aetna®

AETNA BETTER HEALTH® OF VIRGINIA

Learn about your health care benefits

2016 Member Handbook

www.aetnabetterhealth.com/virginia

Important phone numbers for members

Member Services **1-800-279-1878** (TTY/TDD 711 or 1-800-828-1120)

Mental Health Benefits **1-800-279-1878**

24 Hour Nurse Line **1-877-878-8940**

Smiles for Children **1-888-912-3456**

Transportation **1-800-734-0430** (Medicaid/FAMIS Plus members only)

Cover Virginia **1-855-242-8282**

Mailing address

9881 Mayland Drive
Richmond, VA 23233

Personal information

_____

My member ID number

_____

My primary care provider (PCP)

_____

My PCP's phone number

www.aetnabetterhealth.com/virginia

To receive a translated copy of this document, call Member Services at **1-800-279-1878**.

Para recibir una copia traducida de este documento, llame al servicio para miembros al **1-800-279-1878**.

Welcome to Aetna Better Health® of Virginia

Your decision to join Aetna Better Health was a significant one for you and your covered family members. On behalf of all of those associated with our plan, we welcome you. We have built a strong network of area physicians, hospitals and other health care providers to offer a broad range of services for your medical needs.

As an Aetna Better Health of Virginia Medallion member, it's important that you understand the way your plan works. This member handbook contains the information you need to know about your Aetna Better Health benefits.

Please take some time to read these materials to learn more about your Aetna Better Health coverage. Our Member Services Department is available to answer any questions you may have about your coverage and services. You can reach us at **1-800-279-1878**, Monday through Friday, 8 a.m. to 5 p.m. If you are hearing or speech impaired, you can dial **1-800-828-1120** or **711** and they can connect you to the number listed above.

We look forward to serving you and your family.

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Translation services

Aetna Better Health Member Services
1-800-279-1878 (**TTY 1-800-828-1120** or **711**)

If you do not understand English, please call **1-800-279-1878** and we will provide the information about your benefits to you in a language you can understand. We can also help you communicate with your doctor.

Si usted no entiende Inglés, por favor llame al: **1-800-279-1878** y nosotros le proveeremos la información acerca de sus beneficios en español. También podemos ayudarle a comunicarse con su médico.

Если Вы не говорите по-английски, позвоните, пожалуйста, по телефону **1-800-279-1878**, и мы предоставим Вам информацию о Вашей медицинской страховке на русском языке. Мы также можем помочь Вам при разговоре с вашим врачом.

Als u geen Engels spreekt, wilt u dan dit nummer **1-800-279-1878** kiezen en wij zullen u dan informative over uw uitkeringen in uw eigen taal verstrekken. Wij kunnen u ook helpen om met uw arts te spreken.

Nếu quí vị không nói được tiếng Anh, xin gọi số điện thoại: **1-800-279-1878**. Chúng tôi sẽ thông báo cho quí vị về những quyền lợi của quí vị bằng tiếng Việt. chúng tôi cũng có thể giúp quí vị nói chuyện với bác sĩ của quí vị nữa.

اگر با زبان انگلیسی آشنا نیستید، لطفاً با شماره تلفن **1-800-279-1878** تماس بگیرید و ما اطلاعات مربوط به مزایای شما را به زبان مورد نظرتان در اختیارتان قرار خواهیم گذاشت. ما همچنین می توانیم به شما در ارتباط برقرار کردن با پزشکان کمک کنیم.

如果您不会英语，请致电 **1-800-279-1878**，我们将以您能够理解的语言提供与您的福利相关的信息。我们还可以帮助您与您的医生沟通。

Ako ne razumijete engleski jezik, molimo pozovite broj **1-800-279-1878** i pružićemo vam informacije o vašim pogodnostima na jeziku koji razumijete. Možemo da vam pomognemo i da se sporazumijete sa svojim liječnikom.

إذا كنت لا تفهم اللغة الإنجليزية، فيرجى الاتصال على الرقم **1-800-279-1878** وسوف نزودك بمعلومات حول المزايا المستحقة لك باللغة التي تفهمها. كما يمكننا مساعدتك في التواصل مع طبيبك.

Confidentiality and request for your medical records

We understand the importance of keeping your personal and health information secure and private. We are required by law to provide you with the Notice of Privacy Practices. This notice is included in your member packet and our member newsletter. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information. Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. You may request a copy at any time by calling Member Services at **1-800-279-1878** or by going to our website at **www.aetnabetterhealth.com/virginia**. Both Aetna Better Health and your doctors make sure that all your member records are kept safe and private. We limit access to your personal information to those who need it. We maintain safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies.

If needed, we may use and share your personal information for "treatment," "payment" and "health care operations." We - limit the amount of information that we share about you as required by law. For example, HIV/AIDS, substance abuse and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

In your doctor's office, your medical record will be labeled with your identification and stored in a safe location in the office where other people cannot see your information. If your medical information is on a computer, there is a special password needed to see that information.

Your medical record cannot be sent to anyone else without your written permission, unless required by law. When you ask your doctor's office to transfer records, they will give you a release form to sign. It's your doctor's office responsibility to do this service for you. If you have a problem getting your records or having them sent to another doctor, please contact our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). Our Member Services department will help you get your records within 10 working days of the record request. We will assist you:

- To provide quick transfer of records to other in or out-of-network providers for the medical management of your health
- When you change primary care providers, to assure that your medical records or copies of medical records are made available to your new primary care provider.

If you would like a copy of your medical or personal records, you may send us a written request. You may also call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) and ask for a form that you or your representative can fill out and send back to us. When we get your written request, we will send you the requested records within 30 days. If we need longer we will notify you in writing. We will never take more than 60 days from the date of your written request for records to send them to you. You have a right to review your requested medical records and ask they be changed or corrected.

Definitions

Adult
A member who is age 21 or older.

Agreement
The contract between Aetna Better Health of Virginia and the Virginia Department of Medical Assistance Services (DMAS). This handbook is a part of the agreement.

Aetna Better Health (we, our, us)
The Medicaid/FAMIS Plus program offered by us.

Aetna Better Health provider/participating provider
A doctor, hospital, skilled nursing facility, drug store or other duly licensed institution or health professional, such as a nurse midwife that has directly or indirectly signed a contract with us to be part of the Aetna Better Health network. These providers are also called participating providers. The provider directory and the Aetna Better Health website will show these Aetna Better Health providers. Please be aware that the list changes.

Aetna Better Health provider directory/Aetna Better Health provider network
A list of providers that have contracted with us to provide care to Aetna Better Health members. This list changes. Our Aetna Better Health website, **www.aetnabetterhealth.com/virginia**, has a provider list that is updated nightly. You can also call Member Services and request a hard copy of the provider directory.

Child(ren)
A member who is under age 21.

Contract year
July 1 through the following June 30.

Cosmetic services and surgery
Services and surgery that are mainly to improve your looks. Cosmetic services and surgery do not help your body work better or keep you from getting sick.

Covered services (covered care/care)
The medical care, services or supplies which we will pay. This care is described in this Handbook.

Member Services Department
Our Member Services staff can answer questions about your Aetna Better Health benefits. Our toll-free numbers are **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). Member Services is open from 8 a.m. to 5 p.m., Monday through Friday.

Department of Social Services (DSS)
The agency which decides whether or not a person is eligible for Medicaid/FAMIS Plus.

DMAS
The Virginia Department of Medical Assistance Services.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
A program of preventive health care and well-child checkups with age-appropriate tests and shots.

Emergency
A sudden onset of a medical condition that shows itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in: (i) serious jeopardy to the mental or physical health of the member; or (ii) danger of serious impairment of the member's bodily functions; or (iii) serious dysfunction of any of the member's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental/investigational
Care or a supply is experimental or investigational if it includes, but is not limited to, any of the following:
It is in the testing stage or in early field trials on animals or humans.

- It is under clinical investigation by health professionals or is undergoing clinical trial by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration (FDA). Any drug not approved for use by the FDA, any FDA approved drug prescribed for an off-label use whose effectiveness is unproven based on clinical evidence reported in peer-reviewed medical literature, or any drug that is classified as an Investigational New Drug (IND) by the FDA. As used herein, off-label prescribing means prescribing prescription drugs for treatments other than those stated in the labeling approved by the FDA. Drugs for the treatment of a specific type of cancer that are not FDA approved will be covered when they are approved for one type of cancer for which the drug has been prescribed in any of the standard reference compendia. Similarly, drugs for the treatment of a specific indication that are not FDA approved will be covered so long as the drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-Reviewed Medical Literature.
- It is a health product or service that is subject to Investigational Review Board (IRB) review or approval.
- Any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II or III as set forth by FDA regulations, except as specifically covered by defined criteria.
- It does not have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicaid.
- Any health product or service whose effectiveness is unproven based on clinical evidence reported in Peer-Reviewed Medical Literature.

Family Planning Care
Family planning care helps you to plan your family size. It gives you information on birth control methods.

FAMIS MOMS
Members who are uninsured pregnant females, not eligible for Medicaid with family income at or below 200% of the federal poverty level, and who are assigned and enrolled in the aid category of 05. FAMIS MOMS receive the full Medicaid benefit package and have no cost-sharing responsibilities.

FAMIS PLUS
Children who meet "medically indigent" criteria under Medicaid program rules, under 19 years of age. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities.

HMO
Aetna Better Health of Virginia a licensed health maintenance organization (HMO). As an HMO, it is subject to regulation in Virginia by the State Corporation Commission Bureau of Insurance under Title 38.2. It is also subject to regulation by the Virginia Department of Health under Title 32.1. For the purposes of this Handbook, an HMO is considered to be a Managed Care Entity (MCE) or a Managed Care Organization (MCO).

Home and Community Based Waivers (HCBW)
Members who are participating in Federal Waiver Programs for home-based and community based Medicaid coverage prior to managed care enrollment. Individuals enrolled in the Elderly or Disabled with Consumer Direction (EDCD) waiver, if determined to be Medallion 3.0 managed care eligible, shall not be excluded.

Medically Necessary (Medically Needed/Needed)
The use of services or supplies rendered by a hospital, skilled nursing facility, doctor or other provider that is needed to find or treat a member's illness or injury. We must also feel that the care is: (1) consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment or injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for the convenience of the member, his/her doctor, hospital, or other health care provider; and (4) the most appropriate supply or level of service that can be safely given to the member. For members in the hospital, it also means the member's medical symptoms or condition cannot be diagnosed or treated safely out of a hospital.

Member
Any person who gets services from DMAS and who has Aetna Better Health coverage.

Member Handbook (Handbook)
This book, as well as any amendment or related document sent together with this book, that tells you about your coverage and your rights.

Post-Stabilization Care
Medically needed care a member gets after an emergency condition has been stabilized.

Preauthorization/Preauthorized
Approval by us that is needed so that we will pay for certain services to be done.

Primary care provider (PCP)
The Aetna Better Health doctor you pick to give you primary health care. This doctor will arrange for most other care you need as well. All members must pick a PCP. PCPs specialize in the areas of general practice, family practice, internal medicine and pediatrics. For female members age 13 or older, the member can also pick an OB/GYN doctor to give you primary health care and arrange for most other care you need. If you select an OB/GYN doctor, he/she is considered a PCP.

Prudent Layperson
A person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was needed.

Service Area
The geographic area where you can get care under the Aetna Better Health program.

Specialty Care Doctor/Specialist
A doctor who gives health care to members within his or her range of specialty. For the purposes of this Handbook, a specialty care doctor does not mean an OB/GYN since an OB/GYN is a PCP.

Standard Reference Compendia
The American Hospital Formulary Service Drug Information, the National Comprehensive Cancer Network's Drugs & Biologics Compendium or the Elsevier Gold Standard's Clinical Pharmacology.

Urgent Care
Urgent care is medically needed care for an unexpected illness or injury that you need sooner than a routine doctor's visit.

Website
Refer to **www.aetnabetterhealth.com/virginia**.

You, Your
Refers to a member.

Section 1

Important information about your coverage

In the event you need to contact someone about your Aetna Better Health coverage for any reason, please contact us at:

Aetna Better Health of Virginia
ATTN: Member Services
9881 Mayland Drive
Richmond, Virginia 23233
1-800-279-1878 (TTY/TDD: **1-800-828-1120** or **711**)

Please make sure you read and understand the grievance procedure in this handbook, and make use of it before taking any other action. Below are the addresses and telephone numbers for complaints/grievances and appeals.

Complaints/Grievances
Aetna Better Health of Virginia
ATTN: Member Services
9881 Mayland Drive
Richmond, Virginia 23233
1-800-279-1878 (TTY/TDD: **1-800-828-1120**)

Appeals
Aetna Better Health of Virginia
ATTN: Appeals Coordinator
9881 Mayland Drive
Richmond, Virginia 23233
1-800-279-1878 (TTY/TDD: **1-800-828-1120**)

If you have been unable to contact or obtain help from us, you may contact the Virginia State Corporation Commission's Bureau of Insurance or the Department of Medical Assistance Services (DMAS) Division of Appeals at:

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
1-804-371-9741, local or out-of-state calls
1-800-552-7945, in state toll-free number
1-877-310-6560, national toll-free number

Division of Appeals
Department of Medical Assistance Services
(DMAS)
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
1-804-371-8488

Facts about Aetna Better Health of Virginia

Aetna Better Health of Virginia is a managed care organization duly licensed in accordance with the laws of the Commonwealth of Virginia. We offer coverage for the Medicaid/FAMIS Plus programs.

We contract with doctors, hospitals, drug stores and other medical providers to give care to our Aetna Better Health members. They make up Aetna Better Health's provider network and are called participating providers. You should use these providers whenever possible.

We do not pay extra money to providers for deciding if you do or do not need care. We only pay providers for the care you receive. If you have questions about how we pay providers, call us at **1-800-279-1878** to ask for this information.

Aetna Better Health has a quality improvement program to make sure our services meet high standards of quality and safety. Our QI program is reviewed and updated each year. We want to make sure you have:

- The right kind of care
- Easy access to quality medical and behavioral health care
- Help with any chronic conditions or illnesses
- Support when you need it most
- High satisfaction with your doctors and with us

For more information on our QI Program, please go to our website at **www.aetnabetterhealth.com/virginia** or call Member Services at **1-800-279-1878** to request a copy of our program's description.

Section 2

Your rights and responsibilities

Your rights

As an Aetna Better Health member, you have the right to:

- Be informed of Aetna Better Health and all covered services.
- Receive information about Aetna Better Health, our services, doctors, other providers, and member rights and responsibilities.
- Be treated with respect, dignity and the right to privacy.
- Choose your personal Aetna Better Health doctor/primary care provider (PCP).
- Change your Aetna Better Health primary care provider (PCP).
- Be treated regardless of race, gender, religion, disability, ethnicity, national origin, or source of payment.
- Expect all information about your health to be confidential and to have your privacy protected.
- Not have your medical records shown to others without your approval, unless allowed by law.
- Receive information from your doctor about treatment options or other types of care available to you, appropriate to your condition, and explained in a way you can understand.
- Receive services from out of network doctors/providers.
- Receive a second opinion on a medical procedure from an in-plan doctor/provider. If an Aetna Better Health provider is not available, we will help you get a second opinion from a non-participating provider at no cost to you.
- Participate with your doctor/provider in making decisions about your health care.
- Tell the doctor/provider that you do not want treatment, and be told what may happen if you do not have the treatment. You can continue to get Medicaid and medical care without any repercussions even if you say no to treatment.
- Make an official complaint or grievance about Aetna Better Health or file an appeal if you are not happy with the answer to your question, complaint/grievance, or care given.
- Appeal a medical decision made by Aetna Better Health directly to the Department of Medical Assistance Services (DMAS).
- Know the cost to you if you choose to get a service that Aetna Better Health does not cover.
- Be told in writing by Aetna Better Health when any of your health care services requested by your PCP are reduced, suspended, terminated or denied. You must follow the instructions in your notification letter.
- Have you and/or your child's doctor/provider tell you about treatment choices you may have, no matter what the cost or benefit coverage.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Find out what is in your medical records and request that they be corrected or amended.
- Request a copy of your medical records.
- Exercise your rights and to know that you will not have any retaliation against you by Aetna Better Health, any of our doctors/providers or state agencies.
- Access to health care services and medical advice twenty-four (24) hours a day, seven (7) days a week, including urgent and emergency services.
- Get family planning services from any participating Medicaid provider without prior authorization.
- Get information in different formats (i.e., large print, Braille, etc.), at no cost to you, if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading.
- Get interpretation services if you do not speak English or have a hearing impairment to help you get the medical services you need.

- Make recommendations or suggestions regarding Aetna Better Health's member rights and responsibilities.
- Develop Advance Directives or a Living Will, which tell how to have medical decisions made for you if you are not able to make them for yourself.
- To ask for a description of all types of payment arrangements that we use to pay providers for health care services.

Your responsibilities:
As an Aetna Better Health of Virginia member, you are responsible for:
- Reading the member handbook. It tells you about Aetna Better Health services and how to file a complaint or grievance
- Schedule wellness check-ups. Members under twenty-one (21) years of age need to follow the Early Periodic Screening Diagnosis and Treatment [EPSDT] schedule.
- Get care as soon as you know you are pregnant. Keep all prenatal appointments.
- Carrying with you and showing your Aetna Better Health identification (ID) card to each doctor before getting health services.
- Protecting your member ID card and not sharing it with others.
- Getting medical care from providers in our network.
- Knowing the name of your assigned PCP.
- Telling the doctor that you and/or your child are/is a member of Aetna Better Health at the time that you speak with the doctor's office.
- Keeping doctor's appointments or calling to cancel them at least twenty-four (24) hours ahead of time.
- Using the emergency room (ER) for true emergencies only.
- Learning the difference between emergencies and when you need urgent care.
- Treating the doctors/providers, staff and people providing services to you with respect.
- Giving all information about your health to Aetna Better Health and your doctor in order to provide care.
- Telling the doctor if you do not understand what they tell you about your health so that you and your doctor can make health plans together.
- Following what you and your doctor agree to do including making follow up appointments, taking medicines and following your doctor's care instructions.
- Telling Aetna Better Health and DMAS when your address changes.
- Telling Aetna Better Health about changes in your family that might affect your eligibility or enrollment such as family size, employment, and moving out of the state of Virginia.
- Telling Aetna Better Health if you have other health insurance, including Medicare.
- Giving your doctor a copy of your Living Will and/or Advance Directive.
- Learning about prescription drugs and reasons for taking them.
- Letting Aetna Better Health know how we can work better for you.

DMAS pays us a monthly premium for your Aetna Better Health coverage. If you are found not eligible for Aetna Better Health coverage for past months because you did not give truthful information to your case worker or tell your case worker about changes in your circumstances, you may have to pay DMAS back for these premiums even if you do not get medical services under Aetna Better Health benefits during these months.

Aetna Better Health of Virginia distributes its member rights and responsibility statement to new members in enrollment kits and to existing members via newsletter and website access each year. Members can request a copy be mailed to them by contacting Member Services. We also distribute the member rights and responsibility statement to new practitioners when they join our network and to existing practitioners each year via the website.

Section 3

Using your benefits

Getting help

We're here to help you. We have a department called Member Services that helps our Aetna Better Health members get answers to questions about your health care, ID cards, and doctors. You can call our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) when you have a problem or question. Call us any time between 8 a.m. and 5 p.m., Monday through Friday.

If your primary language is not English or you have a hearing impairment, you have the right by law to interpreter services. This is a covered service. This service is free and you don't need to rely on a family member or friend to interpret for you. Tell your doctor that you need a translator or sign language interpreter and he or she will call us. We'll make arrangements for signing or language interpreter services when treatment, medical history or health education needs to be discussed with you. You may also call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) to ask for a translator or sign language interpreter.

If you need to contact us about your benefits and your primary language is not English, we will contact our language line service, which will translate for you.

For our members with hearing disabilities who have access to TTY, if you need to contact us, you may call the TTY number: **711** or **1-800-828-1120**. If you cannot reach us at this number, you may contact us through Virginia Relay toll-free at TDD **1-800-828-1120** or Voice **1-800-828-1140**.

If you are visually impaired, you may call our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) to ask about getting this handbook in a larger print or a recorded or audio taped version.

If you have questions about when you can start getting care under Aetna Better Health or how long you can receive care from us, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

You may also find answers to many of your questions on our website **www.aetnabetterhealth.com/virginia**. Select "For Members" to learn more about benefits and services for you and your family. Check our prescription drug list and the services that require preauthorization. Use the Aetna Better Health secure member portal to check member eligibility and benefits, status of a claim, status of prior authorization request and more! To register, go to our website and select "Login" from the homepage.

24-Hour Care

You will choose a primary care provider (also called a PCP) who can take care of all of your health needs, 24 hours a day, 7 days a week. You can call your PCP for care anytime, day or night. When your PCP is out, he or she will have someone to take his or her place. Your PCP or your PCP's on-call doctor will be able to help you at all hours of the day and night, even on weekends and holidays. For routine and urgent care, call your PCP.

To see your PCP, just call your doctor's office and make plans for a visit. If you need health care and your PCP's office is closed, you should still call his or her office and tell them you are an Aetna Better Health member. Your PCP or someone from his or her office will call you back.

24-Hour nurse helpline

We encourage our members to work with their PCP for their health care needs. However, if you have a medical question and you are not sure what to do, call our 24-hour nurse helpline. Our nurse helpline can help answer specific health questions or give you advice on what to do when you need health care, such as calling your PCP, making an appointment or going immediately to the Emergency Room. Our toll-free number for the nurse helpline is **1-877-878-8940**. This number is also listed on the back of your Aetna Better Health ID card.

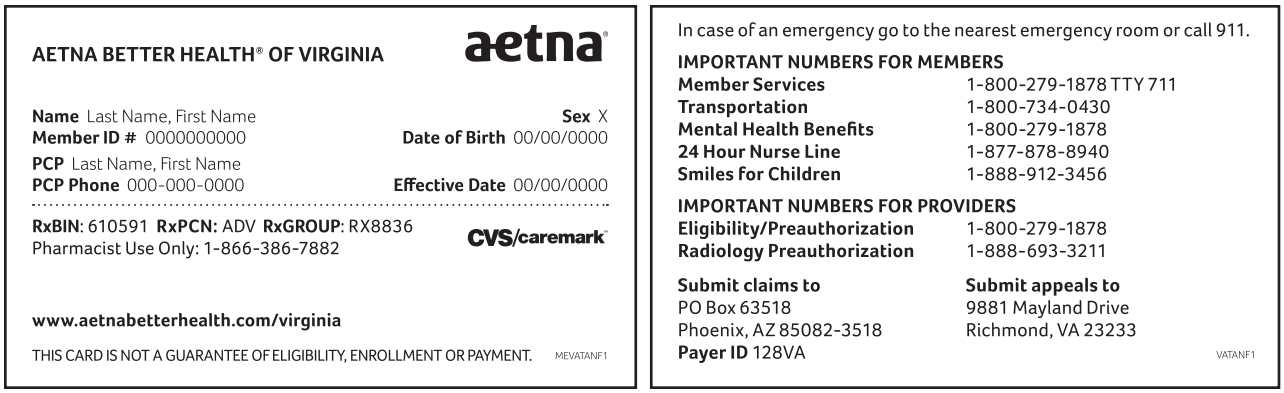
How to use our services

A few easy steps to follow so that we'll cover your health care:

- **Call your PCP and set up a time for a checkup.**
  - As soon as you get your ID card, even if you're not sick, you should set up a time to see your PCP for a checkup. This way, your PCP can get to know you better and help with future health problems before they happen, or at least find them sooner.
  - Your PCP will look for any problems you might have because of your age, weight and habits. Your PCP will also help you find ways to be healthier.
  - Children should also see their PCP for checkups, shots and screenings as soon as possible. For checkups, shots and screening, try to call your PCP two or three weeks ahead to ask for an appointment.
  - When you or someone in your family is sick and needs health care, call your PCP and set up a time for a visit. You can see the doctor at his or her office.
- **Keep your appointments.**
  Please do not miss your doctor visits. Your doctor can take better care of you when you're there for each visit. Give your doctor at least 24-hours notice if you can't keep your appointment.
- **Your PCP will decide who else you need to see.**
  If your PCP says you need other tests or you need to see another doctor, he or she will send you to the doctor or specialist best suited for your needs. Your PCP will help you make plans with other Aetna Better Health providers when you need special care. You don't need a PCP referral for behavioral health services. You should pick a provider in our network. Go to **www.aetnabetterhealth.com/virginia** and click "Find a Provider" at the top of the page. You can also find a behavioral health provider on our website. If you need help finding a behavioral health provider, please call us toll free at **1-800-279-1878**.
- **You can call your PCP after hours.**
  If you need health care and your PCP's office is closed, you should still call his or her office if it's not an emergency. Leave a message. Tell them you are an Aetna Better Health member. In your message, give the reason for your call and be sure to leave your name and phone number where you can be reached. Your PCP or a doctor on call for your PCP will call you back. He or she will tell you where to get care.

Aetna Better Health member ID card and Medicaid ID card

When you join our health plan, each family member receives his or her own Aetna Better Health ID card. Make sure to keep your ID card in a safe place since this is your only Aetna Better Health ID card. Always carry your Aetna Better Health ID card and your blue-and-white plastic Medicaid card. Always show both cards when you see a health care provider. These cards will let your provider know you are an Aetna Better Health member. The first date you can start using your Aetna Better Health ID card and getting care from us under Aetna Better Health is shown on your Aetna Better Health ID card.



Information on your Aetna Better Health ID card includes the following:

- Your name
- Your Medicaid ID number
- Your date of birth
- Your Aetna Better Health ID number
- Your primary care provider's name
- Your primary care provider's office phone number
- The day your Aetna Better Health coverage starts
- The number to call for mental health or substance abuse care
- The number to call for transportation services
- Your ID to obtain prescription drugs and the phone number to call with questions (Pharmacist Help Desk)

If you need an Aetna Better Health ID card, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). If your card is lost or stolen, please call us immediately.

Primary care provider (PCP)

Aetna Better Health members choose their PCP from our online provider directory. Your PCP's name will be listed on your Aetna ID card. We will tell you if your PCP is no longer a part of our provider network. We will help you pick a new doctor. If you don't pick a new PCP, one will be picked for you.

Each time you need to go to your PCP, you should call to set up your visit. Please show up for your visits. If you can't make your PCP appointment, call your PCP's office to cancel. Give them at least 24-hour's notice.

If your PCP is not there when you need care, you should ask to see one of the other doctors in the group. There may be a doctor on call for your PCP that you could see.

If you have a disabling condition or chronic illness, you may ask to see an in-network specialist as your PCP. Also, Aetna Better Health specialists may act as PCPs in giving care for special needs children. Either you or your doctor should contact Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) to make this request.

To find a participating provider or specialist, go to our website at **www.aetnabetterhealth.com/virginia**. Select "Find a Provider" at the top of the page. You can search by zip code or county and state, and even narrow results down to a particular specialty if needed. If you need help finding a provider or specialist near you, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

If you have diabetes:
- Visit your doctor at least twice a year
- Take all medication as prescribed by your doctor
- If you need to see a specialist you will want to see an endocrinologist
- Have a yearly diabetic eye exam (they will need to dilate your eyes)
- Have your HbA1c checked at least twice a year
- Have your cholesterol checked once a year
- Have your kidneys checked once a year with a urine test for microscopic protein

If you have asthma or COPD:
- Visit your doctor at least twice a year
- Take all medication as prescribed by your doctor, even if you feel well
- If you need a special lung doctor you will want to see a pulmonologist and/or allergist
- Follow your Asthma Action Plan. Know what to do if your symptoms get worse

If you have high cholesterol:
- Have your cholesterol checked at least once a year
- Take all medication as prescribed by your doctor
- If you are overweight, ask your doctor for diet guidelines
- Get at least 30 minutes of exercise on most days

If you have heart disease:
- Visit your doctor at least twice a year
- If you need a heart specialist you will want to see a cardiologist
- If you smoke, stop (ask your doctor about getting help with this)
- If you are overweight, even a small amount of weight loss will help
- Have your cholesterol checked at least once a year
- Have your blood pressure checked (take your medicine, as ordered, if the doctor has prescribed some for you)

If you have any questions about the above information, call Member Services at **1-800-279-1878**. If you are hearing or speech impaired and need TDD/TTY services, you may dial the TTY number at **1-800-828-1120** or **711** for assistance in contacting Member Services.

OB/GYN physician

If you are a female age 13 or older you may get female related services directly from a participating obstetrical/gynecological physician (also called an OB/GYN) without asking your PCP. You will need to see an Aetna Better Health network OB/GYN. You can pick your doctor by searching our online provider search or by calling Member Services.

Changing your PCP or OB/GYN

You can change your PCP or OB/GYN on our secure member web portal at **www.aetnabetterhealth.com/virginia**. Or you can call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). You need to do this before you visit your new doctor. Your change will happen the first day of the month. If you make your change by the 20th day of the month, you can use your new PCP or OB/GYN by the 1st of the next month.

Patient utilization management and safety (PUMS) program

Aetna Better Health has a patient utilization management and safety (PUMS) program. We can restrict members to one provider (for example: pharmacy or PCP) if a pattern of abuse is demonstrated.

If you have been enrolled in the PUMS program through another managed care organization or through the Department of Medical Assistance Services, you will be automatically enrolled in Aetna Better Health's PUMS program. If you have been restricted to one provider and you disenroll from Aetna Better Health and you re-enroll within six months, you will be placed back in the PUMS program.

You have the right to request an appeal (including the right to request a State Fair Hearing) of the decision to restrict you to one provider.

Change in your benefits or services

If there is a change in the Aetna Better Health benefits or services that are available to you, we will let you know. We will let you know by telling you in writing or as an update to this handbook.

Access and availability standards

The following are the access and availability standards for different situations for our Aetna Better Health members:

Timely access		
Timely access-standards for hours of operation for PCP's:		
General appointment availability -- twenty hours per week per practice location		
Physician type	**Appointment type**	**Availability standard**
Primary Care Physician (PCP)	Emergency	Immediately upon request
	Urgent Care	Within 24 hours
	Routine	Within 30 calendar days
Behavioral Health	Non-Life Threatening Emergency	Within 6 hours
	Urgent Care	Within 48 Hours
	Initial Visit Routine care	Within 10 working days
Prenatal	First (1st) Trimester	Fourteen (14) calendar days
	Initial Second (2nd) Trimester	Seven (7) calendar days
	3rd Trimester & High Risk	Three (3) working days from date of referral

Continuing services from providers

If your provider leaves our provider network, you may continue to receive covered services from this provider in the following cases:

You may receive covered services from your PCP for a period of up to 90 days after the date your PCP has given to, or received from us, notice that his or her participation status in Aetna Better Health is ending. This can only take place if your PCP remains in the Aetna Better Health service area and is open to see patients.

You may receive covered services from providers other than your PCP for a period of at least 90 days if you were in an active course of treatment with an Aetna Better Health provider before the provider's notice of termination from our provider network. You must make a request to continue receiving health care services from that provider.

You are able to receive care for extended periods under the following circumstances:

- If you have entered your second trimester of pregnancy at the time your provider's participation is terminated and your services from that provider are directly related to the delivery through postpartum care.
- If you have a medical prognosis of life expectancy that is 6 months or less, you may continue to receive treatment from such provider for the remainder of your life for care directly related to the treatment of the terminal illness.

The continuity of care options described above are not available if your provider is terminated for cause or if you are no longer an Aetna Better Health member. We will pay the provider for covered services you receive as described above according to our agreement with the provider.

If your provider leaves the network, call Member Services for help at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

When you may have to pay for services

You may have to pay for care you get from a provider who is not part of the Aetna Better Health provider network. Our Member Services can tell you if a provider is part of our provider network by calling **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). Sometimes we will pay for your care even if you do not go to an Aetna Better Health in-network provider:

- For care in an emergency.
- For urgent care outside our provider network, when approved by us.
- When your PCP sends you and we preauthorize the care before your visit.
- For family planning services.
- For benefits from a drug store that accepts our rate as payment in full.

You must get all your care from an in-network provider, unless your PCP has sent you to a specialist. You may have to pay for health care if you don't go to an Aetna Better Health provider. You may have to pay for care if you receive a non-covered service and you agree in writing to pay the fees before receiving the service. The only times you would not have to pay are listed above.

Providers not in-network

Your doctor may tell you that you need to see a doctor or other health care provider who is not an Aetna Better Health in-network provider. If so, he or she must send, in writing the health information we need to review the request. Our staff will review the information. You can go to a provider outside the Aetna Better Health network only if: (1) the care is needed; and (2) there are no Aetna Better Health in-network providers who can give you the care you need. We have the right to say where you can receive services when no Aetna Better Health provider can give you the care you need. Your care must be preauthorized before your visit. The doctor that wants to give you care should ask for preauthorization. When your receive care outside our network it must be approved by us first, there is no cost to you. If you have questions, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

Utilization management

We know that you want to feel sure that you are getting the most appropriate health care and services in the right place. This is called utilization management (UM). Our UM staff uses clinical review criteria, practice guidelines and written policies to make UM decisions. UM decisions are based on these reasons:

- Services requested are medically needed (also called medically necessary)
- Services requested are covered

You can call us at Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**), Monday-Friday from 8 a.m. to 5 p.m. with questions about our UM program. Member Services may transfer your call to the UM department for a staff member to help you. After business hours, you may be transferred to our after-hours call center. Someone will take your message. We'll call you the next business day.

Utilization management affirmative statement about incentives

We understand members want to feel confident they are receiving the health care and services that are best for them. We have policies our practitioners and providers follow to ensure you receive the right healthcare.

We do not use incentives to encourage barriers to care and/or service, or to reward inappropriate restrictions of care. This is called an affirmative statement.

We want to let you know that:

- Utilization management decisions are based only on appropriateness of care and services and whether they are covered
- We do not reward or pay our network of providers or employees to deny reviews
- No financial incentives are offered to encourage underutilization

The UM staff uses clinical review criteria, practice guidelines and written policies to make these decisions. Utilization decisions are based on the following reasons:

- Services are medically needed.
- Services are covered in the member's plan.

We want to ensure that each member receives the right healthcare. If you need help understanding this information, call Member Services at 1-800-279-1878.

Referrals

We do not require you to get a referral from your PCP or OB/GYN before you see another Aetna Better Health in-network provider. You still should call your PCP to let them know you are going to the other provider. This helps your PCP coordinate your care. Some services may need to be preauthorized.

Preauthorized care

We must preauthorize some health care, drugs and supplies you get. We will give preauthorization to providers when you need health care, drugs or supplies that are medically needed and are listed below. Your doctor needs to call us for approval at least 3 working days before your scheduled care. We may ask to see written notes showing that your care is medically needed before we preauthorize it. Our staff is available from 8 a.m. and 5 p.m. ET. If you have questions, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

You must get your first service on the date or within the dates listed on your preauthorization. If you can't get the care on the date or within the dates listed on your preauthorization or you need more visits, you must call your doctor. Your doctor will call us to change the preauthorized dates. Preauthorization's are good for a specific amount of time. The preauthorization does not go past your last covered date.

Your preauthorization for care is for a specific problem or sometimes for a set number of visits. If you run out of visits and still need more, call your doctor. Your doctor must call us to add more visits.

Preauthorization is required before the date you get care for the care listed below:

- Automatic Internal Cardiac Defibrillator (AICD)
- Behavioral health & substance use services: Inpatient
- Bi-ventricular pacemaker
- Biofeedback therapy
- Cardiac catheterization
- Chemotherapeutic agents
- Clinical trials
- CT scans
- Dental treatment for dental accidents
- Durable Medical Equipment (DME): all rentals of DME and repairs, purchase of DME costing over $500, breast pumps (except ostomy supplies do not require authorization); nebulizers require authorization regardless of dollar amount.
- Genetic testing
- Home health care (nursing, infusion, respiratory, etc.)
- Hospital observation stays
- Hyperbaric oxygen - all places of service
- Injectable and self-administered injectable drugs, if covered under the medical and surgical benefit instead of prescription drug benefits
- Inpatient hospital care
- Insulin pump and supplies
- Intensity-Modulated Radiation Therapy (IMRT)
- Magnetic Resonance Imaging (MRI)/Magnetic Resonance Angiogram (MRA)/Positive Emission Tomography (PET Scan)
- Molecular diagnostic testing
- Medical transportation services
- Non-emergency ambulance transportation
- Non-implanted prosthetic devices
- Nuclear radiology
- Nutritional formulas and supplements
- OB Ultrasounds (beginning with 3rd ultrasound)
- Oral surgery
- Orthotics
- Outpatient polysomnograms (sleep apnea studies)
- Outpatient surgery (hospital or freestanding surgical center)
- Pain management services/programs, including epidural steroid injections
- Psychological or neuropsychological testing, when performed by a medical provider
- Rehabilitative services: includes pulmonary rehabilitation, physical, occupational, or speech therapy whether received inpatient or outpatient
- Services from a non-participating provider except emergency services and family planning
- Stress echocardiograms
- Transplant consultations, evaluations and testing/transplant procedures

Additional information concerning preauthorization
We update the preauthorization list from time to time. If you are not sure about a certain service or medicine, or if you would like a copy of the most current listing, call our Member Services staff at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

Aetna Better Health staff are not paid based on the approval or denial of services. If you have any questions about a utilization management decision, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) or fax your question anytime to **866-207-8901**.

Carved-Out Services
As a member of Aetna Better Health, you may receive the following services through the Department of Medical Assistance Services (DMAS):
- Community rehabilitation mental health services and intellectual disabilities services
- Substance abuse treatment services including emergency counseling services, intensive outpatient services, day treatment, opioid treatment and care management services
- School health services as outlined in the child's Individual Education Plan (IEP)
- Targeted care management services provided to seriously mentally ill adults and emotionally disturbed children
- Abortions - for life or health of mother
- Dental services - Smiles for children
- Early intervention services. These services are provided for members from birth to age 3 with a delay in one or more areas of development. These areas include physical, social, emotional and communication. Services are provided in the child's natural environment. For more information, call your local Infant and Toddler Connection office, or call the main Infant and Toddler Connection office at **1-804-371-6595**, or visit www.infantva.org/Families.htm.

Other services
If your child has elevated blood lead levels, your local health department will investigate and determine the source of the lead contamination.

Section 4

Covered services and limits

We manage the benefits covered in this handbook by:
- Working with your doctor to decide what care you need
- Deciding what care is covered
- Interpreting this handbook when there is a question about coverage

Most care must be given by a participating Aetna Better Health doctor or provider and done at a an Aetna Better Health network facility. The only exceptions will be if: (1) your PCP asks you to go out of the network, we agree and the service has been preauthorized; (2) you receive family planning services; (3) you get benefits from a drug store that accepts our rate as payment in full; or (4) you have an emergency.

We have contracted with a select network of providers for care. Sometimes there may not be an Aetna Better Health provider who can give you the care you need. If this happens, you may go out of our network for care, once preauthorized by us.

We will remain current with reviewing new technology to be included as a covered benefit. We review medical literature to help pick the technologies that provide medically needed care and is approved by any regulating

body required by law to do so. New technologies must show improvement in your health risk over current products or procedures.

Care or supplies must be medically needed for us to cover. Medical need is decided by looking at the generally accepted standards of care. We decide whether your care meets these standards. We cover any of the services in this section if court-ordered when they are medically needed.

Behavioral Health Care (Mental Health Care/Substance Abuse)

Behavioral Health services

If you are in a crisis situation and think you might hurt yourself or someone else, call **911**.

Behavioral health services can help you with personal issues that may affect you. Some examples are depression, anxiety or problems from using drugs or alcohol.

Your PCP may be able to help you with mild depression or anxiety. Your PCP may also be able to help you with alcoholism or attention deficit hyperactivity disorder (ADHD). PCPs may write prescriptions for drugs and check to see how the drugs are working for you. They can also order lab tests and other tests for behavioral health issues.

You do not need a PCP referral for behavioral health services. You should pick a provider in the Aetna Better Health of Virginia network at **www.aetnabetterhealth.com/virginia** and click "Find a Provider" at the top of the page. If you need help finding a behavioral health provider, please call us toll free at **1-800-279-1878**.

Covered services:

- Outpatient services in a psychiatrist's or licensed clinical psychologist's private office, certified hospital outpatient departments, and in the community mental health clinics approved and/or operated by the Virginia Department of Behavioral Health and Developmental Services.
- Medically necessary outpatient individual, family and group mental health and substance abuse treatment services.
- Short-term inpatient hospital services are covered for members under the age of 21 in participating hospitals when preauthorized by the Aetna Better Health mental health provider. Hospital stays for the treatment of medical conditions that relate to substance abuse (like acute gastritis, seizures, pancreatitis and cirrhosis) need to be preauthorized by us.
- Psychological tests when related to an apparent or diagnosed psychiatric illness and as part of your doctor's plan for deciding what the mental illness or disease is and how to treat it.
- Children who have special needs for medically necessary assessment and treatment services, including children who have been victims of child abuse and neglect, can get this care if: (1) the services are delivered by a doctor or provider whose specialty is in the diagnosis and treatment of child abuse and neglect; (2) the services are provided by a doctor or provider who has similar expertise. A provider who meets these standards will be verified by DMAS.
- Services required by a Temporary Detention Order (TDO) are covered for members up to 96 hours.
- All care given in a free-standing psychiatric hospital is covered for members up to the age of 21 and over the age of 64. When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by federal and state law.
- Outpatient substance abuse services.

Limits:
- Inpatient hospital stays for:
  – Treatment of mental illness
  – Functional nervous disorder(s) of any type or cause
  – Psychiatric or psychoanalytic care for adults

Prior authorization
Some behavioral health services need to be approved as "medically necessary" by Aetna Better Health before your provider can arrange for you to get these services. This process is called "prior authorization." Your behavioral health provider will work with Aetna Better Health to request and secure prior authorization for any of these services. Your provider needs to call us for approval at least 3 working days before the scheduled care. We may ask to see written notes showing that your care was medically needed before it is preauthorized. Our staff are available from 8 a.m. - 5 p.m. (ET). If you have questions, call Aetna Better Health Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

Prior authorization process:
1. Your health care provider must contact Aetna Better Health with information that can support your covered service and medical necessity for service.
2. An Aetna Better Health licensed clinician will review the services requested. We will decide if your request can be approved based on Aetna Better Health's clinical guidelines. If our clinician can't approve it, an Aetna Better Health doctor will review it. Our doctor may attempt to contact your requesting provider to discuss the request.
3. If your authorization is approved, we will notify your provider that it's approved.
4. If a denial, reduction, suspension, or termination of your services happens, we will send you a "Notice of Action" letter. Your health care provider will also be notified of this decision. More detailed information is explained in the Grievances and Appeals section of this handbook.
5. At any time, you and your provider may ask for a copy of the clinical criteria that was used to make a denial decision for medical services.
6. If you do not agree with our decision:
   A. You may file an appeal with Aetna Better Health
   B. Your may request a State Fair Hearing

See Section 7 of this handbook for more information.

Services not covered:
- Remedial education
- Day care
- Social behavior modification
- Socialization
- Play therapy
- Telephone consultations
- Inpatient mental health rendered in a state psychiatric facility
- Detox services

Cancer treatment
High-dose chemotherapy, high-dose radiation therapy and bone marrow transplants.

Covered services:

Members under age 21

High-dose chemotherapy and/or high-dose radiation and any supporting allogeneic or syngeneic bone marrow transplants or other forms of allogeneic or syngeneic stem cell rescue (those with a donor other than the patient) are covered for children with the following diagnoses:

- Aplastic anemia
- Acute leukemia
- Stage IV intermediate or high-grade lymphoma with bone marrow involvement
- Severe combined immunodeficiency
- Wiskott-Aldrich syndrome
- Infantile malignant osteopetrosis
- Chronic myelogenous leukemia
- Stage III or IV Neuroblastoma in a child over one year of age
- Thalassemia major
- Lysosomal storage disorders
- Myelodysplastic syndrome

High-dose chemotherapy and/or high-dose radiation and any supporting autologous bone marrow transplants or other forms of autologous stem cell rescue (those in which you are the donor) are covered for children with the following diagnoses:

- Stage III or IV Hodgkin's disease which has come back after an initial complete remission or is in its first remission with poor prognostic factors, with no bone marrow involvement
- Stage III or IV intermediate or high-grade non-Hodgkin's lymphoma which has come back after an initial complete remission or is in first remission with poor prognostic factors, with no bone marrow involvement
- Advanced neuroblastoma or other primitive neuroectodermal tumor without bone marrow involvement
- Acute lymphocytic or non-lymphocytic leukemia which has come back after an initial complete remission or is in first remission with poor prognostic factors
- Germ cell tumors with no prospect for complete remission with standard dose therapy

Members age 21 and over

High-dose chemotherapy and bone marrow transplants for adults who have been diagnosed with lymphoma, leukemia, myeloma, or breast cancer are covered when the attending doctor determines the treatment is justified and preauthorized by us.

The term "high dose" when used to describe chemotherapy or radiation means a dose so high as to predictably require stem cell rescue.

Not covered:

- Services or procedures that are deemed experimental or investigational

Care management/disease management

Care management

If you have a chronic condition, a history of health problems or have problems following our rules for getting health care, we want to work with you and your doctor to meet your health care needs. Care management helps you get the best care in the most efficient manner. We will follow DMAS guidelines or nationally recognized guidelines for any alternative care proposed. Alternative care must be preauthorized by us before services are rendered. The support and education provided under care management will be made to meet your special health care needs.

Our care management program is designed to help make sure you understand your condition and treatment plan. Our staff is made up of registered nurses or social workers who have received training in the care management process. We will help you get the best care in the most efficient manner.

Care managers have a variety of daily activities as they interact with everyone involved in your life. They coordinate care in the following ways:

- Work one-on-one with you to create a plan based on your goals
- Review your plan to help make sure you do not have gaps in care
- Consult with your doctors
- Help you make specialist and primary care doctors appointments
- Verify that the right medicines and treatments are in place
- Help make sure you receive preventive care
- Work to ensure you and your family have the support you need
- Ask questions to make sure your home is safe
- Provide patient and family education about programs and services available in the community and through your doctor
- Make sure you have support for any mental health needs
- Help you transition to other care when your benefits end, if necessary

We have programs if you need a transplant, have high-risk pregnancies, have babies needing neonatal intensive care (NICU), or help you transition your care from the hospital. These programs help you take good care of yourself.

If you feel you need care management services or if you have any questions about care management, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). If you are in the program, but don't want to be, call the same phone number to get out of the program. Tell our Member Services staff you want to speak to a care manager.

Disease management

Our disease management programs can help you take care of chronic health conditions. We offer disease management programs if you have chronic health conditions like asthma or lung disease, heart disease, diabetes, or kidney disease. If you have seen a doctor for one of these conditions, you may be signed up for our disease management program. If you aren't signed up, you can join by calling **1-800-279-1878**. Health coaches will call you and mail you materials to help you take care of your condition.

If you do not want disease management services, you can call us to let us know at **1-800-279-1878**.

Dental services

Dental care for children is provided through the Smiles for Children Program. The toll-free number is **1-888-912-3456**. You should call this number with any questions you have about your dental care. We cover hospitalization and anesthesia-related services for medically necessary dental services, if preauthorized.

Durable Medical Equipment (DME) and medical supplies

Rental or purchase (at the sole option of us) of medically needed DME is covered. We cover repair or replacement of damaged or lost equipment. You must get the equipment from our provider network. All rentals and all DME purchases over $500 must have preauthorization. Orthotics always requires an authorization.

Covered DME includes, but is not limited to:

- Hospital beds
- Bedside commode, shower chair and tub rails

- Canes, crutches, walkers, slings, splints, cervical collars and traction apparatus
- Wheelchairs
- Oxygen and oxygen equipment
- Jet Nebulizers. Nebulizers require authorization regardless of dollar amount.
- Apnea monitors; CPAP machines
- Blood glucose meters
- Jobst stockings or equivalent
- Prosthetic devices - like an artificial arm or leg
- Renal dialysis equipment and supplies
- Orthotics
- Insulin pumps and supplies
- Ostomy supplies
- Nutritional supplements

Limits:
- Orthotics for adults are only covered when part of an approved intensive rehabilitation program.
- Nutritional supplements for adults are covered when they are the only source of nutrition.
- Nutritional supplements for children are covered and billed to DMAS when they are the primary source of nutrition. Medical supplies to administer the nutritional supplements are provided by Aetna Better Health.
- We may not pay for repairs or replace a damaged wheelchair if we determine the damage was intentional member abuse or misuse of the chair.

Not covered:
- Space-conditioning equipment, such as room humidifiers, air conditioners, and air cleaners
- Furniture or appliances not defined as medical equipment
- Items that are only for your comfort and convenience or for the convenience of those caring for you
- Home or vehicle modifications
- Equipment for which the primary function is vocationally or educationally related
- Non-compression type support stockings
- Diabetic shoes and inserts

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

All children are given the care needed to promote health through the EPSDT Program. Under Medicaid/FAMIS Plus, your child may be eligible to receive certain services otherwise not covered under EPSDT. EPSDT covers medically necessary services which will cure an illness or condition or at least keep it from getting worse. These benefits include, but are not limited to, services for nursing care, individualized treatments specific to developmental issues, and accessing carved-out services. EPSDT allows children regular checkups and the care needed when they get sick. Your child will get both sick and well care from the same doctor through this program. This will help your child get to know his or her PCP and help your doctor keep a complete record of your child's health.

Your PCP will give your child checkups and will help plan the care needed to prevent illness. Your child needs routine checkups. Routine checkups help catch health problems before they are serious. These checkups include dental, vision, hearing screenings and shots. If your PCP finds a health problem, he or she will make sure your child gets the care they need. Your child will be sent to another doctor they need care that the PCP does not provide. When health problems are found in the screenings, Aetna Better Health benefits cover follow-up treatment and testing for those problems.

A complete physical exam includes:
- Physical and mental health and developmental history
- Unclothed physical exam
- Lab tests (including hematocrit/hemoglobin, urinalysis, and blood lead toxicity screening)
- Immunizations (shots)
- Nutritional assessment
- Injury prevention
- Checking and counseling about the growth and development of your child
- Vision, hearing and dental screens

Newborns will get their first hearing screening before leaving the hospital after birth. Follow-up visits to an Aetna Better Health audiologist to determine whether or not the child has hearing loss are also covered. Those newborns that were missed for a first hearing screening at the hospital after birth can go to an audiologist in our network for the screening and any needed follow-up visits.

If your child is at risk, a screening may also include the following procedures:
- Tuberculin test (at age 9 months, age 15 months and at each EPSDT screening thereafter)
- Cholesterol screening beginning at age 24 months
- Screening for Sexually Transmitted Diseases beginning at age 13
- Pelvic exam beginning at age 13
- Children should get checkups regularly, at the ages listed below:

Children should get checkups regularly, at the ages listed below:

Age	Age
Birth	12 months
Under 6 weeks	15 months
2 months	18 months
4 months	24 months
6 months	30 months
9 months	Annually from age 3 through 21

Sick visits do not take the place of a routine screening visit.
Children need shots that help their body fight disease. Each shot fights a different disease. Your child must have a record of these shots in order to begin school. You may be required to provide this when you enroll your children into school.

Children should get each shot at the ages given in the chart on the next page. Some shots need to be given more than once.

Immunization Chart (Shots)

Age	Shot
Shortly after birth	• Hepatitis B #1
Between 1 and 2 months	• Hepatitis B #2
2 months	• Diphtheria, Tetanus, acellular Pertussis (DTaP) • H. influenzae type B (Hib) • Inactivated Poliovirus (IPV) • Pneumococcal Conjugate (PCV) • Rotavirus

Age	Shot
4 months	• Diphtheria, Tetanus, acellular Pertussis (DTaP) • H. influenzae type B (Hib) • Inactivated Poliovirus (IPV) • Pneumococcal Conjugate (PCV) • Rotavirus
Between 6 and 18 months	• Hepatitis B #3 • Inactivated Poliovirus (IPV)
At 6 months then yearly to 18 years	• Influenza (Flu) – annually
6 months	• Diphtheria, Tetanus, acellular Pertussis (DTaP) • H. influenzae type B (Hib) • Pneumococcal Conjugate (PCV) • Rotavirus
After 9 months of age for certain high risk groups	• Meningococcal Conjugate (MCV)
Between 12 and 15 months	• H. influeneza type B (Hib) • Measles, Mumps & Rubella (MMR) • Pneumococcal Conjugate (PCV) • Varicella (Chickenpox)
Between 12 and 23 months	• Hepatitis A #1 and Hepatitis A #2
Between 15 and 18 months	• Diphtheria, Tetanus, acellular Pertussis (DTaP)
After 2 years of age for certain high risk groups	• Pneumococcal Polysaccharide (PPV) • Hepatitis A Series
4 to 6 years	• Diphtheria, Tetanus, acellular Pertussis (DTaP) • Inactivated Poliovirus (IPV) • Measles, Mumps, Rubella (MMR) • Varicella (Chickenpox)
7 to 10 years	• Yearly Flu Shot
11 to 12 years	• Yearly Flu Shot • Tetanus, Diphtheria, acellular Pertussis (Tdap) • Meningococcal Conjugate • Human Papillomavirus (HPV) 3 doses
16 years	• Meningococcal Conjugate Booster

Eye care and eye glasses

We cover certain vision services for adults and children when done by one of our participating licensed optometrists and opticians. Call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) to find out how you get care from an Aetna Better Health provider nearest you. You can also search for a provider on our website at **www.aetnabetterhealth.com/virginia**. Select "Find a Provider" at the top of the page, or in your Aetna Better Health of Virginia provider directory.

Covered services:

Diagnostic exams and treatment and eye prostheses for all ages. Members under 21 have coverage for eye exercises (orthoptics), lenses, frames, repairs of lenses and/or frames, dispensing fees, and medically necessary contact lenses. Yearly diabetic eye exams are a covered medical benefit. Make an appointment with an optometrist or ophthalmologist from the specialist section of your Aetna Better Health provider directory. Let your doctor know that you have diabetes and need a special eye exam.

Limits:
- One routine eye exam in each 24 month period - all ages
- Members under 21 can get either 1 pair of covered contact lenses or 1 pair of covered glasses in each 24-month period
- Eye exercises (orthoptics) are limited to 6 sessions

Exceptions:
- Non-routine eye exams are not limited to a 24-month timeframe
- You must pay upgrades and add-ons. These services are not covered and payment is between you and your provider

Not covered:
- Adult lenses, frames or repair of glasses, contact lenses
- Visual augmentation devices

Additional services for adults:
Discount off your provider's usual charge on eyeglass frames, prescription lenses, optical accessories, contact lens exams and contact lens purchases at all participating locations.

Family planning services and supplies

Family planning helps you plan your family size. It gives you information on birth control methods. Family planning is a covered benefit if you are of child-bearing age. Any care given is kept private. You do not need to ask your PCP before getting this care. If you do not want to talk to your PCP about family planning, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). We will help you pick a family planning provider. You may pick a family planning provider and get covered family planning services and supplies from an Aetna Better Health of Virginia provider or a provider outside the network.

Covered services:
- Family planning office visits
- Tubal ligations
- Depo-Provera injections
- Diaphragm
- IUD
- Vasectomies
- Prescription contraceptive devices and birth control medications to include: oral and injectable contraceptive drugs, prescription barrier methods, education and counseling, diagnostic procedures, and lab tests

Limits:
We cover sterilization of an adult member (over 21) only when:
- You request it in writing.
- You are mentally competent.
- It has been 30 days since you signed the consent form.

Not covered:
- Hysterectomies performed solely for the purpose of rendering an individual incapable of reproducing.
- Treatment of infertility or services to promote fertility.

Foot care

Covered services:

- Diagnostic, medical, and surgical treatment of disease
- Injury, or defects of the human foot, when treatment is reasonable and necessary
- Routine foot x-rays as part of the initial exam
- Additional x-rays when medically needed
- Comparative x-rays when the cause of the disorder is uncertain
- Hospital visits by the podiatrist
- House calls subject to the limits set forth below
- Drugs

Limits:

- Hospital visits are only covered for the preauthorized number of days of your hospital stay.
- House calls are only covered if you must stay in bed. They are also covered if a trip to the foot doctor's office would harm you.

Not Covered:

- Routine foot care, such as treatment for corns, bunions and calluses unless the member is diabetic

Hearing services

Covered services:

- Medically necessary diagnostic services for adults
- Diagnosis and treatment for defects in hearing including hearing aids for members under 21

High-risk prenatal and infant services

Our Baby Matters Program provides care management if you are high-risk and pregnant and children up to age 2. We work together with your doctor to decide through risk screenings if you need these extra services.

Covered services:

- Patient education classes
- Nutrition assessment and counseling by a registered dietitian
- Homemaker services if your doctor ordered bed rest
- Coordination of community resources for classes such as childbirth and parenting
- Follow-up monitoring to confirm you are actually getting the care needed
- Guidance and support through the process
- Blood glucose meters
- Testing for HIV
- Coordination to obtain residential or day treatment for substance abuse and transportation to receive those services

Home and Community Based Waivers (HCBW)

Individual and Family Developmental Disabilities Support, Intellectual Disability, Elderly or Disabled with Consumer Direction, Day Support or Alzheimer's. Long-term care services are covered and paid for through DMAS in accordance with Medicaid established coverage criteria and guidelines. These individuals shall receive acute and primary medical services from Aetna Better Health.

Home health care

A licensed or certified nurse or other health care provider may provide care for you in your home. Care is provided in your home when medically necessary. We must preauthorize the care. We will review this care together with your doctor to decide what is appropriate.

Covered services:
- Nursing services
- Home health aide services when considered medically needed (assisting with personal hygiene, eating, walking, meal preparation and feeding, taking and recording blood pressure, pulse and respiration)
- Therapy services
- Medical supplies

Limits:
- Licensed nurse visits must be medically necessary and preauthorized.
- You can get up to 32 visits by a home health aide each calendar year. The number of home health aide visits may not be increased.
- Therapy visits are preauthorized based on medical necessity and a therapy plan of care.

Not covered:
- Community food service delivery
- Custodial care or housekeeping when not part of EPSDT or high-risk pregnancy

Inpatient hospital care

When you do not have an emergency, we must preauthorize your stay before you go to the hospital. You must go to a hospital that is a Aetna Better Health network provider. You will be under the care of your PCP or other doctor to whom your PCP has sent you.

We help manage all hospital stays. We look at the care you get while you are in the hospital. Your care is covered as long as there is a medical need for the care. If all or part of the hospital stay is not medically needed, your doctor will be told that coverage will end. You will not be responsible for payment if you are in an Aetna Better Health participating facility.

Never Events:
You are not responsible for any charges when a provider is denied payment because of a Never Event or a Hospital-Acquired Condition (HAC). An example of a Never Event is a procedure that is done on the wrong side, wrong body part, or wrong person. An example of an HAC is an illness you did not have before being admitted to the hospital.

Covered services:
- Semi-private room and board
- Medical supplies
- X-ray, lab, diagnostic/therapeutic services;
- Use of hospital facilities
- Drugs and biologicals
- Nursing care
- Physical therapy
- Radiation therapy
- Renal dialysis
- Chemotherapy
- Intravenous therapy
- Inhalation therapy
- Occupational therapy
- Speech and hearing services
- Newborn infant care including hearing screenings
- Administration of whole blood and blood plasma

- Supplies, appliances and equipment needed to provide appropriate care and treatment
- Rehabilitation services in a certified rehabilitation hospital when the facility is an Aetna Better Health provider

Not Covered:
- Any services that are not medically needed.
- Cosmetic surgery done only to make you look better.
- Elective surgery which is not medically needed to restore or materially improve a body function. This includes surgery for breast reduction.
- Supplies and devices that are for comfort or convenience only (like radio, TV, phone and guest meals)
- Private rooms, unless a private room is medically needed or a semi-private room is not available. If you stay in a private room, it must be preauthorized by us during your hospital stay.

Maternity

Maternity is pregnancy care, including prenatal, inpatient hospital stay during delivery and postpartum care. Take good care of yourself and your baby. See your doctor as soon as you know you are pregnant. Your doctor will notify us about your pregnancy and we will send you information about our Baby Matters program and how you can participate.

Ask your doctor if you need a Tdap shot while you are still in the hospital with your baby. It helps protect against whooping cough.

If you smoke, we want to help you stop. We cover counseling from a health care provider to help you stop smoking. We cover over-the-counter nicotine replacement products. There is no charge to you for these services.

Not covered:
- Home birth

Medical transportation services

Covered services:

Transportation to medical appointments is a covered benefit. We contract with a transportation company to manage medical transportation services. If you need a ride to a health visit, please call the transportation company using the number shown on your Aetna Better Health ID card. You must call at least 3 working days before your visit or we will not be able to guarantee a ride. We must preauthorize the service. You can ask for medical transportation to get to your eye, dental, behavioral health and medical visits. Transportation is not covered for picking up prescriptions and refills at a pharmacy when drugs can be delivered or mailed. Transportation is covered if your pharmacy doesn't have delivery services or will not mail the prescription or the prescription cannot be filled at the medical facility. **Normally the prescription should be filled initially on the return trip from the medical appointment.** Transportation may be in the form of a public or private vehicle. This transportation must be used only when:
- Your visit is for care covered by the Medicaid/FAMIS Plus program
- You don't have your own transportation.

If you have any questions about medical transportation services, please call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**), 8 a.m. to 5 p.m., Monday through Friday.

Ambulance transportation: In an emergency, call **911** for transportation. Non-emergency medically necessary ambulance and air ambulance transports must be preauthorized by us.

Not covered:
- Aetna Better Health benefits don't cover emergency transportation to treat small cuts, scrapes, bruises, fever and other conditions that do not threaten your life or limbs.
- Aetna Better Health benefits don't cover fees when you are absent or not ready for your scheduled transportation.

Nurse midwife

We cover care given by one of our licensed Aetna Better Health nurse midwives. Your care can be given in your doctor's office, a hospital, a clinic, or any other place needed to treat your illness, injury or disease.

Not covered:
- Home birth

Oral surgery including dental accidents

Oral surgery is covered only for the cases below. Your PCP must send you for the care. We must preauthorize the care. Our benefits only cover repairs needed for daily living.

Covered services:
- Oral surgery is covered for non-dental surgical and hospital procedures for birth defects (like cleft lip and cleft palate).
- Medical or surgical procedures within or next to the oral cavity or sinuses that are medically needed.
- Dental services medically needed because of an accidental injury. Your doctor must submit a plan of treatment to us within 60 days of the date of your injury. You must receive our preauthorization for the plan of treatment and your injury did not occur during the act of biting or chewing.
- Medically needed medical or surgical procedures within or next to the oral cavity or sinuses resulting from the removal of tumors and cysts. This also includes diagnosis and treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Not covered:
- Cosmetic services or repairs we decide are not needed for daily living.
- Any other procedures involving the teeth or areas around the teeth including but not limited to:
  - Shortening of the mandible or maxilla for cosmetic purposes
  - Correction of malocclusion or mandibular retrognathia
  - Treatment of natural teeth due to diseases
  - Repair, removal, or replacement of sound natural teeth

Outpatient hospital care

Outpatient hospital care includes:
- Care to prevent sickness
- Tests to find sickness
- Care to help you heal

You should tell your PCP when you receive outpatient hospital care. We may need to preauthorize this care. You can get the care at hospital outpatient departments, clinics, health centers, or doctors' offices that are in our provider directory.

Covered services:
- Physical, occupational and speech-language pathology therapy
- Hematology
- Chemistry
- Renal dialysis
- Chemotherapy
- Radiation therapy
- Intravenous therapy
- Inhalation therapy
- Diagnostic x-rays
- Isotope studies
- EKG and pulmonary services
- Thyroid function test
- Emergency room
- Medical supplies (e.g. Oxygen and splints)
- Special therapy treatments
- Outpatient surgery room
- 24-Hour observation

Not covered:
- Spinal manipulation or osteopathic manipulation
- Biofeedback
- Acupuncture

Physician services

We cover care given by one of our licensed Aetna Better Health doctors, or a doctor that is out of our network if approved in advance by us. Your care can be given in your doctor's office, a hospital, a clinic, or any other place needed to treat your illness, injury or disease. Care can also be given at these places for family planning, maternity care, well-child screenings under the EPSDT program or other preventive care. Regular health exams are covered for adults.

Covered services:
- Anesthesia
- Office visits
- Chemotherapy
- Concurrent care
- Consultations
- Referrals
- Treatment for End-Stage Renal Disease
- Eye care
- Health education for members under the age of 21 who have a diagnosis of morbid obesity
- Any member with a diagnosis of diabetes
- Hospital visits
- House calls
- Therapeutic injections
- Lab and x-rays
- Routine screenings, Prostate-Specific Antigen (PSA) testing, rectal examinations, colorectal cancer screening, pap smear and mammography
- Disposable medical supplies normally used in physician's office
- Routine newborn care

- Newborn circumcision
- Physical therapy
- Medically needed surgical procedures
- Assistant surgeons; diagnostic surgical procedures (biopsy and endoscopy)
- Preoperative and postoperative care related to surgery

You are never too old to get immunized. Make sure you have all the vaccinations you need before you leave your PCP's office.

Age Vaccine	19–49 years	50–64 years	65 years & older
Influenza	Every fall (or winter).		
Pneumococcal	1–2 doses if you smoke cigarettes or if you have certain chronic medical conditions.*		1 dose at age 65 (or older) if you've never been vaccinated.
Tetanus, diphtheria, pertussis (whooping cough) (Td, Tdap)	A 1-time dose of "Tdap" vaccine if you are younger than age 65 years, are 65+ and have contact with an infant, are a health care worker, or simply want to be protected from whooping cough. You need a Td booster dose every 10 years.		
Hepatitis B (HepB)	You need this vaccine if you have a specific risk factor for hepatitis B virus infection* or you simply wish to be protected from this disease. The vaccine is given in 3 doses.		
Hepatitis A (HepA)	You need this vaccine if you have a specific risk factor for hepatitis A virus infection* or you simply wish to be protected from this disease. The vaccine is usually given as 2 doses.		
Human papillomavirus (HPV)	You need 3 doses of this vaccine if you are age 26 years or younger and have not already had the vaccine.		
Measles, mumps, rubella (MMR)	At least 1 dose of MMR if you were born in 1957 or later. You may also need a 2nd dose.*		
Varicella (Chickenpox)	If you've never had chickenpox or you were vaccinated but received only 1 dose.*		
Meningococcal	If you have not had the shot and are going to college and will live in a dormitory.		
Zoster (shingles)		For ages 60 or older.	

* Ask your PCP if you need this shot.

Limits:
Routine screenings are provided according to most recent guidelines.

Not covered:
- Telephone consultations.
- Cosmetic surgery done only to make you look better.
- Elective surgery, which is not medically needed to restore or materially improve a body function. This includes surgery for breast reduction.
- Surgery which is experimental/investigational.
- Exams needed only for insurance, employment, school, sports or camp that are not part of a covered routine health assessment.
- Shots needed for travel, school and work that are not part of the recommended immunization schedule.

Prescription drugs

Your Aetna Better Health benefits will cover drugs on our prescription drug list. This list is included in your enrollment packet. The formulary can change throughout the year. For the most recent version, visit our website or contact Member Services. At the drug store, you must show your Aetna Better Health ID card to get your medicine. Aetna Better Health Member Services can give you the names of the stores where you may get your medicine or you can look at our website or our provider directory. You may use a drug store that is not in this directory if the store has agreed to accept our rate as payment in full. We will not pay more than the allowable rate.

Covered services:
- Medically needed prescribed drugs; mandatory generic drugs when available; brand name drugs, if medically needed and on our Aetna Better Health prescription drug list
- Over-the-counter products covered according to DMAS guidelines when prescribed by your doctor
- Over-the-counter nicotine replacement products
- Injectable insulin, syringes, glucose test strips, lancets and glucose monitors
- Growth hormones and Clozaril, when preauthorized by us
- Family planning drugs, such as oral and injectable contraceptive drugs, intrauterine devices (IUDs) and prescription barrier methods
- Prenatal vitamins; pediatric vitamins (in established deficiencies); and vitamins or minerals for dialysis patients
- Self-Administered Drugs on the prescription drug list. If a drug is not on the list, you must request an exception.

Limits:
- Up to a 34-day supply will be filled per prescription or refill.
- Some drugs have a limit to the number of pills you can get - this is called a quantity limit (QL).
- Some drugs must be prior authorized before you can get it.
- If a doctor prescribes a medicine in a dose that can be filled with two separate strengths, we may require the most cost effective dose. For example, if your prescribed dose is 450 mg daily and the medicine is available in a 150-mg and a 300-mg tablet, we may require two separate prescriptions: one for the 150-mg tablet and one for the 300-mg tablet, instead of covering three of the 150-mg tablets.

Exceptions:
If you need a drug that is not on our Aetna Better Health prescription drug list, we have a process for you to get specific medically needed prescription drugs. We must determine, after reasonable review and talking with the prescribing doctor, whether or not the drug on the prescription drug list works for your medical condition.

We also allow you to get specific medically needed prescription drugs not on the prescription drug list if you have been getting the drug for at least six months before the change to the prescription drug list. Also, the prescribing doctor must have decided that the drug on the prescription drug list does not work for you and changing the drug presents a significant health risk.

We will act on your request within 24 calendar days. If you want to request a drug that is not on the prescription drug list, have your doctor contact us for review of the request. Either you or your doctor may request an appeal of a previously denied request for a drug not on our prescription drug list.

Not covered:

- Drugs that are not medically necessary.
- Vitamins, other than those vitamins and minerals listed above.
- Anorexiants, except when medically needed.
- Drugs prescribed mainly for a cosmetic purpose. This includes Retin-A when used for any purpose other than treatment for severe acne and Minoxidil when used to treat baldness.
- Experimental and investigational medications; drugs with no approved Food and Drug Administration (FDA) indications; drugs prescribed for purposes other than the FDA-approved use, unless a drug is recognized for treatment of the covered indication in one of the Standard Reference Compendia or other Peer-reviewed Medical Literature. Cancer drugs that are FDA-approved for a certain cancer type may be used for treatment of other types of cancer only if the drug has been recognized as safe and effective for treatment of that specific type of cancer in any of the Standard Reference Compendia. Any drug approved by the FDA for use in the treatment of cancer pain shall not be denied for coverage on the basis that the dosage is in excess of the recommended dosage of the pain relieving agent, if the prescription in excess of the recommended dosage has been prescribed in compliance with Virginia law for a patient with a specific type of cancer.
- Drugs on the list requiring prior approval that do not meet the criteria for medical necessity.
- Infertility medications.
- Drugs not requiring a doctor's prescription, except for certain over-the-counter drugs.
- Drugs for the treatment of erectile dysfunction.

Second medical opinion

You may need a second opinion for an illness, surgery and/or confirming a treatment of care your doctor has told you that you need. Contact your doctor or our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) for help to get a second opinion. The second opinion can be from a participating provider. If there are no participating providers available, you can get a second opinion from a provider outside of our network when authorized. There is no cost to you for the second opinion.

Telemedicine services

We will direct to you to a provider that will be able to provide this service. Call Member Services at **1-800-279-1878** (TTY/TDD: 711 or **1-800-828-1120**) for a list of approved sites.

Therapy services

Physical therapy, occupational therapy, and speech therapy are covered based on medical necessity, a physician's order and a treatment plan of care.

Transplant services: organ, tissue and bone marrow

Covered services:

All transplants must meet medical necessity criteria and be preauthorized. You must get all approved transplants at our Transplant Centers of Excellence. When both the donor and recipient are members, each can get the care described in this Section.

Members under age 21:
- Corneal transplant
- Heart transplant
- Kidney transplant
- Liver transplant
- Lung transplant
- Heart and Lung transplant
- Bone marrow transplant
- Small bowel transplant
- Small bowel with liver transplant

When preauthorized, all medically necessary transplants that are not experimental or investigational are covered for children less than 21 years of age.

Members age 21 and over:
- Corneal transplant
- Heart transplant
- Kidney transplant
- Liver transplant
- Lung transplant
- Bone marrow transplant for specific diagnoses: myeloma, lymphoma, breast cancer and leukemia when preauthorized.

Limits:
Transplant services for liver, heart, and lung procedures for adults are only covered when:
- No other type of medical or surgical therapy is available with outcomes that are at least comparable to the transplant procedure.
- The transplant procedure and application of the procedure in treatment of the specific condition have been clearly demonstrated to be medically effective and not experimental or investigational.
- The patient-selection criteria of the specific transplant center where the surgery is proposed to be performed has been used by the transplant team or program to determine the appropriateness of the patient for the procedure.
- Current medical therapy has failed and the patient has failed to respond to appropriate therapeutic management.
- The patient is not in an irreversible terminal state.
- The transplant is likely to prolong the patient's life and restore a range of physical and social functioning in the activities of daily living.

Not covered:
Organ or tissue transplants other than those listed above are not covered. These include but are not limited to the following:
- Artificial heart transplants
- Pancreas transplants
- Adrenal to brain transplants
- Islet cell transplants
- Heart and lung, small bowel and small bowel with liver for members over 21
- Any transplant considered experimental and investigational

Urgent care
Urgent care is medically needed care for an unexpected illness or injury that you need sooner than a routine doctor's visit. Your PCP can help you determine whether or not you need to receive urgent care. If you have a true emergency, go to the nearest hospital emergency room.

Women's health care services
Women's health care services are direct access services to an OB/GYN for care of or related to the female reproductive system.

Covered services:
- A yearly gynecological exam for female members, age 13 or older, which includes: (1) a breast exam; (2) a pelvic exam; and (3) annual pap smear, to include annual testing performed by any FDA-approved gynecologic cytology screening technologies, when done by an Aetna Better Health provider.
- Screening mammograms using the following schedule: One baseline screening for ages 35 to 39; one mammogram annually for ages 40 and over.
- Prenatal care. We will recommend that the mother have HIV testing, which is covered.
- Services to treat any medical condition that may complicate pregnancy.
- Pregnancy related and postpartum services for 60 days after the pregnancy ends.
- If a newborn and mother or newborn alone is released from the hospital less than 48 hours after the day of delivery, at least one follow-up visit will be covered. The follow-up visit will be given within 48 hours after release. The visit will meet the most recent "Guidelines for Perinatal Care" developed by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. It will also meet the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists.
- Hysterectomies when medically needed.
- Prostheses needed after the medically needed complete or partial removal of a breast for any medical reason.
- Reconstructive breast surgery performed along with, or after a full or partial mastectomy.

Limits:
Reconstructive breast surgery is covered when it's done: (1) along with a full or partial mastectomy; or (2) after a full or partial mastectomy performed on or after July 1, 1998, to regain symmetry between the two breasts.

Not covered:
Hysterectomy done solely to make the member not be able to reproduce.

Section 5

Emergency Services

You and your family need to know what to do in an emergency. Learn the difference between an emergency and urgent care. Only very serious health problems should bring you to an emergency room. Learn what to do in each case. Carry your Aetna Better Health ID card with you at all times.

You can find a list of hospitals that provide emergency services and post-stabilization care in your provider directory or by calling Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

What is an emergency?

Emergency care is care that you need right away. An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby. You don't have to go to an Aetna Better Health provider in an emergency. However, if you are in the service area, you can only go to a provider who is not in the Aetna Better Health provider network when the delay in getting care from an Aetna Better Health provider could reasonably be expected to cause your condition to worsen if left unattended. When you are told you need emergency care by either your PCP or our representative, we will pay for the medical screening exam and any other medically necessary emergency services rendered in the hospital emergency room. Some examples of an emergency are:

- Trouble breathing
- Poisoning
- Broken bones
- Chest pain
- Unconsciousness (blacking out)
- Severe or unusual bleeding
- Convulsions or seizures
- Sudden onset of severe pain
- Any vaginal bleeding in pregnancy
- Severe burns
- Immediate and imminent threat to life or loss of life due to a psychiatric illness or substance use

In the Service Area:

If you have an emergency, you may not have time to call your PCP. If you do have time to call, he or she will help you decide what to do. If it's after your doctor's regular office hours, you should call the after-hours number for your doctor. Keep this number in a place you can get to quickly when you need it.

Your PCP or a doctor on call for your PCP can be reached 24 hours a day. If you need an ambulance for an emergency, call 911. Ambulance service is only covered when there is an emergency or when we have preauthorized it. Hospital emergency rooms that are not in the Aetna Better Health network should only be used when the delay of a longer travel time to a hospital within our network could reasonably be expected by a prudent layperson to cause your condition to worsen if left unattended.

If you must stay in the hospital after an emergency, your provider must call us within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday.

Outside the service area:

If an emergency occurs while you are out of the service area, seek care. If you need to go to a hospital, call Member Services within 24 hours or by the end of the next working day if the 24-hour deadline falls on a weekend or legal holiday. You may need to keep getting care while you are out of the service area. If so, you must get these follow-up visits preauthorized before you go back for any follow-up visits. Call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) to tell us what care you need. We can work with you and your health care providers to review the care you need for preauthorization. However, we won't preauthorize ongoing care out of the service area when you are able to come back to the service area for the care you need.

Show your Aetna Better Health ID card to the health care providers and ask that they file the claims with us. In some cases you may be asked to pay for emergency care. If this happens, you can send a statement that shows what care you got and a receipt for the payment of services. We will pay you back for covered emergency care when you were required to pay the providers. Be sure to give us your name, member number and a short statement about what happened.

Payment for emergency services
In some cases, we may pay a participating provider a reduced fee for emergency services. When we pay a reduced fee, you aren't responsible for any of the emergency facility or provider charges.

Post stabilization care
This is medically needed care you receive after your emergency condition has been stabilized. We don't require preauthorization for post stabilization care.

After-hours choices
You have some after-hours choices. You can visit after hours clinics or urgent care centers in your area. Check Find a Provider search section of our website, **www.aetnabetterhealth.com/virginia**, for other options.

Section 6

General services not covered

If a procedure, service or supply is denied, you or your doctor has the right to request an appeal by sending a request to our Aetna Better Health Appeals Department. This process is described in Section 7 of this handbook.

The following services are not covered:
- Any service or supply that isn't medically needed or isn't a covered service. For example, cosmetic services.
- Any Phase I Clinical Trial or any Phase II, III, or IV Clinical Trial that doesn't meet defined criteria.
- Care from providers not in the Aetna Better Health network, except for family planning services, services received in an emergency or care preauthorized by us.
- Care you get from any provider when the care was not preauthorized by us as required in this handbook.
- Administrative services such as phone calls; filling out forms; copying and/or transfer of health records; returned checks; stop-payment on checks; and other such clerical charges.
- Care at an assisted living facility or nursing facility. Care for rest cures, respite, domiciliary, residential or convalescent care. Private duty nursing except as (1) covered under your home health care benefit; and (2) provided for children when medically needed.
- Fertility services, including but not limited to, in-vitro fertilization and embryo transplants.
- The reversal of sterilization and complications that result from such procedures.
- Procedures, services and supplies related to sex transformations or sexual dysfunction.
- The cost of care for problems that federal, state or local law requires to be treated in a public center. Care or supplies provided or arranged by a government center when no charge would be made if you had no health benefits insurance. The cost of health care covered under the Medicare program or other insurance. Care for military service connected disability and conditions that you are entitled to as long as these centers are reasonably easy for you to get to.
- Health care or remedial care services by Christian Science nurses are not covered. Health care services at Christian Science Sanatoria long-term stay facilities are not covered.
- Medical, surgical or health care supplies that are experimental or investigational aren't covered. Care or a supply is experimental or investigational if it includes, but is not limited to, any of the following:
  – It's in the testing stage or in early field trials on animals or humans.
  – It's under clinical investigation by health professionals or is undergoing clinical trial by any governmental agency, including but not limited to, the Department of Health and Human Services or the Food and Drug Administration.

  - It's a drug for the treatment of a specific type of cancer that is not FDA-approved, is not approved for one type of cancer and the drug has not been recognized as safe and effective for treatment of the specific type of cancer for which the drug has been prescribed in any of the Standard Reference Compendia. It is a drug for the treatment of a specific indication that is not FDA-approved, the drug has not been approved by the United States Food and Drug Administration for at least one indication and the drug is not recognized for treatment of the covered indication in one of the Standard Reference Compendia or in substantially accepted Peer-reviewed Medical Literature.
  - It's a health product or service that is subject to Investigational Review Board (IRB) review or approval.
  - It doesn't have required final federal regulatory approval for commercial distribution for the specific indications and methods of use assessed or has not been approved by the Centers for Medicare and Medicaid Services for coverage by Medicare.
  - It's a health product or service that is not considered to have demonstrated value based on clinical evidence reported by Peer-Review Medical Literature and by generally recognized academic experts.
- Chiropractic services.
- All health services rendered during a member's incarceration in any jail, prison, or other correctional facility.
- Any type of health service, supply or treatment not specifically listed or referred to in this Handbook is not covered.

The following services are not covered by us but you may receive these services through DMAS or your local health department. Call Aetna Better Health Member Services at **1-800-279-1878**; (TTY/TDD: **711** or **1-800-828-1120**) for information on these services. You may also call DMAS to obtain a list of these services.
- Abortion
- Hospice
- School-based services. These are therapy, skilled nursing and psychiatric/psychological services outlined in the Individual Education Plan (IEP) and provided to children who qualify under the federal Individuals with Disabilities Act.
- Skilled nursing facility services

Aetna Better Health benefits do not include WIC (the Special Supplemental Nutrition Program for Women, Infants and Children). Aetna Better Health benefits do not provide transportation for you to pick up WIC checks. The Department of Health provides the WIC Program. We will send expectant mothers information on WIC in their Baby Matters material. If you want to find out more about WIC, call your local health department, or call toll-free 1-888-WIC-FOOD; **1-888-942-3663**.

Section 7

Complaints, Grievances, and Appeals

So that we can meet your needs, complaint, grievance and appeal procedures have been set up. You may use the Complaint, Grievance and Appeal Procedures if:
- You don't agree with the way we interpret this handbook.
- The quality and speed of service doesn't meet your needs.
- You don't agree with our decision not to preauthorize care.
- You're not happy with a provider assigned to you.
- You suspect Medicaid fraud or abuse.

If you're hearing impaired, or if you don't speak English or have a limited understanding of English, we'll provide oral language services. Language services include answering questions and providing help with filing claims, benefit requests, and filing appeals. The language service can also provide written interpretation of a written appeal request that may be received in a language other than English.

Call Aetna Better Health Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). Member Services is open from 8 a.m. to 5 p.m., Monday through Friday.

Inquiries

Inquiries are oral or written communications that Aetna Better Health Member Services receives from you or your representatives. Inquiries can be about:

- The rules allowing you or a family member to get and keep Aetna Better Health coverage
- The health care services available to you as an Aetna Better Health member
- The rules we have for you to get your health care services
- The handbook and other information we send to you
- Giving us your new address if you move
- PCP assignment
- Translation services

If you want to make an inquiry, call Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). We will make every effort to respond to your inquiry on that phone call. If we can't completely respond to your inquiry on the phone, we'll call or write you back within 30 working days of the inquiry. If you want to write to us, send the information to:

Aetna Better Health of Virginia
Attn: Member Services
9881 Mayland Drive
Richmond, Virginia 23233

We'll respond to your written inquiry in writing within 30 working days of the date we received the inquiry.

Complaints/grievances

Complaints/grievances are when you call or send a letter to Aetna Better Health to tell us you are not happy with any part of your benefits, services or Aetna Better Health.

If you:

- Do not agree with a decision made by Aetna Better Health
- Are not happy with any services received
- Are not happy about any other part of Aetna Better Health or your provider, you can file a complaint/grievance.

You may do this by calling Member Services at **1-800-279-1878** (TTY/TDD: **1-800-828-1120** or **711**) or writing it down and sending it to:

Aetna Better Health of Virginia
Attn: Grievance and Appeal Department
9881 Mayland Drive
Richmond, Virginia 23233

By doing this, you are filing a complaint to tell us why you do not like a decision. You have 30 calendar days after the event you are unhappy about to file a complaint/grievance. If you need help in completing any forms or help with any other procedural steps to file a complaint/grievance, including interpreter services, please call **1-800-279-1878** (TTY/TDD: **1-800-828-1120** or **711**).

If you call Member Services at **1-800-279-1878** (TTY/TDD: **1-800-828-1120** or **711**), we will take all of the information you give us and investigate the problem.

We may ask for the following information:
- Your name
- Your Aetna Better Health member ID number
- Your date of birth
- Your provider's name
- The date of service
- Your mailing address

A complaint/grievance should be resolved within 30 calendar days from the date we receive it. You will not be punished in any way for filing a complaint/grievance.

Appeals

If you are not happy with our answer to your complaint/grievance or we have denied any part of your request for a health care service, you or someone with your okay can file something called an appeal. To file an appeal, or to request assistance with filing an appeal, call our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). You have 30 calendar days after you receive our decision on your complaint/grievance or you receive denial for any part of your request for a health care service to file an appeal.

To file an appeal you will need to send us a written request that has:
- Your name
- Your provider's name
- The date of service
- Your mailing address
- An explanation of why we should reverse our decision
- A copy of any information that will support your request, such as additional documents, records or information that are relevant to your appeal

A written appeal needs to be mailed to:
Aetna Better Health of Virginia
Attn: Appeals Coordinator
9881 Mayland Drive
Richmond, Virginia 23233

If you are not able to file a written appeal, you can call us and we will ask for the information listed above and document the appeal for you. We will let you know we've received your appeal and you can get copies of documents, records and information about the appeal. We'll give these documents to you for free.

A committee comprised of persons not involved with the original decision will look at your appeal. If your appeal involves a medical (clinical) issue, the committee will include a health care professional whose training and experience qualifies him or her to make a decision on this medical issue. If your appeal is administrative (not based on a medical issue), the committee will consist of members of our senior management staff. If desired, you can participate in the meeting and speak to members of the committee. You may also ask a doctor, health care provider or member representative to meet with the committee in your place. If you decide to meet with the committee, you will be provided a toll-free number to call.

An appeal should be resolved within 30 calendar days from the date we receive it. If we need more time or more information for the appeal, or if you want to provide more information, you or we can ask for 14 additional calendar days to finish the appeal. If we need more time or information for the appeal, you will be sent a written notice of the delay and the reasons for it before the day 14. You will have the right to file a

grievance if you disagree with the reason for the delay in the appeal decision. If you want to provide more information to us regarding the appeal, you must request the extension before the day 14. The time to make a decision on an appeal can be extended up to 14 more days if you or we need the extra time.

Fast (Expedited) Appeals

There is a fast appeal process to respond to cases where death or serious injury could result or in cancer patients when a delay in a decision could result in severe pain to the patient. This is also called an expedited appeal. You may call us at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) for this type of appeal. If we allow the fast (expedited) appeal, we will make a decision within 72 hours from the initial receipt of the appeal. For appeals relating to prescriptions for pain for cancer patients, the decision will be made in 24 hours or less. If you want to provide more information or if it's your interest, you or we can ask for 14 additional calendar days to finish the appeal. If we need more time or information for the appeal, you'll be sent a written notice of the delay and the reasons for it.

We do not punish your doctor in any way for requesting a fast appeal or for supporting your request for a fast appeal.

If we decide your appeal is not a fast appeal, we will handle your appeal like a regular appeal. You and your doctor will receive a phone call or a letter letting you know that we will be following the normal appeal process. We will let you know what the normal appeal process time frames are when we call or send you and your doctor the letter.

State Fair Hearings Process

If you are not happy with our appeal and your appeal is about our decision to deny, reduce, change or terminate payment for your health care services, you can request a State Fair Hearing if it is within 30 days of the notice of the appeal decision from us. You can also request a State Fair Hearing at the same time as or instead of appealing to us. You can only request a State Fair Hearing if it relates to a denial of a service, a reduction in service, termination of a previously preauthorized service, or failure to provide service timely. Your request for a State Fair Hearing should be in writing and sent to:

Division of Appeals
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
1-804-371-8488

Reporting fraud and abuse

Committing fraud or abuse is against the law. Fraud is a dishonest act done on purpose.

Examples of fraud are:
- Letting someone else use your Aetna Better Health ID card(s) or
- Getting prescriptions with the idea of abusing or selling drugs

An example of provider fraud is:
- Billing for services not provided

Abuse is an act that does not follow good practices. An example of member abuse is:
- Going to the emergency room for something that is not an emergency

Examples of provider abuse are:
- Prescribing a more expensive item than needed
- Giving you treatment or services you do not need

You should report instances of fraud and abuse to Aetna Better Health of Virginia Fraud and Abuse Help Line at **1-844-317-5825** (TTY/TDD: **1-800-828-1120** or **711**) or e-mail: **reportfraudabuseVA@aetna.com**.

Your Benefits During the Appeal or State Fair Hearing Process

While your appeal or state fair hearing is in process, your Aetna Better Health benefits will continue if:
- You or your doctor files the appeal within 10 days of the date on the notice to deny, reduce, change or end payment for your health care services or before the effective date of the notice.
- Your appeal is about our decision to terminate, suspend or reduce a course of treatment that was already preauthorized.
- The services were ordered by an authorized provider.
- The time frame covered by the preauthorization has not passed.
- You request that your benefits be extended.

To request a continuation of benefits, call Aetna Better Health Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

While the appeal is pending, your benefits will continue until:
- You withdraw the appeal
- The time frame of the preauthorization has been met
- The service limit of the preauthorization has been met

If the final result of your appeal is to uphold the original decision, your benefits will not continue past 10 days after we mail the results. If you request to continue your benefits pending a State Fair Hearing decision, your benefits will continue until a State Fair Hearing officer upholds our original decision.

If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, we may take back the money that was paid for the services while the appeal was in process.

Other contacts

You may address complaints about HMOs to the following:

State Corporation Commission
Bureau of Insurance
P.O. Box 1157
Richmond, Virginia 23218
1-804-371-9741, local or out-of-state calls
1-800-552-7945, in-state toll-free number
1-877-310-6560, national toll-free number

Virginia Department of Health
The Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463
1-800-955-1819, in-state toll-free number

You may address complaints about providers to the following:

The Commonwealth of Virginia
Health Professions Department
6603 West Broad Street, 5th Floor
Richmond, Virginia 23230
1-800-533-1560, in-state toll-free number

All claims or complaints of any nature against us, our employees, agents, board members, or officers, whether filed by a member, or a spouse, heir, or personal representative of a member must first go through the Complaint, Grievance and Appeal Procedures discussed above before any action or proceeding may be sought in court.

If you suspect fraud or abuse and you report your concern to us, we will notify DMAS or the State Corporation Commission Bureau of Insurance right away. In no case will it take more than 48 hours from the date it is reported to us to notify DMAS or the State Corporation Commission Bureau of Insurance.

It is our policy to respond promptly to complaints, grievances and appeals through all stages of the process. For more information or to get a copy of the complete process, please call Aetna Better Health Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

For questions or concerns regarding your Medicaid/FAMIS Plus eligibility, call DSS.

Section 8

Eligibility and Enrollment

Eligibility

No person is eligible to enroll in Aetna Better Health unless approved by DMAS and DSS. For eligibility questions or concerns, call DSS.

DMAS pays us a monthly premium for your Aetna Better Health coverage. If you are found to be not eligible for Aetna Better Health coverage for past months because you did not give truthful information to your case worker or tell your case worker about changes in your circumstances, you may have to pay DMAS back for these premiums even if you do not get medical services under Aetna Better Health benefits during these months.

Enrollment

DMAS will give us the name, address, age and sex of each member enrolled in Aetna Better Health. The effective date of your enrollment will be on your Aetna Better Health ID card. DMAS determines your continued enrollment in Aetna Better Health based upon your Medicaid/FAMIS Plus eligibility. To stay enrolled in the program, it is important to complete any review forms as soon as you receive them from DSS. Return them to DSS by the date requested.

Changes in Enrollment

When your family size changes, you move, or get health insurance other than Medicaid, call Aetna Better Health Member Services and your local DSS. Aetna Better Health Member Services can be reached at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**). Call Member Services if:

- You have a new person in your family.
- Someone leaves your family home.
- You move. If you move from your current address, we may not be able to cover you under the Aetna Better Health program but we will help you continue to get services until you are disenrolled. Aetna Better Health Member Services will be able to tell you if your new address is in our service area. Contact your local DSS if you move. You may be disenrolled from the Medicaid program if your mail is returned to DSS.

Babies born to mothers enrolled in Aetna Better Health will be automatically enrolled in Aetna Better Health for the birth month plus two more months. **call your local DSS to get a Medicaid/Famis plus ID number for your baby**. This is important to make sure your baby does not have a problem receiving care. If your baby does not have a Medicaid number by the end of the third month, your baby will no longer be covered by Aetna Better Health or Medicaid.

FAMIS MOMS: Babies born to FAMIS MOMS will be enrolled automatically in Aetna Better Health for the birth month plus 2 additional months. **Please call your local DSS to get a Medicaid/FAMIS Plus ID number for your baby.** This is important to make sure your baby does not have a problem receiving care. If the baby does not have a Medicaid/FAMIS Plus ID number by the end of the third month following birth, the baby will lose coverage.

Waiver Program: If you become enrolled in a waiver program, Aetna Better Health will send you a letter letting you know DMAS has told us about your waiver.

- Aetna Better Health Medical Services - use your Aetna Better Health ID card to receive covered medical services as described in this Handbook. For transportation to medical services, call the number on your Aetna Better Health ID card.
- Waiver Services - use the DMAS Medicaid blue and white ID card to receive waiver services. For transportation to waiver services, call LogistiCare at **1-866-386-8331**.

Disenrollment

You can ask to stop your membership with Aetna Better Health at any time within the first 90 days of enrollment, for any reason. Just call our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) and someone will tell you what needs to be done to stop your membership. You may also call the Managed Care Helpline directly at **1-800-643-2273**.

You will be disenrolled if: (1) Medicaid/FAMIS Plus eligibility is lost; or (2) you lose eligibility for continued enrollment due to a change in eligibility or institutional status (hospice, skilled nursing). Your Aetna Better Health coverage will end on the date of termination, even if you are in the hospital on that date.

Termination

All rights to benefits, including hospital care, shall end on the date termination takes effect, except as stated above. Your Aetna Better Health coverage will end if:

- DMAS disenrolls you as a member.
- You are no longer eligible for Medicaid through the commission of Medicaid fraud. Your Aetna Better Health coverage will end at the end of the month you lose eligibility. In the absence of fraud, all statements made by a member shall be considered representations and not warranties. No statement shall be the basis for

voiding coverage or denying a claim after this coverage has been in force for 2 years from its effective date. But, if the statement was material to the risk and was contained in a written application, coverage may be void beyond the 2-year period.
- The contract between us and DMAS ends. In such a case, coverage shall end for all Aetna Better Health members on the date termination takes effect. DMAS will let you know the date of termination, and the process by which you can continue to get care.

Except as stated in this handbook, care is not covered through us after your Aetna Better Health coverage ends. This includes care that relates to an injury or illness that began before your Aetna Better Health coverage ended.

Section 9

Terms and conditions

Filing claims

Most claims will be filed for you by Aetna Better Health providers. You may have to file claims if you get care outside the Aetna Better Health network. You can get the claim forms from Aetna Better Health Member Services by calling **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**) . Claims should be sent to:
Aetna Better Health of Virginia
P.O. Box 63518
Phoenix, AZ 85082-3518

We will pay you back for needed health care you pay for, up to the Medicaid allowed amount. You must send the claim and receipt that shows what you paid to us. We must receive claims you submit within 365 days from the date of service. Incomplete claim forms will be returned to you.

Copayments

There are no copayments required for any service covered by this Handbook.

If you get a bill or statement

You shouldn't get a bill from or have to pay a network provider for covered benefits or pre-approved services.

If your provider didn't receive payment from us on a provided covered benefit or service, he or she is NOT allowed to bill you for what we didn't pay. This is called balance billing.

Also, you don't have to pay if we don't pay a network provider for covered benefits or services.

Finally, you're not liable to pay for a provided covered benefit or service in the event that we didn't receive payment from the Department.

If you receive a bill from a network provider, you should call the health care provider listed on the bill and make sure they have all of your insurance information. If the provider has your insurance information and you were billed or if you get a bill that you think you should not have gotten, call Aetna Better Health Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

You may get billed for these services:
- Services by out of network providers
- Services without pre approval or prior authorization

Aetna Better Health is only liable for services that are our responsibility.

Relationship to contracting parties

Aetna Better Health doctors have a doctor-patient relationship with you and are solely responsible for all health care. The relationship between us and providers in the Aetna Better Health network is an independent contractor relationship. Aetna Better Health providers are not employees or agents of Aetna Better Health. Neither we nor any person who works for us works for or is an agent of any Aetna Better Health provider. Members are not agents and do not represent us. Members are not liable for any acts or omissions by us, our agents or employees. Members are not liable for any acts or omissions of any other person or company with which we have made or will make arrangements for covered care.

Advance directives

For members 18 years and older, federal law and the Health Care Decisions Act in Virginia gives you the right to decide the medical care you want. You should let your doctor or other health care provider know what specific health care you want or do not want if you become very sick or have a life threatening illness. You can also let your doctor or other health care provider know if you want someone else to make medical decisions for you when you are medically or mentally unable to do so. These are called advance directives. Advance directives can include a living will or medical power of attorney. Your doctor or other health care provider will write down your wishes or make a copy of your written wishes if you already have them. These advance directives will be made a part of your medical records. You may change your mind at any time by putting your change in writing. We will tell you if the law changes within 90 days of the change.

You should tell your doctor or other health care provider if you have certain moral and/or religious beliefs that would stop you from making advance directives. Your doctor or other health care provider will write down your objections to making advance directives and will make this a part of your medical records.

If you have questions about advance directives, call our Member Services at **1-800-279-1878** (TTY/TDD: **711** or **1-800-828-1120**).

Changes

Any statement, term, benefit, or condition of coverage and this handbook may be changed or removed to meet the terms of the agreement between us and DMAS. DMAS needs to approve any changes. Changes may be made without your consent.

Entire agreement

You are covered under our contract with DMAS. DMAS reimburses us for care provided for in the contract. If there is any difference between what is in this handbook and what is in the contract between us and DMAS, the contract will control. You can call DMAS if you have questions about the contract between us and DMAS.

The following items listed make up the entire agreement between you and Aetna Better Health:
- The Member Handbook, its attachments and amendments
- The Aetna Better Health ID card
- The contract between us and DMAS, its attachments and amendments

No part of our charter, by-laws or other document shall constitute part of this contract except as set forth in this handbook or in the Group Enrollment Agreement. No verbal statements made by us shall change the terms of the agreement.

Notice of Insurance Information Practices (NIIP)

The following is a brief notice of our Insurance Information Practices. Please be aware of the following:

- Personal information about the individual proposed for coverage may be collected from persons other than that individual.
- Personal information, as well as other personal or privileged information subsequently collected by us, may be disclosed to third parties without your authorization in order to better coordinate your care.
- You have a right of access and correction with respect to all personal information collected.

If you request, we will provide you with a complete description of our Insurance Information Practices, which includes:

- From whom, other than yourself, personal information may be collected.
- The types of personal information that may be collected and the types of sources and investigative techniques that may be used to collect such information.
- To whom we will disclose information and the circumstances under which such disclosures may be made without your prior authorization.
- A description of your rights by law to be able to access, correct, amend or delete recorded personal information.

For further information, you may write to the Aetna Better Health Member Services Department at the address on the back of this handbook.

Medical and other privileged information provided to us is kept confidential. Such information will be used only for administration of your benefits or for coordinating benefits with other plans.

Coordination of Benefits

If you or a dependent is entitled to any other health care coverage besides Medicaid/FAMIS Plus, you need to tell us, DSS and DMAS.

An example would be if you or your child is covered under health care coverage of some other person, such as a grandparent or natural parent who does not have custody.

If a benefit is covered by us through Aetna Better Health and by another group health care plan (this includes government plans), we will coordinate benefits with such other plan. No more than 100% of the eligible incurred expenses are paid. The benefits provided by us through the Aetna Better Health shall be secondary to any such other plan. If we are secondary, we will provide and arrange for your needed services before coordinating with the other plan.

When we pay a total amount that is more than the highest amount of payment needed to meet the intent of this section, we shall have the right to get back such payments. We shall only have the right to get back the excess amount. We shall have the right to get this back from:

- Any persons to or for or with respect to whom such payments were made
- Any other plan

Each member must give us any information needed to apply this section.

Transfer of benefits and payments

The covered care you get under your handbook belongs only to you. You may not transfer your right to get covered care to someone else.

You may not transfer your right to get payment for covered care. Prior payments to anyone, whether or not there has been a transfer of payment, shall not be a waiver of, and shall not restrict, our right to send future payments to you or any other person or center.

Aetna Better Health Service Area

Alleghany County
Amelia County
Amherst County
Appomattox County
Bath County
Bedford City
Bedford County
Bland County
Botetourt County
Bristol City
Buchanan County
Buena Vista City
Campbell County
Caroline County
Carroll County
Charles City County
Chesterfield County
Colonial Heights City
Craig County
Covington City
Cumberland County
Dickenson County
Dinwiddie County
Essex County
Floyd County
Franklin County
Galax County
Giles County
Goochland County
Grayson County
Hanover County
Henrico County
Henry County
Highland County
Hopewell City
King and Queen County
King William County
Lancaster County
Lee County
Lexington City
Lunenburg County
Lynchburg City
Martinsville City
Mathews County
Mecklenburg County
Middlesex County
Montgomery County
New Kent County
Northumberland County
Norton City
Nottoway County
Patrick County
Petersburg City
Powhatan County
Pulaski County
Prince George County
Radford City
Richmond City
Richmond County
Roanoke City
Roanoke County
Rockbridge County
Russell County
Salem City
Scott County
Smyth County
Surry County
Sussex County
Tazewell County
Washington County
Westmoreland County
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