<DENTAL PLAN NAME’S> FLORIDA MEDICAID DENTAL PROGRAM

MEMBER HANDBOOK

<Plan insert free text>

<Plan insert free text on how to request auxiliary aids and services in accordance with 42 CFR 438.10(d)(6)(iv) in 18 point font>

**Non-Discrimination Notice**

<Insert Plan specific info here. Note: Staff name does not need to be in the document, but it must be listed on the website.>

**“If you do not speak English**, call us at [INSERT MEMBER SERVICES NUMBER]. We have access to interpreter services and can help answer your questions in your language. We can also help you find a dental provider who can talk with you in your language."

**Spanish: Si usted no habla inglés,** llámenos al [INSERT MEMBER SERVICES NUMBER]. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

French: **Si vous ne parlez pas anglais**, appelez-nous au [INSERT MEMBER SERVICES NUMBER]. Nous avons accès à des services d'interprétariat pour vous aider à répondre aux questions dans votre langue. Nous pouvons également vous aider à trouver un prestataire de soins de santé qui peut communiquer avec vous dans votre langue.

Haitian Creole: **Si ou pa pale lang Anglè**, rele nou nan [INSERT MEMBER SERVICES NUMBER]. Nou ka jwenn sèvis entèprèt pou ou, epitou nou kapab ede reponn kesyon ou yo nan lang ou pale a. Nou kapab ede ou jwenn yon pwofesyonèl swen sante ki kapab kominike avèk ou nan lang ou pale a."

Italian: **"Se non parli inglese** chiamaci al [INSERT MEMBER SERVICES NUMBER]. Disponiamo di servizi di interpretariato e siamo in grado di rispondere alle tue domande nella tua lingua. Possiamo anche aiutarti a trovare un fornitore di servizi sanitari che parli la tua lingua."

Russian: **«Если вы не разговариваете по-английски,** позвоните нам по номеру [INSERT MEMBER SERVICES NUMBER]. У нас есть возможность воспользоваться услугами переводчика, и мы поможем вам получить ответы на вопросы на вашем родном языке. Кроме того, мы можем оказать вам помощь в поиске поставщика медицинских услуг, который может общаться с вами на вашем родном языке».

Vietnamese: “**Nếu bạn không nói được tiếng Anh**, hãy gọi cho chúng tôi theo số <số dịch vụ thành viên>. Chúng tôi có quyền truy cập vào các dịch vụ thông dịch viên và có thể giúp trả lời các câu hỏi của bạn bằng ngôn ngữ của bạn. Chúng tôi cũng có thể giúp bạn tìm một nhà cung cấp dịch vụ chăm sóc sức khỏe có thể nói chuyện với bạn bằng ngôn ngữ của bạn."

**Important Contact Information**

|  |  |  |
| --- | --- | --- |
| You can contact | Where | Times |
| Member Services Help Line | <toll free telephone number> | Available 24 hours |
| Member Services Help Line TTY | <toll free telephone number> | Available 24 hours |
| Website | <url> | Available 24 hours |
| Office Address | <full street address>  <city, state, zip> | Monday - Friday  <time> to <time> |
| Office Telephone Number | <telephone #> | Monday - Friday  <time> to <time> |

|  |  |
| --- | --- |
| <Service Name> | <Subcontractor Name>  <Contact information> |
| <Service Name> | <Subcontractor Name>  <Contact information> |
| 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](mailto: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 about urgent care- after hours | <Plan insert free text> |
| For an emergency | 9-1-1  Or go to the nearest emergency room |

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# Welcome to [Insert Plan Name]’s Dental Plan

[Insert Plan Name] has a contract with the Florida Agency for Health Care Administration to provide dental services to people with Medicaid. This is called the **Florida Dental Program**. You are enrolled in our dental plan. This means we will offer you Medicaid dental services. We work with a group of dental providers to help meet your dental needs.

This handbook will be your guide for all dental 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 [INSERT MEMBER SERVICES NUMBER]

**Section 1: Your Plan Dental Identification Card (ID card)**

You should have received your dental 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 dental ID card.

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

Your dental ID card will look like this:

<Plan Sample ID card here>

**Section 2: Your Privacy**

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:

<Insert Plan specific HIPAA and privacy practices>

**Section 3: Getting Help from Member Services**

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

**Contacting Member Services**

You may call us at <toll-free number>, or <TTY/TDD>, Monday to Friday, <time> a.m. to <time> p.m., 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 our <Plan insert free text> at <toll free number>. 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 [INSERT MEMBER SERVICES NUMBER]. 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 dental 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 Dental Plan**

If your dental 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 <Plan Name> to pay for your dental services and dental 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 our Member Services Department. 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.

**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 dental plan. 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 dental 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) to change plans.

**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)[[1]](#footnote-1) :

* We do not cover a service for moral or religious reasons.

You can also leave our plan for the following reasons, if you have completed our appeal process[[2]](#footnote-2):

* You receive poor quality of care, and the Agency for Health Care Administration 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 <Insert Member Services number> or the State’s Enrollment Broker at 1-877-711-3662 (TDD 1-866-467-4970).

**Removal from Our Plan (Involuntary Disenrollment)**

The Agency for Health Care Administration 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.
* You or your caregivers behave in a way that makes it hard for us to provide you with care.

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 dental condition that requires extra support and coordination, you may have a case manager with us. If you have a medical condition or illness that requires extra support and coordination, you may have a case manager with your Medicaid health plan. Whether you have a dental case manager or a health plan case manager, your case manager can help you get the services you need. Your health plan case manager may work with us to coordinate your dental care with your other health care services. If you have a case manager assigned by your Medicaid health plan, call Member Services and ask to speak to Case Management.

Your dental plan case manager is your go-to person. They will help you figure out how to get the dental services you need.

**Changing Case Managers**

You can change case managers at any time. To change case managers, call Member Services.

There may be a time when we need to change your case manager. If we do, we will send a letter to let you know and we may give you a call.

**Important Things to Tell Your Case Manager**

If you don’t like a service or provider, tell your case manager. 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 name, telephone number, address, or county changes

**Section 11: Accessing Services**

Before you get a service or go to some dental appointments, we have to make sure that 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 dentist, doctor, or other health care providers. Then we will decide if that service can help you. We use rules from the Agency for Health Care Administration to make these decisions.

**Continuing Your Care**

When you first enroll in our plan, you may already be receiving services from a provider(s). We will make sure you keep getting the care your providers give you. You can keep getting your care from that provider for up to [90 or negotiated timeframe] days.

Before [60 or negotiated timeframe] days, your provider must check with us to keep giving your services to you. If your provider is not in our plan, we will help you find a new provider that is in our plan, schedule an appointment, and move your health records to the new provider. If you have questions, call Member Services.

**Providers in Our Plan**

For the most part, you must use dentists and other dental providers that are in our **provider network**. Our provider network is the group of dentists and other dental 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 dental 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. If you do not have a provider directory, call [INSERT MEMBER SERVICES NUMBER] to get a copy or visit our website at [Web Address].

**Providers Not in Our Plan**

There are times when you can get services from providers who are not in our plan when the services are reviewed and approved by <DENTAL PLAN NAME’S>. If you need a service and we cannot find a provider in our plan for these services, we will help you find another provider that is not in our plan. 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 Services**

We will cover most of your dental services, but some services may be covered by your medical plan.

Contact Member Services at 1-XXX-XXX-XXXX for help with arranging these services.

**What Do I Have To Pay For?**

You may have to pay for appointments or dental 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[[3]](#footnote-3)**

We must provide all medically necessary dental 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 dental services are medically necessary, dental services have:

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

Your dental 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.

**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 Dental Provider (PDP)**

One of the first things you will need to do when you enroll in our plan is choose a primary dental provider (PDP). This is a general dentist or pediatric dentist. You will contact your PDP to make an appointment for services such as regular dental visits, or when you have a dental problem. Your PDP will also help you get care from other providers or specialists. This is called a **referral**. You can choose your PDP by calling Member Services.

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

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

**Choosing a PDP for Your Child**

It is important that you select a PDP for your child to make sure they get their well-child dental screenings each year. These visits are regular check-ups that help keep your child’s teeth healthy. These visits can help find problems and keep your child healthy.[[4]](#footnote-4)

You can take your child to a pediatric dentist or dentist.

**Preventive Care**

You do not need a referral for dental services to prevent dental problems and keep your mouth healthy. Dental services to prevent dental problems and keep your mouth healthy can be a review of your mouth by a dental provider (screenings or exams), teeth cleanings, and thin plastic coatings painted onto the grooves of your back chewing teeth (sealants). These services are free.

**Specialist Care and Referrals**

Sometimes, you may need to see a provider other than your PDP for dental problems like special conditions, injuries, or illnesses. Talk to your PDP first. Your PDP will refer you to a **specialist**. A specialist is a provider that focuses on one type of dental service.

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 PDP, 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.

**Hospital Care**

If you need to go to the hospital for an appointment, surgery or overnight stay, your PDP will help to request approval for dental services. We must approve a dental provider’s services in the hospital before you go, except for emergencies. We will not pay for a dental provider’s services in a hospital 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 dental provider to get services in place for after you leave the hospital.

**Emergency Care**

You have a dental **emergency** medical conditionwhen you need immediate attention to stop bleeding, relieve severe pain, or save a tooth. Some examples are:

* Abscess
* Bleeding that will not stop
* Infection

Emergency services are what 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 PDP. Your PDP will tell you what to do.

We pay for emergency services that are provided by a dental provider, even if they are not part of our plan or in our service area. Medicaid or your Medicaid health plan pays the cost of the hospital or emergency facility and for any care not provided by a dental provider. 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.

**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 PDP or it is after your PDP’s office has closed. Be sure to ask us before you use an Urgent Care center, or you may have to pay for those services.

If you need Urgent Care after office hours and you cannot reach your PDP, <Plan insert free text>.

You may also find the closest Urgent Care center to you by <Plan insert free text>.

**Filling Prescriptions**

We do not pay for prescription drugs. If your PDP orders a drug for you, we can help you get that drug through Medicaid or your Medicaid health plan. You can call Member Services or your dental case manager if you need help.

**Member Reward Programs**

We offer dental programs to help keep you healthy and to help you live a healthier life. We call these **healthy behavior programs**. You can earn rewards while participating in these programs. Our plan offers the following dental programs:

<Plan healthy behavior program free text here>

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 <Plan insert free text>.

**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:

<<insert quality enhancement programs>>

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.

**Section 13: Your Plan Benefits: Dental Services**

The table below lists the dental services that we cover. Remember, you may need a referral from your doctor, dentist, or approval from us before you go to an appointment or use a service. Services must be medically necessary in order for us to pay for them[[5]](#footnote-5). You may have a $3.00 copayment per day for a non-emergency dental visit in a federally qualified health center.

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.

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

| **Service** | **Description** | **Coverage/ Limitations** | | **Prior Authorization <<Plan insert text >>** |
| --- | --- | --- | --- | --- |
| **Children**  **(ages 0-20)**  **<<Plan insert text >>** | **Adults (ages 21+)**  **<<Plan insert text >>** |
| Dental exams | A review of your tooth, teeth, or mouth by a dentist | * Complete exams are covered 1 time every 3 years * Check-up exams are covered 2 times every year * Emergency exams are covered as medically necessary | * Complete exams for dentures are covered 1 time every 3 years * Emergency exams are covered as medically necessary |  |
| Dental screenings | A review of your mouth by a dental hygienist | * Covered 2 times every year * May be done in a school or Head Start program |  |  |
| Dental X-rays | Internal pictures of teeth with different views | All types of dental x-rays are covered | Only some types of dental x-rays are covered:   * 1 full mouth set of x-rays every 3 years * 1 view of the whole mouth (panoramic) x-ray every 5 years * Other single tooth x-rays as needed |  |
| Teeth Cleanings | Basic cleanings that may include brushing, flossing, scrubbing, and polishing teeth | * Covered 2 times every year * May be done in a school or Head Start program |  |  |
| Fluoride | A medicine put on teeth to make them stronger | * Fluoride is covered: * 4 times every year for children that are 0-5 years old * 2 times every year for children that are 6-20 years old * May be done in a school or Head Start program |  |  |
| Sealants | Thin, plastic coatings painted into the grooves of adult chewing surface teeth to help prevent cavities | * We cover sealants 1 time every 3 years for each adult chewing (back) tooth * May be done in a school or Head Start program |  |  |
| Oral Health Instructions | Education on how to brush, floss, and keep your teeth healthy | * We cover oral health instructions 2 times every year * May be done in a school or Head Start program |  |  |
| Space Maintainers | A way to keep space in the mouth when a tooth is taken out or missing | Covered as medically necessary |  |  |
| Fillings and Crowns | A dental service to fix or repair teeth | Covered as medically necessary |  |  |
| Root Canals | A dental service to fix the inside part of a tooth (nerve) | Covered as medically necessary |  |  |
| Periodontics | Deep cleanings that may involve both your teeth and gums | Covered as medically necessary |  |  |
| Prosthodontics | Dentures or other types of objects to replace teeth | * 1 upper, 1 lower, or 1 set of full dentures * 1 upper, 1 lower, or 1 set of partial dentures * 1 flipper to replace front teeth * 1 improvement for denture fit and comfort (reline) for each denture every year | * 1 upper, 1 lower, or 1 set of full dentures * 1 upper, 1 lower, or 1 set of partial dentures * 1 improvement for denture fit and comfort (reline) for each denture every year | Ask us for approval before you go to an appointment for these services |
| Orthodontics | Braces or other ways to correct teeth location | Covered as medically necessary |  | Ask us for approval before you go to an appointment for these services |
| Extractions | Tooth removal | Covered as medically necessary | Covered as medically necessary |  |
| Sedation | A way to provide dental services where a patient is asleep or partially asleep | Covered as medically necessary | Covered as medically necessary |  |
| Ambulatory Surgical Center or Hospital-based Dental Services | Dental services that cannot be done in a dentist office.  These are services that need to be provided with different equipment and possibly different providers | Covered as medically necessary for any dental services needed | Covered as medically necessary for extractions | Ask us for approval before you go to an appointment for these services |

**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.

**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. These extra services are provided to adults that are ages 21 years or older. For pregnant women that are ages 21 years and older, more services may be available to help with a healthy pregnancy.

| **Service** | **Description** | **Coverage/ Limitations** | | **Prior Authorization <<Plan insert text >>** |
| --- | --- | --- | --- | --- |
| **Adults (ages 21+)**  **<<Plan insert text >>** | **Additional Services for Pregnant Adults (ages 21+)**  **<<Plan insert text >>** |
| Dental exams | A review of your tooth, teeth, or mouth by a dentist | * Complete exams are covered 1 time every 3 years * Check-up exams are covered 2 times every year | Additional dental exams are covered as medically necessary |  |
| Dental screenings | A review of your mouth by a dental hygienist | Covered 2 times every year | Additional dental screenings are covered as medically necessary |  |
| Dental X-rays | Internal pictures of teeth with different views | All types of dental x-rays are covered | Additional dental x-rays are covered as medically necessary |  |
| Teeth Cleanings | Basic cleanings that may include brushing, flossing, scrubbing, and polishing teeth | Covered 2 times every year | Additional dental cleanings are covered as medically necessary |  |
| Fluoride | A medicine put on teeth to make them stronger | Covered 2 times every year | Additional fluoride is covered as medically necessary |  |
| Sealants | Thin, plastic coatings painted into the grooves of adult chewing surface teeth to help prevent cavities | Covered 1 time every 3 years for each adult chewing (back) tooth |  |  |
| Oral Health Instructions | Education on how to brush, floss, and keep your teeth healthy | Covered 2 times every year | Additional oral health instructions are covered as medically necessary |  |
| Fillings | A dental service to fix or repair teeth | Some filling services are covered for front and back (chewing) teeth as medically necessary |  |  |
| Periodontics | Deep cleanings that may involve both your teeth and gums | Some deep cleaning services are covered as medically necessary | Additional deep cleanings are covered as medically necessary |  |
| Extractions | Tooth removal | Covered as medically necessary |  |  |
| General Services | Dental consultations to visit a dentist for an opinion and dental pain treatment | Covered as medically necessary | Additional general services are covered as medically necessary |  |
| Diabetic Testing | Dental office diabetes testing | Covered 1 time every year |  |  |
| Dental Office Visit for Persons with Disabilities | A visit to the dental office to get comfortable with the office and the dentist before dental work is done | Covered for persons with intellectual disabilities 1 time for every new dental office or dentist |  |  |

**Section 15: 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 provider(s). 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.   <Insert phone number> | We will:   * Try to solve your issue within one 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.   <Insert address and phone number> | We will:   * Review your grievance and send you a letter with our decision within 30 days.   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.   <Insert address and phone number> | 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.   <Insert address and phone number> | 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 two 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. * 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.* | We will:   * Provide you with transportation to the Medicaid Fair Hearing, if needed. * 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 Enrollees)**

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

P.O. Box 7237

Tallahassee, FL 33914-7237

1-877-254-1055 (toll-free)

1-239-338-2642 (fax)

[MedicaidFairHearingUnit@ahca.myflorida.com](mailto: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 for Health Care Administration 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 enrollee, you are not allowed to have a Medicaid Fair Hearing.

**Review by the State (for MediKids Enrollees)**

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 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 33914-7237

1-877-254-1055 *(toll-free)*

1-239-338-2642 *(fax)*

[MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)

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

**Continuation of Benefits for Medicaid Enrollees**

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 that you 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 16: Your Member Rights**

As a recipient of Medicaid and an enrollee 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
* 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 dental 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
* 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
* To file a 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 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

**Section 17: Your Member Responsibilities**

As a recipient of Medicaid and a member in a dental 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 understand your dental problems and agree on a treatment plan. 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
* Be responsible for your actions if treatment is refused or if you do not follow the health care provider's instructions
* 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

**Section 18: Other Important Information**

**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 (850) 413-9969 or visit their website at [www.floridadisaster.org](http://www.floridadisaster.org)

**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 <Insert Plan specific information>

**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 PDP 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 primary care provider
* 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).

**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 enrollee record;
* A description of how we operate;
* Quality performance ratings, including member satisfaction survey results;
  + <Plan insert free text that links to website where Plan publishes results for performance measures in a manner that allows recipients to compare the performance of Plan’s – see 409.967.(2)(f)(2), F.S.>; and
* <Plan insert free text>

**Section 19: Additional Resources**

**Florida Department of Health Information**

The Public Health Dental Program leads the Department of Health's efforts to improve and maintain the oral health of all persons in Florida. You can find the following types of information on their website:

* Community Water Fluoridation
* Oral health related sites
* School-based sealant programs

To find more information on the Public Health Dental Program, please visit:

[www.flhealth.gov/dental](http://www.flhealth.gov/dental)

To find information on the quality of oral health in your county, please visit:

<http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.OralHealthProfile>

**MediKids Information**

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

**Section 20: Forms**

**[Optional By Plan]**

Examples:

Designation of Health Care Surrogate

<Plan insert free text tagline on how to request auxiliary aids and services in accordance with 42 CFR 438.10(d) in 18-point font and in top 4 Languages (English, Spanish, Haitian Creole, and Vietnamese)>

**Non-Discrimination Notice**

<Insert Plan specific tagline here. Note: Staff name does not need to be in the document, but it must be listed on the website.>

1. For the full list of For Cause Disenrollment reasons, please see Florida Administrative Rule 59G-8.600, Disenrollment from Managed Care Plans, at: <https://ahca.myflorida.com/medicaid/rules/adopted-rules-service-specific-policies> [↑](#footnote-ref-1)
2. To learn how to ask for an appeal, please turn to page Section 13, Member Satisfaction, on page <PAGE NUMBER FOR SECTION 13>. [↑](#footnote-ref-2)
3. Also known as “Early and Periodic Screening, Diagnosis, and Treatment” or “EPSDT” requirements. [↑](#footnote-ref-3)
4. 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)](https://www.aap.org/en-us/professional-resources/practice-transformation/managing-patients/Pages/Periodicity-Schedule.aspx). [↑](#footnote-ref-4)
5. You can find the definition for Medical Necessityin the Florida Medicaid Definitions Policy at: <https://ahca.myflorida.com/medicaid/rules/adopted-rules-general-policies> [↑](#footnote-ref-5)