

AETNA BETTER HEALTH®

MEMBER HANDBOOK

ILLINOIS INTEGRATED CARE PROGRAM

Address: Aetna Better Health
One South Wacker Drive
Mail Stop F646
Chicago, IL 60606

Hours: Monday through Friday, except
State holidays, between 8:00 a.m. Central Time
and 5:00 p.m. Central Time

24/7 Member Services Hotline: 1-866-212-2851

Hearing Impaired (TDD/TTY): Illinois Relay 7-1-1

Website: www.aetnabetterhealth.com/illinois

PERSONAL INFORMATION

My Member ID Number

My PCP (Primary Care Provider)

My PCP's Phone Number

Welcome to Aetna Better Health®. This member handbook is for people who are enrolled in the Illinois Integrated Care Program, or ICP. The Integrated Care Program is for adults and older adults with disabilities, ages 19 and over, who are eligible for Medicaid but not Medicare.

Members enrolled with the Integrated Care Program and Aetna Better Health must live in one of the following counties:

- Suburban Cook (those areas with ZIP codes that do not begin with 606)
- DuPage
- Kane
- Kankakee
- Lake
- Will

This member handbook also has your Certificate of Coverage (below), which is required by state law. **The effective date of this Certificate of Coverage is the same as the date shown on the front of your Aetna Better Health identification card.**

How to Use Your Member Handbook and Certificate of Coverage

Please read this member handbook very carefully. Much of the information in this handbook is related. Reading just a few of the items or pages may not help you fully understand what you may want to know.

This Certificate of Coverage may be subject to amendment, modification, or termination by mutual agreement between Aetna Better Health Inc., an Illinois corporation ("Health Plan") and the Illinois Department of Healthcare and Family Services ("Department") without the consent of any member. Members will be notified of any such changes as soon as possible after they are made.

By choosing or accepting health care coverage under Aetna Better Health Inc., an Illinois corporation, members agree to all the terms and conditions in this Certificate of Coverage.

CERTIFICATE OF COVERAGE

This Certificate is issued by Aetna Better Health Inc., an Illinois corporation, operating as a health maintenance organization. In consideration of the Member's enrollment, Aetna Better Health shall provide and/or arrange for covered health care services to the Member in accordance with the provisions of this Certificate of Coverage.

IN WITNESS WHEREOF, Aetna Better Health has caused this Certificate of Coverage to be executed by its duly authorized officer on the date indicated below, under which Certificate coverage will begin on the Effective Date indicated on the Member's Aetna Better Health identification card.

EFFECTIVE DATE: May 1, 2011, Aetna Better Health Inc., an Illinois corporation



Robert Mendonsa
Chief Executive Officer, Aetna Better Health, Illinois

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HELPFUL PHONE NUMBERS

Topic	Contact Information
Other Communication Methods Please call Member Services if you want information in other formats. We have audio CD-ROM, large print, cassette tape or Braille.	1-866-212-2851
Behavioral Health Crisis 24 hours a day, 7 days a week	1-866-212-2851, then press 9
Behavioral Health Services For questions about benefits or help finding a behavioral health provider, call Member Services.	1-866-212-2851
Complaints, Grievances or Appeals If you have a complaint, grievance or appeal, call Member Services.	1-866-212-2851 Fax: 855-545-5196
Claims For questions about claims or bills call Member Services.	1-866-212-2851
Emergency If you have a medical condition that could cause serious health problems or even death if not treated immediately.	Call 911 or go immediately to the Emergency Room.
Enrollment and Disenrollment Call the Illinois Client Enrollment Broker if you have questions about eligibility or enrollment.	1-877-912-8880
Hearing Impaired (TDD/TTY)	Illinois Relay 7-1-1
Interpreter Services Language interpretation services, including sign language, are available free of charge. Call Member Services for help.	1-866-212-2851
Transportation Medical Transportation Management (MTM) For non-emergency transportation.	1-888-513-1612
Vision March Vision Care	1-888-493-4070
Prescriptions If you have questions about prescriptions, call Member Services. To sign up for mail order prescriptions, call Express Scripts, Inc. (ESI).	Member Services 1-866-212-2851 Express Scripts, Inc. (ESI) 1-866-698-1325 1-800-899-2114 (TTY)
Dental DentaQuest	1-800-416-9185 1-866-466-7566 (TTY)

WELCOME TO AETNA BETTER HEALTH®

Thank you for choosing Aetna Better Health® as your health plan.

If you have questions, call our Member Services Department toll free at 1-866-212-2851. Member Services can answer questions about your health benefits. We are here to help you. We are open 24 hours a day, 7 days a week.

MEMBER INFORMATION

Your health is important to us. Please read this handbook. It has good information about your health care services, such as:

- How the Member Services Department helps you
- Why it is important to have a Primary Care Provider (PCP) as your medical home
- Which services Aetna Better Health pays for
- Which services Aetna Better Health does not pay for
- How to get care and services
- Your rights and responsibilities
- How to make appointments with health care providers
- How to file a grievance or an appeal
- How to plan for your care if you can't tell providers what you want

MEMBER SERVICES DEPARTMENT

If you have questions, you can call Member Services toll free at 1-866-212-2851. We are here 24 hours a day, 7 days a week. We can answer your questions and give you information. Below is a list of some of the things we can help you with.

- Your rights and responsibilities
- Finding a PCP to be your medical home in your area
- Making an appointment with your PCP
- Changing your PCP
- How to get care from specialists, hospitals and other providers
- Your health care services
- Filing a grievance or appeal
- Making an address, telephone or e-mail

address change

- Getting a free interpreter (language services, including sign language)
- Getting information in a language other than English
- Getting information in other ways, like audio CDs, large print, cassette tape or Braille
- Getting a ride to your provider appointments
- Getting behavioral health care
- Getting dental care
- Getting your medicines
- Getting medical supplies
- Health and wellness programs for members ages 19-20
- Family planning
- Pregnancy care
- Where to get help for domestic violence or elder abuse

Please call us at 1-866-212-2851 for help.

Language Services

Please call 1-866-212-2851 if you need help in another language. We will get you an interpreter in your language. We can also help if you need sign language interpretation. You can also use this service at your health care provider's office. You must call at least three business days in advance to set up this interpretation. Specialized interpretation services, such as tactile interpretation, must be set up at least ten business days in advance. This service is available at no cost to you.

You can get this member handbook interpreted in another language. Call Member Services at 1-866-212-2851 to ask for help.

Other Ways to Get Information

If you have a hearing disability, please call the Illinois Relay at 7-1-1. Illinois Relay can help in many ways:

- TTY users
- TTY users (Spanish)
- Voice users
- VCO (Voice Carry Over)
- Speech to speech
- ASCII
- Telebraille

If you have a hard time seeing or hearing, or you do not read English, you can get information in the following ways:

- Audio CD
- Large print
- Cassette
- Braille
- Website

Our website is www.aetnabetterhealth.com/illinois. It has information to help you get health care.

- Find a PCP or specialist in your area.
- Send us questions through e-mail.
- Get information about your benefits.
- Get health information.
- Get a copy of the member handbook.

ENROLLMENT

Confirmation of Enrollment

There is a confirmation letter in your welcome packet. It has your effective date of enrollment. It shows the name, phone number and address of the primary care provider (PCP) that you will go to for health care. Your identification (ID) card is included with the confirmation letter.

Open Enrollment

If you are new to Aetna Better Health, you will have 90 days from the date of your first enrollment to try the health plan. During the

first 90 days, you can change health plans for any reason. After the 90 days, if you are still eligible for the Integrated Care Program, you will stay enrolled in Aetna Better Health for the next nine months. This is called "lock-in."

At the end of your enrollment year, you will get a letter from the Illinois Client Enrollment Broker (ICEB). The letter will say that you can change health plans if you want to. The letter will give you the dates that you can make the change. You will have 60 days to change. This 60-day period is called "open enrollment." You can change health plans during your 60-day open enrollment period every year.

You do not have to change health plans, but you can if you want to. If you choose to change plans during open enrollment, you will be a member in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay with Aetna Better Health, you will be locked into that plan for the next 12 months.

Reinstatement

If you lose eligibility for 60 days or less and then become eligible again, you will be re-enrolled with Aetna Better Health. We will assign you to your past PCP if they are still accepting patients.

ID Card

You will get an ID card when you join. You need this ID card to get health care. Keep your ID card in a safe place. Show it whenever you need health care services.

Please call us at 1-866-212-2851 if:

- Your PCP's name or phone number are not on your ID card
- You don't have an ID card
- You lose your ID card
- You move or change your telephone number

We will send you a new ID card.

You are the only one who can use your ID

card. Do not give, loan or sell your ID card to anyone. Do not give the information on the ID card to anyone. If you give your card to someone, you could have problems getting health benefits.



Aetna
Better Health

Member ID# 000000000-00 Date of Birth 00/00/0000
 Member Name Last Name, First Name Sex X

PCP Last Name, First Name No Copay
 PCP Phone 000-000-0000 Effective Date 00/00/0000

RxBIN 003858 RxPCN A4 RxGRP KC2A
 Pharmacist Use Only 1-800-824-0898

THIS ID CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.
www.aetnabetterhealth.com/illinois

To verify member eligibility please call 1-866-212-2851.

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call 1-866-212-2851.

Send Medical Claims To Aetna Better Health
 Aetna Better Health Payer ID 26337
 PO Box 66545 Provider Claims Questions
 Phoenix, AZ 85082-6545 1-866-212-2851

Member Services	1-866-212-2851 (24 hours/7 days a week)
Behavioral Health Services	1-866-212-2851
Dental Services	1-800-416-9185
Hearing Impaired	Illinois Relay 7-1-1
Transportation Services	1-888-513-1612
Vision Services	1-888-493-4070

Privacy Notice

Your welcome packet has a Notice of Privacy Practices. It says how we use your personal information. It tells how you can get copies of your health records. It shows how to make changes in your records. Your health care information is private. We will only give it out if the law allows or if you let us give it out. For another copy, please call Member Services at 1-866-212-2851 or visit our website at www.aetnabetterhealth.com/illinois.

MEMBER RIGHTS AND RESPONSIBILITIES

You have rights and responsibilities as a member. You can use all of your member rights

without being treated differently. You can use all of your member rights without losing any health care services.

You have the right to information about your treatment or treatment options. You have a right to get this information in a language you understand. This information includes the following things.

- Names of health care providers and care managers
 - Copies of medical records as allowed by law
 - A description of our services or covered benefits
 - A description of your rights and responsibilities as a member, including the right to refuse treatment
 - How we provide for after-hours and emergency health care services
 - How we pay providers and manage costs
 - How you can use services
 - Member survey and grievance results
 - How much a service will cost you if it is not covered
 - How to get services
 - What type of authorization may be needed for services
 - A description of how we evaluate new technology for inclusion as a covered benefit
 - What treatment choices or types of care are available to you, and the benefits or drawbacks of each choice
 - Informing you about your right to make advance directives
 - Health care benefit or network changes
- You also have a right to respect, fairness and dignity. This includes the following rights.
- To get covered services without concern about payer source, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay or to speak English
 - Quality medical services that support your beliefs, medical condition and background

- Interpreter services if you do not speak English or you have impaired hearing
- Written information in other formats (e.g., audio CD-ROM, large print, cassette, Braille)
- To be free from any form of restraint or seclusion

You have a right to make decisions about your health care. You can also have a representative, such as a family member or friend, make decisions on your behalf. This includes the following rights.

- To choose a participating Primary Care Provider (PCP) to help with planning and coordinating care.
- To see a women's health care provider (WHCP) without a referral.
- Timely access to providers and care from a specialist when it is needed.
- Timely access to prescriptions from a network pharmacy.
- To know about all treatment options, no matter what they cost or whether they are covered.
- To be told about any risks in your care.
- To be told in advance if a proposed care or treatment is part of a research experiment and the right to refuse experimental treatments.
- To change your PCP.
- To request specific, condition-related information from a PCP.
- To request information about procedures and who will perform them.
- To decide who should be in attendance at treatments and examinations.
- To choose to have a female in the room for breast and pelvic exams.
- To refuse a treatment, including leaving the hospital, even though a provider advises against it, and requesting an explanation of consequences. Eligibility or medical care does not depend on your agreement to follow a treatment plan.
- To stop taking medications.
- To receive written notification when health

care services are reduced, suspended, terminated or denied. The notification has instructions on how to file a grievance or request a Fair Hearing from the Illinois Department of Healthcare and Family Services (DHFS).

You have a right to seek emergency care and specialty services. This includes the following rights.

- Getting emergency services without prior approval in an emergency
- Getting services from a specialist with a recommendation from the PCP
- Refusing care from a specialist you were referred to and request another recommendation
- Getting a second opinion

You have a right to confidentiality and privacy. This includes the following rights.

- Private and confidential health care information
- Information only given out as allowed by law
- Getting a copy of your medical records
- Asking for changes to the records
- Asking how your health care information has been given out
- Talking to providers and care managers privately

You have a right to report your concerns. This includes the following rights.

- Filing a complaint or grievance against Aetna Better Health or our providers
- Asking for a state fair hearing
- Asking for changes to policies and services
- Getting a detailed explanation if you are denied care that you think you should receive

You have the following responsibilities.

- Knowing the name of your assigned PCP and/or care manager
- Knowing your coverage and the rules you must follow to get care

- Telling us about any changes in eligibility, or any other information that may affect your membership, health care needs or access to benefits
- Respecting those who are providing services to you
- Sharing any concerns, questions or problems with us
- Providing all health information needed by providers
- Asking questions if you do not understand a treatment plan or health condition
- Following instructions and guidelines agreed upon with providers
- Protecting your ID card and showing it when you get health care
- Telling us about other insurance you have and about other benefits you may be eligible for
- Scheduling appointments during office hours, when you can
- Arriving at appointments on time
- Telling your providers when you have to cancel an appointment
- Following your providers' instructions
- Providing consent to managed care plans, health care providers and their designees for the purpose of providing patient care management, outcomes improvement and research

GETTING CARE

Aetna Better Health members must use in-network, contracted providers to obtain health care services.

Co-pays

Aetna Better Health members do not pay co-pays for standard Medicaid services, medications, or additional services offered by Aetna Better Health, such as transportation. This includes dental and vision services offered through DentaQuest and March Vision.

Providers may not bill Aetna Better Health members for any services, including co-pays.

If you do receive a bill from a provider, call Member Services toll-free at 1-866-212-2851. A Member Services representative will help you.

Provider Directory

Aetna Better Health's provider directory is online at www.aetnabetterhealth.com/illinois. It lists health care providers and hospitals in our network. The directory has the names of PCPs, Women's Health Care Providers (WHCPs), specialists, behavioral health and other health care providers in your area. You can also use the online directory to find a dentist, pharmacy or vision care provider.

Aetna Better Health members receive dental services from DentaQuest providers and eye care services from March Vision Care providers. See page 19 for more information about dental services. See page 20 for more information about vision services. See page 16 for more information about pharmacy services.

If you want help finding a provider for any of our services, call Member Services at 1-866-212-2851. They will be glad to help you. You may also call Member Services if you want a provider to be added to our network.

Your Medical Home

A medical home is the place where your primary care provider (PCP) is located. A medical home also includes the support team who works with your PCP to coordinate the services and care you need. The goal is to help you be as healthy as possible.

Having a medical home is important because it is the first place you go to get the care you need to stay healthy.

This is what having a medical home means.

- Your personal PCP gets to know you well.
- Your PCP works with your other health care providers, such as specialists and hospitals, to coordinate your care.
- You get better health care because your PCP

knows your health care needs.

- You can better understand your illnesses and how to care for yourself.
- You can understand how to get and take your medicine.
- You only use the emergency room for health care emergencies.
- The PCP may use other team members to help you get better care.

Your PCP may be one of the following types of health care providers.

- Family doctor
- General practitioner
- Internist
- Federally Qualified Health Center or a Rural Health Center
- Women's Health Care Provider (WHCP) or OB/GYN

In some cases, a specialist may be a PCP. If you have a specialist that you want to be your PCP, the specialist must call Aetna Better Health. There is a process the specialists must go through to be your PCP.

You most likely picked your PCP when you joined Aetna Better Health. If you did not pick your own PCP, the ICEB gave you one. Your PCP's name and phone number are listed on your ID card. Your PCP's address will also be on your welcome letter. If this information is not listed on your ID card, call Member Services at 1-866-212-2851.

It is important to choose the medical home that is right for you. If you don't already have a medical home and you need help choosing one, call Member Services at 1-866-212-2851.

Your Provider's Office

When you see your provider, ask him or her, and the office staff, these questions. By knowing the answers, you will be better prepared for getting health care services.

- What are your office hours?
- Do you see patients on weekends or at

night?

- What kinds of special help do you offer for people with disabilities?
- *(If you have a hearing disability)* Do you have sign language interpreters? (**Note:** if the provider's office does not have sign language interpreters, Aetna Better Health can provide you with a sign language interpreter at no cost to you. Call Member Services at 1-866-212-2851 at least three days before your appointment and ask to arrange for a sign language interpreter at your provider office visit.)
- Will you talk about problems with me over the phone?
- Who should I contact after hours if I have an urgent situation?
- How long do I have to wait for an appointment?

Other Questions to Ask

Use the questions below when you talk to your provider or pharmacist. These questions may help you stay well or get better. Write down the answers to the questions and always follow your provider's directions.

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Quick Tips about Appointments

Call your provider early in the day to make an appointment. Let them know if you need special help, like a sign language interpreter.

- Tell the staff person your symptoms.
- Take your member ID card with you.
- If you are a new patient, go to your first appointment at least 30 minutes early so you can give them information about you and your health history.
- Let the office know when you arrive. Check in at the front desk.
- If you need a ride to your appointment, call Medical Transportation Management (MTM) toll free at 1-888-513-1612. You must call at least three days in advance to set up your ride.

If you cannot go to your appointment, please call your provider's office before the appointment time to cancel. If you also have an appointment with the transportation company to pick you up, be sure to call them before the appointment to cancel your ride.

CHANGING YOUR PCP

It is a good idea to stay with your PCP. This will help your PCP get to know you and your health care needs. If you need to change your PCP, call Member Services toll free at 1-866-212-2851. Some reasons for making a change are below.

- You do not understand what your PCP says.
- You do not feel comfortable talking to your PCP.
- Your PCP's office is too far away.
- Your PCP's office building is not set up to accommodate people with disabilities.

If you need a provider directory to choose a new PCP, you can see one online at www.aetnabetterhealth.com/illinois. You can also call our Member Services Department for help at 1-866-212-2851. Our staff can help you choose or change your PCP. A letter and a new ID card with the changes will be sent to you with the changes. You may see your new PCP right away. Your new ID card will arrive in 10-14 days.

If Aetna Better Health finds out that your provider no longer will be in our network, we will let you know. You will get a letter in the mail from us within 15 business days after we find out. We will help you find a new provider. We will work with the new provider so you can continue any treatment your previous provider is giving you.

GETTING SPECIALIST CARE

Your PCP or Women's Health Care Provider (WHCP) can recommend a specialist to you if you have a specific problem. Your PCP or WHCP can also recommend a lab or hospital to you for special services. We may need to review and

approve service requests before you can get services. If it is medically necessary you can get a standing authorization to see a specialist. The specialist, lab or hospital will know how to get approval for these services.

SELF REFERRALS

You can see your PCP or a WHCP any time you need to. This is called a self referral. There are some other services you can self refer to. These include:

- Behavioral health
- Family planning
- Emergency services
- Shots (immunizations)
- Vision care
- Dental care

GETTING A SECOND OPINION

You can get a second opinion from another provider in our network. You can do this at no cost to you. If you need help finding a provider call Member Services at 1-866-212-2851. They will help you find another provider for a second opinion. If you go to a provider who is not part of our network, you may have to pay the cost of the visit.

PRIOR AUTHORIZATION

Some services must be approved before you can get them. This is called "prior authorization." If your provider thinks you need a service, they will ask us for prior authorization. Our medical staff makes decisions about the care and services you need. These decisions are based on three things:

- Your medical needs
- National clinical guidelines
- Information from your provider

If you are new to Aetna Better Health, we will honor prior authorizations of services from Medicaid or another health plan for 90

calendar days after you join.

Call Member Services at 1-866-212-2851 if you have questions about this.

Prior Authorization Steps

1. Your provider contacts us by phone, fax or online to ask for prior authorization. They tell us about the service and why you need it.
2. Our medical staff looks at the information to decide if the service can be approved. They may talk more with your provider.
3. If the service is approved, we tell your provider.
4. If the service is not approved, we send a letter to you and your provider. This is called a "Notice of Action letter." It explains the decision.
5. You and your provider can get a copy of the medical reasons used to make a denial decision.
6. If you disagree with the decision, you can file an appeal or ask for a State Fair Hearing. See "Grievance and Appeals" beginning on page 26 to learn more.

We do not reward a provider for denying, limiting or delaying coverage of health care services. We do not give money to staff that make medical necessity decisions to get them to turn down services.

You do not pay for medically necessary covered services. You may have to pay when we do not cover the service provided. Your provider should tell you that a service is not covered before you get it.

What is Medical Necessity?

When your provider asks for prior authorization, they must tell us why the service is medically necessary.

A service is medically necessary if it meets the descriptions below.

- It is appropriate.
- It is considered by other health professionals to be good medical practice.
- It meets Aetna Better Health's guidelines, policies and procedures.
- It is used to diagnose or treat a covered illness or injury.
- It is used to prevent an illness.
- It is used to help you get well or stay well.

This definition also applies to supplies and medicines.

COVERED SERVICES

Services covered by Aetna Better Health are listed below. Some limitations and prior authorization requirements may apply. All services must be medically necessary.* If you have questions about covered services, call Member Services at 1-866-212-2851.

Type of Care	Covered Services	Coverage and Benefit Limitations
Abortions		Covered benefit when necessary to preserve the woman's life or health or when the pregnancy is the result of rape or incest.

Type of Care	Covered Services	Coverage and Benefit Limitations
Ambulatory Surgery	<ul style="list-style-type: none"> ■ Preoperative examinations ■ Operating and recovery room services ■ All required drugs and medicines 	Covered benefit.
Behavioral Health	<p>Mental health services including but not limited to:</p> <ul style="list-style-type: none"> ■ Mental health assessment and/or psychological evaluation ■ Medication management ■ Community treatment and support, including peer specialists or family peer specialist support services ■ Therapy/counseling <p>Subacute alcohol and substance abuse treatment, including but not limited to:</p> <ul style="list-style-type: none"> ■ Outpatient treatment ■ Residential treatment ■ Detoxification ■ Psychiatric evaluation services ■ Day treatment 	Covered benefit.
Chiropractic	Services are limited to the treatment of the spine by manual manipulation.	Covered benefit.

Type of Care	Covered Services	Coverage and Benefit Limitations
Dental	<ul style="list-style-type: none"> ■ Exams (1 per year for members under age 21; limited to first visit per dentist for members over age 21) ■ Cleanings (2 per year) ■ X-rays ■ Fluoride treatments (1 per year for members under age 21) ■ Sealants ■ Fillings ■ Crowns (caps) ■ Root canals ■ Dentures ■ Extractions (pulling) ■ "Practice" visits for members to become more comfortable with the dentist's office ■ Mobile dental services for members in intermediate care facilities and nursing homes 	<p>Covered benefit.</p> <p>Call DentaQuest toll free at 1-800-416-9185/ TTY 1-866-466-7566 or see page 19 for more information.</p>
Dialysis – Outpatient		Covered benefit.
Medical Equipment and Supplies	<p>Nondurable medical supplies, including, but not limited to:</p> <ul style="list-style-type: none"> ■ Asthma medical supplies such as peak flow meter (not including medicine) ■ Diabetes testing supplies such as glucometer (not including medicine) <p>Durable medical supplies (DME) including but not limited to:</p> <ul style="list-style-type: none"> ■ Wheelchairs ■ Oxygen supplies ■ Apnea monitors 	<p>Covered benefit.</p> <p>The provider must get authorization for these services.</p> <p>The member must use a medical supply company or pharmacy that is in our network.</p>
Emergency Room		Covered benefit.
Emergency Transportation		Covered benefit.

Type of Care	Covered Services	Coverage and Benefit Limitations
Eye Care	<ul style="list-style-type: none"> ■ Routine eye exam (1 per year) ■ Glasses (1 pair per year) ■ Medically necessary contacts ■ Replacement glasses for members ages 19 and 20 as needed. This includes lenses and frames. ■ Replacement lenses for members ages 21 and older, when medically necessary. ■ One replacement pair of glasses each year if the first pair of glasses is lost or broken beyond repair, for members ages 21 and older. 	<p>Covered benefit.</p> <p>Call March Vision Care toll free at 1-888-493-4070 or see page 20 for more information.</p> <p>Limitations on exams and glasses:</p> <ul style="list-style-type: none"> ■ 1 per year
Family Planning	<p>Including but not limited to:</p> <ul style="list-style-type: none"> ■ Provider visit ■ Birth control and family planning education and counseling ■ Contraceptives (birth control) ■ Testing for sexually transmitted diseases and HIV ■ Sterilization 	<p>Covered benefit.</p> <p>Limitations on sterilization include:</p> <ul style="list-style-type: none"> ■ Age 21 or older ■ Completed consent form
Hearing Care	<p>Includes:</p> <ul style="list-style-type: none"> ■ Audiologist services ■ Hearing screening ■ Cochlear implants ■ Hearing aids and repairs 	<p>Covered benefit.</p>
Home Health Care		<p>Covered benefit.</p>
Hospice Services		<p>Covered benefit.</p>
Hospital - Inpatient		<p>Covered benefit.</p>
Hospital - Outpatient		<p>Covered benefit.</p>
Immunizations (Shots)		<p>Covered benefit.</p>
Laboratory Services/X-rays		<p>Covered benefit.</p>
Nurse Midwife Services		<p>Covered benefit.</p>

Type of Care	Covered Services	Coverage and Benefit Limitations
Maternity Care	<ul style="list-style-type: none"> ■ Prenatal care (before birth) ■ Labor and delivery ■ Postpartum care (after the baby is born) 	Covered benefit.
Nursing Care	Members under the age of 21 can get medically necessary in-home shift nursing and personal care services provided by a registered nurse (RN), licensed practical nurse (LPN) or Certified Nurses Aide under the direction of a qualified home health agency.	<p>Covered benefit for members ages 19- 20 who are not in the Medically Fragile Technology Dependent (MFTD) waiver.</p> <p>The home health agency providing the nursing services must be in our network.</p>
Organ Transplant		Covered benefit.
Orthotics/Prosthetics		Covered benefit.
PCP Visit		Covered benefit.
Podiatric Services		Covered benefit.
Provider Office Visits/ Preventive Care	<p>Includes:</p> <ul style="list-style-type: none"> ■ Periodic well adolescent visits (members 19-20) ■ Well woman visits ■ Well man visits 	Covered benefit.
Rehabilitative Services	<p>Including but not limited to:</p> <ul style="list-style-type: none"> ■ Occupational therapy ■ Physical therapy ■ Speech and language therapy 	Covered benefit.
Radiology		Covered benefit.

***Definition of medically necessary**

Aetna Better Health considers a service, supply or medicine to be medically necessary if it meets the descriptions below.

- It is appropriate.
- It is considered by other health professionals to be good medical practice.
- It meets Aetna Better Health’s guidelines, policies and procedures.
- It is used to diagnose or treat a covered illness or injury.
- It is used to prevent an illness.
- It is used to help you get well or stay well.

NON-COVERED SERVICES

The following are some services that Aetna Better Health does not cover. For more information call Member Services at 1-866-212-2851.

- Experimental procedures
- Cosmetic procedures or surgery
- Infertility testing and treatment
- Consultation requested by a third party or agency
- Acupuncture

BEHAVIORAL HEALTH SERVICES

If you have a behavioral health crisis, call the behavioral health crisis line at 1-866-212-2851; then press option 9. Help is available 24 hours a day, 7 days a week.

You can get treatment for substance abuse and other behavioral health issues through our provider network. You do not need a referral to see a behavioral health provider that is in our network. Call Member Services at 1-866-212-2851 to find out more about behavioral health services.

These are some of the behavioral health services we offer.

- Mental health assessment and/or psychological evaluation
- Medication management
- Community treatment and support including peer specialists or family peer specialist support services
- Therapy/counseling

We also cover treatment for substance abuse, such as:

- Outpatient treatment
- Inpatient treatment
- Day treatment
- Detoxification
- Psychiatric evaluation services

PHARMACY SERVICES

Prescriptions

Aetna Better Health covers prescription medications. You can get your prescriptions at no cost to you when:

- You get your prescriptions filled at a network pharmacy
- Your prescriptions are on our preferred drug list (also called a formulary)

It is important that you tell your provider or dentist about prescriptions you are already taking. Also, tell them about non-prescription medicine or vitamin or herbal supplements you may be taking.

Preferred Drug List

You can find out if your medicines are on the preferred drug list in one of two ways.

- Call Member Services toll free at 1-866-212-2851. Have a list of your prescriptions ready when you call. Ask the representative to look up your medicines to see if they are on the list.
- Go online to www.aetnabetterhealth.com/illinois to see the list of covered drugs.

Over-the-Counter Drugs

Aetna Better Health also covers certain over-the-counter drugs if they are on our list. Some of these may have rules about whether they will be covered. If the rules for that drug are met, Aetna Better Health will cover the drug. Like other drugs, over-the-counter drugs must have a prescription from a provider for them to be covered at no cost to you.

You can find out if your over-the-counter medicines are on the preferred drug list in one of two ways.

- Call Member Services toll free at 1-866-212-2851. Have a list of your over-the-counter medicines ready when you call. Ask the representative to look up your medicines to see if they are on the list.
- Go online to: 17
- www.aetnabetterhealth.com/illinois to see the list of covered over-the-counter drugs.

How to Get Your Prescriptions

Here is how to get your prescriptions as an Aetna Better Health member.

1. If you need medicine, your provider will choose a drug from our list of preferred drugs.
2. Your provider will write you a prescription. Ask your provider to make sure that the medicine is on the list.
3. Take the prescription to a network pharmacy to have it filled.
4. Show your Aetna Better Health member ID card at the pharmacy. As long as you show your member ID card and use medicines from the preferred drug list, you will not have to pay for your prescriptions.

How to find a Network Pharmacy

You can find a network pharmacy in one of two ways.

- Call Member Services toll free at 1-866-212-2851. Ask the representative to help you find a network pharmacy in your area.
- Go online to our website at www.aetnabetterhealth.com/illinois. Click on "Find A Provider." Then click on the link to "ESI Pharmacies" to search for a pharmacy in your area.

All prescriptions must be filled at a network pharmacy. Prescriptions filled at other pharmacies that are not in the Aetna Better Health network will not be covered.

Mail Order Prescriptions

If you take medicine for an ongoing health condition, you can have your medicines mailed to your home. Aetna Better Health works with a company called Express Scripts, Inc. (ESI), to give you this service, which you can get at no cost to you.

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

- Pharmacists check each order for safety.
- You can order refills by mail, by phone, online, or you can sign up for automatic refills.
- You can talk with pharmacists by phone at any time - 24 hours a day, 7 days a week.

You can sign up for this service in one of three ways.

- Call ESI toll free at 1-866-698-1325 Monday to Friday between 8 a.m. and 5 p.m., Central time. They will help you sign up for home delivery. If you say it's okay, they will call your provider to get a prescription. If you have trouble hearing, call ESI's TTY line toll free at 1-800-899-2114.
- Go to StartHomeDelivery.com. Then log in and sign up for Home Delivery. If you say it's okay, ESI will call your provider to get a prescription.
- Ask your provider to write a prescription for a 90-day supply with up to one year of refills. Call ESI and ask them to mail you a Home Delivery order form. When you receive the form, fill it out and then mail ESI the prescription and the order form. Mail the form to:

**Express Scripts
Home Delivery Service
PO Box 52101
Phoenix, AZ 85072-2101**

If Your Medicines Are Not on the Preferred Drug List

If your medicine is not on the preferred drug list, there are some things you can do.

- Ask your provider for a similar drug that is on the list.
- Ask your provider to ask Aetna Better Health to cover your drug through the prior authorization process. Your provider will know how to do this.

Refills

Your medicine bottle label says how many refills you can have. If your provider or dentist has not ordered refills and you think you may need a refill, you must call him or her at least five days before your medicine runs out. When

you call, ask your provider or dentist about getting a refill. They may want to see you before giving you a refill.

Questions to Ask About Your Medicines

Aetna Better Health wants you to be as healthy as possible. This includes being informed about the different medicines you may need to take. To help you, we have included a list of questions you should always ask your provider when he or she gives you a prescription.

- Why am I taking this medicine? What is it supposed to do for me?
- How should the medicine be taken? When? For how many days?
- Are there any side effects or possible allergic reactions to this medicine?
- What should I do if I have a side effect or allergic reaction?
- What will happen if I don't take this medicine?

Carefully read the drug information the pharmacy gives you with your medicine. It will tell you what you should and should not do while taking the medicine. If you still have questions after you get your medicine, ask to speak with the pharmacist or call your provider.

SERVICES FOR MEMBERS WITH DISABILITIES

Our care coordinators can help you with different needs. They can put you in touch with community services that you may find helpful.

- Setting up health care appointments
- Rides to appointments
- Making sure you can get needed health care services
- Helping you understand paperwork from your provider
- Support groups, if needed

For more information call Member Services at 1-866-212-2851.

SERVICES FOR MEMBERS WITH VISUAL DISABILITIES

Our care coordinators can help you with different needs. They can put you in touch with community services that you may find helpful.

- Making sure you can get member information on audio CD, in large print, on cassette or in Braille
- Setting up health care appointments
- Rides to health care appointments
- Making sure can get needed health care services
- Helping you understand paperwork from your provider
- Support group, if needed

For more information call Member Services at 1-866-212-2851.

SERVICES FOR MEMBERS WHO ARE SENIOR CITIZENS

Our care coordinators can help you with different needs. They can put you in touch with community services that you may find helpful.

- Setting up health care appointments
- Rides to health care appointments
- Making sure you can get needed health care services
- Helping you understand paperwork from your provider
- Becoming active at your local senior center
- Support groups, if needed

For more information call Member Services at 1-866-212-2851.

SPECIFIC SERVICES FOR MEMBERS AGES 19-20

We have a program for members ages 19-20 called EPSDT (Early and Periodic Screening, Diagnosis and Treatment). Members ages 19-20 can get checkups and covered health and

dental services at no cost. Follow-up treatment for any problems found during the checkup is also covered.

EPSDT services include:

- Health screenings
- Taking the member's medical history
- Blood and/or urine tests
- Shots (immunizations)
- Screening and testing lead levels in blood
- Checking the member's progress
- Vision, hearing and dental screenings
- Referral and follow up for conditions found during a health screen

An EPSDT checkup helps members ages 19-20 stay healthy or find problems that may need medical treatment. If you are a member age 19-20 years old, you should get these checkups. Aetna Better Health will send you a reminder to set up this important visit with your PCP.

TRANSPORTATION SERVICES

If you need a ride to your health care visits, please call Medical Transportation Management (MTM) toll free at 1-888-513-1612. You can also use this service to get a ride to the pharmacy to pick up your prescriptions, as long as the trip to the pharmacy takes place immediately after your provider visit. If you need a family member or personal care attendant to ride with you, they can at no cost to you.

If you have a medical emergency, dial 911. Use of emergency transportation must be for emergencies only.

You can call Medical Transportation Management (MTM) toll free at 1-888-513-1612 to set up a ride Monday - Saturday from 8 am - 6 pm Central time.

You need to set up a ride at least three days before your visit. You can also get a ride to the pharmacy if you go right after your provider visit.

Mileage reimbursement is available if you use your own car or get a ride from someone. You have seven days after your appointment to ask for mileage reimbursement. Call Member Services at 1-866-212-2851 and they will help you do this.

DENTAL SERVICES

Dental services are provided by DentaQuest's providers. Please call DentaQuest Member Services at 1-800-416-9185/ TTY 1-866-466-7566 for more information. You can find a dentist by linking to the DentaQuest provider directory on our website at www.aetnabetterhealth.com/illinois.

You may choose any general dentist from the list. If you need to change, just choose a new dentist from the same list.

See the covered benefits chart beginning on page 11 for a list of covered dental services.

Aetna Better Health also covers practice dental visits for members who ask for them. Here is what happens at a practice dental visit.

- You can come to the office.
- You can meet the staff.
- You can view the equipment.
- You can sit in the chair.
- You can ask questions.

No dental services are provided at a practice visit. The goal is to help you feel more comfortable with the dentist's office.

You are limited to one practice visit per dentist, with up to two practice visits (with two different dentists) per year. In other words, if you have a practice visit with a particular dentist but you are not comfortable with that dentist, you may have another practice visit with a second dentist within any given year. However, you may not have more than one practice visit with the same dentist.

Aetna Better Health also offers mobile dental

services for members who live in intermediate or nursing care facilities. To find out more, call DentaQuest Member Services toll free at 1-800-416-9185/TTY 1-866-466-7566.

EYE CARE SERVICES

Eye care services are provided by March Vision Care. If you have questions about eye care or vision benefits, call March Vision Care at 1-888-493-4070.

You do not need a referral to see a vision provider that is in our network.

Eye care services include:

- One routine eye exam each year.
- One pair of glasses each year.
- Medically necessary contact lenses.
- Replacement glasses for members ages 19 and 20 as needed. This includes lenses and frames.
- Replacement lenses for members ages 21 and older, when medically necessary.
- One replacement pair of glasses each year if the first pair of glasses is lost or broken beyond repair, for members ages 21 and older.

SERVICES FOR WOMEN

Women who are sexually active or who are age 19 and older should have a yearly well woman exam. Your PCP, WHCP or an OB/GYN provider can do this exam. You do not need to get a referral from your PCP to see a WHCP or an OB/GYN provider. You can find WHCPs or OB/GYN providers in the online provider directory at www.aetnabetterhealth.com/illinois. If you need help, call Member Services at 1-866-212-2851.

Your well-woman exam will include a screening for cervical cancer, which is called a Pap smear. This is an important test that can save your life. It is done right in your provider's office.

If you are age 40 or older, you should also have a mammogram every year. Your provider may offer this service in their office. Or you

may need to go to a special center that offers this service. These centers are called radiology or imaging centers. You can find one in your area by calling Member Services toll free at 1-866-212-2851. Tell the staff you want to find a location to get your mammogram. Or find a provider online at www.aetnabetterhealth.com/illinois.

Aetna Better Health will send you a reminder in the mail to make appointments for these important screenings.

FAMILY PLANNING SERVICES

You can receive family planning services from any provider without prior authorization or a referral from your PCP.

Aetna Better Health covers the following family planning services.

- Birth control counseling
- Birth control pills
- Birth control shots (Depo Provera)
- "Morning after pill" - no prior authorization needed
- IUD (Intra-uterine devices)
- Diaphragms
- Condoms
- Foams and suppositories
- Male and female sterilization for members ages 21 and older with completed consent form
- Natural family planning
- Medical and lab exams, including ultrasounds related to family planning
- Treatment of complications resulting from the use of birth control

The following are not covered family planning services.

- Infertility services, including diagnostic testing, treatment or reversal of surgical infertility
- Some methods of sterilization

PREGNANCY CARE

Pregnant women need special care. If you are pregnant, please call Member Services at 1-866-212-2851. They can help you with the following.

- Choosing a PCP, WHCP or OB/GYN for your pregnancy (prenatal) care
- Getting you into special programs for pregnant members, such as childbirth classes, or help getting healthy food through the Women Infants and Children (WIC) program

If you are not sure you are pregnant, make an appointment with your provider for a pregnancy test.

Here are some important reminders about pregnancy care.

- If you are pregnant and have chosen your pregnancy provider, make an appointment to see them.
- If you need help finding a provider, call Member Services at 1-866-212-2851.
- Your provider must set up a visit for you within 10 days of your call.
- Your provider will tell you about the schedule for pregnancy visits. Keep all of these appointments.
- Call Medical Transportation Management (MTM) toll free at 1-888-513-1612 if you need a ride to your appointments. You must call at least three days in advance to set up your ride.
- If you had a baby in the last two months and need a post-delivery checkup, call your provider's office.

Early and regular care is very important for your health and your baby's health.

Your PCP, WHCP or OB/GYN will tell you about the following:

- Regular pregnancy care and services
- Special classes for moms-to-be, such as childbirth or parenting classes

- What to expect during your pregnancy
- Information about good nutrition, exercise and other helpful advice
- Family planning services, including birth control pills, condoms and tubal ligation (getting your tubes tied) for after your baby is born

Healthy Pregnancy Tips

- During your pregnancy, your provider will tell you when you need to come back for a visit. **It is important for your health and your baby's health to keep all your appointments with your provider while you are pregnant.**
- Childbirth classes can help with your pregnancy and delivery. These classes are available at no cost to you. Ask your provider about the classes and how you can sign up for them.
- High lead levels in a pregnant woman can harm her unborn child. If you are pregnant, talk to your provider to see if you may have been exposed to lead.
- **If you are pregnant, it is important that you do not smoke, drink alcohol or take illegal drugs because they will harm you and your baby.**

After You Have Your Baby

You should see your own PCP, WHCP or OB/GYN within 3-8 weeks after your baby is born. You will get a well-woman checkup to make sure you are healthy. Your PCP will also talk with you about family planning.

TYPES OF CARE

There are three different kinds of health care you can get: preventive, urgent and emergency.

The chart on the next page gives you examples of each type of care and tells you what to do. Always check with your PCP if you have questions about your care. If you have an emergency, call 911 or go to the nearest emergency room.

Type of Care	What to do
<p>Preventive - This is regular care to keep you healthy. For example:</p> <ul style="list-style-type: none"> ■ Checkups ■ Yearly exams ■ Shots (immunizations) 	<p>Call your provider to make an appointment for preventive care. You can expect to be seen by:</p> <ul style="list-style-type: none"> ■ Your PCP within 21 days ■ A specialist within 45 days ■ A dentist within 45 days
<p>Urgent/Sick Visit - This is when you need care right away, but you are not in danger of lasting harm or of losing your life. For example:</p> <ul style="list-style-type: none"> ■ Sore throat ■ Flu ■ Migraines <p>You should NOT go to the emergency room for urgent/sick care.</p>	<p>Call your PCP. Even if it is late at night or on the weekends, the PCP has an answering service that will take your message. Your PCP will call you back and tell you what to do.</p> <p>You can also go to an urgent care center if you have an urgent problem and your provider cannot see you right away. Find an urgent care center on our website at www.aetnabetterhealth.com/illinois.</p> <ul style="list-style-type: none"> ■ For urgent/sick visits, you can expect to be seen by: ■ Your PCP within 2 days ■ A specialist or dentist within 3 days
<p>Emergency - This is when one or more of the following is happening.</p> <ul style="list-style-type: none"> ■ You are in danger of lasting harm or the loss of your life if you do not get help right away. ■ For a pregnant woman, she or her unborn child is in danger of lasting harm or losing their life. ■ Your bodily functions are seriously impaired. ■ You have a serious problem with any bodily organ or body part. 	<p>Call 911 or go to the nearest emergency room. You can go to any hospital or facility that provides emergency services and post-stabilization services.</p> <p>The Provider Directory at www.aetnabetterhealth.com/illinois contains a list of facilities that provide emergency services and post-stabilization services. You can also call Member Services toll free at 1-866-212-2851 and ask for the name and location of a facility that provides emergency services and post-stabilization services.</p>

Type of Care	What to do
<p>For example:</p> <ul style="list-style-type: none"> ■ Poisoning ■ Sudden chest pains - heart attack ■ Other types of severe pain ■ Car accident ■ Seizures ■ Very bad bleeding, especially if you are pregnant ■ Broken bones ■ Serious burns ■ Trouble breathing ■ Overdose <p>What is Not an Emergency? Some medical conditions that are NOT usually emergencies:</p> <ul style="list-style-type: none"> ■ Flu, colds, sore throats, earaches ■ Urinary tract infections ■ Prescription refills or requests ■ Health conditions that you have had for a long time ■ Back strain ■ Migraine headaches <p>What are Post-Stabilization Services? These are services related to an emergency medical condition. They are provided after the person's immediate medical problems are stabilized. They may be used to improve or resolve the person's condition.</p>	<p>But you DO NOT have to call anyone at the health plan or call your provider before you to an emergency room. You can go to ANY emergency room during an emergency - or for post-stabilization services.</p> <p>If you can, show the facility your Aetna Better Health ID card and ask the staff to call your provider.</p> <p>You must be allowed to remain at the hospital, even if the hospital is not part of our provider network (in other words, not an Aetna Better Health hospital), until your condition is stable and you can safely be transferred to a hospital within our network.</p>

AFTER HOURS CARE

Except in an emergency, if you get sick after your PCP's office is closed, or on a weekend, call the office anyway. An answering service will make sure your PCP gets your message. Your PCP will call you back to tell you what to do. Be sure your phone accepts blocked calls. Otherwise, your PCP may not be able to reach you.

You can even call your PCP in the middle of the night. You might have to leave a message with the answering service. It may take a while, but your PCP will call you back to tell you what to do.

If you are having an emergency, you should ALWAYS call 911 or go to the nearest emergency room.

OUT-OF-AREA COVERAGE

Aetna Better Health covers Integrated Care Program members who live in the following counties:

- Suburban Cook (areas with ZIP codes not beginning with "606")
- DuPage
- Kane
- Kankakee
- Lake
- Will

If you plan to take a trip away from home, please call your care manager or Member Services at 1-866-212-2851 so we can help you stay healthy while you are away.

If you get sick in another county or state, we will only pay for **emergency services**. If you have an emergency while you are away from home, go to the closest emergency room. When you get there, show your member ID card to the hospital and tell them you are an Aetna Better Health member. Ask the hospital

to send the bill to us for payment. **Do not pay the bill yourself.**

Follow-up care is not covered while you are away. You should get follow-up care from your PCP when you get home.

Aetna Better Health **does not** cover services outside of the United States.

Sometimes the care you need is not close to where you live. In these cases, we may approve health care services in another county or state. If so, we may pay for your ride, stay and food costs. Aetna Better Health will only pay for these services if we approve them first.

SERVICES FOR SPECIAL HEALTH CARE NEEDS

We have a program called Integrated Care Management, or ICM, that supports people with special health care needs. This program helps people who have the following types of special needs.

- Disabilities
- Behavioral health concern
- Chronic condition, like asthma or diabetes
- Other special needs

We are here to help as much or as little as you want us to.

If you are in the ICM program with Aetna Better Health, you will work with a team of people. Your team may include the following people:

- Case manager
- Care management associate

Sometimes your team may include both. Your team has experience in supporting people with special health care needs. They will work with you and your providers to create a care plan and bring together your health care or other services that you may need. Their goal is to help everything run smoothly.

Your team can help you learn more about your health care needs. They will support you in working with your providers to meet the health goals that are important to you.

If you are our member and you would like to participate in this program, you can. Providers, family members or caregivers can also refer a member for care management. Call Member Services at 1-866-212-2851 to ask about our ICM program.

Aetna Better Health also offers telemonitoring services. Telemonitoring is for members who have ongoing health conditions that need extra attention. Telemonitoring uses special equipment to check on members' health at home, when needed. Health conditions that can be monitored at home include blood pressure, blood sugar, pulse and weight, among others.

Your case manager can help determine if you need this service. Call Member Services toll free at 1-866-212-2851 to find out more.

HEALTH TIPS

Below is a list of some useful health tips.

- See your PCP for regular checkups.
- Always go to your PCP visits. If you cannot keep your appointment, call to cancel it and make another one.
- Follow the directions your PCP gives you.
- If you take prescription medicine every day, get refills at least five days before you run out.
- Never share your medicine with anyone else.
- Eat right, get enough sleep and exercise.
- Brush your teeth at least two times a day.
- Always wear your seat belt when you are in a car.

HEALTH GUIDELINES FOR ADULTS

Adults need regular checkups to stay healthy. Here are some important tests and checkups for adults. Please refer to the Types of Care section of this handbook for Aetna Better Health's coverage frequency.

Health Exams	
Age	How Often and Other Details
19-25	Every 5 years
26-39	Every 5 years
40-49	Every 3 years
50-65	Every 1-2 years
65 and older	Every 1-2 years
Mammogram	Every year for women starting at age 40.
Pap tests (cervical cancer screening)	Every one to three years for women starting at age 19 or when sexually active. Frequency may decrease when there is no history of abnormal Pap tests and three or more tests are normal.
Prostate exams	For men starting at age 40. Frequency to be determined by the PCP based on individual circumstances.
Diabetes screening	Test at age 45 for adults with no symptoms and then every three years.

Age	How Often and Other Details
Shots (immunizations) Check with your provider to see if you need any of these shots.	<ul style="list-style-type: none"> ■ TD (tetanus and diphtheria) ■ Pneumococcal (pneumonia) ■ Influenza (flu) ■ Hepatitis A and B ■ MMR (measles, mumps and rubella) ■ Varicella (chicken pox) ■ Meningococcal (meningitis)

COMPLAINTS, GRIEVANCES AND APPEALS

We want you to be happy with services you get from Aetna Better Health and our providers. If you are not happy, you can make a complaint to us.

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service.

Aetna Better Health takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. Aetna Better Health has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits coverage.

These are examples of when you might want to file a grievance.

- Your provider or an Aetna Better Health staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or an Aetna Better Health staff member was rude to you.

- Your provider or an Aetna Better Health staff member was insensitive to your cultural needs or other special needs you may have.

You can make your grievance on the phone or in writing. You can call Member Services for help at 1-866-212-2851. You can also send or fax a letter telling us about your grievance to:

Aetna Better Health
 Attn: Grievance and Appeals Dept.
 One South Wacker Drive, Mail Stop F646
 Chicago, IL 60606
 Fax: 1-855-545-5196

In the letter, give us as much information as you can. For example, include the date the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance.

If you do not speak English, we can provide an interpreter at no cost to you. If you are hearing impaired, call the Illinois Relay at 711.

You can have someone represent you, such as a family member, friend or provider. You must agree to this in writing. Send us a letter telling us that you want someone else to represent you and file a grievance for you. Include your name, member ID number from your ID card, the name of the person you want to represent you and what your grievance is about. When we get the letter from you, the person you picked can represent you. If someone else files a grievance for you, you cannot file one yourself about the same item.

We will try to resolve your grievance right away. If we cannot, it will go to our Grievance Committee. We may contact you for more information. The Grievance Committee will make a decision within 30 calendar days from the date you filed your grievance. You will get a letter from Aetna Better Health with our decision.

The time for making a decision about your grievance can be extended by up to 14 calendar days. We may extend the time to collect more information. You can also ask for an extension, if you need more time. If we do need more time, we will send you a letter explaining the reason for the delay.

If you don't like our decision, you may ask for a State Fair Hearing. To find out how to ask for a State Fair Hearing, see page 28.

Appeals

An appeal is a way for you to ask for someone to review our actions. The list below includes examples of when you might want to file an appeal.

- Not approving a service your provider asks for
- Stopping a service that was approved before
- Not paying for a service your PCP or other provider asked for
- Not giving you the service in a timely manner
- Not answering your appeal in a timely manner
- Not approving a service for you because it was not in our network

If we decide that the requested service cannot be approved, or if a service is reduced, stopped or ended, you will get a "Notice of Action" letter from us. This letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing from the Department of Healthcare and Family Services and how to do it

- Your right to ask for an expedited resolution and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it and when you may have to pay for the services
- You must file your appeal within 30 calendar days from the date on the Notice of Action letter. (See section on Prior Authorization, page 10).

Here are two ways to file an appeal.

Call Member Services at 1-866-212-2851. If you do not speak English, we can provide an interpreter at no cost to you. If you are hearing impaired, call the Illinois Relay at 711.

Write to us at:

Aetna Better Health
Attn: Grievance and Appeals Dept
One South Wacker Drive, Mail Stop F646
Chicago, IL 60606
Fax: 1-855-545-5196

You can have someone represent you when you file your appeal, such as a family member, friend or provider. You must agree to this in writing. Send us a letter telling us that you want someone else to represent you and file an appeal for you. Include your name, member ID number from your ID card, the name of the person you want to represent you and what action you are appealing. When we get the letter from you, the person you picked can represent you. If someone else files an appeal for you, you cannot file one yourself for that action.

You or your representative, including a provider acting with your written permission, may start an appeal within **30 calendar days** from the date on our Notice of Action letter. But if you want your services to continue while your appeal is reviewed, you must file your appeal no later than **10 business days** from the date on our Notice of Action letter. We can help you write your appeal, if needed.

What Happens Next

- We will send you a letter within three business days saying we got your appeal. We will tell you if we need more information.
- We will tell you how to give us more information in person or in writing, if needed.
- You provide more information about your appeal, if needed.
- You can see your appeal file.
- You can be there when the Appeals Committee reviews your appeal.
- The Appeals Committee will review your appeal. They will let you know if they need more information and will make a decision within 15 business days of receiving that information but no more than 30 calendar days. We will call you to tell you the decision. We will also send the results to you in writing. The decision letter will tell you what we will do and why.
- A provider with the same or like specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.
- The provider who reviews your appeal will not report to the provider who made the original decision about your case.
- We can extend the time for making a decision about your grievance by up to 14 days. We may extend the time to get more information. If we do this, we will send you a letter explaining the delay.
- You can also ask for an extension, if you need more time.
- If the Appeals Committee's decision agrees with the Notice of Action, you may have to pay for the cost of the services you got during the review. If the Appeals Committee's decision does not agree with the Notice of Action, we will let the services start right away.

How Can You Expedite Your Appeal?

You may start an appeal within 30 calendar days from the date of the Notice of Action letter.

However, if the usual time for an appeal will harm your health, you can ask us to make an expedited decision. You or your provider can ask for an expedited resolution by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action letter, information about your case and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. We will call you with the decision within 24 hours after we receive all the information we asked you for.

You can ask that your services continue while you start an appeal if you start your appeal within **10 business days** from the date on the Notice of Action letter.

If it is determined that processing your appeal in the usual 30 calendar day timeframe will not harm your health, we will let you know if we need more information and will decide your appeal within 15 business days of receiving the information we requested but not more than 30 calendar days. We will call you to let you know that your appeal will be processed in the usual timeframe. We will send you a written letter within two calendar days. If you are not happy with this decision, you can request a State Fair Hearing.

State Fair Hearing

You may ask for a State Fair Hearing at any time during the appeals process. You do not have to wait until Aetna Better Health gives you an answer. However, you must ask for a State Fair Hearing within **30 calendar days** of receiving the Notice of Action letter.

At the State Fair Hearing, you may represent yourself, use a lawyer or have a relative or friend speak for you. You can ask for a State Fair Hearing in one of the following ways.

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.

- You can make your request by writing to:
Illinois Department of
Healthcare and Family Services
Bureau of Administrative Hearings
401 S Clinton Street, 6th Floor
Chicago, IL 60607

Or you may call 1-800-435-0774
(TTY: 1-877-734-7429). The call is free. They
are available Monday through Friday from 8:30
a.m. to 4:45 p.m.

You can also ask the Department of Healthcare
and Family Services to look at our answer to
your appeal.

Illinois Department of
Healthcare and Family Services
Bureau of Administrative Hearings
401 S. Clinton, 6th Floor
Chicago, Illinois 60607
1-800-435-0774 (voice) or 1 877-734-7429 (TTY)
Monday through Friday
(8:30 a.m. to 4:45 p.m.)

We will send our file and information to the
Illinois Department of Healthcare and Family
Services. If after the hearing, our answer was
upheld, you may be responsible for the cost of
the services you got during the review. If the
hearing decision is that our answer was wrong,
we will let the services start right away.

External Review

If you don't like our decision, you can ask for
a review by someone outside of Aetna Better
Health. This is called an external review.

The outside reviewer has to meet certain
requirements. They must meet the following
requirements.

- Board certified provider with the same or
like specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Not know you and will not know your
identity during the review

What Happens Next?

- You or your representative send us a
letter within four months of the date on
the Notice of Action letter or the Appeal
Decision Letter. You can only ask one time
for an external review about a specific
action. **Your letter must ask for an
external review of that action.**

Aetna Better Health
Attn: Grievance and Appeals Dept
One South Wacker Drive, Mail Stop F646
Chicago, IL 60606

- We will review your request to see if it
meets the qualifications for external review.
We have five (5) business days to do this.
We will send you a letter letting you know
if your request meets these requirements.
If your request meets the requirements, the
letter will have the name of the external
reviewer.
- You have five (5) business days from the
letter we send you to send any additional
information about your request to the
external reviewer.
- The reviewer will send you and/or your
representative and Aetna Better Health
a letter with their decision within five
(5) calendar days of receiving all the
information they need to complete their
review.
- If you disagree with the reviewer's decision
you can ask for a State Fair Hearing by HFS.

Illinois Department of Healthcare
and Family Services
Bureau of Administrative Hearings
401 S. Clinton, 6th Floor
Chicago, Illinois 60607
1-800-435-0774 (voice) or 1 877-734-7429 (TTY)
Monday through Friday (8:30 a.m. to 4:45 p.m.)

For more information on State Fair Hearings,
please refer to the "Grievance and Appeals"
chapter of the Aetna Better Health member
handbook.

Expedited External Review

If you don't like our decision, and the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an **expedited external review**. You can do this over the phone or in writing. To ask for an expedited external review over the phone, call Member Services toll-free at 1-866-212-2851. To ask in writing, send us a letter at the address below. You can only ask one time for an external review about a specific action. Your letter must ask for an external review of that action.

Aetna Better Health

Attn: Grievance and Appeals Dept
One South Wacker Drive, Mail Stop F646
Chicago, IL 60606

What happens next?

- Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to let you know the decision. If your request meets the requirements, we will give you the name of the reviewer.
- If we determine your request does not meet the requirements for an expedited external review, you can appeal that decision to the Director of the Department of Insurance (DOI). You can contact the Department of Insurance to make this request.

Illinois Department of Insurance
Office of Consumer Health Insurance
EXTERNAL REVIEW REQUEST
320 W. Washington Street
Springfield, IL 62767
(877) 850-4740 (toll-free phone)
(217) 557-8495 (Fax)

DOI.externalreview@illinois.gov
<http://insurance.illinois.gov/externalreview>

- We will also send the necessary information to the external review organization so they can begin their review.
- As quickly as your health condition requires, but no more than two (2) business days after

it receives all the information it needs, the external review organization will make a decision about your request. They will let you and/or your representative and Aetna Better Health know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Aetna Better Health with the decision within 48 hours.

- If you disagree with the reviewer's decision you can ask for a State Fair Hearing by HFS.

Illinois Department of Healthcare
and Family Services
Bureau of Administrative Hearings
401 S. Clinton, 6th Floor
Chicago, Illinois 60607

1-800-435-0774 (voice) or 1 877-734-7429 (TTY)
Monday through Friday (8:30 a.m. to 4:45 p.m.)

For more information on State Fair Hearings, please refer to the "Grievance and Appeals" chapter of your Aetna Better Health member handbook."

FRAUD AND ABUSE

You must report any member or provider fraud, waste or abuse. The Department of Healthcare and Family Services' Office of the Inspector General (OIG) audits and investigates fraud and abuse. The OIG is responsible for the following activities.

- Investigating providers suspected of overbilling or defrauding the Illinois Department of Healthcare and Family Services Medical Program
- Recovering overpayments
- Issuing administrative sanctions
- Referring cases of suspected fraud for criminal investigation

You can make a report over the phone. Call the:

Welfare and Medical Fraud Hotline
Monday - Friday (except state holidays)
8:30 a.m. - 5 p.m.
1-800-252-8903
TTY users: Call 1-800-447-6404.

Here are examples of member fraud.

- Lending, selling or giving your Aetna Better Health ID card to someone else
- Changing the information on your ID card by any means other than calling Member Services to get a new ID card
- Changing information on a prescription

Here are examples of provider fraud.

- Billing for services that were not given
- Ordering services that are not medically necessary
- Referring members to an emergency room or other services when it is not medically necessary

You do not have to give your name when you call. If you do give your name, the person you are reporting will not be told that you called.

ADVANCE DIRECTIVES

A time may come when you are too sick to talk to your provider, family or friends. You may not be able to tell anyone what kind of health care you want. It is important to plan for this kind of situation.

Even if you are not sick or injured now, you should think about what kind of care you would want if you couldn't speak for yourself. This is where advance directives can help. Advance directives are legal documents that tell your providers and family what you want for end-of-life care.

There are several kinds of advance directives.

Living Will

A living will is a legal document that tells others your wishes for care that could keep you alive if you were in danger of dying. This care might include life support systems, such as:

- Breathing machines
- Tube feeding
- Resuscitation if your breathing or heartbeat stops

- Dialysis if your kidneys stop working

Health Care Power Of Attorney

A health care power of attorney is a document in which you choose a person to make health care decisions for you if you cannot make them for yourself. You must give this person permission in writing to make your health care decisions for you.

Mental Health Treatment Preference Declaration

A mental health treatment preference declaration lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you want to be admitted to a mental health facility for up to 17 days of treatment.

Do Not Resuscitate (DNR) Orders

You can also ask your PCP to help you make a Do Not Resuscitate, or DNR, order. A DNR order is an order for medical treatment that says cardiopulmonary resuscitation, or CPR, will not be used if your heart and/or breathing stops. If this is something you want, talk to your PCP about helping you with a DNR order.

Please note: you do not have to make an advance directive to receive medical care. You can still get health care if you do not have advance directives. This includes being admitted to a hospital or other facility. But most hospitals strongly encourage you to have them.

(More details on the types of advance directives in Illinois are in your welcome packet.)

Other Information

- If you do not have an advance directive, talk to your PCP. Or call Member Services at 1-866-212-2581 for information.

- An advance directive is part of your medical record.
- Give all of your providers a copy of your advance directives.
- An advance directive does not require a lawyer. You may still want to talk to one to get the best advice for you.
- You may change or cancel an advance directive. Any changes should be written, signed and dated.
- If you have filled out an advance directive in another state, you must still fill out advance directives forms for the state of Illinois.
- Keep a card in your purse or wallet that says that you have an advance directive and where it is located.
- If you have a car, keep a copy of your advance directives in your car.

If you have complaints about non-compliance with advance directive laws and regulations, call the state's complaint hotline at 1-800-252-8903 (TTY 1-800-447-6404). The call is free.

We will update you of any changes to the advance directive laws as soon as possible from the change date.

CHANGING HEALTH PLANS

If you are new to Aetna Better Health, you have 90 calendar days from when you first sign up with us to try the health plan. During the first 90 calendar days, you can change health plans for any reason. After the first 90 calendar days, if you are still eligible for the Integrated Care Program, you will stay enrolled in Aetna Better Health for the next nine (9) months. This is called "lock-in."

You can change health plans at a certain time every year. Each year, at the end of your enrollment year, you will get a letter from the ICEB. The letter will say that you can change plans if you want to. The letter will give you the dates that you can do this. You will have 60

calendar days to make a change. This 60-day period is called "open enrollment." You do not have to change health plans, but you can if you want to. If you choose to change plans during open enrollment, you will be a member in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay with Aetna Better Health, you will be locked in that plan for the next 12 months.

DISENROLLMENT

Disenrollment means that you are no longer a member of Aetna Better Health. If you are no longer a member, that means you cannot receive services from us.

These are the only two agencies that can enroll you or disenroll you.

- Department of Healthcare and Family Services (HFS)
- Illinois Client Enrollment Broker (ICEB)

Call the ICEB with questions at 1-877-912-8880 or TTY 1-866-565-8576.

Disenrollment for Cause

Under certain circumstances, Aetna Better Health can ask HFS to disenroll you from our health plan. This is called "disenrollment for cause." Aetna Better Health can ask that you be disenrolled for cause for the following reasons.

- You misuse the member ID card. In such cases, we will also report this to the Office of the Inspector General (OIG).
- Your behavior is disruptive, unruly, abusive or uncooperative to the point that keeping you in our health plan seriously impairs our ability to give services to you or to other members.

An involuntary disenrollment request for member behavior must include proof that Aetna Better Health did the following things.

- Gave the member at least one verbal warning and at least one written warning of what their actions or behavior may mean

- Tried to educate the member regarding rights and responsibilities
- Offered help through care management that would help the member to stop the behaviors
- Determined that the member's behavior is not related to the member's medical or behavioral health

Aetna Better Health *does not* end your enrollment because your health gets worse, your health changes or because you use covered services.

We *will not* have you disenrolled for diminished mental capacity. We *will not* have you disenrolled for uncooperative or disruptive behavior caused by special needs (unless keeping you on our health plan seriously impairs Aetna Better Health's ability to furnish covered services to you or other members). We will not have you disenrolled for exercising your appeal or grievance rights.

Please note: you will be disenrolled from Aetna Better Health if you move out of the service area. Aetna Better Health serves Integrated Care Program members in the following counties only:

- Suburban Cook (those areas with ZIP codes that begin with 606)
- DuPage
- Kane
- Kankakee
- Lake
- Will

Voluntary Disenrollment

Members can ask to leave the health plan with an oral or written request to either HFS or Aetna Better Health. Members can ask to leave the health plan for any the reasons below:

- The member moves out of the covered area.
- The member feels that Aetna Better Health does not cover the services they are seeking because of moral or religious conflict.
- The member needs services to be done at the same time, but not all services are covered. The member's doctor or another doctor believes that not getting the services together would put the member's health care needs at risk.
- A poor quality of care.
- A lack of access to services covered under the contract.
- There are limited doctors who know how to deal with the member's health care needs.

KEY HEALTH CARE TERMS

The list below includes definitions for health care terms.

Terms	Definitions
Advance Directive	A document that tells your health care provider and family how you wish to be cared for. It is used to when you are too ill to make health care decisions for yourself.
Appeal	A request that you, your provider or representative can make when you do not agree with Aetna Better Health's decision to deny, reduce and/or end a covered benefit or service.
Covered Benefits	Health care services that are covered by Aetna Better Health.
Durable Medical Equipment	Items such as wheelchairs and oxygen tanks.
Emergency	A life-threatening or serious medical condition that must be treated right away.
Grievances	When you let us know you are not satisfied with a provider, Aetna Better Health or a benefit. You can do this in writing or tell us verbally. Someone you appoint can file a grievance for you.
Identification Card	A card that shows you are an Aetna Better Health member.
Managed Care Plan	A health plan like Aetna Better Health that works with health care providers to keep you well.
Medically Necessary Services	A service, supply or medicine that: <ul style="list-style-type: none"> ■ Is appropriate ■ Is considered by other health professionals to be good medical practice ■ Meets Aetna Better Health's guidelines, policies and procedures ■ Is used to diagnose or treat a covered illness or injury ■ Is used to prevent an illness or used to help you get well or stay well
Member	A person who has chosen Aetna Better Health in the Illinois Integrated Care Program.
Prescription Medicine	A drug for which your provider writes an order so you can get it filled at a pharmacy.
Primary Care Provider (PCP)	Your personal provider. He or she manages all your health care needs.
Prior Authorization	When Aetna Better Health needs to approve health care services or medicines requested by your provider before you can get them.
Provider	Doctors, nurse practitioners, dentists, hospitals, pharmacies and laboratories that work with Aetna Better Health to provide you with health care services.

Specialist	A doctor who practices in a specific field of medicine.
Treatment	The care you get from providers and facilities.
Women's Health Care Provider (WHCP)	A doctor, nurse practitioner or other provider who specializes in obstetrics, gynecology, or family practice selected by a female member to see as needed and without a referral.

COMMON QUESTIONS

Q. What should I do if I lose my Member ID card? Or if I don't get one?

A. Call Member Services toll free at 1-866-212-2851 to get a new ID card.

Q. How will I know the name of my PCP?

A. Your ID card will list the name and phone number of your PCP. This will be on the front of your ID card.

Q. Can I change my PCP if I need to?

A. Yes. Please call Member Services toll free at 1-866-212-2851 for help. We will check if the new PCP is accepting new patients.

Q. How do I know which services are covered? Not covered?

A. Lists of covered services begins on page 11. These pages also list non-covered services. You can also ask your provider. You can call Member Services for help at 1-866-212-2851. You can also check our website at www.aetnabetterhealth.com/illinois.

Q. What should I do if I get a bill?

A. If you get a bill, call the provider's office. Give the staff your information. If you keep getting a bill, please call Member Services for help at 1-866-212-2851.

Q. I need help getting to my appointments. What can I do?

A. If you are not able to find a ride, please call Medical Transportation Management (MTM) toll free at 1-888-513-1612 for help. You must call at least three days in advance

to set up your ride.

Q. Which hospitals can I use?

A. We use many contracted hospitals. Check the provider directory online at www.aetnabetterhealth.com/illinois. You can also call Member Services at 1-866-212-2851 to get a current list of our contracted hospitals.

Q. What is an emergency?

A. An emergency is when you have a serious medical problem. This means you are in danger of lasting harm or dying. If you have an emergency, go to the nearest hospital or call 911.

Q. Do you have urgent care?

A. Yes. If you have an urgent care need, call your PCP. At night or on weekends or holidays, your PCP's answering service will take your call. Your PCP will call you back and tell you what to do. See page 22 for more information on urgent care.

Q. How do I get services that are not covered by Aetna Better Health, but are covered under my Medicaid benefits?

A. Call Member Services at 1-866-212-2851 and our staff will tell you how to get these services.

