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

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.

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

Summary of Healthcare Plan Benefits

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

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

Summary of Medical Benefits

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

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8. Primary Care/Physician Office Visits • Includes Issue focused visits and wellness benefits • Specialist • Outpatient Surgery	**$10 per visit** **$25 per visit** **$25 per surgical procedure**	Wellness Benefits include : ▪ Routine Physical Examinations (including gynecological exam and diagnostic services) ▪ Immunizations ▪ Routine Examination for Prostate Cancer ▪ Routine Examination for Rectal/Colon Cancer ▪ Routine Mammograms Referral must be made by the Primary Care Provider Procedures performed in a Primary Care Provider/ Physician's Office, Hospital, or surgical facility as an outpatient procedure.
9. Therapy • **Occupational Therapy** (if related to an illness or Injury) • **Physical Therapy** • **Speech Therapy**	 **$10 per visit** **$10 per visit** **$10 per visit**	Therapy must be related to an illness or injury and ordered by the Primary Care Provider and not be covered by other Insurance, liability, automobile, no-fault, or workers' compensation coverage. 20 visits per calendar year per discipline

Summary of Dental Benefits

Covered Dental Expenses:	Copayment	Limits
1. Basic, Preventive and Routine Dental Care *(See page 5)*	**$10 per visit**	$1,000 per calendar year
	To offset the cost of parking, patients at the **UF College of Dentistry: $7 per visit**	$1200 per calendar year for Disease Management patients
2. Denture Therapy • Complete Upper Denture • Complete Lower Denture • Partial Upper Denture • Partial Lower Denture	**$50 each** **$50 each** **$50 each** **$50 each** ***No additional copayments for the above denture therapy services***	$1,000 per calendar year Once every five (5) years

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Summary of Vision Benefits

Covered Vision Care Expenses:	Copayment	Limits
1. Comprehensive Eye Exam	**$10.00**	Once annually or as medically necessary
2. Eyeglasses	**$25.00**	One pair annually
3.		

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Summary of Prescription Drug Benefits

Covered Prescription Drug Expenses:	Participating Pharmacy
Pharmacy Options (30-day supply):	
Copayment, per prescription or refill, for generic	**$5**
Copayment, per prescription or refill, for name brands*	**$5**

**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.*

***The following is an overview of the services which are covered under the CHOICES Health Services Plan.* Alachua County's CHOICES Health Services Program**

(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 work 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.

Deleted: 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.

Deleted: 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.

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**
- **Bariatric Surgery and services associated with Bariatric Surgery**
- **Breast Reduction**
- **Charges Imposed by Immediate Relatives of the Patient or Members of the Patient's Household**
- **Chemotherapy**
- **Contact Lenses**
- **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.
- **Hearing Aids**
- **Auditory Implants**
- **HIV/AIDS Treatment.** Care, supplies, services and treatment for HIV/AIDS.

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- **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.
- **Pain Management Services**
- **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.

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- **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.
- **Sleep Studies**
- **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.

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