custodial Care** is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

**Durable Medical Equipment (DME)** means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

**Enrollee** an individual who has applied and is accepted into the CHOICES program based upon meeting the eligibility criteria as defined by CHOICES.

**Experimental and/or Investigational** means services, supplies, care and treatment that do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

**Formulary** means a list of prescription medications compiled by the third party payor of safe, effective therapeutic drugs specifically covered by this Plan.

**Generic** drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**Home Health Care Services and Supplies** include: nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

**Hospital** is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

**Illness** means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

**Injury** means an accidental physical Injury to the body caused by unexpected external means.

**Medically Necessary** care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly

for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient. All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

**No-Fault Auto Insurance** is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

**Outpatient Care and/or Services** is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgery Center, or the patient's home.

**Contracted Provider** is a Hospital, Physician or other health care provider that has entered into an agreement with CHOICES Health Services.

**Pharmacy** means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

**Healthcare Professional** means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Licensed Social Worker (L.S.W), Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Advanced Registered Nurse Practitioner (ARNP), Dentist (D.D.S. or D.M.D.) and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

**Plan** means the CHOICES Health Services Program and its benefits.

**Plan Administrator** as used herein shall be the person or firm responsible for the day-to-day functions and the management of the Plan. The Plan Administrator is CHOICES. The Plan Administrator shall have the exclusive right and discretionary authority to interpret terms and conditions of the Plan and to decide any and all matters arising hereunder,

including the right to remedy possible ambiguities, inequities, inconsistencies, or omissions. All interpretations and decisions made by the Plan Administrator with respect to any matter related to the Plan shall be final, conclusive and binding on all parties affected thereby.

**Plan Participant or Enrollee** is any participant who is covered under this Plan.

**Prescription Drug** means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

**Spinal Manipulation/Chiropractic Care** means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

**Substance Abuse** is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine containing drinks.

## SUMMARY OF COVERED HEALTHCARE SERVICES

***CHOICES Health Services covers Ambulatory and Outpatient Services which are covered by Medicare unless explicitly stated as excluded by the Plan. Ambulatory and Outpatient Services are those services provided in a physician or other healthcare provider's office or outpatient facility and does not include confinement. CHOICES also covers the following services which are excluded fully or partially by Medicare.***

- Dental Services
- Family Planning Services
- Immunizations
- Routine Physicals
- Vision Services

***The following is an overview of the services which are covered under the CHOICES Health Services Plan.***

- (1) Physician and Primary Care Services.** The professional services of a Physician or ARNP for medical services. Routine care, consultation, and care for illness or injury. Includes the services of a Primary Care Provider and Specialist.
- (2) Disease Management Services.** These are services provided through the CHOICES Disease Management Program. Services aimed at improving health outcomes and quality of life for Enrollees who have certain chronic diseases such as diabetes and hypertension, are eligible to participate in this initiative. Disease Management works with the primary care physician, Enrollee, and specialists to provide disease-specific education to the Enrollee and monitor compliance with the physician's treatment plan. They also provide feedback to the primary care physician/specialist on a regular basis. Care managers become an extension of the physician's services by helping the Enrollee better understand his or her disease and make necessary life style and behavioral changes with the goal of self-management.
- (3) Outpatient Hospital Services.** The medical services and supplies furnished by a Hospital. Outpatient hospital services are preventive, diagnostic, therapeutic, and service items provided to an outpatient. The services must be provided under the direction of a licensed physician or dentist.
- (4) Prescription Drugs.** Prescribed medications, contraceptive devices, and other prescribed medical supplies, such as diabetes testing strips and lancets. Generic drug coverage unless prior authorized as medically necessary.
- (5) Dental Services.** Comprehensive oral evaluation; acute emergency dental procedures to alleviate pain or infection; incision and drainage of an abscess;

necessary radiographs to make a diagnosis; problem-focused oral evaluation; periodic oral prophylaxis; non-surgical periodontal treatments including scaling and root planing; restorative dental procedures including amalgam and tooth colored fillings; dental extractions; surgical procedures essential to the preparation of the mouth for dentures; complete and partial dentures and denture therapy.

**(6) Family Planning Services.** Examinations; Family planning counseling visits; Family planning supply visits; Birth control; Family planning laboratory tests; Family planning related pharmaceuticals; Evaluation and management visits for STD treatment and follow-up; Antibiotics for treatment of STDs.

**(7) Immunizations.** Examples include Influenza, Pneumococcal, Hepatitis B

**(8) Routine Preventive Care.** Services that help prevent or lessen complications from a condition you already have, find health problems early when treatment works best, or manage a medical problem. Routine Physicals, Colorectal Cancer Screening, Screening Mammography, Screening Pap Test, Prostate Cancer Screening; Cardiovascular Disease Screening; Diabetes Screening; Glaucoma Screening; Bone Mass Measurement; Diabetes Self-Management, Supplies, and Services.

**(9) Vision Services.** Services rendered by licensed ophthalmologists, optometrists and opticians. Services include comprehensive eye exams and eyeglasses. Contact lenses may be covered if medically necessary by prior authorization only.

**(10) Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- **Anesthesia.** Local or general anesthetic to reduce or block the awareness of sensation or pain.
- **Blood** and Blood derivatives that are not donated or replaced. Intravenous injections and solutions. Administration of these items is included.
- **Respiratory Therapy** respiratory care to evaluate, treat, and care for breathing or other cardiopulmonary disorders.
- **Laboratory Services.** Diagnostic clinical laboratory procedures and studies. Examples include blood glucose, cholesterol, basic metabolic panel, and complete blood count.

- **Radiology Services.** Diagnostic radiology services. Examples include X-Ray, CT, MRI and Ultrasound.
- **Chiropractic Services.** Manipulation of the spine, and spinal x-rays. The new patient visit consists of a screening and any required manipulation of the spine by a licensed M.D., D.O. or D.C.
- **Durable Medical Equipment and Medical Supplies.** Equipment that can be used repeatedly, serves a medical purpose, and is appropriate for use in the patient's home. Medical supplies are medical or surgical items that are consumable, expendable, disposable or non-durable, and are appropriate for use in the patient's home. Examples of reimbursable equipment and supplies include, but are not limited to: Ambulatory equipment (canes, crutches, walkers); Blood glucose meters and strips; Diabetic supplies; Peak flow meters. Prior Authorization Required for Some Equipment and Supplies.
- Diagnostic **Hearing Services.** Hearing testing. Hearing Aids may be covered by prior authorization only.
- Outpatient treatment of **Mental and Behavioral Disorders.** Care, supplies and treatment of Mental Disorders and Substance Abuse. Services are provided for the maximum reduction of the recipient's mental health or substance abuse disability and restoration to the best possible functional level. Services can reasonably be expected to improve the recipient's condition or prevent further regression so that the services will no longer be needed. Services include assessments, treatment planning, medical and psychiatric services.
- **Occupational Therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Occupational therapy addresses the functional needs of an individual related to the performance of self-help skills; adaptive behavior; and sensory, motor, and postural development. Services include evaluation and treatment to prevent or correct physical and emotional deficits or to minimize the disabling effect of these deficits. Typical activities are perceptual motor activity exercises to enhance functional performance, kinetic movement, guidance in the use of adaptive equipment, and other techniques related to improving motor development. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- **Physical Therapy** by a licensed physical therapist and supervised physical therapy assistants. Physical therapy addresses the development,

improvement or restoration of neuromuscular or sensory motor function; relief of pain; or control of postural deviation to attain maximum performance. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy. Services include the evaluation and treatment related to range-of-motion, muscle strength, functional abilities and the use of adaptive or therapeutic equipment. Activities include rehabilitation through exercises, the use of equipment and rehabilitation through therapeutic activities.

- **Speech-Language Pathology Services** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Speech-language pathology services involve the evaluation and treatment of speech-language disorders.
- **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- **Urgent and Immediate Care Services.** Unscheduled ambulatory services for immediate diagnosis and treatment of illness or injury.

## PLACES OF SERVICE

The following is an example of places where covered services may be provided. All facilities must be a CHOICES Contracted Provider unless services are prior authorized by CHOICES. Coverage is subject to covered services as defined in the CHOICES Indigent Care Surtax Use Plan.

- **Physician or Healthcare Provider's Office** Location where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
- **Ambulatory Surgery Centers (ASCs)** A freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.
- **Comprehensive Outpatient Rehabilitation Facility** A facility that provides comprehensive rehabilitation services under the supervision of a physician to outpatients with physical disabilities. Services include physical therapy, occupational therapy, and speech pathology services.
- **Dental School Clinic, private dental office, or other dental facility.** A facility that provides comprehensive dental services under the supervision of a dentist.
- **Diagnostic Imaging Center** A facility that provides diagnostic and interventional imaging services including the following: X-Ray, CT, Ultrasound, Nuclear Medicine, Mammography, Breast Biopsy and Bone Densitometry.
- **Endoscopy Center** An ambulatory surgery center that is designed specifically to perform out-patient diagnostic and therapeutic endoscopic procedures. Endoscopy refers to direct visualization of the digestive tract which allows the physician to see the area being studied such as the esophagus, stomach, small intestine, rectum or colon.
- **Hospital - Outpatient** A portion of a hospital that provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
- **Independent Laboratory** A laboratory certified to perform diagnostic and/or clinical tests independent of an institution or a physician's office.

- **Pharmacy** A facility or location where drugs and other medically related items and services are sold, dispensed, or otherwise provided directly to patients.
- **Public Health Clinic** A facility maintained by either state or local health departments that provides ambulatory dental services and primary medical care under the general direction of a physician.
- **Urgent or Immediate Care Facility** Location, distinct from a hospital emergency department, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention.

## EXCLUSIONS

The following services and supplies are restricted as described or not covered by CHOICES Health Services Program. These services are not eligible for reimbursement or subject to appeal.

- **Abortion.** Services, supplies, care or treatment in connection with an abortion.
- **Alternative Therapies** including Acupuncture, Aqua Therapy, Aromatherapy, Chelation, Hypnotherapy, Magnetic Therapy, Music Therapy.
- **Ambulance Services**
- **Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household**
- **Chemotherapy**
- **Cosmetic Surgery** Any surgical procedure or treatment directed at improving appearance, except when required for the prompt repair of accidental injury or for the improvement of the functioning of a malformed body member.
- **Custodial Care.** Services, supplies provided to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, and preparation of special diets.
- **Dialysis**
- **Electrolysis**
- **Emergency Department Services and Admissions**
- **Experimental or Investigational.** Care and treatment that is either experimental or investigational.
- **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- **Furniture.** Geri-chairs, roll-about chairs, seat-lift chairs, elevator lift chairs for climbing stairs, motorized scooters, and custom and motorized wheelchairs.
- **Government coverage. Items and Services Furnished, Paid for or Authorized by Governmental Entities - Federal, State, or Local Governments.** Items or services paid for directly or indirectly by a Federal, State or local governmental entity. Care, treatment or supplies furnished by a program or agency funded by or eligible for funding by any other government program.
- **Auditory Implants**
- **HIV/AIDS Treatment.** Care, supplies, services and treatment for HIV/AIDS.
- **Inpatient Hospital and Rehabilitation Services.** Care and treatment billed by a hospital, skilled nursing facility, or physician for Inpatient Services.

EXCEPTION: When medically necessary due to complications from a covered service in order to stabilize a patient. Coverage limits apply.

- **Infertility.** Procedures, pharmaceuticals and treatment modalities intended to induce pregnancy.
- **Insurance or Workers' Compensation.** Services for which payment has been made or can reasonably be expected to be made under a liability, automobile, no-fault or workers' compensation law.
- **Joint Replacements**
- **No Legal Obligation to Pay for or Provide Services.** Items or services which neither the Enrollee nor any other person or organization has a legal obligation to pay for or provide.
- **Non-Formulary and Non-Prescription Medications**
- **Non-Participating physician or provider.** Services that are provided by any non- contracted provider without prior authorization.
- **Not Delivered Directly or Under Arrangement by a Contracted Provider**
- **Not specified as covered.** Medical services, treatments and supplies which are not specified as covered under the Plan.
- **Obstetrics and Maternity Care.** Any treatment or supplies related to pregnancy or its complications.
- **Organ Transplants.** Any charges for services, supplies, work-ups, treatments, harvesting of organs or organ transplants.
- **Orthodontia, dental crowns, dental implants, and aesthetic dental services.**
- **Other Health Coverage.** Enrollee is covered by another health insurance plan or program.
- **Personal Comfort Items.** Items that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member are not covered.
- **Prisoners.** Services furnished to individuals or groups of individuals who are in the custody of the police or other penal authorities or in the custody of a government agency.
- **Radial keratotomy** or other eye procedures and surgery to correct refractive disorders (i.e. Lasik).
- **Radiation Therapy**
- **Services and items furnished outside the United States**
- **Services and items which a State or local government facility furnishes free of charge**
- **Services incurred before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under the Plan or after coverage terminated.
- **Services Not Covered Under CHOICES.** Medical services required to treat a condition that arises as a result of services that are not covered.
- **Services Not Reasonable and Necessary.** Items and services which are not reasonable and necessary for the diagnosis or treatment of illness or

injury or to improve the functioning of a malformed body member are not covered.

- **Sexual Reassignment and Dysfunction.** Services, supplies and/or surgery and any related complications due to sexual reassignment, dysfunction or reversal of sexual reassignment. Treatment and testing for impotency, implants of any kind or any related medications.
- **Skilled Nursing Care.** Care received in an inpatient facility, such as a nursing home or rehabilitation facility.
- **Surgical sterilization and reversal.** Care and treatment for voluntary sterilization or reversal of surgical sterilization.
- **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician.
- **Tuberculosis**
- **Veteran's Administration.** Services Covered by or eligible for payment by Veteran's Administration.
- **Vocational Rehabilitation (VR).** Services and care which is provided or eligible to be provided by VR.
- **War.** Services Resulting from an act of declared or undeclared war.
- **Warranty.** Defective equipment or a defective medical device covered under a warranty.

**Alachua County's CHOICES Health Services Program**

**Summary of Healthcare Plan Benefits**

<b>Summary of Annual Maximum Medical Benefits for:</b>	
<b>All Medical Benefits</b> (Inclusive of DME and TMJ Services)	\$50,000
<b>Durable Medical Equipment (DME)</b>	\$1,000
<b>Temporomandibular Joint Disorder</b>	\$1,000

<b>Summary of Annual Maximum Dental Benefits for:</b>	
<b>Dental Care</b> (Exclusive of Dentures and Denture Therapy Services)	\$1,000
<b>Dental Care: Disease Management Patients*</b> (Exclusive of Dentures and Denture Therapy Services)	\$1,200
<b>Dentures and Denture Therapy</b> (Exclusive of Dental Care)	\$1,000
<i>*Patients who have a diagnosed chronic condition and participating in Disease Management Program.</i>	

**Summary of Medical Benefits**

<b>Covered Medical Expenses:</b>	<b>Copayment</b>	<b>Limits</b>
1. Chiropractic Care	<b>\$10 per visit</b>	10 visits per calendar year
2. Colonoscopy	<b>No Copayment</b>	One routine exam every 5 years (over age 50) or as medically necessary
3. Durable Medical Equipment (DME)	<b>No Copayment</b>	\$1000 per calendar year
4. Home Health Care	<b>No Copayment</b>	20 visits per calendar year maximum
5. Immediate or Urgent Care Center	<b>\$25 per visit</b>	2 visits per calendar year
6. Outpatient Diagnostic Lab	<b>No Copayment</b>	
7. Outpatient Diagnostic Radiology	<b>\$5.00</b>	



### Summary of Dental Benefits

Covered Dental Expenses:	Copayment	Limits
1. Basic, Preventive and Routine Dental Care <i>(See pages 6-7)</i>	<b>\$10 per visit</b>  To offset the cost of parking, patients at the <b>UF College of Dentistry:</b> <b>\$7 per visit</b>	\$1,000 per calendar year  \$1200 per calendar year for Disease Management patients
2. Denture Therapy  <ul style="list-style-type: none"> <li>• Complete Upper Denture</li> <li>• Complete Lower Denture</li> <li>• Partial Upper Denture</li> <li>• Partial Lower Denture</li> </ul>	<b>\$50 each</b> <b>\$50 each</b> <b>\$50 each</b> <b>\$50 each</b>  <i>No additional copayments for the above denture therapy services</i>	\$1,000 per calendar year  Once every five (5) years

### Summary of Vision Benefits

Covered Vision Care Expenses:	Copayment	Limits
1. Comprehensive Eye Exam	<b>\$10.00</b>	Once annually or as medically necessary
2. Eyeglasses	<b>\$25.00</b>	One pair annually
3. Contact Lenses	<b>\$25.00</b>	Statement of Medical Necessity Required.

### Summary of Prescription Drug Benefits

Covered Prescription Drug Expenses:	Participating Pharmacy
<b>Pharmacy Options (30-day supply):</b>	
Copayment, per prescription or refill, for generic	<b>\$5</b>
Copayment, per prescription or refill, for name brands*	<b>\$5</b>
<i>*Prior authorization is required: Primary Care Provider must submit a statement of medical necessity and failure to respond to generic to the Pharmacy Benefits Manager.</i>	

**\$10.00 COPAY EACH COVERED SERVICE VISIT**  
**\*SELECTED DENTURE THERAPY SERVICES REQUIRE \$50.00**  
**COPAY**

**NOTE: Health care services NOT listed in this Attachment are Non-Covered Oral Health Care Services. For example, Orthodontia is a Non-Covered Oral Health Care Services.**

**\$1,000.00 per Enrollee maximum per calendar year. If enrolled in CHOICES Disease Management, the maximum per calendar year is \$1,200.00.**

**Additional \$1,000.00 maximum per calendar year for Denture Therapy Services.**

<b>CHOICES Health Services Covered Dental Services</b>			
<b>CPT</b>	<b>PROCEDURE</b>	<b>SERVICE LIMIT</b>	<b>FEE</b>
<b>BASIC</b>			
0120	Periodic Exam	yearly	\$30.00
0140	Limited Exam	as needed	\$30.00
0150	Comprehensive Exam	yearly	\$58.00
0160	Detailed and Problem Focused Exam	as needed	\$35.00
0210	Full Mouth Series	1/3yrs	\$63.00
0220	X-ray (Single)	as needed	\$15.00
0230	X-ray (Each Additional)	as needed	\$10.00
0240	X-ray (Occlusal)	as needed	\$20.00
0270	X-ray (Bitewing)	as needed	\$16.00
0272	X-ray (2/3 Bitewing)	yearly	\$26.00
0274	X-ray (4 Bitewings)	yearly	\$32.00
0330	Panorex	yearly	\$53.00
0460	Pulp vitality test	as needed	\$10.00
<b>PREVENTIVE</b>			
1110	Prophylaxis (Adult)	2/year	\$45.00
1204	Topical Fluoride (adult)	2/year	\$15.00
1310	Topical Fluoride Varnish	4/year	\$15.00
1330	Oral Hygiene Instruction	2/year	\$16.00
1351	Sealant – per tooth	as needed	\$15.00
2999	Sealant – each add'l tooth, same visit	as needed	\$8.00

1310	Nutritional Counseling	2/year	\$25.00
<b>RESTORATIVE</b>			
2140	Amalgam 1 surf. (perm)	as needed	\$50.00
2150	Amalgam 2 surf. (perm)	as needed	\$70.00
2160	Amalgam 3 surf. (perm)	as needed	\$80.00
2161	Amalgam 4 surf. (perm)	as needed	\$90.00
2330	Resin/Composite 1 surf. (perm)	as needed	\$50.00
2331	Resin/Composite 2 surf. (perm)	as needed	\$60.00
2332	Resin/Composite 3 surf. (perm)	as needed	\$65.00
2335	Resin/Composite 4+ surfs. (perm)	as needed	\$80.00
2391	Resin – one surface, posterior, permanent	as needed	\$60.00
2392	Resin – two surfaces, posterior – permanent	as needed	\$80.00
2393	Resin – three or more surfaces, posterior – permanent	as needed	\$90.00
2394	Resin-based composite – 4 or more surfaces, posterior permanent	as needed	\$100.00
2920	Recement Crown	as needed	\$30.00
6930	Recement Bridge	as needed	\$45.00
2940	Sedative Filling	as needed	\$35.00
2951	Pin retention (excl. of restoration)	as needed	\$20.00
3110	Pulp Cap	as needed	\$40.00
3120	Indirect Pulp Cap	as needed	\$30.00
2950	Core Buildup	as needed	\$70.00
2954	Prefab. Post and Core	as needed	\$90.00
<b>ENDODONTICS</b>			
3310	Root Canal Therapy – anterior, single canal (excluding final restoration)	as needed	\$225.00
3320	Root Canal Therapy – bicuspid, single canal (excluding final restoration)	as needed	\$250.00
3330	Root Canal Therapy – molar (excluding final restoration)	as needed	\$350.00
3346	Retreatment – anterior	as needed	\$255.00

3347	Retreatment – premolar	as needed	\$275.00
3348	Retreatment – molar	as needed	\$350.00
<b>PERIODONTICS</b>			
4341	Scaling and Root Planing = 4+ teeth/quad.	≤4/year	\$70.00
4342	Scaling and Root Planing = ≤3 teeth/quad	≤4/year	\$50.00
4355	Full Debridement for Oral Exam	as needed	\$60.00
4380	Phase I Perio Evaluation	1/year	\$45.00
4910	Periodontal Maintenance (SPT)	≤4/year	\$50.00
<b>ORAL SURGERY</b>			
7140	Extraction (Single Tooth)	as needed	\$50.00
7210	Surgical Extraction of Erupted Tooth	as needed	\$65.00
7220	Removal of Impacted Tooth – soft tissue	as needed	\$70.00
7230	Removal of Impacted Tooth – partial bony	as needed	\$105.00
7240	Removal of Impacted Tooth – completely bony	as needed	\$140.00
7241	Removal of Impacted Tooth – completely bony with unusual surgical complications	as needed	\$380.00
7250	Surgical Removal of Residual Tooth Roots Cutting Procedure	as needed	\$190.00
7260	Oral Antral Fistula Closure	as needed	\$120.00
7285	Biopsy of Oral Tissue – hard	as needed	\$70.00
7286	Biopsy of Oral Tissue – soft	as needed	\$60.00
7310	Alveoplasty in Conjunction with Extractions – per quadrant	as needed	\$60.00
7320	Alveoplasty not in Conjunction with Extractions – per quadrant	as needed	\$75.00
7470	Removal of Exostosis	as needed	\$95.00
7471	Removal of Exostosis – per site	as needed	\$410.00
7510	Surgical Incision and Drainage	as needed	\$63.00
<b>MISCELLANEOUS</b>			

9110	Palliative Emergency Treatment	as needed	\$45.00
9230	Analgesia – inhaled (nitrous oxide)	as needed	\$30.00
9310	Consult Professional	as needed	\$80.00

### DENTURE THERAPY SERVICES

**Additional \$1,000.00 maximum per calendar year for Denture Therapy Services.**

**\*Selected services require \$50.00 Copay**

PROCEDURE	CODE	FEES	SERVICE LIMIT
<b>DENTURE SERVICES:</b>			
Diagnostic Casts	0470	\$15.00	yearly
<b>*Complete Upper Denture - \$50.00 Copay</b>	5110	\$400.00	every 5 years
<b>*Complete Lower Denture - \$50.00 Copay</b>	5120	\$400.00	every 5 years
<b>*Immediate Upper Denture - \$50.00 Copay</b>	5130	\$450.00	initial placement limit
<b>*Immediate Lower Denture - \$50.00 Copay</b>	5140	\$450.00	initial placement limit
<b>*Overdenture – Complete - \$50.00 Copay</b>	5860	\$440.00	every 5 years
Adjust Complete Denture - upper	5410	\$35.00	as needed
Adjust Complete Denture - lower	5411	\$35.00	as needed
Repair Broken Complete Denture Base	5510	\$80.00	as needed
Replace Missing or Broken teeth - complete denture (each tooth)	5520	\$70.00	as needed
Rebase Complete Upper Denture	5710	\$250.00	yearly
Rebase Complete Lower Denture	5711	\$250.00	yearly
Reline Upper Complete Denture (chairside)	5730	\$100.00	yearly
Reline Lower Complete Denture (chairside)	5731	\$100.00	yearly
Reline Upper Complete Denture (laboratory)	5750	\$170.00	yearly
Reline Lower Complete Denture (laboratory)	5751	\$170.00	yearly
<b>*Interim Complete Denture – upper - \$50.00 Copay</b>	5810	\$250.00	Initial placement limit
<b>*Interim Complete Denture – lower - \$50.00 Copay</b>	5811	\$250.00	Initial placement limit
Tissue Conditioning - upper	5850	\$60.00	yearly
Tissue Conditioning - lower	5851	\$60.00	yearly
<b>PARTIAL DENTURE SERVICES:</b>			
<b>*Upper Partial - resin base (including clasps, rests and teeth) - \$50.00 Copay</b>	5211	\$300.00	yearly
<b>*Lower Partial - resin base (including clasps, rests and teeth) - \$50.00 Copay</b>	5212	\$300.00	yearly
<b>*Upper Partial - cast metal base with resin saddles (including clasps, rests and teeth) - \$50.00 Copay</b>	5213	\$500.00	every 5 years

<b>*Lower Partial – cast metal base with resin saddles (including clasps, rests and teeth) - \$50.00 Copay</b>	5214	\$500.00	every 5 years
<b>* Unilateral Partial Denture – cast metal (including clasps and teeth) - \$50.00 Copay</b>	5281	\$250.00	every 5 years
<b>*Interim Partial Denture – upper - \$50.00 Copay</b>	5820	\$200.00	initial placement limit
<b>*Interim Partial Denture - lower - \$50.00 Copay</b>	5821	\$200.00	initial placement limit
<b>*Overdenture – Partial - \$50.00 Copay</b>	5861	\$480.00	every 5 years
Adjust Partial Denture - upper	5421	\$35.00	as needed
Adjust Partial Denture - lower	5422	\$35.00	as needed
Repair Resin Saddle or Base	5610	\$110.00	as needed
Repair Cast Framework	5620	\$110.00	as needed
Repair or Replace Broken Clasp	5630	\$110.00	as needed
Replace Broken Tooth - partial denture per tooth	5640	\$70.00	as needed
Add Tooth to Existing Partial Denture	5650	\$110.00	as needed
Add Clasp to Existing Partial Denture	5660	\$110.00	as needed
Rebase Upper Partial Denture	5720	\$250.00	yearly
Rebase Lower Partial Denture	5721	\$250.00	yearly
Reline Upper Partial Denture (chairside)	5740	\$95.00	yearly
Reline Lower Partial Denture (chairside)	5741	\$95.00	yearly
Reline Upper Partial Denture (laboratory)	5760	\$165.00	yearly
Reline Lower Partial Denture (laboratory)	5761	\$165.00	yearly

## APPEALS

When a Claimant receives an adverse benefit determination, the Claimant has 180 days following receipt of the notification in which to appeal the decision. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she will be provided free of charge reasonable access to and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures for the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

- (1) Was relied upon in making the benefit determination;
- (2) Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- (3) Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Claimants; or
- (4) Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of the individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

**Alachua County CHOICES Health Services  
Payment Appeal Form**

This form has been developed to assist you in notifying the Claims Department of appeal issues. Appeals need to be received within 30 calendar days of notification of a denial or payment issue (i.e. within 30 days of EOB date).

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Provider Name

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Address (Number, City, state, Zip)

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Telephone Fax

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Contact Person Date

**Claim Summary Information**

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Enrollee Name

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Claim number from EOB Date of Service

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**Please provide a detailed explanation for appeal.** Be sure to include all supporting documentation (i.e. copy of denial form, EOB, copy of original claim, copy of electronic submission confirmation form for timely filing, etc).

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Mail or fax completed form and documentation to: **MCA Administrators, Inc., Manor Oak Two, Suite 605, 1910 Cochran Road, Pittsburgh, PA 15220. Fax: (412) 922-3071. Reference CHOICES Health Services.**

