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TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

AETNA BETTER HEALTH®
Medicaid (STAR) Member Handbook

Bexar and Tarrant Service Areas

Member Services
1-800-248-7767 (Bexar)
1-800-306-8612 (Tarrant)

Aetna Better Health covers Medicaid members in the following counties:
Tarrant Service Area: Tarrant, Denton, Hood, Johnson, Parker and Wise
Bexar Service Area: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson

www.aetnabetterhealth.com/texas

February 2015
)

Aetna Better Health
STAR Member Handbook

To learn more, please call 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar)

www.aetnabetterhealth.com/texas

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Tarrant Service Area: Tarrant, Denton, Hood, Johnson, Parker, and Wise Counties.

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Tarrant/Bexar Service Areas –February 2015

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TEXAS STAR PROGRAM
Your Health Plan ■ Your Choice

Table of Contents

Introduction

Your STAR Member Handbook

This handbook is a guide to help you understand your Aetna Better Health plan.

If you have questions about your benefits, or what is covered, refer to the benefits section of this handbook.

If you cannot find the answer to your question(s) in this handbook, use our website **www.aetnabetterhealth.com/texas**, or call us at the toll free number on your ID card. We will be happy to help you.

Tips for members

- Keep this handbook for future use.
- Write your ID number(s) in the front of this book or other safe place.
- Always carry your ID card with you.
- Keep your Primary Care Provider's name and number near the phone.
- Use the hospital Emergency Room (ER) only for emergencies

Questions or Need Help Understanding / Reading Member Handbook?

We have staff who speak English or Spanish that can help you understand this handbook. We also have special services for people who have trouble reading, hearing, seeing, or speaking a language other than English or Spanish. You can ask for the Member Handbook in audio, other languages, Braille or larger print. If you need an audiocassette or CD, we will mail it to you. To get help, visit our website at **www.aetnabetterhealth.com/texas** or call us at the toll free number on your ID card.

Member Services

Member Services Department

We are available to assist you by phone Monday through Friday from 8 a.m. to 5 p.m. Call us at the toll free number on your Medicaid ID card.

- Ask questions about your benefits and coverage.
- Change your address or phone number.
- Change your Primary Care Provider.
- Find out more about how to file a complaint.

For assistance after hours and weekends, please leave a message on the voice mail box.

Call your Primary Care Provider with questions about appointments, hours of service or getting care after hours.

Plan Information and Resources Online

Aetna Better Health℠ Website

Get information 24 hours a day, 7 days a week on our website at **www.aetnabetterhealth.com/texas**. You can find information and answers to your questions without calling us.

This website allows you to:

- See member newsletters.
- See Questions and Answers about Medicaid.
- Search our provider directory to find Aetna doctors and hospitals in your area.
- Get information on different health topics.

Provider Directory Resource

Our provider directory has a list of all types of network providers and their names, addresses, phone numbers, specialty, education, board certification, languages spoken, ages served and more. The latest directory is always at www.aetnabetterhealth.com/texas. Call Member Services if you need help locating a network practitioner or if you'd like us to send you a printed copy.

How Your Aetna Better Health Plan Works

The Basics

- You pick a primary care provider (PCP) from our large list of providers. You can pick a different Primary Care Provider for each covered member in your family.
- Go to your Primary Care Provider for routine and preventive care.
- Your Primary Care Provider will send you to a specialist or coordinate precertification for care when needed.
- You have coverage in an emergency.
- Generally, no claim forms or balance bills.

About Your Plan

As a member of Aetna Better Health, you can ask for and get the following information each year:

- Information about network providers - at a minimum primary care doctors, specialists and hospitals in your service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits.
- This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
- What makes up emergency medical conditions, emergency services and post-stabilization services
- The fact that you do not need prior authorization from your Primary Care Provider for emergency care services
- How to get emergency services, including instructions on how to use the 911 telephone system or its local
- equivalent
- The addresses of any places where providers and hospitals furnish emergency services covered by the Medicaid program.
- A statement saying you have a right to use any hospital or other settings for emergency care
- Post-stabilization rules
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Aetna Better Health's practice guidelines.

Important Numbers

Your Medicaid ID Number _____

Your Primary Care Provider (PCP) Name _____

Your Primary Care Provider (PCP) Address _____

Your Primary Care Provider (PCP) Phone _____

In case of an emergency, call 911 or your local emergency hotline.

Visit the website: www.aetnabetterhealth.com/texas

Call us: Aetna Better Health Member Services

Toll-free:
Tarrant Service Area: 1-**800-306-8612**
Bexar Service Area: 1-**800-248-7767**

English/Spanish/Interpreter Services available
Member Services Hours: Monday – Friday 8 a.m. – 5 p.m. central standard time
After Hours and Weekends: Leave a message on the voice mail box
Write us: Aetna Better Health
Attention: Aetna Better Health Member Services
PO Box 569150
Dallas, TX 75356-9150

TTY: For people that are deaf or hearing impaired, please call through TTY line at 1-800-735-2989 and ask them to call the Aetna Better Health Member Services Line.

Important Phone Numbers	
Informed Health® Line (Health information from a registered nurse) 24 hours a days, 7 days a week	**1-800-556-1555**
Transportation for Medical Services ***(services provided by Logisticare for TARRANT SERVICE AREA MEMBERS ONLY)***	**1-877-633-8747 (Bexar)** **1-855-687-3255 (Tarrant)**
STAR Help Line	**1-800-964-2777**
Prescription Information	**1-800-306-8612 (Tarrant)** **1-800-248-7767 (Bexar)**
Dental Contractors	**Dental Quest -- 1-800-516-0165** **MCNA Dental -- 1-855-691-6262**
Block Vision – vision services	**1-800-879-6901**
Medicaid Managed Care Help Line/ MMC Help Line TTY	**1-866-566-8989 / 1-866-222-4306**
Behavioral Health Services (includes mental health and substance abuse)* 24 hours a day, 7 days a week	**1-800-306-8612 (Tarrant)** **1-800-248-7767 (Bexar)**
*For behavioral health care services, call the number on your ID card. If you have a medical or behavioral health emergency and need treatment, please go to the closest Emergency Room. You or someone on your behalf will need to call us at 1-800- 306-8612 (Tarrant) or 1-800-248-7767 (Bexar) and tell us you had an emergency. Staff are available who speak both English and Spanish.	

Aetna Better Health Privacy Notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on September 16, 2013.

What do we mean when we use the words "health information"

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

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

How we use and share your health information

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

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us.
If you are under eighteen and don't want us to give your health information to your parents, call us. We can help in some cases if allowed by state law.

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

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

- Health promotion
- Case management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

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

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

Other reasons we might share your health information
We also may share your health information for these reasons:

- Public safety – To help with things like child abuse. Threats to public health.
- Research – To researchers. After care is taken to protect your information.
- Business partners –To people that provide services to us. They promise to keep your information safe.
- Industry regulation – To state and federal agencies. They check us to make sure we are doing a good job.
- Law enforcement – To federal, state and local enforcement people.
- Legal actions –To courts for a lawsuit or legal matter.

Reasons that we will need your written okay
Except for what we explained above, we will ask for your okay before using or sharing your health information. For example, we will get your okay:

- For marketing reasons that have nothing to do with your health plan.
- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons as required by law.

You can cancel your okay at any time. To cancel your okay, write to us. We cannot use or share your genetic information when we make the decision to provide you health care insurance.

What are your rights

- You have the right to look at your health information.
  - You can ask us for a copy of it.
  - You can ask for your medical records. Call your doctor's office or the place where you were treated.
- You have the right to ask us to change your health information.
  - You can ask us to change your health information if you think it is not right.
  - If we don't agree with the change you asked for. Ask us to file a written statement of disagreement.
- You have the right to get a list of people or groups that we have shared your health information with.

- You have the right to ask for a private way to be in touch with you.
  - If you think the way we keep in touch with you is not private enough, call us.
  - We will do our best to be in touch with you in a way that is more private.
- You have the right to ask for special care in how we use or share your health information.
  - We may use or share your health information in the ways we describe in this notice.
  - You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
  - We don't have to agree. But, we will think about it carefully.
- You have the right to know if your health information was shared without your okay.
  - We will tell you if we do this in a letter.

Call us toll free at **1-800-248-7767 (Bexar); 1-800-306-8612 (Tarrant); TTY: 1-800-735-2689** to:

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

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

Aetna Better Health
P.O. Box 569150
Dallas, TX 75356-9150

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

Protecting your information
We protect your health information with specific procedures. For example, we protect entry to our computers and buildings. This helps us to block unauthorized entry. We follow all state and federal laws for the protection of your health information.

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

Member Identification (ID) Cards

When you sign-up with Aetna Better Health, you will get an ID card from us. You will not get a new Aetna ID card every month. If you call us to change your Primary Care Provider, you will get a new card.

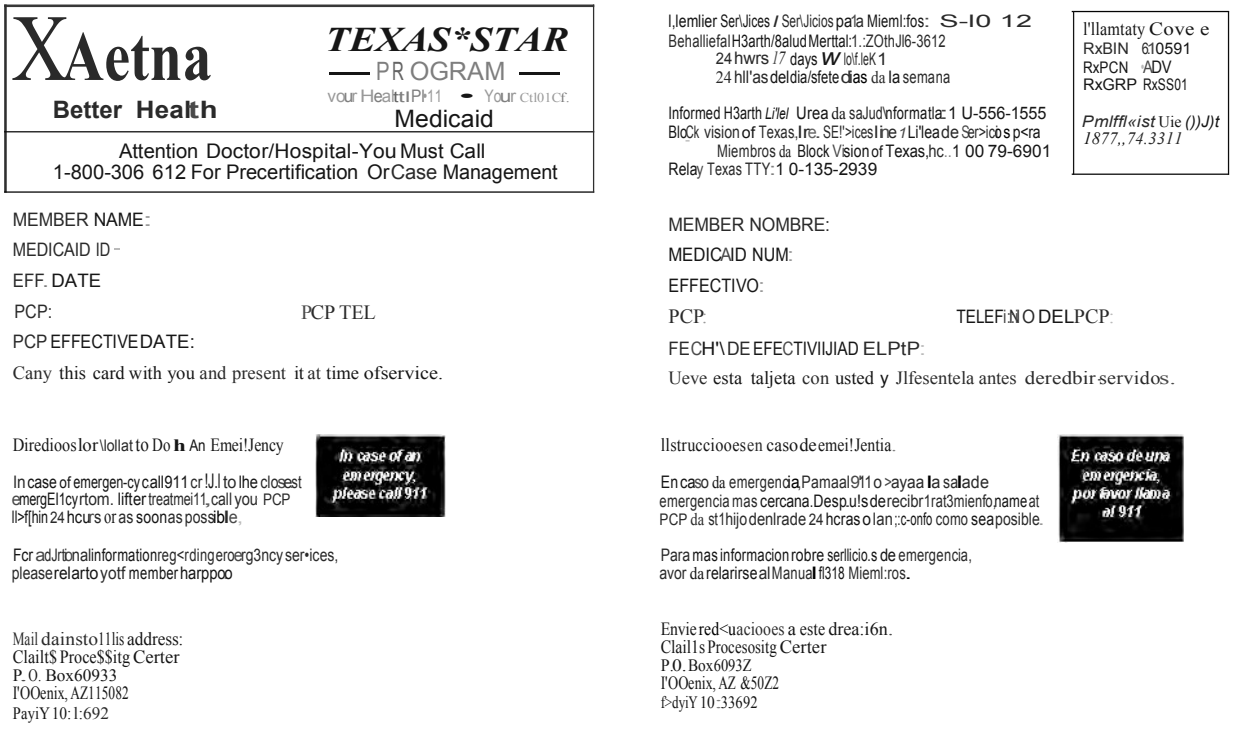
How to read your card: The ID card lists the name and phone number(s) of your Primary Care Provider. The back of the ID card has important phone numbers for you to call if you need help. Please make sure your information on your ID card is correct.

- Medicaid ID: Member identification number
- Eff date: Effective date of coverage with the health plan
- PCP: Name and phone number of Primary Care Provider
- PCP Effective Date: Effective date of coverage with the provider
- RxBIN: Bank identification number pharmacy uses to submit claims.
- RxGrp: Prescription Group number pharmacy uses to identify the health plan
- RxPCN: Processor control number pharmacy uses to submit claims

How to Use your card: Always carry your ID card with you when going to see the doctor. You will need it to get health care. You must show it each time you get services.

How to replace your card if lost or stolen: please call us right away so we can send you another ID card.

Aetna Better Health Member ID Card Sample



XAetna
Better Health

TEXAS*STAR
PROGRAM
Your Health Plan
Medicaid

Attention Doctor/Hospital-You Must Call
1-800-306 612 For Precertification OrCase Management

MEMBER NAME:
MEDICAID ID -
EFF. DATE
PCP: PCP TEL
PCP EFFECTIVE DATE:
Cany this card with you and present it at time ofservice.

Diredioos lor\lollat to Do h An Emei!Jency

In case of emergency, please call 911

In case of emergen-cy call 911 cr !J.I to lhe closest emergEI1cyrtom. lifter treatmei11, call you PCP ll>f[hin 24 hcurs or as soonas possible.

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Relay Texas TTY:1 0-135-2939

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En caso de una emergencia, por favor llama al 911

En caso da emergencia,Pamaal9'11 o >ayaa la salade emergencia mas cercana.Desp.u!s derecibr1rat3mienfo,name at PCP da st1hijo denlrade 24 hcras o lan;:c-onfo como seaposible.

Para mas informacion robre serllicio.s de emergencia, avor da relarirse al Manual fl318 Mieml:ros.

Envie red<uaciooes a este drea:i6n.
Clail1s Procesositg Certer
P.0. Box6093Z
I'OOenix, AZ &50Z2
f>dyiY 10:33692

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a Your Texas Benefits Medicaid Card. This plastic card will be your everyday Medicaid ID card. You should carry and protect it just like your driver's license or a credit card. The card has a magnetic stripe that holds your Medicaid ID number. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will only be issued one card, and will only receive a new card in the event of the card being lost or stolen. If your Medicaid ID card is lost or stolen, you can get a new one by calling toll-free 1-855-827-3748.

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at 1-800-252-8263. You can also call 2-1-1. First pick a language and then pick option 2.

Your health history is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your health history through the secure online network, call toll-free at 1-800-252-8263.

The Your Texas Benefits Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Texas Women's health Program (TWHP)
  - Hospice
  - STAR Health
  - Emergency Medicaid, or
  - Presumptive Eligibility for Pregnant Women (PE).
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the Your Texas Benefits Medicaid card has a website you can visit (www.YourTexasBenefits.com) and a phone number you can call (1-800-252-8263) if you have questions about the new card.

If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

Information About The Temporary ID Card (Form 1027 – A)

Medicaid also has a temporary ID card called a Form 1027-A. You will get this card in the mail when Your Texas Benefits Medicaid Card has been lost or stolen. The Medicaid temporary ID card tells providers about you and the services that you can get for the time period listed on the Form 1027-A.

Be sure to read the back of the Form 1027-A. The back of the card tells you how and when to use the card. There is a box that has specific information for providers.

You **must** take your Form 1027-A and your Health Plan ID card with you when you get any health care services. You will need to show these cards every time you need services. You can use the temporary ID card until you get Your Texas Benefits Medicaid Card.

Medicaid Eligibility Verification
Confirmación de elegibilidad para Medicaid

	Name of Doctor/Nombre del doctor	**Name of Pharmacy**/Nombre de la farmacia

THIS FORM DOES NOT AUTHORIZE MEDICAID COVERAGE. PLEASE VERIFY ELIGIBILITY PRIOR TO PROVIDING SERVICES.
ESTA FORMA NO AUTORIZA LA COBERTURA DE MEDICAID. FAVOR DE VERIFICAR LA ELEGIBILIDAD ANTES DE PRESTAR LOS SERVICIOS.

■ **Each person listed below has applied for MEDICAID BENEFITS for the dates indicated below, but has not yet received a client number. Do not submit a claim until you are given a client number. Pharmacists have 90 days from the date the number is issued to file clean claims. However, check your provider manual because other providers may have different filing deadlines. Call the eligibility worker named below if you have not been given the client number(s) within 15 days.**

■ **The Medicaid Identification form is lost or late. The client number must appear on all claims for health services.**

Date Eligibility Verified	Verification Method	BIN
	■ **SAVERR Direct Inquiry** ■ **Regional Procedure** ■ **Data Integrity (A & D Staff Only)**	**610098**

CLIENT NAME NOMBRE DEL CLIENTE	**DATE OF BIRTH** FECHA DE NACIMIENTO	**CLIENT NO.** CLIENTE NÚM.	**ELIGIBILITY DATES** PERIODO DE ELEGIBILIDAD		**MEDICARE CLAIM NO.** NÚM. DE SOLICITUD DE PAGO DE MEDICARE	**STAR/STAR+PLUS HEALTH PLAN INFORMATION** INFORMACIÓN DEL PLAN DE SALUD STAR/STAR+PLUS **Plan Name and Member Services Toll-Free Telephone No.** Nombre del plan y teléfono gratuito de Servicios para Miembros
			From/Desde	**Through**/Hasta		

I hereby certify, under penalty of perjury and/or fraud, that the above client(s) have lost, have not received, or have no access to Medicaid Identification (Your Texas Benefits Medicaid Card). I have requested and received Form 1027-A, Medicaid Eligibility Verification. I understand that using this form to obtain Medicaid benefits (services or supplies) for people not listed above is fraud and is punishable by fine and/or imprisonment.

CAUTION: If you accept Medicaid benefits (services or supplies), you give and assign to the state of Texas your right to receive payments for those services or supplies from other insurance companies and other liable sources, up to the amount needed to cover what Medicaid spent.

Por este medio certifico, bajo pena de perjurio o fraude, que los clientes nombrados arriba hemos perdido, no hemos recibido o por otra razón no tenemos en nuestro poder la tarjeta de Medicaid de Your Texas Benefits, Identificación de Medicaid del mes actual. Solicité y recibí esta Forma 1027-A, Confirmación de elegibilidad para Medicaid. Comprendo que usar esta confirmación para obtener beneficios (servicios o artículos) de Medicaid para alguna persona no nombrada arriba como beneficiario constituye fraude y se puede castigar con una multa o la cárcel.

ADVERTENCIA: Si usted acepta beneficios de Medicaid (servicios o artículos), otorga y concede al estado de Texas el derecho de recibir pagos por los servicios o artículos de otras compañías de seguros y otras fuentes responsables, hasta completar la cantidad que se requiere para cubrir lo que haya gastado Medicaid.

_____ _____
Signature–Client or Representative/ Firma–Cliente o Representante **Date**/Fecha

Office Address and Telephone No./Oficina y Teléfono

Name of Worker (type)/Nombre del trabajador	Worker BJN	Worker Signature **X**	Date
Name of Supervisor* (type)/Nombre del supervisor*	Supervisor* BJN	Supervisor Signature **X**	Date

***or Authorized Lead Worker**/*o Trabajador encargado

Form 1027-A
Page 2/10-2004

Medicaid clients do not have to pay bills which Medicaid should pay. It is very important that you tell your doctor, hospital, drugstore, and other health care providers right away that you have Medicaid. If you do not tell them that you have Medicaid, you may have to pay these bills. If you get a bill from a doctor, hospital, or other health care provider, ask the provider why they are billing you. If you still get a bill, call the Medicaid hotline at 1-800-252-8263 for help. If Medicaid will not pay the bill or if Medicaid benefits (services and supplies) are denied, you may request a fair hearing by writing to the address or calling the telephone number listed on the letter you get.
NOTE: Family planning clinics and other providers give physical exams, lab tests, birth control methods (including sterilization) and contraceptive counseling at no cost to you.

El cliente de Medicaid no tiene que pagar cuentas médicas que Medicaid debe pagar. Es muy importante que usted avise inmediatamente a su médico, al hospital, a la farmacia y a otros proveedores de servicios médicos que usted tiene Medicaid. Si no les dice que tiene Medicaid, es posible que usted tenga que pagar estas cuentas. Si usted recibe una cuenta de un doctor, un hospital u otro proveedor de servicios médicos, pregunte por qué le mandaron la cuenta. Si de todas maneras recibe una cuenta, llame a la línea directa de Medicaid al 1-800-252-8263 para pedir ayuda. Si Medicaid no va a pagar la cuenta o si se niegan los beneficios de Medicaid (los servicios o los artículos), usted puede pedir una audiencia imparcial escribiendo a la dirección o llamando al número de teléfono que aparecen en la carta que recibió.
NOTA: Las clínicas de planificación familiar y otros proveedores ofrecen exámenes físicos, análisis de laboratorio, métodos anticonceptivos (inclusive la esterilización) y orientación sobre los anticonceptivos, gratis.

Provider Information/Información para el proveedor

This form does not authorize Medicaid coverage. Please verify eligibility prior to providing services.
PLEASE NOTE: Payment for Family Planning Services is available without the consent of the client's parent or spouse. Confidentiality is required. Family planning drugs, supplies, and services are exempt from the prescription drug and "LIMITED" restrictions.
Key to terms that may appear on this form:
LIMITED – Except for family planning services, and for Texas Health Steps (EPSDT), medical screening, dental, and hearing aid services, the client is limited to seeing the doctor **and/or** limited to using the pharmacy named on the form for drugs obtained through the Vendor Drug Program. In the event of an emergency medical condition as defined below, the "LIMITED" restriction does not apply.
EMERGENCY – The client is limited to coverage for an emergency medical condition. This means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (who possesses an average knowledge of health and medicine) would think that the absence of immediate medical attention could reasonably be expected to result in (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.
HOSPICE – The client is in hospice and waives the right to receive services related to the terminal condition through other Medicaid programs. If a client claims to have canceled hospice, call the local hospice agency or Texas Department of Aging and Disability Services to verify.
QMB – The Medicaid agency is providing coverage of Medicare premiums, deductible, and coinsurance liabilities, but the client is not eligible for regular Medicaid benefits.
MQMB – The Medicaid agency is providing regular Medicaid coverage as well as coverage of Medicare premiums, deductibles, and coinsurance liabilities.
PE – Medicaid covers only family planning and medically necessary outpatient services.
STAR/STAR+PLUS HEALTH PLAN – The client is enrolled in the Medicaid Managed Care program and is assigned to the health plan named on the form.

NOTE TO PHARMACY/NOTA PARA LA FARMACIA**: Medicaid will pay for more than three prescriptions each month for any Medicaid client who is under age 21, or lives in a nursing facility, or has the STAR/STAR+PLUS Health Plan, or gets services through the Community Living Assistance and Support Services (CLASS), Community Based Alternatives (CBA) and other non-SSI community-based waiver programs. Clients with Medicare who are enrolled in STAR+PLUS may be limited to three prescriptions per month. Contact the Pharmacy Resolution Help Desk at 1-800-435-4165 for information.**

Primary Care Provider (PCP) Information

Role of the Primary Care Provider (PCP)

What is a Primary Care Provider (PCP)?

A Primary Care Provider is your primary health care provider. Your Primary Care Provider will give or arrange for all the medical care you need. Your Primary Care Provider can take care of routine medical problems. Sometimes you may have a problem that needs to be handled by a specialist. The Primary Care Provider can arrange to have you see the right specialist. The Primary Care Provider will authorize you to see the specialist with a referral and tell you how to schedule an appointment. If you need to be admitted to a hospital, your Primary Care Provider can arrange that for you.

Our goal is your good health. We urge you to see your Primary Care Provider to get preventive care services within the next sixty (60) days or as soon as possible. This will help your doctor learn about you so he or she can help you plan for your future health care needs. Getting started with your doctor can also help prevent delays in care when you are sick. Remember that you and your Primary Care Provider are the most important members of your healthcare team.

Choosing Your Primary Care Provider

Can a Clinic Be My Primary Care Provider (PCP)?

If you have been getting health care services at a clinic and you want to keep going there, please pick one of the doctors in the clinic as your Primary Care Provider. The Primary Care Provider you pick needs to be listed in our Provider Directory.

Some of the providers that you can also pick from to be your Primary Care Provider are: family doctors; pediatricians (for children); OB/GYNs (woman's doctor); general practitioners (GPs); advanced nurse practitioners (ANPs); Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

Please look at our Provider Directory to get more information on Primary Care Providers. You must pick a Primary Care Provider who is in our Aetna Better Health network. You can get a copy of the provider directory on **www.aetnabetterhealth.com/texas** or by calling us at 1-800-306-8612 for Tarrant or 1-800-248-7767 for Bexar.

Can a specialist ever be considered a PCP? You can keep seeing your current Primary Care Provider if the Primary Care Provider is listed in our Provider Directory. There might be times when we can let a specialist be your Primary Care Provider.

Visiting Your Primary Care Provider

What Do I Need to Bring with Me to My Doctor's Visit?

You should take the following items with you when you go to your doctor's visits:

- Your Texas Benefits Medicaid Card and/or your Form 1027A
- Aetna Better Health ID card
- Immunization (shot) records
- Paper to take notes on information you get from the doctor

What If I Choose to Go to Another Doctor Who Is Not My Primary Care Provider?

You will need to go to your Primary Care Provider for most health services or you might have to pay for the services.

What Type of Care Does Not Require Me to First Be Seen by Primary Care Provider?

For the following types of care, you do not have to go to your Primary Care Provider first:

- Emergency
- OB/GYN
- Family Planning
- Routine Eye Care
- Behavioral Health
- Texas Health Step Medical and Dental Check-ups

To learn more, use our website (www.aetnabetterhealth.com/texas) or call us at the toll free number on your ID card.

Changing Your Primary Care Provider

How Can I Change My Primary Care Provider?

You can change your Primary Care Provider by calling us at the toll free number on your ID card. For a list of doctors and clinics, please see our Provider Directory. You can view this online at www.aetnabetterhealth.com/texas .

How Many Times Can I Change My/ My Child's Primary Care Provider?

There is no limit on how many times you can change your or your child's primary care provider. You can change primary care providers by calling us toll-free at 1-800-306-8612 for Tarrant or 1-800-248-7767 for Bexar or writing to:

Aetna Better Health
Attention: Aetna Better Health Member Services
PO Box 569150
Dallas, TX 75356-9150

When Will My Primary Care Provider Change Become Effective?

If you change your Primary Care Provider, you will get a new ID card. The new ID card will tell you the new Primary Care Provider's name, address, phone number and date the new Primary Care Provider will be effective. The Primary Care Provider change will become effective the same day that you call Member Services to make the change.

Are There Reasons Why A Request to Change a Primary Care Provider May Be Denied?

In some cases, your request to change your Primary Care Provider can be denied. Your request can be denied if:

- The Primary Care Provider you picked is not accepting new patients, or
- The Primary Care Provider you picked is no longer a part of Aetna Better Health.

Can My Primary Care Provider Move Me to Another Primary Care Provider for Non-Compliance?

Your Primary Care Provider can request that you pick a new Primary Care Provider for the following reasons:

- You often miss your appointments and do not call to let the Primary Care Provider know, or
- You do not follow advice from your Primary Care Provider.

What If My Primary Care Provider Leaves the Aetna Better Health Network?

If your Primary Care Provider leaves the Aetna Better Health network, we will send you a letter telling you the new Primary Care Provider we have chosen for you. If you are not happy with the new Primary Care Provider, call us at the toll free number on your ID card and tell us the Primary Care Provider you want. If you are getting medically necessary treatments, you might be able to stay with that doctor if he or she is willing to see you. When we find a new Primary Care Provider on our list who can give you the same type of care, we will change your Primary Care Provider.

After Hours Care

How Do I Get Medical Care After My Primary Care Provider's Office is Closed?

If you get sick at night or on a weekend and cannot wait to get medical care, call your Primary Care Provider. Your Primary Care Provider or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-hour Informed Health Line® at 1-800-556-1555 to speak with a registered nurse to help you decide what to do.

Medicaid Lock-in Program

You may be put in the Lock-In Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more call Aetna Better Health

Physician Incentive Plan Information

A physician incentive plan rewards doctors for treatments that reduce or limit services for people covered by Medicaid. Right now, Aetna Better Health does not have a physician incentive plan.

Health Plan Information

Changing Your Health Plan

What If I Want to Change My Health Plan? Who do I Call?

You can change your health plan by calling the Texas STAR or STAR+PLUS Program Helpline at 1-800-964-2777. You can change health plans as often as you want, but not more than once a month.
If you are in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will not be able to change health plans until you have been discharged**.**
If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

How Many Times Can I Change My Health Plan?

You can change plans as often as you want, but not more than once a month. If you **are** in the hospital, a residential Substance Use Disorder (SUD) treatment facility, or residential detoxification facility for SUD, you will **not** be able to change health plans until you have been discharged.

When will my Health Plan Change Become Effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Disenrollment from the Health Plan

Can Aetna Better Health Ask that I Get Dropped from Their Health Plan (for Non-Compliance, etc?

You can be disenrolled from our plan if:

- You move out of the service area.
- You keep going to the ER when you do not have an emergency.
- You keep going to another doctor or clinic without first getting approval from your Primary Care Provider.
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition.
- You miss many appointments without letting your doctor know.
- You let someone else use your ID card.
- You often do not follow your doctor's advice.

Benefits

Health Care Benefits

What are My Health Care Benefits?

Here is a list of services you can get. You should see your Primary Care Provider to ask about medical services. Please follow your Primary Care Provider's advice. Your Primary Care Provider is responsible for coordinating all of your care.

- Needed medical care for adults and children
- Vaccines to prevent illness (immunizations)
- Chiropractic services
- Podiatrists (foot doctor)
- Laboratory and x-ray services
- Surgery as an outpatient (no hospital stay)

- Hospital care and outpatient care
- Maternity care and newborn care
- 24-hour nurse help line
- 24-hour emergency care from an emergency room
- Eye doctor services (includes eyeglasses and contact lens, if medically necessary)
- Hearing services and hearing aids
- Home health agency services
- Ambulances (for emergencies only)
- Dialysis for kidney problems
- Major organ transplants
- Texas Health Steps Medical and Dental Check-ups
- Once a year physical exam for adults
- Physical, occupational and speech therapy
- Family planning services and supplies
- HIV and sexually transmitted disease treatment
- Behavioral health services – (such as counseling and treatment)
- Substance abuse assistance (such as alcohol or drug abuse)
- Diabetic supplies
- Health education classes
- Transportation to medical appointments through the Medical Transportation Program

Services covered for members birth through 20 years of age can be different than services covered for members 21 years of age or older.

How do I Get These Services?

You should see your Primary Care Provider to ask about medical services. To learn how to get these or other services, please use the website (**www.aetnabetterhealth.com/texas**) or call us at the toll free number on your ID card.

Are There Any Limits to Any Covered Services?

There can be limits on some services. Call us at the toll free number on your ID card to learn more.

What Services are Not Covered?

Aetna Better Health does not cover all health care services. The following is a list of services that are *not covered:*

- Faith healing
- Acupuncture
- Cosmetic surgery
- Any service that is not medically necessary
- Any service that your Primary Care Provider does not approve, except for Texas Health Steps Medical and Dental check-ups, family planning services, routine vision and hearing services, Ob/Gyn, behavioral health services and emergency services.

If you agree to get services that we do not cover or approve, you might have to pay for them.

What are My Prescription Drug Benefits?

Aetna Better Health covers all prescription drugs approved by the State Medicaid program. For a listing of covered drugs, please go to our website www.aetnamedicaid.com www.aetnabetterhealth.com/texas or call us at the toll-free number on your ID card.

Additional Benefits

What Extra Benefits Do I Get As Member of Aetna Better Health?

Aetna Better Health members get the following value-added services and extra benefits: Value-added Services

- Informed Health Line™ -1-800-556-1555 – You can talk to a nurse 24 hours a day, 7 days a week. The nurse can help you with questions or help you decide what to do about your health needs. Only your doctor can give medical advice or medicines. The Informed Health nurses can give information on over 5,000 health topics. Call your doctor first with any questions or concerns about your health care needs.

- Vital Savings by Aetna (SM) - Discount Program - 1-888-238-4825 – *(only members over 21)* You can get discounts on dental services from dental providers participating within our network. You will get a packet in the

mail with a Vital Savings ID card. You will need to show your Vital Savings ID card when you go to a participating dentist office. You will pay a discounted fee at the time of service directly to the dentist. YOU WILL HAVE TO PAY FOR ALL SERVICES OR PRODUCTS BUT WILL GET A DISCOUNT FROM PROVIDERS WHO HAVE CONTRACTED WITH THE DISCOUNT MEDICAL PLAN ORGANIZATION (AETNA LIFE INSURANCE COMPANY). To get a list of participating dentists, you can call the phone number listed above or go to our website at www.aetnabetterhealth.com/texas . This program also provides you with discounted fees for fitness club memberships, exercise equipment, chiropractic care, acupuncture, nutrition counseling and vitamins. Please call Vital Savings to learn more on the types of discounts that are offered.

- Sports Physical Exams – Aetna Better Health members 19 years and younger, can get one sports physical exam per year. Make an appointment with your doctor or other provider who offers sports physical exams.
- Smoking Cessation Program – Aetna Better Health will offer smoking cessation benefits including assessment and counseling to Medicaid members 12 years of age and older *(counseling services for non-pregnant members only)*. Please call us at the toll-free number on your ID card to find a provider near you. Nicotine replacement products to Medicaid members 18 years of age and older unless prescribed by a physician. If you buy a nicotine replacement product, please call us to find out where to send your receipt(s).
- Weight Management Program –Aetna Better Health will offer weight management programs including family counseling with a nutritionist/dietician for non-pregnant members 12-19 years old. Please call us at the toll-free number on your ID card to find a provider near you.
- Contact Lenses Program –Aetna Better Health will offer a benefit for contact lenses, including a fitting exam, with additional benefits to be applied towards the purchase of contact lenses to correct vision for members 12-18 years old. Please call the Block Vision number on your ID card or on page ii of this book for more information.
- Promise (SM) Program – Aetna Better Health will offer a rewards program for pregnant women who complete at least 10 prenatal and 1 postpartum visit(s). Diapers will be mailed to you after you complete your visits. You will need to call us at the toll-free number on your ID card to claim your gift - a Member Newsletter – You will get a newsletter in the mail with information on health topics to help you.
- Case Management and Disease Management - Nurses give you information about your health concerns and help coordinate services for those members who have chronic or complex illnesses.

How Can I Get These Benefits?

You do not have to go to your Primary Care Provider to get these services. If you have questions or need help with these services, go to our website (**www.aetnabetterhealth.com/texas**) or call us at the toll free number on your ID card.

What Health Education Classes does Aetna Better Health offer

We work with our community partners to make available at no cost to you and/or low-cost classes for parents and children. Some health topics include:

Car Seat Safety	Poison Safety
Drug & Alcohol Awareness	Prenatal Care
Immunizations	Sexually Transmitted Diseases
Infant Mortality	Smoking Cessation
Nutrition	Teen Pregnancy Prevention
Oral Health	Vision Awareness
Physical Fitness	Weight Management

Please call us to learn more. Please check with your provider before you begin any new health or wellness program.

What Other Services Can Aetna Better Health Help Me Get (non-capitated services)?

In addition to the services listed in the benefits section, you may be able to get some of the following services or programs:

- Department of State Health Services (DSHS) Targeted Mental Health Case Management
- DSHS mental health services
- DSHS Case Management for Children and Pregnant Women
- Department of Assistive and Rehabilitative Services (DARS) Case Management for the Blind
- Tuberculosis (TB) services offered by DSHS-approved providers
- Department of Aging and Disability Services (DADS) Hospice Services
- Medical Transportation Program

- Supplemental Nutrition Program for Women, Infants and Children (WIC)

Additional services available for members birth through 20 years of age include:

- Texas Health Steps Dental, including braces (These services are available when medically necessary and do not include dental services that are mainly for cosmetic purposes.)
- Early Childhood Intervention (ECI) Program
- Texas School Health and Related Services (SHARS)

You do not have to go to your Primary Care Provider to get these services. If you have questions or need help with these services, call us at the toll free number on your ID card.

Health Care and Other Services

Routine Medical Care

What Is Routine Medical Care?
How Soon Can I Expect to be Seen ?

Routine care is non-emergency or non-urgent care that you receive from your Primary Care Provider and/or other health care providers.

The Primary Care Provider you picked is called your "medical home" and will help you with all of your medical care. Your Primary Care Provider will give you regular check-ups, and treat you when needed. Your Primary Care Provider will order prescription drugs and medical supplies. Your Primary Care Provider will also send you to a specialist if needed. A specialist can be your Primary Care Provider as decided by your Primary Care Provider and Aetna Better Health. It is important that you follow your Primary Care Provider's advice and take part in decisions about your health care.

When you need care, call your Primary Care Provider's phone number on your ID card. The doctor's office or clinic will make an appointment for you. It is very important that you keep your appointments. If you cannot keep your appointment, please call your doctor to let him/her know. Your Primary Care Provider should be able to see you within two (2) weeks after you ask for a routine care appointment or within eight (8) weeks after you ask for an appointment for a physical or a wellness checkup.

Urgent Medical Care

What Is Urgent Medical Care?

Another type of care is **urgent care**. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts
- Earaches
- Sore throat
- Muscle sprains/strains

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Aetna Better Health of Texas Medicaid. For help, call us toll-free at Tarrant Service Area: 1-800-306-8612, Bexar Service Area: 1-800-248-7767. You also can call our 24-hour Nurse HelpLine at 1-800-556-1555 for help with getting the care you need.

How Soon Can I Expect to Be Seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take (insert name of MCO) Medicaid.

Emergency Care

What Is Emergency Medical Care?
How Soon Can I expect to be Seen ?

Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

- placing the patient's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- serious disfigurement; or
- in the case of a pregnant woman, serious jeopardy to the health of a woman or her unborn child.

"Emergency Behavioral Health Condition" means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson, possessing average knowledge of medicine and health :

- Requires immediate intervention and/or medical attention without which the Member would present an immediate danger to themselves or others; or
- Which renders the Member incapable of controlling, knowing or understanding the consequences of their actions.

"Emergency Services" and "Emergency Medical Care" means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition or Emergency Behavioral Health Condition, including post stabilization services.

Guidelines

You should be seen the same day if you need emergency care. We ask that you follow the guidelines below when you believe you need emergency care.

- Call 911 or the local emergency hotline or go to the nearest emergency facility. If a delay would not be harmful to your health, call your Primary Care Provider. Tell your Primary Care Provider as soon as possible after getting treatment.
- As soon as your health condition is stabilized, the emergency facility should call your Primary Care Provider for information on your medical history.
- If you are admitted to an inpatient facility, you, a relative, or friend on your behalf should tell your Primary Care Provider as soon as possible.

Some good reasons to go to the ER are:

- danger of losing life or limb
- very bad chest pains
- poisoning or overdose of medicine
- choking or problems breathing
- possible broken bones
- uncontrolled diarrhea or vomiting
- heavy bleeding
- serious injuries or burns
- fainting
- suddenly not being able to move (paralysis)
- victim of violent attack (rape, mugging, stab, or gunshot wound)
- you have thoughts of causing harm to yourself or others
- about to deliver a baby

Emergency Dental Care

Are Emergency Dental Services Covered? Aetna Better Health covers limited emergency dental services for the following:

- Dislocated jaw.
- Traumatic damage to teeth and supporting structures.
- Removal of cysts.
- Treatment of oral abscess of tooth or gum origin.
- Treatment and devices for craniofacial anomalies.
- Drugs for any of the above conditions.

Aetna Better Health also covers dental services your child gets in the hospital or ambulatory surgical center including other

services your child might need, like anesthesia.

What Do I Do If My Child Needs Emergency Dental Care?

During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, call us toll-free at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) or call 911

What Is Post Stabilization?

"Post-stabilization care services" are services covered by Medicaid that keep your condition stable following emergency medical care.

Follow-Up Care after Emergency

You might need follow-up care after you go to the emergency room. If so, make an appointment with your Primary Care Provider. Do not go back to the emergency room (unless it is an emergency). Do not go back to the doctor that treated you at the hospital unless told to by your Primary Care Provider.

After-Hours Care

How do I get medical care after my Primary Care Provider's office is closed?

If your Primary Care Provider's office is closed and you get sick at night or on a weekend and cannot wait to get medical care, call your Primary Care Provider for advice to help by phone 24 hours a day, 7 days a week. You may also call the Informed Health Line at 1-800-556-1555 to help you decide what to do.

Getting Care When Traveling

What If I Get Sick When I Am Out of Town or Traveling?

If you need medical care when traveling, call us toll-free at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

What if I am out of state?

If you need medical care while out of state, call us toll-free at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar).

What If I Am Out of the Country?

Medical services performed out of the country are not covered by Medicaid.

Specialty Care

What if I Need to See a Special Doctor (Specialist)?

Your Primary Care Provider can send you to another doctor if a special type of care your Primary Care Provider cannot offer. Your Primary Care Provider will tell you if you need to see a specialist. You should not go to another doctor for services if your Primary Care Provider does not agree to make a referral. If you see a specialist without a referral, you might have to pay for the services.

How Soon Can I Expect to Be Seen by the Specialist?

After getting a referral from your Primary Care Provider, you should be able to see a specialist within 3 weeks for a routine appointment; within 24 hours for urgent care appointments.

How Can I Ask for a Second Opinion?

You can get a second opinion about the use of any health care service from a network provider. If a network provider is not available, you can see an out-of-network provider. There is no cost to you for getting a second opinion. To learn

more on how to ask for a second opinion please call us at the toll free number on your ID card.

What if I Need to Receive Services in My Home?

In certain cases your doctor may recommend home nursing care. You may also need equipment or supplies that can be delivered to your home. These services require prior authorization. Your provider will need to send documentation about the medical need before these services can be approved.

- HHSC has settled a lawsuit that affects Private Duty Nursing, Home Health Skilled Nursing, Durable Medical Equipment and Supplies, and Personal Care Services for Medicaid beneficiaries under the age of 21. A copy of the Settlement Agreement is at: www.hhsc.state.tx.us and www.advocacyinc.org. If you have any questions, call Advocacy, Inc. at (800) 252-9108.

What if my PCP wants to see a Provider that is not in the Aetna Better Health Network?

If your PCP wants you to see a provider who is not in Aetna Better Health provider network, he/she must request prior authorization from Aetna Better Health. You may go to a non-participating provider only if:

- The care is needed AND
- There are no Aetna Better Health providers to give the care AND
- Aetna Better Health has approved the care.

Aetna Better Health has the right to decide where you can get services when there is not a Aetna Better Health provider available to give the care. The non-participating provider who plans to give you care should assure prior authorization is obtained by your PCP to provide services.

Call us at 1-800-245-5380 (Tarrant) or 1-866-818-0959 (Bexar) with any questions.

You may see any provider at any time in the case of an emergency or for family planning services

What about coverage of New Technology?

We are always looking at new medical procedures and services to make sure you get safe, up to date and high quality medical care. A team of doctors reviews new health care methods and decides if they should become covered services. Researched and studied investigational services and treatments are not covered services.

To decide if new technology will be a covered benefit or service, we will:

- Study the purpose of each technology
- Review medical literature
- Determine the impact of a new technology
- Develop guidelines on how and when to use the technology

Explanation of Precertification, Medically Necessary & Referral

What is Pre-Certification?

Some services need approval before they are given. Your doctor should get this approval from Aetna Better Health before you are treated. You can ask us or your doctor if an approval is needed for a service or treatment.

What does Medically Necessary Mean?

"Medically necessary" means:

- For Members birth through age 20, the following Texas Health Steps services:
  - Screening, vision and hearing services; and
  - Other health care services, including behavioral health services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition;
    - Must comply with the requirements of the Alberto N., et al.v. Suehs et al. partial settlement agreements; and
    - May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g_ and (3)(b- g) of this definition.
- For Members over age 20, non-behavioral health related health care services that are:
  - reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or

limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;
    - provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;
    - consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
    - consistent with the diagnoses of the conditions;
    - no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
    - are not experimental or investigative; and
    - are not primarily for the convenience of the Member or Provider; and
- For Members over age 20, behavioral health services that are:
    - are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve or to maintain, or prevent deterioration of function resulting from such a disorder;
    - are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
    - are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
    - are the most appropriate level or supply of service that can safely be provided;
    - could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;
    - are not experimental or investigative; and
    - are not primarily for the convenience of the Member or Provider.

What is a Referral?

A referral is an approval from your Primary Care Provider for you to get specialty care and follow-up treatment.

Important Points about Referrals:

- You should talk to your Primary Care Provider about the referral to know what special services you may be getting and why.
- Only some benefits can be used directly. If the specialist suggests more treatments or tests, you might need another referral from your Primary Care Provider. If you need another referral and you do not get one, you might have to pay.
- *You **cannot ask for referrals** for specialist services **after** you go to see a specialist.* You must get the referral from your Primary Care Provider before getting specialty care (except in an emergency).

What Services Do Not Need a Referral?

The following services**do not** require a referral and can be used directly:

- Emergency care;
- Texas Health Steps (Medical and Dental Check-ups from birth through age 20);
- Obstetrician/Gynecologist (OB/GYN) care;
- Routine eye care;
- Family planning services;
- Behavioral health (mental health and drug and alcohol abuse) services.

Behavioral Health

Behavioral Health

How Do I Get Help If I Have Mental Health, Alcohol or Drug Problems?

Aetna Better Health covers health for you as a whole person. That includes help for mental health problems like depression. You also can get help when you or someone else thinks you are drinking too much or using drugs.

If you need help right away, call our hotline. 24 hours a day, 7 days a week:
Medicaid (Tarrant): 1-800-306-8612 press 9.
Medicaid (Bexar): 1-800-248-7767 press 9.
CHIP (Tarrant): 1-800-245-5380 press 9.
CHIP (Bexar): 1-866-818-0959 press 9.

Do I Need a Referral For This?

You may go to any mental health provider in our network. You do not need to ask your doctor to refer you to someone. You

may need to get plan approval first before you get some services. Emergency care is covered anywhere in the United States.

What are Mental Health Rehabilitation Services and Mental Health Targeted Case Management
These benefits help you know more about your mental health, provide peer support and much more!

How do I get these services?
To access these services, call us. We will help you find a provider to determine your eligibility.

1-800-306-8612 Medicaid Tarrant
1-800-248-7767Medicaid Bexar

Medications

How Do I Get My Medications?
Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription for you

How Do I Find a Network Drug Store?
- • You can find a network pharmacy by visiting our website at www.aetnamedicaid.com, and then search for a pharmacy in your area.
- • Call Member Services toll-free at ***1-800-306-8612Tarrant, 1-800-248-7767 Bexar***. Ask the representative to help you find a network pharmacy in your area.

What If I Go To a Drug Store Not In the Network?
Prescriptions filled at other pharmacies that are not in the Aetna Better Health network will not be covered. All prescriptions must be filled at a network pharmacy

What Do I Bring With Me To the Drug Store?
You will need to bring the prescription your doctor wrote for you. You will also need to show Your Texas Benefits Medicaid Card and your Aetna Better Health Plan ID card
.

Do Some Medicines Need to Be Prior Approved - Prior Authorization?
Aetna Better Health must approve some medicines on our drug list before we cover them. We do this through prior authorization or Step Therapy. Prior authorization is an approval that Aetna Better Health requires for certain services and medications.

What is Step Therapy?
Some drugs are not approved unless another drug has been tried first. Step-Therapy (ST) coverage requires that a trial of another drug be used before a requested drug is covered.

When you get a new prescription, ask your provider if we need to approve the medicine before you can get it. If we do, ask if there is another medicine you can use that does not need approval. When we need to approve your medicine, your provider must call Aetna Better Health for you. We will review the request to approve your medicine. If the pharmacist cannot reach Aetna Better Health to make sure it is approved, your pharmacist can give you a three (3) day temporary supply of the new prescription.

We will tell you in writing if we do not approve the request. We will also tell you how to start the appeal/grievance process.

What if I Can't Get My Medication My Doctor Ordered Approved?
If your doctor cannot be reached to approve a prescription, you may be able to get a three day emergency supply of your medication. Call Aetna Better Health at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) for help with your medications and refills.

What if I Can't Get The Medication My Doctor Prescribed?
If the medicine your doctor feels you need isn't on our formulary and you cannot take any other medication except the one prescribed, your doctor may request an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception.

Who Do I Call If I Have Problems Getting My Medications?
If you have a problem getting your medications, call us at the toll free number on your ID card.

What If I Lose My Medication(s)?

If you have a problem getting your medications, call us at the toll free number on your ID card.

What If I Need My Medications Delivered To Me?

If you take medication for an ongoing health condition, you can have your medications mailed to your home. CVS Caremark is your mail service pharmacy.

If you choose this option, your medication comes right to your door. You can schedule your refills and reach pharmacists if you have questions. Here are some other features of home delivery.

- • Pharmacists check each order for safety.
- • You can order refills by mail, by phone, online, or you can sign up for automatic refills.
- • You can talk with pharmacists by phone.

It's easy to start using mail service

Choose ONE of the following three ways to use mail service for a medication that you take on an ongoing basis:

- Call the FastStart® toll-free number at 1-800-875-0867, Monday through Friday, 7 a.m. to 7 p.m. (CT). A representative will let you know which of your prescriptions can be filled through CVS Caremark Mail Service Pharmacy. CVS Caremark will then contact your doctor for a prescription and mail the medication to you.
  - When you call, be sure to have:
    - • Your Aetna Better Health member ID card
    - • Your doctor's first and last name and phone number
    - • Your payment information and mailing address
- Log on to . Going online is a quick and easy way to start using mail service. Once you provide the requested information, CVS Caremark will contact your doctor for a new prescription. If you haven't registered yet on , be sure to have your member ID card handy when you register for the first time.
- Fill out and send a mail service order form. If you already have a prescription, you can send it to CVS Caremark with a completed mail service order form. If you don't have an order form, you can print on online or you can request one by calling toll-free 1-855-271-6603.
- Please have the following information with you when you complete the form:
  - • Your Aetna Better Health member ID card
  - • Your complete mailing address, including ZIP code
  - • Your doctor's first and last name and phone number
  - • A list of your allergies and other health conditions
  - • Your original prescription from your doctor.

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medication:

- • One for a short-term supply (30 days or less) that can be filled at a participating network pharmacy AND
- • One for the maximum days' supply allowed by your plan, with refills as needed. Enclose this prescription along with the mail service order form.

What is the Medicaid Limited Program?

You may be put in the Limited Program if you did not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same.
Medicaid pharmacy rules to follow:

- • Pick one pharmacy at one location to use all the time
- • Be sure your main doctor or the specialists he refers you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors. To learn more call 1-800-436-6184 Option 4

What If I Need Durable Medical Equipment (DME) or Other Products Normally Found in a Pharmacy? Some durable medical equipment (DME) and products normally found in a pharmacy are covered by Medicaid. For all members, Aetna Better Health pays for nebulizers, ostomy supplies, and other covered supplies and equipment if they are medically necessary. For children (birth through age 20), Aetna Better Health also pays for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) for more information about these benefits

How do I obtain or review a list of pharmaceuticals?

. Aetna Better Health covers the medicines included on the Vendor Drug Preferred Drug List. This is the list of drugs that we cover when they are medically necessary. This list was included in your Welcome Packet. Aetna Better Health does not pay for drugs that have not been approved by the Federal Drug Administration (FDA).

You can find a list of your medication by going to either of the following websites www.aetnabetterhealth.com/texas or www.txvendordrug.com. There you will find the drugs on the Preferred Drug List and those that are non-preferred with the reasons for not being able to obtain the non-preferred agents

Family Planning Services

Family Planning

How Do I Get Family Planning Services?

Family planning services help you plan or control pregnancy. **You do not need a referral from your Primary Care Provider to receive family planning services or supplies.** If you are under age 21, you do not have to get permission from your parent to get family planning services or supplies. You can get family planning services from your Primary Care Provider, or you can go to any family planning provider who is in our Provider Directory. The services you can get include:

- A yearly check-up
- An office or clinic visit for a problem, counseling, or advice
- Laboratory tests
- Prescriptions and contraceptive supplies like birth control pills, diaphragms, and condoms
- Pregnancy testing
- Sterilization services (Only if you are 21 years of age or older; Federal Sterilization Consent Form needed)

Do I Need a Referral For This?

You do not need a referral from your Primary Care Provider to get family planning services or supplies.

Where Do I Find a Family Planning Services Provider?

You can find the location of family planning providers near you online at http://www.dshs.state.tx.us/famplan/locator.shtm or you can call Aetna Better Health at 1-800-306-8612 (Tarrant) 1-800-248-7767 (Bexar) for help in finding a family planning provider.

Case Management for Children and Pregnant Women

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?

Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems.
- Are at a high risk for getting health problems.

What do case managers do?

A case manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?

Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?

Call the **Texas Health Steps at 1-877-847-8377** (toll-free), Monday to Friday, 8 a.m. to 8 p.m.To learn more, go to: **www.dshs.state.tx.us/caseman**

Vision Services

How Do I Get Eye Care Services?
Block Vision will offer vision services like exams and glasses. Block Vision will help you get the care you need while coordinating with Aetna Better Health.

If you need vision services, please call Block Vision at 1-800-879-6901.

For routine eye exams, you can visit an eye care doctor without a referral from your Primary Care Provider. You can pick an eye doctor that is close to you. Vision services are different for adults and children.

Children, teens, and young adults, birth through age 20, you can get an eye exam and prescription eyeglasses once during a 12 month period. You may be able to get more services if there is a change in your vision. You may be able to get more services if they are requested in writing by the child's Primary Care Provider, teacher or school nurse.

If you are age 21 or over, you can get an eye exam once every 24 months.

Dental Services

How Do I Get Dental Services For My Child?
Your child's Medicaid dental plan provides dental services including services that help prevent tooth decay and services that fix dental problems. Call your child's Medicaid dental plan to learn more about the dental services they offer.

Aetna Better Health covers emergency dental services your child gets in a hospital or ambulatory surgical center. This includes services the doctor provides and other services your child might need like anesthesia.

Texas Health Steps Check-ups

What is Texas Health Steps? What Services Are Offered by Texas Health Steps?

Texas Health Steps is the Medicaid health care program for children, teens and young adults, birth through 20.

Texas Health Steps gives your child:
- Regular medical checkups starting at birth, at no cost to you.Free dental checkups starting at 6 months of age.
- A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:
- Find health problems before they get worse and harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

How and When Do I Get Texas Health Steps Medical and Dental Check-ups for My Child?
When to set up a checkup:
- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor or dentist to set up the checkup.
- Set up the checkup at a time that works best for your family.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:
- Eye tests and eyeglasses.
- Hearing tests and hearing aids.
- Dental care
- Other health care.
- Treatment for other medical conditions.

Call Aetna Better Health or Texas Health Steps 1-877-847-8377 (1-877-THSTEPS) (toll-free) if you:
- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store.

- Houston/ Beaumont area: 1-855-687-4786.
- Dallas/ Ft. Worth area: 1-855-687-3255.

All other areas: 1-877-633-8747 (1-877-MED-TRIP)..

Why is it Important to Get Texas Health Steps Check-up for My Child within 90 Days?

As a new member to Aetna Better Health, it is important for your child to see a provider within the first 90 days you are enrolled with us for a Texas Health Steps check-up. To avoid health problems for your children, teens, and young adults, make sure they get their Texas Health Steps medical and dental checkups.

Does My Doctor Have To Be Part of the Aetna Better Health Network?

Members can go to **any** Texas Health Steps Provider. The Texas Health Steps Provider does not have to be a part of the Aetna Better Health Network This can include your Primary Care Provider. If you go to a Texas Health Steps provider who is not your Primary Care Provider, ask the Texas Health Step provider to send a copy of your check-up results to your Primary Care Provider.

Do I Have to Have a Referral?

You do **not** need a referral from your Primary Care Provider to get Texas Health Steps medical or dental check-ups.

What If I Need to Cancel an Appointment?

If you need to cancel or change your appointment for a Texas Health Steps check-up, please call your Texas Health Steps provider as soon as possible.

What If I Am Out of Town and My Child is Due for a Texas Health Steps Checkup?

It is important to schedule your child's check-up before you leave town. If you are out of town when the Texas Health Steps check-up is due, make an appointment with a Texas Health Steps provider as soon as you get home. If you have moved, please call Aetna Better Health Services at the toll free number on your ID card to get the name of a Texas Health Steps provider close to where you live.

What if I am a Migrant Farmworker?

You can get your checkup sooner if you are leaving the area.

Medical Transportation Services (MTP)

Transportation

What is MTP?

MTP is an HHSC program that helps with non-emergency transportation to healthcare appointments for eligible Medicaid clients who have no other transportation options. MTP can help with rides to the doctor, dentist, hospital, drug store, and any other place you get Medicaid services.

What services are offered by MTP?

- Passes or tickets for transportation such as mass transit within and between cities
- Air travel
- Taxi, wheelchair van, and other transportation
- Mileage reimbursement for enrolled individual transportation participant (ITP). The enrolled ITP can be the responsible party, family member, friend, neighbor, or client.
- Meals at a contracted vendor (such as a hospital cafeteria)
- Lodging at a contracted hotel and motel
- Attendant services (responsible party such as a parent/guardian, etc., who accompanies the client to a healthcare service)

Who Do I Call for a Ride to a Medical Appointment?

If you live in the counties of Collin, Dallas, Denton, Ellis, Hood, Hunt, Johnson, Kaufman, Navarro, Parker, Rockwall, Tarrant, and Wise:

Call LogistiCare

Phone Reservations: 1-855-687-3255

Phone Ride Help Line: 1-877-564-9834

Hours: LogistiCare takes requests for routine transportation by phone Monday through Friday from 8:00 a.m. to 5:00 p.m. Routine transportation should be scheduled 48 hours (2 business days) before your appointment.

If you live in the counties of Austin, Brazoria, Chambers, Fort Bend, Galveston, Hardin, Harris, Jasper, Jefferson, Liberty, Matagorda, Montgomery, Newton, Orange, Polk, San Jacinto, Tyler, Walker, Waller and Wharton.

Call MTM

Phone Reservations: 1-855-687-4786

Where's My Ride: 1-888-513-0706

Hours: 7am to 6pm, Monday-Friday/ Call (855) MTP-HSTN or (855) 687-4786 at least 48 hours before your visit. If it's less than 48 hours until your appointment and it's not urgent, MTM might ask you to set up your visit at a different date and time.

If you live in any other county

Call MTP

Phone Reservations: 1-877-633-8742.

All requests for transportation services should be made within 2-5 days of your appointment. Exceptions may be authorized in the event of an emergency.

Interpreter Services

Interpreter Services

Can Someone Interpret for Me When I Talk with My Doctor? Who Do I Call for an Interpreter?

Our staff speaks both English and Spanish. We have a language line if your first language is not English or Spanish. If you need an interpreter, call us at the toll free number on your ID card. At the time of your call, we will get a language interpreter that speaks your language on the line. People that are deaf or hearing impaired can call the TTY line at 1-800-735-2989.

How Can I Get a Face-to-Face Interpreter in the Provider's Office? How Far in Advance Do I Need to Call?

We can also help you if you need an interpreter to go with you to your doctor's office. As soon as you know the date of your appointment, please call us at the toll free number on your ID card. We need 72 hours advance notice of a need for an interpreter.

Women's Health

Obstetric and Gynecologic Care

What If I Need Ob/Gym Care? Do I Have the Right to Choose an Ob/Gym?

Attention Female Members -

Aetna Better Health allows you to pick an OB/GYN but this doctor must be in the same network as your Primary Care Provider.

You have the right to pick an OB/GYN without a referral from your Primary Care Provider. An OB/GYN can give you:

- one well-woman checkup each year
- care related to pregnancy
- care for any female medical condition
- referral to special doctor within the network

How Do I Choose an Ob/Gym?

Check our Provider Directory to find an in-network Ob/Gyn. You can also get a copy of the provider directory online at www.aetnabetterhealth.com/texas or call us at the toll free number on your ID card for help in finding an Ob/Gyn.

If I Do not Choose an Ob/Gym, Do I Have Direct Access?
You can contact any Ob/Gyn in the Aetna Better Health network directly to receive services.

Will I Need a Referral?
You have the right to pick an Ob/Gyn from our network without a referral from your Primary Care Provider.

How Soon Can I Be Seen After Contacting My Ob/Gyn for an Appointment?
If you are pregnant, you should be seen within 2 weeks of enrollment or by the 12th week of your pregnancy. If you are not pregnant, you should be seen within 3 weeks of asking for an appointment.

Can I Stay with My Ob/Gyn if they are not with Aetna Better Health?
If you are pregnant and are the past the 24th week of your pregnancy when you join, you will be able to stay under the care of your current Ob/Gyn. If you want, you can pick an Ob/Gyn who is in our network as long as the provider agrees to treat you. We can help with the changes between doctors.

What If I Am Pregnant? Who do I Need to Call?
Call us at the toll free number on your ID card, as soon as you know you are pregnant. You will need to call your Medicaid caseworker as soon as your baby is born to enroll your baby in Medicaid. Your baby can be eligible for Medicaid from birth up to a year old.

Where Can I Find a List of Birthing Centers?
Please contact Member Services at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) or you can search our Provider Directory online at www.aetnabetterhealth.com/texas to find out which birthing centers are in our network.

How do I sign up my newborn baby? How and when do I tell my Health Plan?
It is important that you call us at the toll free number on your ID card, as soon as possible so we can make sure you know about the health services for your baby.

Can I Pick a Primary Care Provider for My Baby before the Baby is Born?
You should call us before your baby is born or as soon as possible to pick a pediatrician (baby doctor). You will be able to pick your baby's doctor from a list of doctors in the Aetna Better Health Provider Directory.

How and When Can I Switch My Baby's Primary Care Provider?
To change your baby's Primary Care Provider, call us at the toll free number on your ID card. . We can change your baby's Primary Care Provider on the same day you ask for the change. The change will be effective immediately.

Can I Switch My Baby's Health Plan?
For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at 1-800-964-2777

You cannot change health plans while your baby is in the hospital.

How and When Do I Tell My Caseworker?
You will need to contact your Medicaid caseworker as soon as your baby is born to enroll your baby in Medicaid

What is Case Management for Children and Pregnant Women?
Case Management of Children and Pregnant Women is a program offered by DSHS. It provides services to children with a health condition or risk, birth through 20 years for age and high-risk pregnant women of all ages.

What Type of Services Would My Child or I Get?

Case Management for Children and Pregnant Women is a Medicaid service. They can help you or your child get medical and dental services; get medical supplies or equipment, work on school or education issues, or work on other problems. To learn more about the program, go to **http://www.dshs.state.tx.us/caseman/default.shtm**

What Other Services/Activities/Education Does Aetna Better Health Offer Pregnant Women?

Case Management
Case management services are offered by Aetna Better Health to help you if you are pregnant to get the services you need. We can also help you get referrals when needed.

Prenatal Education
We will mail a prenatal packet to all pregnant women. This packet has information about how to stay healthy during pregnancy and other topics. Call us for information regarding prenatal classes. We can help you locate prenatal classes in the community (fees might apply-usually discounted fee for Medicaid eligibles).

Other Member Services

Special Health Care Needs

Who Do I Call if I Have Special Health Care Needs and Need Someone to Help Me?
Case Managers are ready to help you if you have special health care needs. You can also have your health care provided by a specialist if you have special health care needs. If you have special health care needs and you need someone to help you, please call us at the toll free number on your ID card to learn more.

Medical Care Decisions

What If I Am Too Sick to Make a Decision About my Medical Care? What Are Advance Directives? How Do I Get an Advance Directive?
An advance directive is a written statement that you complete before a serious illness. This statement tells how you want medical decisions made. If you can't make treatment decisions, your doctor will ask your closest relative or friend to help you decide what is best for you. Sometimes everyone doesn't agree about what to do. That's why it is helpful if you tell us in advance what you want to happen if you can't speak for yourself.

If you do not have an advance directive and you would like more information on how to get one, call us at the toll free number on your ID card. We will be glad to help you.

Provider Billing

What If I Get a Bill from my Doctor? Who Do I Call? What Information Will They Need?
If the bill is for a Medicaid covered service, you will not have to pay. Call us at the toll free number on your ID card if you get a bill in the mail from your doctor. We will call the doctor's office for you to explain your benefits and arrange for your bill to be paid. When you call us, please have your Aetna ID card, Your Texas Benefits Medicaid Card, and the doctor's bill with you. We will need this information so we can help you quickly.

Member Services Notice

What Do I Have to Do If I Move?
As soon as you have your new address, give it to the local HHSC benefits office and Aetna Better Health's Member Services Department at 1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar). Before you get Medicaid services in your new area, you must call Aetna Better Health unless you need emergency services. You will continue to get care through Aetna Better Health until HHSC changes your address.

What If I Have Other Health Insurance In Addition to Medicaid?

Medicaid and Private Insurance
You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case file if

- Your private health insurance is cancelled
- You get new insurance coverage
- You have general questions about third party insurance.

You can call the hotline toll-free at 1-800-846-7307.

If you have other insurance, you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure that Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance, as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

What Happens If I Lose My Medicaid Coverage?

If you lose Medicaid coverage but get it back again within six (6) months, you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

Member Rights and Responsibilities

MEMBER RIGHTS:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    a. Be treated fairly and with respect.
    b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and primary care provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
    a. Be told how to choose and change your health plan and your primary care provider.
    b. Choose any health plan you want that is available in your area and choose your primary care provider from that plan.
    c. Change your primary care provider.
    d. Change your health plan without penalty.
    e. Be told how to change your health plan or your primary care provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
    a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.
    b. Be told why care or services were denied and not given.
4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    a. Work as part of a team with your provider in deciding what health care is best for you.
    b. Say yes or no to the care recommended by your provider.
5. You have the right to use each complaint and appeal process available through the managed care organization and through Medicaid, and get a timely response to complaints, appeals and fair hearings. That includes the right to:
    a. Make a complaint to your health plan or to the state Medicaid program about your health care, your provider or your health plan.
    b. Get a timely answer to your complaint.
    c. Use the plan's appeal process and be told how to use it.
    d. Ask for a fair hearing from the state Medicaid program and get information about how that process works.
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
    b. Get medical care in a timely manner.
    c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
    e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. You have the right to not be restrained or secluded when it is for someone else's convenience, or is meant to force you to do something you do not want to do, or is to punish you.
8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
9. You have a right to know that you are not responsible for paying for covered services. Doctors, hospitals, and others cannot

require you to pay copayments or any other amounts for covered services.

10. You have the right to receive information about the organization, it services, its practitioners and providers and members rights and responsibilities.
11. You have the right to make recommendation regarding the organizations member rights and responsibilities policy.

MEMBER RESPONSIBILITIES:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
    a. Learn and understand your rights under the Medicaid program.
    b. Ask questions if you do not understand your rights.
    c. Learn what choices of health plans are available in your area.
2. You must abide by the health plans and Medicaid's policies and procedures. That includes the responsibility to:
    a. Learn and follow your health plan's rules and Medicaid rules.
    b. Choose your health plan and a primary care provider quickly.
    c. Make any changes in your health plan and primary care provider in the ways established by Medicaid and by the health plan.
    d. Keep your scheduled appointments.
    e. Cancel appointments in advance when you cannot keep them.
    f. Always contact your primary care provider first for your non-emergency medical needs.
    g. Be sure you have approval from your primary care provider before going to a specialist.
    h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your primary care provider and learn about service and treatment options. That includes the responsibility to:
    a. Tell your primary care provider about your health.
    b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.
    c. Help your providers get your medical records.
4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:
    a. Work as a team with your provider in deciding what health care is best for you.
    b. Understand how the things you do can affect your health.
    c. Do the best you can to stay healthy.
    d. Treat providers and staff with respect.
    e. Talk to your provider about all of your medications.
5. You must follow plans and instructions for care that they have agreed to with their practitioners.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at 1-800-368-1019. You also can view information concerning the HHS Office of Civil Rights online at www.hhs.gov/ocr.

Member Safety

We think it is important to teach our members about health safety. Here are some important tips:

- Be involved in every decision about your health care. You can know what you and your doctor can do to improve and/or stay healthy if you are involved.
- Ask questions. You have a right to question anyone who is involved with your care.
- Make sure your doctor knows about all medicines you are taking. Medications can include those given to you by your doctor or bought in a store. Ask that these be written down in your medical file.
- Make sure your doctor knows if you have any allergies or bad reactions to medicines. This can help you avoid getting medicines that could harm you.
- Ask for information about your health care in a language you can understand. Be sure you are clear on the amounts of medicine you should take. You should ask your doctor how you will react if taking one or more kinds of medicines at the same time.

Complaint Process

Complaints

What Should I Do If I Have a Complaint? Who Do I Call to Help Me With Filing a Complaint?

We want to help. If you have a complaint, please call us toll-free at 1-800-302-8612 (Tarrant) or 1-800-248-7767 (Bexar) to tell us about your problem. An Aetna Better Health Member Services Advocate can help you file a complaint. Just call 1-800-306-8612 (Tarrant), 1-800-248-7767 (Bexar) or 214-200-8140. Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Aetna Better Health complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free at 1-866-566-8989. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Health Plan Operations H-320
PO Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us.

Can Someone from Aetna Better Health Help Me File a Complaint?

Our Member Advocate can help you file a complaint. The Member Advocate will write down your concern. You can also send a written complaint to the Member Advocate at:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150
1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar)

How Long Will It Take to Process My Complaint?

When we get the complaint from you, we will send you a letter within five (5) days to let you know that your complaint came to us. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results.

What are the Requirements and Timeframes for Filing a Complaint?

If you have a complaint, please call us toll-free at 1-800-302-8612 (Tarrant) or 1-800-248-7767 (Bexar). You can also send a written complaint to us at:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150

If I am Not Satisfied with the Outcome, Who Else Can I Contact?

If you are not happy, you can call us at the toll free number on your ID card and ask for an appeal. You can ask for an appeal of a complaint resolution by writing to:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150
1-800-306-8612 (Tarrant) or 1-800-248-7767 (Bexar) or 214-200-8140

Do I Have a Right to Meet with a Complaint Appeal Panel?

Within five (5) days of getting your request for an Appeal of a Complaint, the Member Advocate will send you a letter to let you know that your complaint appeal came to us. The Complaint Appeal Panel will look over the information you sent us and discuss your case. It is not a court of law. You have the right to appear in front of the Complaint Appeal Panel at a specific place to talk about the written complaint appeal you sent to us. When we make the decision on your appeal, we will send you a response in writing within thirty (30) after we receive your appeal.

Once you have gone through the Aetna Better Health complaint process, you can complain to the Texas Health and Human Services Commission (HHSC) by calling 1-866-566-8989 or writing to:

Texas Health and Human Services Commission
Health Plan Operations H-320
PO Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us

Appeal Process

Appeal

What Can I Do if My Doctor Asks for a Service or Medicine for me that's Covered but Aetna Better Health Denies it or Limits it?

Aetna Better Health will send you a letter about an action on a covered service that your doctor requests. An **action** means the denial or limited authorization of a requested service. It includes:

- the denial in whole or part of payment for a service
- the denial of a type or level of service
- the reduction, suspension, or termination of a previously authorized service

You have the right to ask for an appeal if you are not happy or disagree with the action. An appeal is the process by which you or a person authorized to act on your behalf, including your doctor, requests a review of the action. You or your doctor can send any additional medical information that supports why you disagree with the decision. You can call us at the toll free number on your ID card and ask for an appeal. The Member Advocate will write down the information and send it to you for review. A written appeal can be sent to:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150

How Will I Find Out If Services are Denied?

If your services are denied, you and your doctor will get a letter that tells you the reason for denial. The letter will tell you how to file an appeal and how to ask for a State Fair Hearing.

What are the Timeframes for the Appeal Process?

Your request for an appeal must be filed within thirty (30) days from the date of the notice of the action. To ensure continuity of currently authorized services, you must file the appeal on or before the later of 10 days following: Aetna Better Health mailing of the notice of the action or the intended start date of the proposed action.

The timeframe for the resolution of the appeal will depend on what services have been denied. If you are in the hospital or are already receiving services that are being limited or denied, you can call and ask for an expedited appeal. The expedited appeal process is explained below.

Your request for an appeal can be verbal or in writing. If the appeal is received verbally, the Member Advocate will write down the information and send it to you for review. You will need to return the form to the Member Advocate.

A written request can be sent to:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150

The resolution of your appeal can be extended up to fourteen (14) calendar days of the appeal if you ask for more time, or if Aetna Better Health can show that we need more information. We can only do this if more time will help you. We will send you a letter telling you why we asked for more time.

For a standard appeal, the Member Advocate will send you a letter within five (5) days of receiving the request for an Appeal. This letter is to let you know that your request came to us. Aetna Better Health will send all information we have to a doctor who was not part of making the first decision. You will get a written response on your appeal within thirty (30) days after your appeal was sent to us. You can ask a State Fair Hearing any time during or after Aetna Better Health's appeal process.

When Do I have the Right to Ask for an Appeal?

If you don't agree with the decision made by Aetna Better Health about a benefit or service, you can ask Aetna Better Health for an appeal. You do not have a right to an appeal if the services you requested are not covered under Medicaid. You do not have a right to an appeal if a change is made to the state or federal law, which affects some or all of Medicaid recipients.

Does My Request Have to be in Writing?

Your request does not have to be in writing. You can ask for an appeal by calling us and asking for the Member Advocate. We will write down what you tell us and send it to you to review. Every verbal appeal must be confirmed by a written, signed Appeal form by the member or his or her representative, unless an expedited appeal is requested.

Can Someone from Aetna Better Health Help Me File an Appeal?

You can get help in filing an appeal by calling us at the toll free number on your ID card or writing to:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150

The Member Advocate will listen to your appeal and tell you about the rules. The Member Advocate will answer your questions and see that you are treated fairly.

Expedited Appeal Process

Expedited Appeal

What is an Expedited Appeal?

An expedited appeal is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I Ask for an Expedited Appeal?

You can ask for an expedited appeal by calling us at the toll free number on your ID card or writing to:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150

Does My Request Have to be in Writing?

Your request does not have to be in writing. You can ask for an expedited appeal by calling our Member Services Department.

What are the Timeframes for an Expedited Appeal?

The timeframe for resolution will be based on your medical emergency condition, procedure, or treatment, but will not take more than one (1) business day from the date we receive all information necessary to review your appeal. Aetna Better Health will let you know the final decision of the expedited appeal in writing within three (3) business days.

What Happens if Aetna Better Health Denies the Request for an Expedited Appeal?

If you ask for an expedited appeal that does not involve an emergency, an ongoing hospitalization, or services that are already being provided, you will be told that the appeal cannot be rushed. We will continue to work on the appeal within the standard timeframe and respond to you within thirty (30) days from the time the appeal was received.

Once you have gone through the Aetna Better Health complaint process, you can complain to the Texas Health and Human Services Commission by calling 1-866-566-8989 or writing to:

Texas Health and Human Services Commission
Health Plan Operations H-320
PO Box 85200
Austin, TX 78708-5200
ATTN: Resolution Services

If you can get on the Internet, you can send your complaint in an email to HPM_Complaints@hhsc.state.tx.us

If you do not agree with this decision, you can ask for a State Fair Hearing. The procedure for asking for a State Fair Hearing is explained below.

Who Can Help Me in Filing an Expedited Appeal?

You can ask for an appeal by calling us at the toll free number on your ID card and asking for the Member Advocate or writing to:

Aetna Better Health Attention: Member Advocate
PO Box 569150
Dallas, TX 75356-9150

The Member Advocate will listen to your appeal and explain the rules to you. The Member Advocate will answer your questions and see that you are treated fairly.

State Fair Hearing

Can I Ask for a State Fair Hearing?

If you, as a member of the health plan, disagree with the health plan's decision, you have the right to ask for a fair hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A doctor or other medical provider may be your representative. If you want to challenge a decision made by your health plan, you or your representative must ask for the fair hearing within 90 days of the date on the health plan's letter with decision. If you do not ask for the fair hearing within 90 days, you may lose your right to a fair hearing. To ask for a fair hearing you or your representative should either send a letter to the health plan at:

Aetna Better Health, Attention: Member Advocate
P.O Box 569150
Dallas, TX 75356-9150

or call:

Bexar - 1-800-248-7767
Tarrant -1-800-306-8612

You have the right to keep getting any service the health plan denied or reduced, at least until the final hearing decision is made if you ask for a fair hearing by the later of: (1)10 days from the date you get the health plan's decision letter, or (2) the day the health plan's letter says your service will be reduced or end. If you do not request a fair hearing by this date, the service the health plan denied will be stopped.

If you ask for a fair hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most fair hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within 90 days from the date you asked for the hearing.

Fraud Information

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting benefits is doing something wrong. Doing something wrong could be waste, abuse or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at 1-800-436-6184;

- Visit https://oig.hhsc.state.tx.us/ Under the box labled " I WANT TO" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:

Aetna Better Health
Attention: SIU Coordinator
PO Box 569150
Dallas, TX 75356-9150
1-888-761-5440 (toll free)

To report waste, abuse or fraud, gather as much information as possible.

- When reporting about a provider (doctor, dentist, counselor, etc) include:
  - Name, address and phone number of provider;
  - Name and address of the facility (hospital, nursing home, home health agency, etc);
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc);
  - Names and the number of other witnesses who can help in the investigation;
  - Dates of events
  - Summary of what happened.

- When reporting about someone who gets benefits include:
  - The person's name;
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse or fraud.

Annual Notification

The following information is available to you on an annual basis:

As a member of Aetna Better Health you can ask for and get the following information each year:

- Information about network providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each network provider, plus identification of providers that are not accepting new patients.
- Any limits on your freedom of choice among network providers.
- Your rights and responsibilities.
- Information on complaint, appeal and fair hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from out-of-network providers and/or limits to those benefits.
- How you get after hours and emergency coverage and/or limits to those kinds of benefits, including:
  - What makes up emergency medical conditions, emergency services and post-stabilization services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get emergency services, including instructions on how to use the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish emergency services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.
- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider.
- Aetna Better Health's practice guidelines.

Subrogation

Subrogation

We can ask for reimbursement for medical expenses to treat an injury or illness that was caused by someone else. This is

a “right of subrogation” provision. Under our right of subrogation, we reserve the right to get back the cost of medical benefits paid when another party is (or can be responsible) for causing the illness or injury to you. We can also ask to get back the cost of medical expenses from you if you get expenses from the other party.

Personal information

_____

My Member ID Number

_____

My PCP (Primary Care Practitioner)

_____

My PCP's Phone Number