aetna®

MI HEALTH LINK
Linking Medicare and Medicaid for you

AETNA BETTER HEALTH℠ PREMIER PLAN

2015 Member Handbook

Aetna Better Health℠ Premier Plan (Medicare-Medicaid Plan) is a health plan that contracts with Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

www.aetnabetterhealth.com/michigan

MI-14-09-03 Combined

H8026_15_164 ACCEPTED

Helpful information

Member Services
1-855-676-5772 (toll free)

For members with hearing impairments,
please call **711** (TTY)

Representatives available
24 hours a day, 7 days a week

Address
Aetna Better Health℠ Premier Plan
1333 Gratiot Avenue, Suite 400
Detroit, MI 48207

Personal information

_____
My primary care provider's (PCP) name and phone number

_____
My care manager's name and phone number

Aetna Better Health[SM] Premier Plan

Member Handbook

January 2015 – December 2015

Your Health and Drug Coverage under the Aetna Better Health[SM] Premier Plan

This handbook tells you about your coverage under Aetna Better Health[SM] Premier Plan through December 31, 2015. It explains health care services, behavioral health coverage, prescription drug coverage, and long term supports and services. Long term supports and services help you stay at home instead of going to a nursing home or hospital. **This is an important legal document. Please keep it in a safe place.**

This plan is offered by Aetna Better Health® of Michigan. When this *Member Handbook* says "we," "us," or "our," it means Aetna Better Health® of Michigan. When it says "the plan" or "our plan," it means Aetna Better Health[SM] Premier Plan.

You can speak with someone about getting this information in other languages. Call **1-855-676-5772** (TTY **711**). The call is free.

Puede hablar con alguien sobre cómo obtener esta información en otros idiomas. Llame al **1-855-676-5772** (TTY **711**). Esta llamada es gratuita.

يمكنك التحدث إلى شخص حول الحصول على هذه المعلومات بلغات أخرى. يُرجى الاتصال برقم الهاتف 1-855-676-5772 (خدمة TTY: 711). الاتصال مجاني.

You can ask for this handbook in other formats, such as Braille or large print. Call **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week.

Disclaimers

Aetna Better Health[SM] Premier Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

Limitations, restrictions, and patient pay amounts may apply. This means that you may have to pay for some services and that you need to follow certain rules to have Aetna Better Health[SM] Premier Plan pay for your services. For more information, call Aetna Better Health[SM] Premier Plan Member Services or read the Aetna Better Health[SM] Premier Plan Member Handbook.

If you have questions, please call Aetna Better Health Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

Benefits, List of Covered Drugs, and pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year. Please contact the plan for more details.

Chapter 1: Getting started as a member

Table of Contents

A. Welcome to Aetna Better Health[SM] Premier Plan

Aetna Better Health[SM] Premier Plan is a Medicare-Medicaid Plan. A *Medicare-Medicaid Plan,* also known as an *Integrated Care Organization* (or *ICO*)*,* is an organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

Aetna Better Health[SM] Premier Plan was approved by the State of Michigan and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MI Health Link program.

MI Health Link is a program jointly run by Michigan and the federal government to provide better health care for people who have both Medicare and Michigan Medicaid. Under this program, the state and federal government want to test new ways to improve how you receive your Medicare and Michigan Medicaid health care services.

B. What are Medicare and Michigan Medicaid?

Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or older,
- some people under age 65 with certain disabilities, and
- people with end-stage renal disease (kidney failure).

Michigan Medicaid

Michigan Medicaid is a program run by the federal government and the State of Michigan that helps people with limited incomes and resources pay for long term supports and services and medical costs. It also covers extra services and drugs not covered by Medicare.

Each state has its own Medicaid program. This means that each state decides what counts as income and resources and who qualifies for Medicaid. They also decide what services are covered by Medicaid and the cost for those services. States can decide how to run their own Medicaid programs, as long as they follow the federal rules.

Medicare and the State of Michigan must approve Aetna Better Health[SM] Premier Plan each year. You can get Medicare and Michigan Medicaid services through our plan as long as:

- you are eligible to participate

- we choose to offer the plan, and
- Medicare and the State of Michigan approve the plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Michigan Medicaid services would not be affected.

C. What are the advantages of this plan?

You will now get all your covered Medicare and Michigan Medicaid services from Aetna Better Health[SM] Premier Plan, including prescription drugs. You do not pay extra to join this health plan.

Aetna Better Health[SM] Premier Plan will help make your Medicare and Michigan Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will not pay a deductible or copayment when you get services from a provider or pharmacy in our health plan's provider network.
- You will have your own care coordinator who will ask you about your health care needs and choices and will work with you to create a personal care plan based on your goals.
- Your care coordinator will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve.
- If you qualify, you will have access to home and community-based supports and services to help you live independently.
- Aetna Better Health[SM] Premier Plan members get additional benefits. Please see Chapter 4 for more information.

D. What is Aetna Better Health[SM] Premier Plan's service area?

Our service area includes the following regions and counties:

Region 4: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren counties.

Region 7: Wayne County

Region 9: Macomb County

Only people who live in our service area can get Aetna Better Health[SM] Premier Plan.

If you move outside of our service area, you cannot stay in this plan.

E. What makes you eligible to be a plan member?

You are eligible for our plan as long as:

- you live in our service area, ***and***
- you have Medicare Part A, Part B, and Part D, ***and***
- you are eligible for full Michigan Medicaid benefits, ***and***
- you are not enrolled in hospice, ***and***
- you are not enrolled in the MI Choice Waiver Program or the Program of All-inclusive Care for the Elderly (PACE). If you are enrolled in either of these programs, you need to disenroll before enrolling in the MI Health Link program through Aetna Better Health[SM] Premier Plan.

F. What to expect when you first join our plan

"You will receive a Level I Assessment within the first 45 days of joining our plan."

One of our Care Coordinators will contact you within the first 45 days of enrolling with Aetna Better Health[SM] Premier Plan. The Care Coordinator will ask you a few questions to identify your immediate and long-term needs. The Care Coordinator will then will work with you, your providers, your family and anyone else you chose to develop a care plan that will help you get all the services and care you need.

If Aetna Better Health[SM] Premier Plan is new for you, you can keep receiving services and seeing the doctors and other providers you go to now for at least 90 days from your enrollment start date. If you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP, you will be able to receive services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time period if your current provider is not part of Aetna Better Health[SM] Premier Plan's provider network. Call Aetna Better Health[SM] Premier Plan for information about nursing home services.

After your first 90 days in Aetna Better Health[SM] Premier Plan (180 days if you get services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP), you will need to see doctors and other providers in the Aetna Better Health[SM] Premier Plan network. *A network provider* is a provider who works with the health plan. See Chapter 3, Section D, page 32 for more information on getting care.

G. What is a care plan?

A *care plan* is the plan for what supports and services you will get and how you will get them.

After your Level I Assessment, your care team will meet with you to talk about what health services you need and want. Together, you and your care team will make a care plan.

Every year, and when the health services you need and want change, your care team will work with you to update your care plan.

H. Does Aetna Better Health[SM] Premier Plan have a monthly plan premium?

No.

I. About the Member Handbook

This *Member Handbook* is part of our contract with you. This means that we must follow all of the rules in this document. If you think we have done something that goes against these rules, you may be able to appeal, or challenge, our action. For information about how to appeal, see Chapter 9, Section 5.3, page 137, or call **1-800-MEDICARE** (1-800-633-4227).

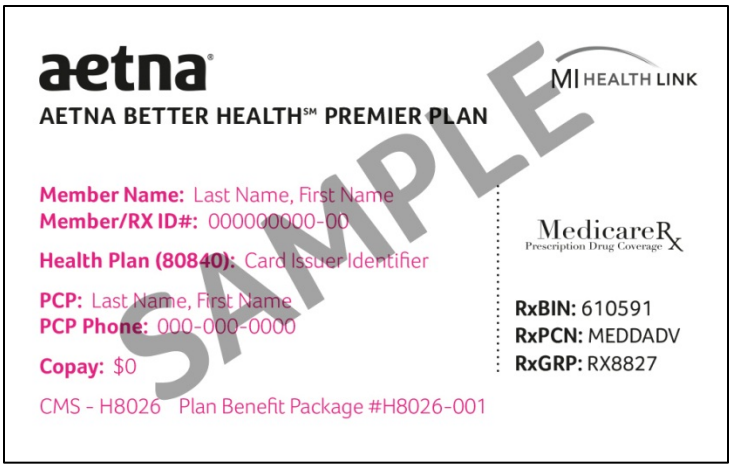
The contract is in effect for the months you are enrolled Aetna Better Health[SM] Premier Plan between January 1, 2015 and December 31, 2015.

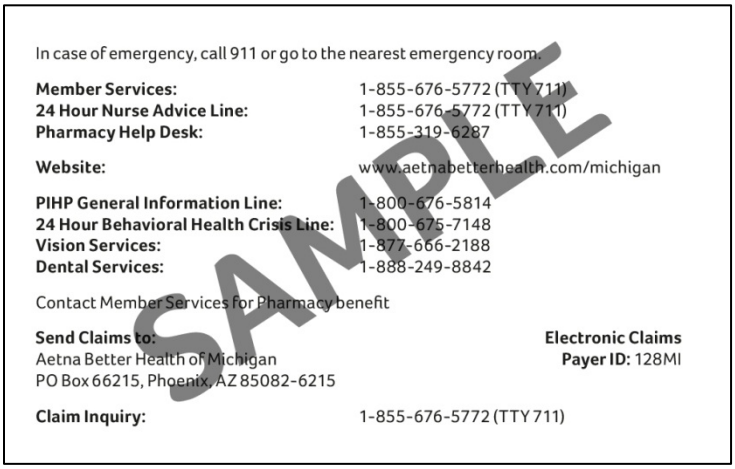
J. What other information will you get from us?

You should have already gotten an Aetna Better Health[SM] Premier Plan member ID card, information about how to access a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*.

Your Aetna Better Health[SM] Premier Plan member ID card

Under our plan, you will have one card for your Medicare and Michigan Medicaid services, including long term supports and services and prescriptions. You must show this card when you get any services or prescriptions. Here's a sample card to show you what yours will look like:





If your card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Michigan Medicaid card to get services. Keep those cards in a safe place, in case you need them later.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Aetna Better Health[SM] Premier Plan network. While you are a member of our plan, you must use network providers to get covered services. There are some exceptions when you first join our plan (see page 8).

➔ You can request an annual *Provider and Pharmacy Directory* by calling Member Services at **1-855-676-5772** (TTY **711**) 24 hours a day, 7 days a week.

You can also see the *Provider and Pharmacy Directory* at **www.aetnabetterhealth.com/michigan**, or download it from this website. The website also has a searchable provider and pharmacy directory. Both Member Services and the website can give you the most up-to-date information about changes in our network providers.

What are "network providers"?

- Network providers are doctors, nurses, and other health care professionals that you can go to as a member of our plan. Network providers also include clinics, hospitals, nursing facilities and other places that provide health services in our plan. They also include home health agencies, medical equipment suppliers and others who provide goods and services that you get through Medicare or Michigan Medicaid.
- Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are "network pharmacies"?

- Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you *must* fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week, for more information or to get a copy of the *Provider and Pharmacy Directory.* You can also see the *Provider and Pharmacy Directory* at **www.aetnabetterhealth.com/michigan**, or download it from this

website. Both Member Services and the website can give you the most up-to-date information about changes in our network pharmacies and providers.

List of Covered Drugs

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells which prescription drugs are covered by Aetna Better Health[SM] Premier Plan.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. See Chapter 5, Section C, page 94 for more information on these rules and restrictions.

Each year, we will send you a copy of the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week.

The Explanation of Benefits

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or *EOB*).

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services.

K. How can you keep your membership record up to date?

You can keep your membership record up to date by letting us know when your information changes.

The plan's network providers and pharmacies need to have the right information about you. **They use your membership record to know what services and drugs you get and how much it will cost you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know the following:

- If you have any changes to your name, your address, or your phone number

- If you have any changes in any other health insurance coverage, such as from your employer, your spouse's employer, or workers' compensation
- If you have any liability claims, such as claims from an automobile accident
- If you are admitted to a nursing home or hospital
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your caregiver or anyone responsible for you changes
- If you are part of a clinical research study

If any information changes, please let us know by calling Member Services at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week.

Do we keep your personal health information private?

Yes. Laws require that we keep your medical records and personal health information private. We make sure that your health information is protected. For more information about how we protect your personal health information, see Chapter 8, Section D, page 114.

Chapter 2: Important phone numbers and resources

Table of Contents

A. How to contact Aetna Better Health[SM] Premier Plan Member Services

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week
FAX	1-855-854-3245
WRITE	Aetna Better Health[SM] Premier Plan 1333 Gratiot Avenue Suite 400 Detroit, MI 48207
WEBSITE	**www.aetnabetterhealth.com/michigan**

Contact Member Services about:

- **Questions about the plan**
- **Questions about claims, billing or member cards**
- **Coverage decisions about your health care**

  A coverage decision about your health care is a decision about:

  » your benefits and covered services, ***or***

  » the amount we will pay for your health services.

  Call us if you have questions about a coverage decision about health care.

  ➔ To learn more about coverage decisions, see Chapter 9, Section 4, page 131.

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

- **Appeals about your health care**

  An *appeal* is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

  ➔ To learn more about making an appeal, see Chapter 9, Section 5.3, page 137.

- **Complaints about your health care**

  You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section F, page 25 below).

  ➔ If your complaint is about a coverage decision about your health care, you can make an appeal (see the section above).

  ➔ You can send a complaint about Aetna Better Health[SM] Premier Plan right to Medicare. You can use an online form at **www.medicare.gov/MedicareComplaintForm/home.aspx.** Or you can **call 1-800-MEDICARE** (1-800-633-4227) to ask for help.

  ➔ To learn more about making a complaint about your health care, see Chapter 9, Section 10, page 173.

- **Coverage decisions about your drugs**

  A coverage decision about your drugs is a decision about:

  » your benefits and covered drugs, ***or***

  » the amount we will pay for your drugs.

  This applies to your Part D drugs, Michigan Medicaid prescription drugs, and Michigan Medicaid over-the-counter drugs.

  ➔ For more on coverage decisions about your prescription drugs, see Chapter 9, Section 5, page 134.

- **Appeals about your drugs**

  An *appeal* is a way to ask us to change a coverage decision.

  To file an appeal, contact Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. You can also write or fax us your appeal:

Aetna Better Health[SM] Premier Plan
Attn: Appeals and Grievances Dept.
1333 Gratiot Avenue, Suite 400
Detroit, MI 48207

Fax: 1- 844-321-9567

➔ For more on making an appeal about your prescription drugs, see Chapter 9, Section 5, page 134.

- **Complaints about your drugs**

You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.

➔ If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. *(See the section above.)*

➔ You can send a complaint about Aetna Better Health[SM] Premier Plan right to Medicare. You can use an online form at https://www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.

➔ For more on making a complaint about your prescription drugs, see Chapter 9, Section 10, page 173.

- **Payment for health care or drugs you already paid for**

➔ For more on how to ask us to pay you back, or to pay a bill you have gotten, see Chapter 7, Section A, page 107.

➔ If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. See Chapter 9, Section 5.5, page 147 for more on appeals.

B. How to contact your Care Coordinator

As an Aetna Better Health[SM] Premier Plan member, you will be assigned a Care Coordinator. This is a person who works with you and your care providers to make sure you get the care and services you need. Your Care Coordinator will give you his or her phone number and email address so you can contact him or her. It is important that you have a good relationship with your care coordinator. If you want to change your Care Coordinator please call Member Services and ask to speak to the Care Management department.

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week
WRITE	Aetna Better Health[SM] Premier Plan Attn: Care Management Dept. 1333 Gratiot Avenue Suite 400 Detroit, MI 48207

Contact your Care Coordinator about:

- **Questions about your health care**
- **Questions about getting behavioral health services, transportation, and long term supports and services (LTSS)**
- **Questions about any other supports and services you need**

When you first join Aetna Better Health[SM] Premier Plan, one of our Care Coordinators will meet with you to do an assessment. The assessment will help us learn about your health needs. It will

also help us identify if you are eligible for LTSS. If you are eligible, you will be reevaluated annually to identify if your needs or eligibility have changed.

To be eligible for LTSS you must be at an institutional level of care. You may be eligible to receive some LTSS through a waiver.

Sometimes you can get help with your daily health care and living needs. You might be able to get these services:

» Skilled nursing care

» Physical therapy

» Occupational therapy

» Speech therapy

» Personal Care Services

» Home health care

See Chapter 4 for additional information about Home and Community Based waiver services.

C. How to contact the 24 Hour Nurse Advice Line

Aetna Better Health[SM] Premier Plan has a Nurse Advice Line available to help answer your medical questions. The Nurse Advice Line does not take the place of your primary care provider but is available as another resource for you. This service is available 24 hours a day, 7 days a week. It is staffed by medical professionals.

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

Contact the 24 Hour Nurse Advice Line about:

- **Questions about your health care**

D. How to contact the PIHP General Information Line and Behavioral Health Crisis Line

Behavioral health services will be available to Aetna Better Health[SM] Premier Plan members through the local Pre-paid Inpatient Health Plan (PIHP) provider network. Members receiving services through the PIHP will continue to receive them according to their plan of care. Aetna Better Health[SM] Premier Plan will provide the personal care services previously provided by the Department of Human Services (DHS) Home Help program. Other medically necessary behavioral health, intellectual/developmental disability, and substance use disorder services, including psychotherapy or counseling (individual, family and group) when indicated, are available and coordinated through the health plan and PIHP.

Region 4 PIHP General Information Line:

Serving: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties

CALL	**1-800-676-5814** This call is free. Monday through Friday 8 a.m. - 6 p.m. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. Monday through Friday 8 a.m. - 6 p.m.

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

Region 7 PIHP General Information Line:

Serving: Wayne county

CALL	**1-800-241-4949** This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week.

Region 9 PIHP General Information Line:

Serving: Macomb county

CALL	**1-855-996-2264** This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week.

Contact the PIHP General Information Line about:

- **Questions about behavioral health services**
- **Where and how to get an assessment**

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

- **Where to go to get services**
- **A list of other community resources**

Region 4 Behavioral Health Crisis Line:

Serving: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties

CALL	**1-800-675-7148** This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Region 7 Behavioral Health Crisis Line:

Serving: Wayne County

CALL	**1-800-241-4949** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. 24 hours a day, 7 days a week

Region 9 Behavioral Health Crisis Line:

Serving: Macomb county

CALL	**1-800-273-8255** This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it, 24 hours a day, 7 days a week.

Contact the Behavioral Health Crisis Line for any of the following reasons:

- **Suicidal thoughts**
- **Information on mental health/illness**
- **Substance abuse/addiction**
- **To help a friend or loved one**
- **Relationship problems**
- **Abuse/violence**
- **Economic problems causing anxiety/depression**
- **Loneliness**
- **Family problems**

If you are experiencing a life or death emergency, please call 9-1-1 or go to the nearest hospital.

E. How to contact the State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP).

MMAP is not connected with any insurance company or health plan.

CALL	**1-800-803-7174** This call is free.
TTY	**711** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	6105 St Joe Hwy #204 Lansing Charter Township, MI 48917
EMAIL	info@mmapinc.org
WEBSITE	http://mmapinc.org/

Contact MMAP about:

- **Questions about your Medicare and Medicaid health insurance**

  MMAP counselors can:

  » help you understand your rights,

  » help you understand drug coverage, such as prescription and over-the-counter drugs,

  » help you understand your plan choices,

  » answer your questions about changing to a new plan,

  » help you make complaints about your health care or treatment, ***and***

  » help you straighten out problems with your bills.

F. How to contact the Quality Improvement Organization (QIO)

Our state uses an organization called KEPRO for quality improvement. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KEPRO is not connected with our plan.

CALL	**1-855-408-8557** This call is free. Helpline hours of operation are: Monday through Friday 9 a.m. to 5 p.m. Saturdays, Sundays, and Holidays 11 a.m. to 3 p.m.
TTY	**1-855-843-4776** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	KEPRO 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609
EMAIL	KEPRO.Communications@hcqis.org
WEBSITE	**http://www.keproqio.com**

Contact KEPRO about:

- **Questions about your health care**

  You can make a complaint about the care you have received if:

  - » You have a problem with the quality of care,
  - » You think your hospital stay is ending too soon, ***or***
  - » You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services, or CMS.

CALL	**1-800-MEDICARE** (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	**http://www.medicare.gov** This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print right from your computer. You can also find Medicare contacts in your state by selecting "Help & Resources" and then clicking on "Phone numbers & websites." The Medicare website has the following tool to help you find plans in your area: **Medicare Plan Finder:** Provides personalized information about Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Find health & drug plans." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

H. How to contact Michigan Medicaid

Michigan Medicaid helps with medical and long term supports and services costs for people with limited incomes and resources.

You are enrolled in Medicare and in Michigan Medicaid. If you have questions about the help you get from Michigan Medicaid, call the Beneficiary Help Line.

CALL	**1-800-642-3195** This call is free. Office hours are Monday through Friday 8 a.m. to 7 p.m.
TTY	**1-866-501-5656** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	PO Box 30479 Lansing, MI 48909-7979

Michigan Medicaid eligibility is determined by the local Department of Human Services. If you have questions about your Michigan Medicaid eligibility or yearly renewal, contact your DHS Specialist. For general questions about DHS assistance programs, call **1-855-275-6424** between 8 a.m. and 5 p.m. Monday through Friday.

I. How to contact the MI Health Link Ombudsman program

The MI Health Link Ombudsman program helps people enrolled in Michigan Medicaid with service or billing problems. They can help you file a complaint or an appeal with our plan. This program is currently being developed. For now, if you have any problems with services or billing or need help filing a complaint or an appeal, you can call the Medicaid Beneficiary Help Line at **1-800-642-3195**. We will let you know once the MI Health Link Ombudsman program is in place and will provide you with the program's contact information.

J. How to contact the State Long Term Care Ombudsman program

The State Long Term Care Ombudsman program helps people learn about nursing homes and other long term care settings. It also helps solve problems between these settings and residents or their families.

CALL	**1-866-485-9393**
TTY	**711** This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	State Long Term Care Ombudsman 300 E. Michigan Ave. P.O. Box 30676 Lansing, MI 48909
EMAIL	SLTCO@michigan.gov
WEBSITE	**www.michigan.gov/ltc**

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

Chapter 3: Using the plan's coverage for your health care and other covered services

Table of Contents

A. About "services," "covered services," "providers," and "network providers"

Services are health care, long term supports and services, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care and long term supports and services are listed in the Benefits Chart in Chapter 4, Section D, page 46.

Providers are doctors, nurses, and other people who give you services and care. The term *providers* also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long term supports and services.

Network providers are providers who work with the health plan**.** These providers have agreed to accept our payment as full payment. Network providers bill us directly for care they give you. When you see a network provider, you will pay nothing for covered services.

B. Rules for getting your health care, behavioral health, and long term supports and services covered by the plan

Aetna Better Health[SM] Premier Plan covers all services covered by Medicare and Michigan Medicaid. This includes,long term care and prescription drugs.

Aetna Better Health[SM] Premier Plan will generally pay for the health care and other supports and services you get if you follow the plan rules. To be covered:

- The care you get must be a **plan benefit.** This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4, Section D, page 46 of this handbook).
- The care must be **medically necessary.** *Medically necessary* means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.

- As a plan member, you must choose a network provider to be your PCP.

  ➔ To learn more about choosing a PCP, see page 33.

  - » **Please note:** In your first 90 days (or 180 days if you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP) with our plan, you may continue to see your current providers, at no cost, if they are not a part of our network. During the first 90 days (or 180 days if you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP), our Care Coordinator will contact you to help you find providers in our network. After the first 90 days (or 180 days if you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP) we will no longer cover your care if you continue to see out-of-network providers. There are some exceptions. Please talk to your Care Coordinator if you have questions.

- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
  - » The plan covers emergency or urgently needed care from an out-of-network provider. To learn more and to see what *emergency* or *urgently needed care* means, see page 36.
  - » If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. The out-of-network provider must first get prior authorization from Aetna Better Health[SM] Premier Plan. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval to see an out-of-network provider, see page 34.
  - » The plan covers kidney dialysis services when you are outside the plan's service area for a short time. You can get these services at a Medicare-certified dialysis facility.
  - » When you first join the plan, you can keep receiving services and seeing the doctors and other providers you go to now for at least 90 days from your enrollment start date. If you receive services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP, you will be able to receive services and see the doctors and providers you go to now for up to 180 days from your enrollment start date. Your care coordinator will work with you to choose new providers and arrange services within this time period. Call Aetna Better Health[SM] Premier Plan for information about nursing home services.

C. Your Care Coordinator

- What is a Care Coordinator?

  A Care Coordinator is a person who will *work with you to* help you get the Medicare and Michigan Medicaid covered supports and services you need and want.

- How can I contact my Care Coordinator?

  When you first meet with your Care Coordinator, he or she will give you his or her phone number. You can also reach your Care Coordinator by calling Member Services.

- How can I change my Care Coordinator?

  Call Member Services and let us know you'd like to change Care Coordinators. We will connect you to the Care Management department who will discuss your options.

D. Getting care from primary care providers, specialists, other network providers, and out-of-network providers

Getting care from a primary care provider

You must choose a primary care provider (PCP) to provide and manage your care.

What is a "PCP," and what does the PCP do for you?

- Your primary care provider (PCP) is an individual physician who will work with you and your care coordinator to direct and coordinate your health care. Your PCP will do your preventive care checkups and treat you for most of your routine health care needs. If needed, your PCP will send you to other doctors (specialists) or admit you to the hospital. Although you do not need approval (called a referral) from your PCP to see other providers, it is still important to contact your PCP before you see a specialist or after you have an urgent or emergency department visit. This allows your PCP to manage your care for the best outcomes.
- A PCP is a practitioner of primary care. They may also be nurse practitioners, physician assistants, or in some cases specialists. If you want a specialist to be your PCP, the specialist must agree to do so and must contact us first to make arrangements. PCPs may specialize in:
  - General Practice
  - Family Practice
  - Internal Medicine

- OB/GYN
- Geriatrics

How do you choose your PCP?

You can find a PCP by:

- Using our provider search tool on our website at **www.aetnabetterhealth.com/michigan**
- Calling your Care Coordinator or Member Services
- If you have one, looking in your printed Provider and Pharmacy Directory.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network. We can help you find a new PCP.

To find a new PCP, use our provider search tool on our website at **www.aetnabetterhealth.com/michigan**. You can also call Member Services to find a new PCP. The change will take effect immediately.

How to get care from specialists and other network providers

A *specialist* is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- *Oncologists* care for patients with cancer.
- *Cardiologists* care for patients with heart problems.
- *Orthopedists* care for patients with bone, joint, or muscle problems.

You can go to any specialist in our network. Your PCP or Care Coordinator can recommend a specialist to you. You can also call Member Services at **1-855-676-5772** (TTY **711**) 24 hours a day, 7 days a week. We will help you find a specialist near you. You do not need a referral to see a network specialist.

The specialist may have to contact us to get approval to see you before your appointment. This is called prior authorization. The prior authorization decision is made by Aetna Better Health[SM] Premier Plan prior authorization nurses who review the services to make sure they are what you need. See the Benefits Chart in Chapter 4 for information about which services require prior authorization.

What if a network provider leaves our plan?

A network provider you are using might leave our plan. If one of your providers does leave our plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out one of your providers is leaving our plan, please contact us so we can assist you in finding a new provider and managing your care. Talk to your Care Coordinator or call Members Services for help.

How to get care from out-of-network providers

Generally you must see providers that are in our network. There are some times when you can see an out-of-network provider. You can see can an out-of-network provider if:

- You need emergency services
- You need urgent care
- You are out of the service area and need dialysis
- Aetna Better Health[SM] Premier Plan has approved you to see an out-of-network provider during or after your transition of care time period. The out-of-network provider will have to contact us to get approval to see you before your appointment.
- A provider with a certain specialty is not available in network, you can see an out-of-network provider with that specialty. The provider will have to get prior authorization before your appointment.

➔ **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Michigan Medicaid. If you go to a provider who is not eligible to

participate in Medicare, you must pay the full cost of the services you get. Providers must tell you if they are not eligible to participate in Medicare.

E. How to get long term supports and services (LTSS)

As an Aetna Better Health[SM] Premier Plan member, you may qualify to receive long term services and supports (LTSS) in a nursing facility or at home. LTSS can provide assistance with bathing, dressing and other basic activities of daily living. LTSS may also include home modification, adaptive equipment and supplies, and chore services. Long-term services and supports provide assistance to help you stay at home instead of going to a nursing home or hospital or may assist you to transition from the nursing facility to the community. In order to qualify for these services you must meet nursing facility level of care. Your care coordinator will meet with you and assess your needs in order to make the determination. Once you qualify for these services, you will be reassessed at least annually to see if the services are meeting your needs. If you have questions about LTSS or to see if you qualify, call your care coordinator.

F. How to get behavioral health services

Behavioral health services will be available to Aetna Better Health[SM] Premier Plan members through the local Pre-paid Inpatient Health Plan (PIHP) provider network. Members receiving services through the PIHP will continue to receive them according to their plan of care. Other medically necessary behavioral health, intellectual/developmental disability, and substance use disorder services, including psychotherapy or counseling (individual, family and group) when indicated, are available and coordinated through your care coordinator and the PIHP.

If you need behavioral health services you can talk to your care coordinator. To contact the PIHP directly, see the contact information in Chapter 2, Section D, page 20.

G. How to participate in self-determination arrangements

- **What are arrangements that support self-determination?**

  Self-determination is an option available to enrollees receiving services through the MI Health Link HCBS home and community based waiver program. It is a process that allows you to design and exercise control over your own life. This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget." If you choose to do so, you would also have control over the hiring and management of providers.

- **Who can receive arrangements that support self-determination**?

Arrangements that support self-determination are available for enrollees who receive services through the home and community-based services waiver program called MI Health Link HCBS.

- **How to get help in employing providers?**

  You may work with your care coordinator and fiscal intermediary to get help employing providers.

H. How to get transportation services

If you need a ride to your appointments call us at **1-855-676-5772** (TTY **711**) and listen for the option for transportation. You can also call MTM directly at **1-844-549-8347** (TTY **711**) Monday – Friday 8 a.m. – 8 p.m. You must call at least 3 days before your appointment. If you need help talk to your care coordinator or call Member Services.

I. How to get covered services when you have a medical emergency or urgent need for care

Getting care when you have a medical emergency

What is a medical emergency?

A *medical emergency* is a medical condition recognizable by symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or any prudent layperson with an average knowledge of health and medicine could expect it to result in:

- placing the person's health in serious risk; ***or***
- serious harm to bodily functions; ***or***
- serious dysfunction of any bodily organ or part; ***or***
- in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - » There is not enough time to safely transfer the member to another hospital before delivery.
  - » The transfer may pose a threat to the health or safety of the member or unborn child.

What should you do if you have a medical emergency?

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call your care coordinator or Member Services.

What is covered if you have a medical emergency?

You may get covered emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. To learn more, see the Benefits Chart in Chapter 4, Section D, page 46.

If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is over.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by our plan. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

What if it wasn't a medical emergency after all?

Sometimes it can be hard to know if you have a medical emergency. You might go in for emergency care and have the doctor say it wasn't really a medical emergency. As long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor says it was *not* an emergency, we will cover your additional care *only* if:

- you go to a network provider, ***or***
- the additional care you get is considered "urgently needed care" and you follow the rules for getting this care. (See the next section.)

Getting urgently needed care

What is urgently needed care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition and need to have it treated.

Getting urgently needed care when you are in the plan's service area

In most situations, we will cover urgently needed care *only* if:

- you get this care from a network provider, ***and***

- you follow the other rules described in this chapter.

However, if you can't get to a network provider, we will cover urgently needed care you get from an out-of-network provider.

If you think you need urgent care, call your PCP. Your PCP must give you an appointment by the end of the next working day if you need urgent care. Do not use an emergency room for urgent care.

You can call your PCP day or night. If you have an urgent need your PCP or on-call provider will tell you what to do. If your PCP is not in the office, leave a message with the answering service and your PCP will return your call.

Your PCP may tell you to go to an urgent care center. You can find an urgent care center on our website at **www.aetnabetterhealth.com/michigan** or by calling Member Services at **1-855-676-5772** (TTY **711**) 24 hours a day, 7 days a week.

You can also call our Nurse Advice Line if you have medical questions. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. The phone number is **1-855-676-5772** (TTY **711**) 24 hours a day, 7 days a week. Select the option for Nurse Advice Line.

Getting urgently needed care when you are outside the plan's service area

When you are outside the service area, you might not be able to get care from a network provider. In that case, our plan will cover urgently needed care you get from any provider.

➔ Our plan does not cover urgently needed care or any other care that you get outside the United States.

J. What if you are billed directly for the full cost of services covered by our plan?

If a provider sends you a bill instead of sending it to Aetna Better Health[SM] Premier Plan, you should not pay the bill yourself. If you do, we may not be able to pay you back. If you have paid for your covered services or if you have gotten a bill for covered medical services, see Chapter 7, Section A, page 107 to learn what to do.

What should you do if services are not covered by our plan?

Aetna Better Health Premier Plan[SM] covers all services:

- that are medically necessary, ***and***
- that are listed in the plan's Benefits Chart (see Chapter 4, Section D, page 46)***, and***
- that you get by following plan rules.

If you have questions, please call Aetna Better Health[SM] Premier Plan at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week. The call is free. **For more information**, visit **www.aetnabetterhealth.com/michigan**.

➔ If you get services that aren't covered by our plan, **you must pay the full cost yourself.**

If you want to know if we will pay for any medical service or care, you have the right to ask us. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9, Section 5.3, page 137 explains what to do if you want the plan to cover a medical item or service. It also tells you how to appeal the plan's coverage decision. You may also call Member Services to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you go over the limit, you will have to pay the full cost to get more of that type of service. Call Member Services to find out what the limits are and how close you are to reaching them.

K. How are your health care services covered when you are in a clinical research study?

What is a clinical research study?

A *clinical research study* (also called a *clinical trial*) is a way doctors test new types of health care or drugs. They ask for volunteers to help with the study. This kind of study helps doctors decide whether a new kind of health care or drug works and whether it is safe.

If you volunteer for a clinical research study, we will pay any costs if Medicare approves the study. If you are part of a study that Medicare has *not* approved, **you will have to pay any costs for being in the study**.

Once Medicare approves a study you want to be in, someone who works on the study will contact you. That person will tell you about the study and see if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must also understand and accept what you must do for the study.

If you are in a Medicare-approved clinical research study, Medicare pays for most of the covered services you get. While you are in the study, you may stay enrolled in our plan. That way you continue to get care not related to the study.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your primary care provider. The providers that give you care as part of the study do *not* need to be network providers.

You <u>do</u> need to tell us before you start participating in a clinical research study.
Here's why:

- We can tell you if the clinical research study is Medicare-approved.

- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan to be in a clinical research study, you or your Care Coordinator should contact Member Services.

When you are in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for most items and services you get as part of the study. This includes:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure that is part of the research study.
- Treatment of any side effects and complications of the new care.

Medicare pays most of the cost of the covered services you get as part of the study. After Medicare pays its share of the cost for these services, our plan will also pay for the rest of the costs.

Learning more

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (**www.medicare.gov/publications/pubs/pdf/02226.pdf**). You can also call **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

L. How are your health care services covered when you are in a religious non-medical health care institution?

What is a religious non-medical health care institution?

A *religious non-medical health care institution* is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we will cover care in a religious non-medical health care institution. You may choose to get health care at any time for any reason. This benefit is only for Medicare Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are against getting medical treatment that is "non-excepted."

- "Non-excepted" medical treatment is any care that is *voluntary* and *not required* by any federal, state, or local law.
- "Excepted" medical treatment is any care that is *not* voluntary and *is required* under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services is limited to *non-religious* aspects of care.
- Our plan will cover the services you get from this institution in your home, as long as they would be covered if given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following applies:
  - » You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - » You must get approval from our plan before you are admitted to the facility or your stay will not be covered.

For more information on inpatient hospital stay coverage, see the Benefits Chart in Chapter 4, Section D, page 46.

M. Rules for owning durable medical equipment

Will you own your durable medical equipment?

Durable medical equipment means certain items ordered by a provider for use in your own home. Examples of these items are oxygen equipment and supplies, wheelchairs, canes, crutches, walkers, and hospital beds.

You will always own certain items, such as prosthetics. In this section, we discuss durable medical equipment you must rent.

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. As a member of Aetna Better Health[SM] Premier Plan, however, you usually will not own the rented equipment, no matter how long you rent it.

In certain situations, we will transfer ownership of the durable medical equipment item. Call Member Services to find out about the requirements you must meet and the papers you need to provide.

What happens if you switch to Medicare?

You will have to make 13 payments in a row under Original Medicare to own the equipment if:

- you did not become the owner of the durable medical equipment item while you were in our plan ***and***
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program.

If you made payments for the durable medical equipment under Original Medicare before you joined our plan, those Medicare payments do not count toward the 13 payments. You will have to make 13 new payments in a row under Original Medicare to own the item.

➔ There are no exceptions to this case when you return to Original Medicare.

Chapter 4: Benefits Chart

Table of Contents

A. Understanding your covered services

This chapter tells you what services Aetna Better Health[SM] Premier Plan pays for. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5, Section B, page 94. This chapter also explains limits on some services.

You pay nothing for your covered services as long as you follow the plan's rules. See Chapter 3, Section B, page 30 for details about the plan's rules. The only exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Human Services.

If you need supports and services related to a behavioral health condition, intellectual or developmental disability, or a substance use disorder, please work with your Care Coordinator to get services provided through the Prepaid Inpatient Health Plan (PIHP). You will also receive a PIHP Member Handbook which will further explain the PIHP eligibility and covered specialty services.

Depending on eligibility criteria, some items, supplies, supports and services may be offered through our plan or the PIHP. To ensure our plan and PIHP are not paying for the same items, supplies, supports or services, your Care Coordinator can help you get what you need from either our plan or the PIHP. Services from the PIHP have different eligibility or medical necessity criteria. See Section E in this chapter on page 82 and the PIHP handbook for more information.

If you need help understanding what services are covered, call your Care Coordinator and/or Member Services at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week.

B. Our plan does not allow providers to charge you for services

We do not allow Aetna Better Health[SM] Premier Plan providers to bill you for services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

➔ **You should never get a bill from a provider. If you do, see Chapter 7, Section A, page 107.**

C. About the Benefits Chart

This benefits chart tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections:

- General Services
  - » Offered to all enrollees
- Home and Community-Based Waiver Services

» Offered only to enrollees who: 1) require nursing facility level of care but are not residing in a nursing facility, and 2) have a need for covered waiver services

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below. The only exception is if you have a Patient Pay Amount (PPA) for nursing facility services as determined by the local Department of Human Services.

- Your Medicare and Michigan Medicaid covered services must be provided according to the rules set by Medicare and Michigan Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- You get your care from a network provider. A network provider is a provider who works with the health plan. In most cases, the plan will not pay for care you get from an out-of-network provider. Chapter 3, Section D, page 32 has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) that is providing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called *prior authorization*. Covered services that need approval first are marked in the Benefits by a footnote.

All preventive services are free. You will see this apple 🍎 next to preventive services in the benefits chart.

D. The Benefits Chart

General Services that our plan pays for	What you must pay
Abdominal aortic aneurysm screening The plan will pay only once for an ultrasound screening for people at risk. You must get a referral for it at your "Welcome to Medicare" preventive visit.	$0
Adaptive Medical Equipment and Supplies[1] The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include: ▪ shower chairs/benches ▪ lift chairs ▪ raised toilet seats ▪ reachers ▪ jar openers ▪ transfer seats ▪ bath lifts/room lifts ▪ swivel discs ▪ bath aids such as long handle scrubbers ▪ telephone aids ▪ automated/telephone or watches that assist with medication reminders ▪ button hooks or zipper pulls ▪ modified eating utensils ▪ modified oral hygiene aids ▪ modified grooming tools	$0

[1] Prior Authorization may be required

General Services that our plan pays for	What you must pay
▪ heating pads ▪ sharps containers ▪ exercise items and other therapy items ▪ voice output blood pressure monitor ▪ nutritional supplements such as Ensure	
Alcohol misuse screening and counseling The plan will pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider or practitioner in a primary care setting.	$0
Ambulance services Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. Ambulance services for other cases must be approved by the plan. In cases that are *not* emergencies, the plan *may* pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	$0

General Services that our plan pays for	What you must pay
Annual wellness visit If you have been in Medicare Part B for more than 12 months, you can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. The plan will pay for this once every 12 months. **Note**: You cannot have your first annual checkup within 12 months of your "Welcome to Medicare" preventive visit. You will be covered for annual checkups after you have had Part B for 12 months. You do not need to have had a "Welcome to Medicare" visit first.	$0
Bone mass measurement The plan will pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. The plan will pay for the services once every 24 months or more often if they are medically necessary. The plan will also pay for a doctor to look at and comment on the results.	$0
Breast cancer screening (mammograms) The plan will pay for the following services: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Clinical breast exams once every 24 months	$0

General Services that our plan pays for	What you must pay
Cardiac (heart) rehabilitation services The plan will pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions with a doctor's order. The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	$0
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan pays for one visit a year with your primary care provider to help lower your risk for heart disease. During this visit, your doctor may: ▪ discuss aspirin use, ▪ check your blood pressure, or ▪ give you tips to make sure you are eating well.	$0
Cardiovascular (heart) disease testing The plan pays for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	$0

General Services that our plan pays for	What you must pay
Cervical and vaginal cancer screening The plan will pay for the following services: ▪ For all women: Pap tests and pelvic exams once every 24 months ▪ For women who are at high risk of cervical cancer: one Pap test every 12 months ▪ For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	$0
Chiropractic services[2] The plan will pay for the following services: ▪ Adjustments of the spine to correct alignment ▪ Diagnostic x-rays	$0
Colorectal cancer screening For people 50 and older, the plan will pay for the following services: ▪ Flexible sigmoidoscopy (or screening barium enema) every 48 months ▪ Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).	$0

[2] Prior Authorization may be required

General Services that our plan pays for	What you must pay
Community Transition Services[3] The plan will pay for non-reoccurring expenses for you to transition from a nursing home to another residence where you are responsible for your own living arrangement. You must have a 6 month continuous stay in the nursing home to receive this service. Covered services may include: ▪ housing or security deposits ▪ utility hook-ups and deposits (excludes television and internet) ▪ furniture (limited) ▪ appliances (limited) ▪ moving expenses (excludes diversion or recreational devices) ▪ cleaning including pest eradication, allergen control, and over-all cleaning This service does not include ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes. Coverage is limited to once per year.	$0

[3] Prior Authorization may be required

General Services that our plan pays for	What you must pay
Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: ▪ The plan will pay for two counseling quit attempts in a 12-month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: ▪ The plan will pay for two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. As an added benefit, we will also cover certain gums and patches to help you quit smoking. Talk to your Care Coordinator for more information.	$0

General Services that our plan pays for	What you must pay
Dental services Aetna Better Health[SM] Premier Plan will pay for the following services: ▪ Examinations and evaluations are covered once every six months ▪ Cleaning is a covered benefit once every six months ▪ X-rays » Bitewing x-rays are a covered benefit only once in a 12-month period » A panoramic x-ray is a covered benefit once every five years » A full mouth or complete series of x-rays is a covered benefit once every five years ▪ Fillings ▪ Tooth extractions ▪ Complete or partial dentures are covered once every five years As an added benefit, we cover up to $800 comprehensive dental services each year. This includes services such as: ▪ Extractions ▪ Endodontic services (root canals) ▪ Periodontics (gum treatment) ▪ Restorative services (taking care of tooth decay, fillings and single-unit crowns) ▪ Anesthesia services when needed	$0
Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals, which include referrals to your primary care provider or the Prepaid Inpatient Health Plan (PIHP) for further assessment and services.	$0

General Services that our plan pays for	What you must pay
Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: ▪ High blood pressure (hypertension) ▪ History of abnormal cholesterol and triglyceride levels (dyslipidemia) ▪ Obesity ▪ History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.	$0

General Services that our plan pays for	What you must pay
Diabetic self-management training, services, and supplies The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): ▪ Supplies to monitor your blood glucose, including the following: » A blood glucose monitor » Blood glucose test strips » Lancet devices and lancets » Glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: » One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, ***or*** » One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. ▪ The plan will pay for training to help you manage your diabetes, in some cases.	$0

General Services that our plan pays for	What you must pay
Durable medical equipment and related supplies[4] (For a definition of "Durable medical equipment," see Chapter 12 of this handbook.) The following items are covered: ■ Breast Pumps ■ Canes ■ Commodes ■ CPAP Device ■ Crutches ■ Enteral Nutrition ■ Home Uterine Activity Monitor ■ Hospital Beds ■ Incontinence Supplies ■ Insulin Pump and Supplies ■ IV Infusion Pumps ■ Lifts, Slings and Seats ■ Lymphedema Pump ■ Nebulizers ■ Negative Pressure Wound Therapy ■ Orthopedic Footwear ■ Orthotics ■ Osteogenesis Stimulator ■ Ostomy Supplies ■ Oxygen Equipment ■ Parenteral Nutrition ■ Peak Flow Meter ■ Pressure Gradient Products	$0

[4] Prior Authorization may be required

General Services that our plan pays for	What you must pay
▪ Pressure Reducing Support Surfaces ▪ Prosthetics ▪ Pulse Oximeter ▪ Speech Generating Devices ▪ Surgical Dressings ▪ Tracheostomy Care Supplies ▪ Transcutaneous Electrical Nerve Stimulator ▪ Ventilators ▪ Walkers ▪ Wearable Cardioverter-Defibrillators ▪ Wheelchairs Some durable medical equipment is provided based on Michigan Medicaid policy. Requirements for referral, physician order and assessment apply along with limitations on replacement and repair. Other items may be covered, including environmental aids or assistive/adaptive technology. Aetna Better Health[SM] Premier Plan may also cover you learning how to use, modify, or repair your item. Your Integrated Care Team will work with you to decide if these other items and services are right for you and will be in your Plan of Care. Some items may also be covered through the Prepaid Inpatient Health Plan (PIHP) based on eligibility criteria. These items should be paid for by **either** the ICO **or** PIHP, **not by both**. We will pay for all medically necessary durable medical equipment that Medicare and Michigan Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you..	
Emergency care *Emergency care* means services that are: ▪ given by a provider trained to give emergency services, ***and***	$0

General Services that our plan pays for	What you must pay
▪ needed to treat a medical emergency. A *medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: ▪ placing the person's health in serious risk; ***or*** ▪ serious harm to bodily functions; ***or*** ▪ serious dysfunction of any bodily organ or part; ***or*** ▪ in the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur: » There is not enough time to safely transfer the member to another hospital before delivery. » The transfer may pose a threat to the health or safety of the member or unborn child. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay. Emergencies are only covered within the United States and its territories.	

General Services that our plan pays for	What you must pay
Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will pay for the following services: ■ Family planning exam and medical treatment ■ Family planning lab and diagnostic tests ■ Family planning methods (birth control pills, patch, ring, IUD, injections, implants) ■ Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) ■ Counseling and diagnosis of infertility, and related services ■ Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions ■ Treatment for sexually transmitted infections (STIs) ■ Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) ■ Genetic counseling The plan will also pay for some other family planning services. However, you must see a provider in the plan's network for the following services: ■ Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) ■ Treatment for AIDS and other HIV-related conditions ■ Genetic testing	$0
Health and wellness education programs We have programs focused on health conditions such as diabetes, asthma, congestive heart failure, and chronic obstructive pulmonary disease (COPD). As an added benefit we also have an adult weight management	$0

General Services that our plan pays for	What you must pay
program. This includes health coaching to help you succeed. For information about any of these programs, please talk to your Care Coordinator.	
Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. As an added benefit, you can get routine hearing exams every two years. We will also cover hearing aid costs up to $800 every three years.	$0
HIV screening The plan pays for one HIV screening exam every 12 months for people who: ▪ ask for an HIV screening test, ***or*** ▪ are at increased risk for HIV infection. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0

General Services that our plan pays for	What you must pay
Home health agency care[5] Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies ▪ Home health aide when provided with a nursing service	$0
Immunizations The plan will pay for the following services: ▪ Pneumonia vaccine ▪ Flu shots, once a year, in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B or Michigan Medicaid coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6, Section D, page 105 to learn more.	$0

[5] Prior Authorization is required.

General Services that our plan pays for	What you must pay
Inpatient hospital care[6] The plan will pay for the following services, and maybe other services not listed here: ■ Semi-private room (or a private room if it is medically necessary) ■ Meals, including special diets ■ Regular nursing services ■ Costs of special care units, such as intensive care or coronary care units ■ Drugs and medications ■ Lab tests ■ X-rays and other radiology services ■ Needed surgical and medical supplies ■ Appliances, such as wheelchairs ■ Operating and recovery room services ■ Physical, occupational, and speech therapy ■ Inpatient substance use disorder services ■ In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or at a distant location outside the service area. If Aetna Better Health[SM] Premier Plan provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. ■ Blood, including storage and administration	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

[6] Prior Authorization is required

General Services that our plan pays for	What you must pay
» The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. » The plan will pay for all other parts of blood beginning with the first pint used. ▪ Physician services	
Inpatient behavioral health care The plan will refer you to the Pre-paid Inpatient Health Plan (PIHP) for this service. Refer to Section E in this chapter on page 82 for more information.	$0
Kidney disease services and supplies[7] The plan will pay for the following services: ▪ Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. ▪ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, Section B, page 30. ▪ Inpatient dialysis treatments if you are admitted as an inpatient to a hospital for special care ▪ Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments ▪ Home dialysis equipment and supplies ▪ Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply	$0

[7] Some services may require Prior Authorization

General Services that our plan pays for	What you must pay
Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" below.	
Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if your treatment is needed in the next calendar year.	$0
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Aetna Better Health[SM] Premier Plan will pay for the following drugs: ▪ Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself	$0

General Services that our plan pays for	What you must pay
▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents] (such as Procrit®) ▪ IV immune globulin for the home treatment of primary immune deficiency diseases ➔ **Chapter 5, page 87 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. ➔ **Chapter 6, Section C, page 104 explains what you pay for your outpatient prescription drugs through our plan.**	
Non-emergency medical transportation The plan will cover transportation for you to travel to or from your medical appointments if it is a covered service. Types of non-emergency transportation include: ▪ Wheelchair equipped van ▪ Service car ▪ Taxicab	$0
Nursing facility care[8] The plan will pay for the following services, and maybe other services not listed here: ▪ A semi-private room, or a private room if it is medically needed ▪ Meals, including special diets	When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility.

[8] Prior Authorization is required.

General Services that our plan pays for	What you must pay
▪ Nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ▪ Medical and surgical supplies given by nursing facilities ▪ Lab tests given by nursing facilities ▪ X-rays and other radiology services given by nursing facilities ▪ Appliances, such as wheelchairs, usually given by nursing facilities ▪ Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's for payment: ▪ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ▪ A nursing facility where your spouse or significant other lives at the time you leave the hospital ▪ The nursing home where you were living when you enrolled in Aetna Better Health[SM] Premier Plan This service is intended to be long term custodial care and does not overlap with skilled nursing facility care. You must meet Michigan Medicaid Nursing Facility Level of Care standards to receive this service.	However, you might not end up having to pay each month. Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.
Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary	$0

General Services that our plan pays for	What you must pay
care provider to find out more. As an added benefit we also have an adult weight management program. This includes health coaching to help you succeed. For information about any of these programs, please talk to your Care Coordinator.	
Outpatient diagnostic tests and therapeutic services and supplies[9] The plan will pay for the following services, and maybe other services not listed here: ▪ X-rays ▪ Radiation (radium and isotope) therapy, including technician materials and supplies ▪ Surgical supplies, such as dressings ▪ Splints, casts, and other devices used for fractures and dislocations ▪ Lab tests ▪ Blood, beginning with the first pint of blood that you need, including storage and administration ▪ Other outpatient diagnostic tests	$0

[9] Prior Authorization may be required.

General Services that our plan pays for	What you must pay
Outpatient hospital services[10] The plan pays for medically needed services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services, and maybe other services not listed here: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ Labs and diagnostic tests billed by the hospital ▪ Behavioral health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ▪ X-rays and other radiology services billed by the hospital ▪ Medical supplies, such as splints and casts ▪ Some screenings and preventive services ▪ Some drugs that you can't give yourself	$0

[10] Prior Authorization may be required.

General Services that our plan pays for	What you must pay
Outpatient mental health care The plan will pay for mental health services provided by a state-licensed: ▪ psychiatrist or doctor, ▪ clinical psychologist, ▪ clinical social worker, ▪ clinical nurse specialist, ▪ nurse practitioner, ▪ physician assistant, ***or*** ▪ any other Medicare or Michigan Medicaid-qualified mental health care professional as allowed under applicable state laws. You may contact the PIHP, or the plan can refer you to the PIHP for some services. The plan will pay for the following services, and maybe other services not listed here: ▪ Clinic services ▪ Day treatment[11] ▪ Psychosocial rehab[11]	$0
Outpatient rehabilitation services[12] The plan will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	$0

[11] Must be provided in a Michigan Department of Community Health approved setting, must be provided as part of a person-centered plan of service, and must be medically necessary.
[12] Prior Authorization may be required.

General Services that our plan pays for	What you must pay
Outpatient surgery[13] The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	$0
Over-the-counter supplies As an added benefit, Aetna Better Health[SM] Premier Plan offers you $20 in certain over-the-counter (OTC) supplies each month. This benefit allows you to get some OTC supplies delivered to your home (up to $20 each month). This benefit can be used for supplies such as*: • Pain relievers • Digestion/Laxatives/Antacids • Cough/Cold/Allergy • First Aid *This is not a complete list. In order to use this benefit, you have to order through our vendor. We have an order form on our website at **www.aetnabetterhealth.com/michigan**. For more information talk to your Care Coordinator or call Member Services.	
Partial hospitalization services The plan will refer you to the Pre-paid Inpatient Health Plan (PIHP) for these services. Refer to Section E in this chapter on page 82 for more information.	$0

[13] Prior Authorization is required.

General Services that our plan pays for	What you must pay
Personal Care Services[14] The plan will pay for hands-on assistance to help you remain in your home for as long as possible. Services include assistance with activities of daily living (ADLs), which are tasks like bathing, eating, dressing, and toileting. This service can include instrumental activities of daily living (IADLs) but only when there is also a need for an ADL. IADLs include things like shopping, laundry, meal preparation, medication reminders, and taking you to your appointments.	$0
Personal Emergency Response System[15] The plan covers an electronic in home device that secures help in an emergency. You may also wear a portable "help" button to allow for mobility. The system is connected to your phone and programmed to signal a response center once a "help" button is activated.	$0

[14] Prior Authorization is required.
[15] Prior Authorization is required.

General Services that our plan pays for	What you must pay
Physician/provider services, including doctor's office visits The plan will pay for the following services: ▪ Medically necessary health care or surgery services given in places such as: » physician's office » certified ambulatory surgical center » hospital outpatient department ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams given by your primary care provider, if your doctor orders it to see whether you need treatment ▪ Second opinion by another network provider before a medical procedure ▪ Non-routine dental care. Covered services are limited to: » surgery of the jaw or related structures, » setting fractures of the jaw or facial bones, » pulling teeth before radiation treatments of neoplastic cancer, ***or*** » services that would be covered when provided by a physician.	$0
Podiatry services The plan will pay for the following services: ▪ Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) ▪ Routine foot care for members with conditions affecting the legs, such as diabetes As an added benefit we cover one adult routine podiatry visit every three months.	$0

General Services that our plan pays for	What you must pay
Prostate cancer screening exams For men age 50 and older, the plan will pay for the following services once every 12 months: ▪ A digital rectal exam ▪ A prostate specific antigen (PSA) test	$0

General Services that our plan pays for	What you must pay
Prosthetic devices and related supplies[16] *Prosthetic devices* replace all or part of a body part or function. The plan will pay for the following prosthetic devices, and maybe other devices not listed here: ■ Colostomy bags and supplies related to colostomy care ■ Pacemakers ■ Braces ■ Prosthetic shoes ■ Artificial arms and legs ■ Breast prostheses (including a surgical brassiere after a mastectomy) The plan will also pay for some supplies related to prosthetic devices. They will also pay to repair or replace prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See "Vision Care" later in this section on page 77 for details. The plan will not pay for prosthetic dental devices except for full and partial dentures (see "Dental services").	$0
Pulmonary rehabilitation services[17] The plan will pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). The member must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	$0

[16] Prior Authorization may be required.
[17] Prior Authorization may be required.

General Services that our plan pays for	What you must pay
Respite[18] You may receive respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. Respite is limited to 14 overnight stays per 365 days unless Aetna Better Health[SM] Premier Plan approves additional time.	$0
Sexually transmitted infections (STIs) screening and counseling The plan will pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. The plan will also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. The plan will pay for these counseling sessions as a preventive service only if they are given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	$0
Skilled nursing facility care[19] The plan will pay for the following services, and maybe other	$0

[18] Prior Authorization is required
[19] Prior Authorization is required.

General Services that our plan pays for	What you must pay
services not listed here: ■ A semi-private room, or a private room if it is medically needed ■ Meals, including special diets ■ Nursing services ■ Physical therapy, occupational therapy, and speech therapy ■ Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors ■ Blood, including storage and administration: » The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. » The plan will pay for all other parts of blood beginning with the first pint used. ■ Medical and surgical supplies given by nursing facilities ■ Lab tests given by nursing facilities ■ X-rays and other radiology services given by nursing facilities ■ Appliances, such as wheelchairs, usually given by nursing facilities ■ Physician/provider services A hospital stay is not required to receive Skilled Nursing Facility care. You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: ■ A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) ■ A nursing facility where your spouse lives at the time you leave the hospital	

General Services that our plan pays for	What you must pay
Urgently needed care *Urgently needed care* is care given to treat: ▪ a non-emergency, ***or*** ▪ a sudden medical illness, ***or*** ▪ an injury, ***or*** ▪ a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider. We only cover urgently needed care within the United States and its territories.	$0
Vision care Routine eye examinations are covered once every year. The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions. The plan will pay for basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids.) The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: ▪ people with a family history of glaucoma, ▪ people with diabetes, and ▪ African-Americans who are age 50 and older. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs	$0

General Services that our plan pays for	What you must pay
of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also pay for corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant.	
"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: ▪ a review of your health, ▪ education and counseling about the preventive services you need (including screenings and shots), and ▪ referrals for other care if you need it. **Important:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0
Home and Community Based Waiver Services that our plan pays for	**What you must pay**
Adult Day Program[20] The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: ▪ provides personal attention, and ▪ promotes social, physical and emotional well-being	$0
Assistive Technology[21] The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify.	$0

[20] Prior Authorization is required.
[21] Prior Authorization is required.

General Services that our plan pays for	What you must pay
Some examples of services include: ▪ van lifts ▪ hand controls ▪ computerized voice system ▪ communication boards ▪ voice activated door locks ▪ power door mechanisms ▪ specialized alarm or intercom ▪ assistive dialing device	
Chore Services[22] The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include: ▪ heavy household chores (washing floors, windows, and walls) ▪ tacking loose rugs and tiles ▪ moving heavy items of furniture ▪ mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks.	$0
Environmental Modifications[23] The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include:	$0

[22] Prior Authorization is required.
[23] Prior Authorization is required.

General Services that our plan pays for	What you must pay
▪ installing ramps and grab bars ▪ widening of doorways ▪ modifying bathroom facilities ▪ installing specialized electric systems that are necessary to accommodate medical equipment and supplies	
Expanded Community Living Supports[24] To get this service, you MUST have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself.	$0
Fiscal Intermediary Services[25] The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community based services authorized in your plan of care. You have the authority to hire the caregiver of your choice.	$0
Home delivered meals[26] The plan covers up to two prepared meals per day brought to your home if you qualify.	$0

[24] Prior Authorization is required.
[25] Prior Authorization is required.
[26] Prior Authorization is required.

General Services that our plan pays for	What you must pay
Non-medical transportation[27] The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify.	$0
Preventive Nursing Services[28] The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may receive other nursing services during the nurse visit to your home. These services are not provided on a continuous basis.	$0
Private Duty Nursing (PDN)[29] The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service.	$0

[27] Prior Authorization is required.
[28] Prior Authorization is required.
[29] Prior Authorization is required.

General Services that our plan pays for	What you must pay
Respite Care Services[30] You may receive respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time.	

E. Covered benefits provided through the Prepaid Inpatient Health Plan (PIHP)

The following services are covered by Aetna Better Health[SM] Premier Plan but are available through the Pre-paid Inpatient Health Plan (PIHP) and its provider network.

Inpatient behavioral health care

The plan will pay for behavioral health care services that require a hospital stay.

Outpatient substance use disorder services

We will pay for treatment services that are provided in the outpatient department of a hospital if you, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or if you require treatment but do not require the level of services provided in the inpatient hospital setting.

Partial hospitalization services

Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital.

➔ Please see the separate PIHP Member Handbook for more information and work with your Care Coordinator to get services provided through the PIHP.

[30] Prior Authorization is required.

F. Benefits *not* covered by the plan

This section tells you what kinds of benefits are excluded by the plan. *Excluded* means that the plan does not pay for these benefits.

The list below describes some services and items that are not covered by the plan under any conditions and some that are excluded by the plan only in some cases.

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*). Medicare and Michigan Medicaid will not pay for them either. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, see Chapter 9, Section 5.3, page 137.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this *Member Handbook*, **the following items and services are not covered by our plan:**

- Services considered not "reasonable and necessary," according to the standards of Medicare and Michigan Medicaid, unless these services are listed by our plan as covered services.
- Experimental medical and surgical treatments, items, and drugs, unless covered by Medicare or under a Medicare-approved clinical research study or by our plan. See Chapter 3, Section K, page 39 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is medically needed and Medicare pays for it.
- A private room in a hospital or nursing facility, except when it is medically needed.
- Private duty nurses except for those that qualify for this waiver service.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically needed.
- Cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, the plan will pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare and Michigan Medicaid coverage guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

- Radial keratotomy, LASIK surgery, and vision therapy. However, the plan will pay for glasses after cataract surgery.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Hospice services: If you choose to enroll in a hospice program, you will be disenrolled from Aetna Better Health[SM] Premier Plan and receive all of your medical care and services through Original Medicare and Original (fee-for-service) Michigan Medicaid.
- Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.

Chapter 5: Getting your outpatient prescription drugs through the plan

Table of Contents

Introduction

This chapter explains rules for getting your *outpatient prescription drugs.* These are drugs that your provider orders for you that you get from a pharmacy or by mail order. They include drugs covered under Medicare Part D and Michigan Medicaid.

Aetna Better Health[SM] Premier Plan also covers the following drugs, although they will not be discussed in this chapter:

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, see the Benefits Chart in Chapter 4, Section D, page 46.

Rules for the plan's outpatient drug coverage

The plan will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider you see such as a specialists

   You generally must use a network pharmacy to fill your prescription.

2. Your prescribed drug must be on the plan's *List of Covered Drugs*. We call it the "Drug List" for short.

   - If it is not on the Drug List, we may be able to cover it by giving you an exception. See page 96 to learn about asking for an exception.

3. Your drug must be used for a *medically accepted indication.* This means that the use of the drug is either approved by the Food and Drug Administration or supported by certain reference books.

A. Getting your prescriptions filled

Fill your prescription at a network pharmacy

In most cases, the plan will pay for prescriptions *only* if they are filled at the plan's network pharmacies. A *network pharmacy* is a drug store that has agreed to fill prescriptions for our plan members. You may go to any of our network pharmacies.

➔ To find a network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact your Care Coordinator or Member Services.

Show your plan ID card when you fill a prescription

To fill your prescription, **show your plan ID card** at your network pharmacy. The network pharmacy will bill the plan for your covered prescription drug. You will not be required to pay a copay.

If you do not have your plan ID card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, *you may have to pay the full cost of the prescription when you pick it up.* You can then ask us to pay you back. If you cannot pay for the drug, contact Member Services right away. We will do what we can to help.

➔ To learn how to ask us to pay you back, see Chapter 7, Section B, page 109.

➔ If you need help getting a prescription filled, you can contact your Care Coordinator or Member Services.

What if you want to change to a different network pharmacy?

If you change pharmacies and need a refill of a prescription, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy.

➔ If you need help changing your network pharmacy, you can contact your Care Coordinator or Member Services.

What if the pharmacy you use leaves the network?

If the pharmacy you use leaves the plan's network, you will have to find a new network pharmacy.

➔ To find a new network pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact your Care Coordinator or Member Services.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a *specialized pharmacy.* Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long term care facility, such as a nursing home. Usually, long term care facilities have their own pharmacies. Residents may get prescription drugs through a facility's pharmacy as long as it is part of our network. If your long term care facility's pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that supply drugs requiring special handling and instructions on their use.

➔ To find a specialized pharmacy, you can look in the *Provider and Pharmacy Directory*, visit our website, or contact your Care Coordinator or Member Services.

Can you use mail-order services to get your drugs?

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs that are not available through the plan's mail-order service are marked with "NM" in our Drug List.

Our plan's mail-order service allows you to order up to a 90-day supply. A 90-day supply has no co-pay.

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, talk to your Care Coordinator or call Member Services. Forms are also available on our website at **www.aetnabetterhealth.com/michigan**.

Usually, a mail-order prescription will get to you within 14 days. If a mail order is delayed by the mail order pharmacy, you will be contacted and told about the delay. If you have not received an order within 14 calendar days of when you sent the order, call CVS Caremark Customer Care at **1-800-552-8159** (**TTY 1-800-231- 4403**) and they will begin processing a replacement order. The order will be quickly sent to you. Calls to this number are free.

How will the mail-order service process my prescription?

The mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions:

1. **New prescriptions the pharmacy receives from you**

   The pharmacy will automatically fill and deliver new prescriptions it receives from you.

2. **New prescriptions the pharmacy receives directly from your provider's office**

   After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop or delay the order before it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

3. **Refills on mail-order prescriptions**

   For refills of your drugs, you have the option to sign up for an automatic refill program called Ready Fill at Mail. Under this program we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

   To opt out of our program Ready Fill at Mail that automatically prepares mail order refills, please contact us by calling CVS Caremark Customer Care at **1-800-552-8159**.

   So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Call Member Services or your Care Coordinator to make sure we have your correct contact information. If we don't know the best way to reach you, you might miss the chance to tell us whether you want a refill and you could run out of your prescription drugs. Remember, your drugs will not be shipped unless you confirm you still want to receive the order. This policy won't affect refill reminder programs in which you go in person to pick up the prescription and it won't apply to long–term care pharmacies that give out and deliver prescription drugs.

Can you get a long term supply of drugs?

You can get a long term supply of *maintenance drugs* on our plan's Drug List. *Maintenance drugs* are drugs that you take on a regular basis, for a chronic or long term medical condition.

Some network pharmacies allow you to get a long term supply of maintenance drugs. A 90-day supply has no co-pay. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long term supply of maintenance drugs. You can also call Member Services for more information.

For certain kinds of drugs, you can use the plan's network mail-order services to get a long term supply of maintenance drugs. See the section above on page 90 to learn about mail-order services.

Can you use a pharmacy that is not in the plan's network?

Generally, we pay for drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- Prescriptions you get in connection with emergency care.
- Prescriptions you get in connection with urgently needed care when network pharmacies are not available.
- If you are unable to obtain a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distances that provides 24 hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).
- If you are traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot access a network pharmacy.
- If you receive a Part D prescription drug, dispensed by an out-of-network institutional-based pharmacy while you are in the emergency department, provider-based clinic, outpatient surgery or other outpatient setting.
- If you have not received your prescription during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence.

➔ In these cases, please check first with Member Services to see if there is a network pharmacy nearby.

Will the plan pay you back if you pay for a prescription?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost when you get your prescription. You can ask us to pay you back.

➔ To learn more about this, see Chapter 7, Section A, page 107.

B. The plan's Drug List

The plan has a *List of Covered Drugs.* We call it the "Drug List" for short.

The drugs on the Drug List are selected by the plan with the help of a team of doctors and pharmacists. The Drug List also tells you if there are any rules you need to follow to get your drugs.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

What is on the Drug List?

The Drug List includes the drugs covered under Medicare Part D and some prescription and over-the-counter drugs covered under your Michigan Medicaid benefits.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same active ingredients as brand-name drugs. Generally, they work just as well as brand-name drugs and usually cost less.

We will generally cover a drug on the plan's Drug List as long as you follow the rules explained in this chapter.

Our plan also covers certain over-the-counter drugs and products. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

How can you find out if a drug is on the Drug List?

To find out if a drug you are taking is on the Drug List, you can:

- Check the most recent Drug List we sent you in the mail.
- Visit the plan's website at **www.aetnabetterhealth.com/michigan**. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

What is *not* on the Drug List?

The plan does not cover all prescription drugs. Some drugs are not on the Drug List because the law does not allow the plan to cover those drugs. In other cases, we have decided not to include a drug on the Drug List.

Aetna Better Health[SM] Premier Plan will *not* pay for the drugs listed in this section. These are called *excluded drugs.* If you get a prescription for an excluded drug, you must pay for it yourself. If you

think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, see Chapter 9 Section 5.3, page 137.)

Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage (Medicare Part D) cannot cover a drug that would be covered under Medicare Part A or Part B. Drugs that would be covered under Medicare Part A or Part B are covered under our plan's medical benefit.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- The use of the drug must be either approved by the Food and Drug Administration or supported by certain reference books as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called *off-label use.* Our plan usually does not cover drugs when they are prescribed for off-label use.

Also, by law, the types of drugs listed below are not covered by Medicare or Michigan Medicaid.

- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs when the company who makes the drugs say that you have to have tests or services done only by them

What are tiers?

Every drug on the plan's Drug List is in one of 3 tiers.

Tier 1	Part D eligible generic drugs. No copay.
Tier 2	Part D eligible brand drugs. No copay
Tier 3	Non Part D eligible prescription and over the counter drugs. No copay.

To find out which tier your drug is in, look for the drug in the plan's Drug List.

C. Limits on coverage for some drugs

Why do some drugs have limits?

For certain prescription drugs, special rules limit how and when the plan covers them. In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug will work just as well as a higher-cost drug, the plans expects your provider to use the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider think our rule should not apply to your situation, you should ask us to make an exception. We may or may not agree to let you use the drug without taking the extra steps.

➔ To learn more about asking for exceptions, see Chapter 9,Section 6.2, page 150.

What kinds of rules are there?

1. Limiting use of a brand-name drug when a generic version is available

Generally, a generic drug works the same as a brand-name drug and usually costs less. If there is a generic version of a brand-name drug, our network pharmacies will give you the generic version. We usually will not pay for the brand-name drug when there is a generic version. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand-name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from Aetna Better Health[SM] Premier Plan before you fill your prescription. If you don't get approval, Aetna Better Health[SM] Premier Plan may not cover the drug.

3. Trying a different drug first

In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.
If Drug A does not work for you, the plan will then cover Drug B. This is called *step therapy*.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. For example, the plan might limit:

- how many refills you can get, ***or***
- how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

To find out if any of the rules above apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services or check our website at **www.aetnabetterhealth.com/michigan**.

D. Why your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug might not be covered in the way that you would like it to be. For example:

- **The drug you want to take is not covered by the plan.** The drug might not be on the Drug List. A generic version of the drug might be covered, but the brand name version you want to take is not. A drug might be new and we have not yet reviewed it for safety and effectiveness.
- **The drug is covered, but there are special rules or limits on coverage for that drug.** As explained in the section above on page 94, some of the drugs covered by the plan have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception to a rule.

There are things you can do if your drug is not covered in the way that you would like it to be.

You can get a temporary supply

In some cases, the plan can give you a temporary supply of a drug when the drug is not on the Drug List or when it is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask the plan to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. **The drug you have been taking:**
   - is no longer on the plan's Drug List, ***or***
   - was never on the plan's Drug List, ***or***
   - is now limited in some way.
2. **You must be in one of these situations:**

   For Medicare Part D Drugs:

We will cover a temporary supply of your drug **during the first 90 days of the calendar year**. This temporary supply will be for up to 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 day supply of medication. You must fill the prescription at a network pharmacy.

- **You are new to the plan and do not live in a long term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. This temporary supply will be for up to a 30 day supply of medication.

- **You are new to the plan and live in a long term care facility.**

  We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The total supply will be for up to a 91-day supply and may be up to a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 98 days of medication. (Please note that the long term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **You have been in the plan for more than 90 days and live in a long term care facility and need a supply right away.**

  We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long term care transition supply.

For Michigan Medicaid drugs:

- **You are new to the plan.**

  We will cover a supply of your Michigan Medicaid drug for up to 180 calendar days after enrollment and will not terminate it at the end of the 180 calendar days without advance notice to you and a transition to another drug, if needed.

➔ To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. Here are your choices:

- **You can change to another drug.**

  There may be a different drug covered by the plan that works for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. The list can help your provider find a covered drug that might work for you.

  OR

- **You can ask for an exception.**

You and your provider can ask the plan to make an exception. For example, you can ask the plan to cover a drug even though it is not on the Drug List. Or you can ask the plan to cover the drug without limits. If your provider says you have a good medical reason for an exception, he or she can help you ask for one.

➔ To learn more about asking for an exception, see Chapter 9, Section 6.2, page 150.

➔ If you need help asking for an exception, you can contact your Care Coordinator or Member Services.

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1. However, the plan might make changes to the Drug List during the year. The plan might:

- Add drugs because new drugs, including generic drugs, became available or the government approved a new use for an existing drug.
- Remove drugs because they were recalled or because cheaper drugs work just as well.
- Add or remove a limit on coverage for a drug.
- Replace a brand-name drug with a generic drug.

If any of the changes below affect a drug you are taking, the change will not affect you until January 1 of the next year:

- We put a new limit on your use of the drug.
- We remove your drug from the Drug List, but not because of a recall or because a new generic drug has replaced it.

Before January 1 of the next year, you usually will not have added limits to your use of the drug. The changes will affect you on January 1 of the next year.

In the following cases, you *will* be affected by the coverage change before January 1:

- If a brand name drug you are taking is replaced by a new generic drug, the plan must give you at least 60 days' notice about the change.
  - » The plan may give you a 60-day refill of your brand-name drug at a network pharmacy.
  - » You should work with your provider during those 60 days to change to the generic drug or to a different drug that the plan covers.
  - » You and your provider can ask the plan to continue covering the brand-name drug for you. To learn how, see Chapter 9, Section 6.2, page 150.

- If a drug is recalled because it is found to be unsafe or for other reasons, the plan will remove the drug from the Drug List. We will tell you about this change right away.
  - » Your provider will also know about this change. He or she can work with you to find another drug for your condition.

➔ If there is a change to coverage for a drug you are taking, **the plan will send you a notice.** Normally, the plan will let you know at least 60 days before the change.

F. Drug coverage in special cases

If you are in a hospital or a skilled nursing facility for a stay that is covered by the plan

If you are admitted to a hospital or skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. You will not have to pay a co-pay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage.

If you are in a long term care facility

Usually, a long term care facility, such as a nursing home, has its own pharmacy or a pharmacy that supplies drugs for all of its residents. If you are living in a long term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long term care facility's pharmacy is part of our network. If it is not, or if you need more information, please contact Member Services.

If you are in a long term care facility and become a new member of the plan

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a temporary supply of your drug during the first 90 days of your membership, until we have given you a 91 and may be up to 98-day supply. The first supply will be for up to 31-day supply, or less if your prescription is written for fewer days. If you need refills, we will cover them during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and you need a drug that is not on our Drug List, we will cover one 31-day supply. We will also cover one 31-day supply if the plan has a limit on the drug's coverage. If your prescription is written for fewer than 31 days, we will pay for the smaller amount.

When you get a temporary supply of a drug, you should talk with your provider to decide what to do when your supply runs out. A different drug covered by the plan might work just as well for you. Or you and your provider can ask the plan to make an exception and cover the drug in the way you would like it to be covered.

➔ To learn more about asking for exceptions, see Chapter 9, Section 6.2, page 150.

If you are in a Medicare-certified hospice program

If you choose the Medicare hospice benefit, you will be disenrolled from the MI Health Link program. You will receive the hospice benefit through Original Medicare.

G. Programs on drug safety and managing drugs

Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as:

- Drug errors
- Drugs that may not be needed because you are taking another drug that does the same thing
- Drugs that may not be safe for your age or gender
- Drugs that could harm you if you take them at the same time
- Drugs that are made of things you are allergic to

If we see a possible problem in your use of prescription drugs, we will work with your provider to correct the problem.

Programs to help members manage their drugs

If you take medications for different medical conditions, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program helps you and your provider make sure that your medications are working to improve your health. A pharmacist or other health professional will give you a comprehensive review of all your medications and talk with you about:

- How to get the most benefit from the drugs you take
- Any concerns you have, like medication costs and drug reactions
- How best to take your medications
- Any questions or problems you have about your prescription and over-the-counter medication

You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication

list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

Medication therapy management programs are voluntary and free to members that qualify. If we have a program that fits your needs, we will enroll you in the program and send you information. If you do not want to be in the program, please let us know, and we will take you out of the program.

➔ If you have any questions about these programs, please contact your Care Coordinator or Member Services.

Chapter 6: What you pay for your Medicare and Medicaid prescription drugs

Table of Contents

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, ***and***
- drugs and items covered under Michigan Medicaid, ***and***
- drugs and items covered by the plan as additional benefits.

Because you are eligible for Michigan Medicaid, you are getting "Extra Help" from Medicare to help pay for your Medicare Part D prescription drugs.

To learn more about prescription drugs, you can look in these places:

- **The plan's *List of Covered Drugs.*** We call this the "Drug List." It tells you:
  - » Which drugs the plan pays for
  - » Which of the 3 tiers each drug is in
  - » Whether there are any limits on the drugs

  If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at **www.aetnabetterhealth.com/michigan**. The Drug List on the website is always the most current.
- **Chapter 5 of this Member Handbook.** Chapter 5, page 87 tells how to get your outpatient prescription drugs through the plan. It includes rules you need to follow. It also tells which types of prescription drugs are *not* covered by our plan.
- **The plan's *Provider and Pharmacy Directory.*** In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that have agreed to work with our plan. The *Provider and Pharmacy Directory* has a list of network pharmacies. You can read more about network pharmacies in Chapter 5, Section A, page 88.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of your total drug costs. This includes the amount of money the plan pays (or others pay for you) for your prescriptions.

When you get prescription drugs through the plan, we send you a report called the *Explanation of Benefits.* We call it the *EOB* for short. The EOB includes:

- **Information for the month**. The report tells what prescription drugs you got. It shows the total drug costs and what the plan paid, and what others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made for you since January 1.

➔ We offer coverage of drugs not covered under Medicare. Payments made for these drugs will not count towards your Part D total out-of-pocket costs. To find out which drugs our plan covers, see the Drug List.

B. Keeping track of your drug costs

To keep track of drug costs, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your plan ID card.

Show your plan ID card every time you get a prescription filled. This will help us know what prescriptions you fill.

2. Send us information about the payments others have made for you.

Payments made by certain other people and organizations also count toward your total costs. For example, payments made by a state pharmaceutical assistance program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs.

3. Check the reports we send you.

When you get an Explanation of Benefits in the mail, please make sure it is complete and correct. If you think something is wrong or missing from the report, or if you have any questions, please call Member Services. Be sure to keep these reports. They are an important record of your drug expenses.

C. A summary of your drug coverage

The plan's tiers

Tiers are groups of drugs. Every drug on the plan's Drug List is in one of 3 tiers. There is no cost to you for drugs on any of the tiers.

- Tier 1 drugs are Part D eligible generic drugs.
- Tier 2 drugs are Part D eligible brand drugs.
- Tier 3 drugs are Medicaid eligible prescription and over-the-counter drugs.

Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. There is no cost to you for a long-term supply.

➔ For details on where and how to get a long-term supply of a drug, see Chapter 5, Section A, page 88 or the *Provider and Pharmacy Directory.*

Your coverage for a *one-month or long-term* supply of a covered prescription drug from:	**A network pharmacy** A one-month or up to a 90-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 90-day supply	**An out-of-network pharmacy** Up to a 90-day supply. Coverage is limited to certain cases. See Chapter 5 for details.
Tier 1 (Part D generic drugs)	$0	$0	$0	$0
Tier 2 (Part D brand name drugs)	$0	$0	$0	$0
Tier 3 (Medicaid and over the counter prescription drugs)	$0	$0 Mail order is not available for Tier 3.	$0	$0

➔ For information about which pharmacies can give you long-term supplies, see the plan's *Provider and Pharmacy Directory.*

D. Vaccinations

Our plan covers Medicare Part D vaccines. You will not have to pay for vaccines if you receive the vaccine through an in-network provider.

There are two parts to our coverage of Medicare Part D vaccinations:

1. The first part of coverage is for the cost of **the vaccine itself**. The vaccine is a prescription drug.
2. The second part of coverage is for the cost of **giving you the shot**.

Before you get a vaccination

We recommend that you call us first at Member Services whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan

Chapter 7: Asking us to pay a bill you have gotten for covered services or drugs

Table of Contents

A. When you can ask us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your services and drugs already received. A *network provider* is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, see page 109.

- If the services or drugs are covered, we will pay the provider directly.
- If the services or drugs are covered and you already paid the bill, we will pay you back. It is your right to be paid back if you paid for the services or drugs.
- If the services or drugs are **not** covered, we will tell you.

➔ Contact Member Services or your Care Coordinator if you have any questions. If you get a bill and you do not know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   You should ask the provider to bill the plan.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you do not owe. Send us the bill and proof of any payment you made.
     - » If the provider should be paid, we will pay the provider directly.
     - » If you have already paid for the service, we will pay you back.

2. **When a network provider sends you a bill**

   Network providers must always bill the plan.

   - Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
   - If you have already paid a bill from a network provider, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. **When you use an out-of-network pharmacy to get a prescription filled**

   If you go to an out-of-network pharmacy, you will have to pay the full cost of your prescription.

➔ In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back. Please see Chapter 5, Section A, page 88 to learn more about out-of-network pharmacies.

4. **When you pay the full cost for a prescription because you do not have your plan ID card with you**

   If you do not have your plan ID card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.

   - Send us a copy of your receipt when you ask us to pay you back.

5. **When you pay the full cost for a prescription for a drug that is not covered**

   You may pay the full cost of the prescription because the drug is not covered.

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
  - » If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (see Chapter 9, Section 4, page 131).
  - » If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (see Chapter 9, Section 5.2, page 135).
- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

When you send us a request for payment, we will review your request and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide it should be covered, we will pay for the service or drug. If we deny your request for payment, you can appeal our decision.

➔ To learn how to make an appeal, see Chapter 9, Section 5.3, page 137.

B. How and where to send us your request for payment

Send us your bill and proof of any payment you have made. Proof of payment can be a copy of the check you wrote or a receipt from the provider. It is a good idea to make a copy of your bill and receipts for your records. You can ask your Care Coordinator for help.

Mail your request for payment together with any bills or receipts to us at this address:

Aetna Better Health[SM] Premier Plan
Attn: Member Services Department
1333 Gratiot Avenue, Suite 400
Detroit, MI 48207

You may also call our plan to request payment. Call Member Services at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week.

C. We will make a coverage decision

When we get your request for payment, we will make a *coverage decision.* This means that we will decide whether your health care or drug is covered by the plan. We will also decide the amount, if any, you have to pay for the health care or drug.

- We will let you know if we need more information from you.
- If we decide that the health care or drug is covered and you followed all the rules for getting it, we will pay for it. If you have already paid for the service or drug, we will mail you a check for what you paid. If you have not paid for the service or drug yet, we will pay the provider directly.

➔ Chapter 3, Section B, page 30 explains the rules for getting your services covered. Chapter 5, Section A, page 88 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.

➔ To learn more about coverage decisions, see Chapter 9, Section 4, page 131.

D. You can make an appeal

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called *making an appeal.* You can also make an appeal if you do not agree with the amount we pay.

➔ The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, see Chapter 9, Section 5.3, page 137.

- If you want to make an appeal about getting paid back for a health care service, go to page 147.
- If you want to make an appeal about getting paid back for a drug, go to page 148.

Chapter 8: Your rights and responsibilities

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Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights.

A. You have a right to get information in a way that meets your needs

We must tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

➔ To get information in a way that you can understand, call Member Services at **1-855-676-5772** (TTY **711**) or your Care Coordinator at **1-855-676-5772** (TTY **711**). Our plan has people who can answer questions in different languages. We can also give you information in Braille or large print.

➔ If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at **1-800-MEDICARE** (1-800-633-4227). You can call 24 hours a day, seven days a week. **TTY** users should call **1-877-486-2048**. You may also file a complaint with Michigan Medicaid. Please see Chapter 9 for more information.

B. We must treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Race
- Ethnicity
- National origin
- Religion
- Sex
- Sexual orientation
- Age
- Mental ability
- Behavior
- Mental or physical disability
- Health status
- Receipt of health care
- Use of services
- Claims experience
- Appeals
- Medical history
- Genetic information
- Evidence of insurability
- Geographic location within the service area

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience or retaliation.

We cannot deny services to you or punish you for exercising your rights.

➔ For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697). You can also call the Michigan Department of Civil Rights at 1-800-482-3604.

➔ If you have a disability and need help accessing care or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. We must ensure that you get timely access to covered services and drugs

If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A *network provider* is a provider who works with the health plan. You also have the right to change the PCP within your health plan.
  - » Call Member Services or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a gynecologist or another women's health specialist without getting a referral. We do not require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
  - » This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3, Section D, page 32.

Chapter 9, Section 5, page 134 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9, Section 5.3, page 137 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. We must protect your personal health information

We protect your personal health information as required by federal and state laws.

- Your personal health information includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.
- You have rights to get information and to control how your health information is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your health information.

How we protect your health information

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your health information to anyone who is not providing your care or paying for your care. If we do, *we are required to get written permission from you first.* Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
  - » We are required to release health information to government agencies that are checking on our quality of care.
  - » We are required to give Medicare and Michigan Medicaid your health and drug information. If Medicare or Michigan Medicaid releases your information for research or other uses, it will be done according to Federal and State laws.

You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a reasonable fee for making a copy of your medical records.
- You have the right to amend or correct information in your medical records. The correction will become part of your record.
- You have the right to know if and how your health information has been shared with others.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

Notice of Privacy Practices

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

Please review it carefully.

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

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

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

How we use and share your health information

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

Share with family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us.

If you are under eighteen and don't want us to give your health information to your parents. Call us. We can help in some cases if allowed by state law.

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

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

- Health promotion
- Case management
- Quality improvement

- Fraud prevention
- Disease prevention
- Legal matters

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

Sharing with other businesses

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

Other reasons we might share your health information

We also may share your health information for these reasons:

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

Reasons that we will need your written okay

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

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

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

What are your rights?

You have the right to look at your health information.

- You can ask us for a copy of it.
- You can ask for your medical records. Call your doctor's office or the place where you were treated.

You have the right to ask us to change your health information.

- You can ask us to change your health information if you think it is not right.
- If we don't agree with the change you asked for. Ask us to file a written statement of disagreement.

You have the right to get a list of people or groups that we have shared your health information with.
You have the right to ask for a private way to be in touch with you.

- If you think the way we keep in touch with you is not private enough, call us.
- We will do our best to be in touch with you in a way that is more private.

You have the right to ask for special care in how we use or share your health information.

- We may use or share your health information in the ways we describe in this notice.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.

You have the right to know if your health information was shared without your okay.

- We will tell you if we do this in a letter.

Call us toll free at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week to:

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

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

Aetna Better Health[SM] Premier Plan
Attn: Privacy Officer
1333 Gratiot Avenue, Suite 400
Detroit, MI 48207

You also can file a complaint with regard to your privacy with the U.S. Department of Health and Human Services, Office for Civil Rights. Call us toll free at **1-855-676-5772** (TTY **711**) to get the address.

If you are unhappy and tell the Office for Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.

Protecting your information

We protect your health information with specific procedures, such as:

- Administrative. We have rules that tell us how to use your health information no matter what form it is in – written, oral or electronic.
- Physical. Your health information is locked up and is kept in safe areas. We protect entry to our computers and buildings. This helps us to block unauthorized entry.
- Technical. Access to your health information is "role-based." This allows only those who need to do their job and give care to you to have access.

We follow all state and federal laws for the protection of your health information.

Will we change this notice?

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

E. We must give you information about the plan, its network providers, and your covered services

As a member of Aetna Better Health[SM] Premier Plan, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at **1-855-676-5772** (TTY **711**). This is a free service. We can also give you information in Braille or large print.

If you want any of the following, call Member Services:

- **Information about how to choose or change plans**
- **Information about our plan, including:**
  - » Financial information
  - » How the plan has been rated by plan members

- » The number of appeals made by members
- » How to leave the plan

- **Information about our network providers and our network pharmacies, including:**
  - » How to choose or change primary care providers
  - » The qualifications of our network providers and pharmacies
  - » How we pay the providers in our network

  ➔ For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at **www.aetnabetterhealth.com/michigan**.

- **Information about covered services and drugs and about rules you must follow, including:**
  - » Services and drugs covered by the plan
  - » Limits to your coverage and drugs
  - » Rules you must follow to get covered services and drugs

- **Information about why something is not covered and what you can do about it, including:**
  - » Asking us to put in writing why something is not covered
  - » Asking us to change a decision we made
  - » Asking us to pay for a bill you have received

F. Network providers cannot bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7, Section A, page 107.

G. You have the right to leave the plan at any time

No one can make you stay in our plan if you do not want to. You can leave the plan at any time. If you leave our plan, you will still be in the Medicare and Michigan Medicaid programs. You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan. You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan. If there is another MI Health Link plan in your service area, you may also change to a different MI Health Link plan and continue to receive the coordinated Medicare and

Michigan Medicaid benefits. You can get your Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.

H. You have a right to make decisions about your health care

You have the right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices *in a way that you can understand*.

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **You can get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **You can say "no.**" You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **You can ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **You can ask us to cover a service or drug that was denied or is usually not covered.** Chapter 9, Section 4, page 131 tells how to ask the plan for a coverage decision.

You have the right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you**.
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an *advance directive.* There are different types of advance directives and different names for them. Examples are a psychiatric advance directive and a durable power of attorney for health care.

Now is a good time to write down your advance directives because you can make your wishes known while you are healthy. Your doctor's office has an advance directive you fill out to tell your doctor what you want done. Your advance directive often includes a do-not-resuscitate order. Some people do this after talking to their doctor about their health status. It gives written notice to health care workers who may be treating you should you stop breathing or your heart stops. Your doctor can help you with this if you are interested.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Michigan Medicaid such as the Michigan Office of Services to the Aging and the Michigan State Long Term Care Ombudsman Program may also have advance directive forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

- The hospital will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

What to do if your instructions are not followed

In Michigan, your advance directive has binding effect on doctors and hospitals. However, if you believe that a doctor or a hospital did not follow the instructions in your advance directive, you may file a complaint with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services at **1-800-882-6006.**

I. You have the right to make complaints and to ask us to reconsider decisions we have made

Chapter 9, Section 3, page 130 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Member Services.

What to do if you believe you are being treated unfairly or your rights are not being respected

If you believe you have been treated unfairly—and it is *not* about discrimination for the reasons listed on page 112—you can get help in these ways:

- You can **call Member Services**.
- You can **call the State Health Insurance Assistance Program (SHIP).** In Michigan, the SHIP is called the Medicare/Medicaid Assistance Program (MMAP). For details about this organization and how to contact it, see Chapter 2, Section E, page 24.
- You can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.
- You can **call the MI Health Link Ombudsman program**.

How to get more information about your rights

There are several ways to get more information about your rights:

- You can **call Member Services**.
- You can **call MMAP**. For details about this organization and how to contact it, see Chapter 2, Section E, page 24.
- You can **contact Medicare**.
  - » You can visit the Medicare website to read or download "Medicare Rights & Protections." (Go to http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.)
  - » Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can **call the MI Health Link Ombudsman program**.

J. You also have responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the *Member Handbook* to learn what is covered and what rules you need to follow to get covered services and drugs.**
  - » For details about your covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - » For details about your covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage you have.** Please call Member Services to let us know.
  - » We are required to make sure that you are using all of your coverage options when you receive health care. This is called *coordination of benefits.*
  - » For more information about coordination of benefits, see Chapter 1, Section K, page 11.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan ID card whenever you get services or drugs.
- **Help your doctors and other health care providers give you the best care.**
  - » Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - » Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - » If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - » Your patient pay amount for nursing facility services. This is determined by the local state Department of Human Services. Chapter 4, Section D, page 65 provides additional information about the patient pay amount for nursing facility services.
  - » If you get any services or drugs that are not covered by our plan, you must pay the full cost.

➔ If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9, Section 5.3, page 137 to learn how to make an appeal.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
  - » **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1, Section D, page 7 tells about our service area. We can help you figure out whether you are moving outside our service area. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Michigan Medicaid know your new address when you move. See Chapter 2, Sections G and H for phone numbers for Medicare and Michigan Medicaid.
  - » **If you move *within* our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call Member Services for help if you have questions or concerns.**
- **Enrollees age 55 and older who are receiving long term care services may be subject to estate recovery upon their death.** For more information, you may:
  - » Contact your Care Coordinator, ***or***
  - » Call the Beneficiary Helpline at 1-800-642-3195, ***or***
  - » Visit the website at **www.michigan.gov/estaterecovery**, ***or***
  - » Email questions to **MDCH-EstateRecovery@michigan.gov**.

Chapter 9: What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What's in this chapter?

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan has said it will not pay for.
- You disagree with a decision that your plan has made about your care.
- You think your covered services are ending too soon.

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. This chapter is broken into different sections to help you easily find what you are looking for.

If you are facing a problem with your health or long term supports and services

You should receive the health care, drugs, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your care plan. You should try to work with your providers and Aetna Better Health[SM] Premier Plan first. If you are still having a problem with your care or our plan, you will be able to call the MI Health Link Ombudsman starting in mid-2015. To find out about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**). This chapter will explain the different options you have for different problems and complaints, but you can always call the MI Health Link Ombudsman to help guide you through your problem.

Table of Contents

Section 1: Introduction

Section 1.1: What to do if you have a problem

This chapter will tell you what to do if you have a problem with your plan or with your services or payment. These processes have been approved by Medicare and Medicaid. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Section 1.2: What about the legal terms?

There are difficult legal terms for some of the rules and deadlines in this chapter. Many of these terms can be hard to understand, so we have used simpler words in place of certain legal terms. We use abbreviations as little as possible.

For example, we will say:

- "Making a complaint" rather than "filing a grievance"
- "Coverage decision" rather than "organization determination" or "coverage determination"
- "Fast coverage decision" rather than "expedited determination"

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

Section 2: Where to call for help

Section 2.1: Where to get more information and help

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

You can get help from the MI Health Link Ombudsman

Beginning in mid-2015, MI Health Link expects to have an Ombudsman program. If you need help getting answers to your questions or understanding what to do to handle your problem, you can call the MI Health Link Ombudsman. The MI Health Link Ombudsman is not connected with us or with any insurance company. They can help you understand which process to use. To find out about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**). The services are free.

You can get help from the State Health Insurance Assistance Program (SHIP)

You can also call your State Health Insurance Assistance Program (SHIP). In Michigan the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP counselors can answer your questions and help you understand what to do to handle your problem. MMAP is not connected with us or with any insurance company or health plan. MMAP has trained counselors and their services are free. The MMAP phone number is **1-800-803-7174**. You can also find information on MMAP's website at **www.mmapinc.org**.

Getting help from Medicare

You can call Medicare directly for help with problems. Here are two ways to get help from Medicare:

- Call **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week. **TTY: 1-877-486-2048**. The call is free.
- Visit the Medicare website (**www.medicare.gov**).

Getting help from Medicaid

You can also call Medicaid for help with problems. Call the Beneficiary Help Line at **1-800-642-3195 (TTY: 1-866-501-5656),** open Monday through Friday from 8 a.m. to 7 p.m.

Getting help from KePRO

Our state uses an organization called KePRO for quality improvement. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. KePRO is not connected with our plan. You can make a complaint to KePRO about the care you have received if:

- You have a problem with the quality of care,
- You think your hospital stay is ending too soon, or
- You think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon

Call KePRO at **1-855-408-8557** (TTY **1-855-843-4776**) Monday through Friday 9 a.m. to 5 p.m. Saturdays, Sundays, and holidays 11 a.m. to 3 p.m.

Section 3: Which process to use to help with your problem

Section 3.1: Should you use the process for coverage decisions and appeals? Or do you want to make a complaint?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The chart below will help you find the right section of this chapter for problems or complaints.

Is your problem or concern about your benefits or coverage? (This includes problems about whether particular medical care, behavioral health care, long term supports and services, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care, behavioral health care, long term supports and services, or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go to the next section of this chapter, **Section 4, "Coverage decisions and appeals."**	**No.** My problem is <u>not</u> about benefits or coverage. Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint."**

Section 4: Coverage decisions and appeals

Section 4.1: Overview of coverage decisions and appeals

The process for asking for coverage decisions and making appeals deals with problems related to your benefits and coverage. It also includes problems with payment.

➔ **Please note:** Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about coverage decisions and appeals on behavioral health services. See Chapter 2, Section D, page 20 for the contact information for the PIHP in your region.

What is a coverage decision?

A *coverage decision* is an initial decision we make about your benefits and coverage or about the amount we will pay for your medical services, items, or drugs. We are making a coverage decision whenever we decide what is covered for you and how much we pay.

If you or your providers are not sure if a service, item, or drug is covered by Medicare or Medicaid, either of you can ask for a coverage decision before you get the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our coverage decision and change it if you think we made a mistake. For example, we might decide that a service, item, or drug that you want is not covered or is not medically necessary for you. If you or your provider disagree with our decision, you can appeal.

Section 4.2: Getting help with coverage decisions and appeals

Who can I call for help asking for coverage decisions or making an appeal?

You can ask any of these people for help:

- You can talk to your **Care Coordinator** at **1-855-676-5772** (TTY **711**).
- You can call us at **Member Services** at **1-855-676-5772** (TTY **711**).
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Call the **MI Health Link Ombudsman** for free help. The MI Health Link Ombudsman can help you with questions about or problems with MI Health Link or our plan. The MI Health Link Ombudsman is an independent program, and is not connected with this plan. It will be

available starting mid-2015. To find out about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**).

- Call the **Michigan Medicare/Medicaid Assistance Program (MMAP)** for free help. MMAP is an independent organization. It is not connected with this plan. The phone number is **1-800-803-7174**.
- Talk to a **friend or family member** and ask him or her to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal. Your designated representative will have the same rights as you do in asking for a coverage decision or making an appeal.
  - » If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at **www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf** or on our website at **www.aetnabetterhealth.com/michigan**. The form will give the person permission to act for you. You must give us a copy of the signed form. You do not need to submit this form for your doctor or other provider to act as your representative.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you choose to have a lawyer, you must pay for those legal services. However, some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.

  However, **you do not need a lawyer** to ask for any kind of coverage decision or to make an appeal.

Section 4.3: Which section of this chapter will help you?

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow.

- **Section 5** gives you information if you have problems about services, items, and some drugs (not Part D drugs). For example, use this section if:
  - o You are not getting medical care or other supports and services that you want, and you believe that this care is covered by our plan.
  - o We did not approve services, items, or drugs that your doctor wants to give you, and you believe that this care should be covered and is medically necessary.

        - **NOTE:** Only use Section 5 if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs* with an asterisk (*) are not covered by Part D. See Section 6 for Part D drug appeals.
    - You received medical care or other supports and services that you think should be covered, but we are not paying for this care.
    - You got and paid for medical care or other supports and services you thought were covered, and you want to ask us to pay you back.
    - You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
        - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate section of this chapter because special rules apply to these types of care. See Sections 7 and 8.
- **Section 6** gives you information about Part D drugs. For example, use this section if:
    - You want to ask us to make an exception to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List).
    - You want to ask us to waive limits on the amount of the drug you can get.
    - You want to ask us to cover a drug that requires prior approval.
    - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
    - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section 7** gives you information on how to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon. Use this section if:
    - You are in the hospital and think the doctor asked you to leave the hospital too soon.
- **Section 8** gives you information if you think your home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

If you're not sure which section you should be using, please call your Care Coordinator at **1-855-676-5772** (TTY **711**) or Member Services at **1-855-676-5772** (TTY **711**). Starting in mid-2015, you can also get help or information from the MI Health Link Ombudsman. For information about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**).

Section 5: Problems about services, items, and drugs (not Part D drugs)

Section 5.1: When to use this section

This section is about what to do if you have problems with your benefits for your medical care or other supports and services. You can also use this section for problems with drugs that are not covered by Part D. Drugs in the List of Covered Drugs with an asterisk (*) are not covered by Part D. Use Section 6 for Part D drug appeals.

This section tells what you can do if you are in any of the five following situations:

1. **You think the plan covers a medical service or other supports and services that you need but are not getting.**

   What you can do: You can ask the plan to make a coverage decision. Go to Section 5.2 (page 135) for information on asking for a coverage decision.

2. **The plan did not approve care your provider wants to give you, and you think it should have.**

   What you can do: You can appeal the plan's decision to not approve the care. Go to Section 5.3 (page 137) for information on making an appeal.

3. **You received services or items that you think the plan covers, but the plan will not pay.**

   What you can do: You can appeal the plan's decision not to pay. Go to Section 5.4 (page 141) for information on making an appeal.

4. **You got and paid for medical services or items you thought were covered, and you want the plan to reimburse you for the services or items.**

   What you can do: You can ask the plan to pay you back. Go to Section 5.5 (page 147) for information on asking the plan for payment.

5. **Your coverage for a certain service is being reduced or stopped, and you disagree with our decision.**

   What you can do: You can appeal the plan's decision to reduce or stop the service.

   NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, special rules apply. Read Sections 7 or 8 to find out more.

➔ In all cases where we tell you that medical care you have been getting will be stopped, use the information in Section 5.3 of this chapter; *Will my benefits continue during Internal appeals?* (page 141) as your guide for what to do.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get medical care or long term supports and services (LTSS)

To ask for a coverage decision, call, write, or fax us, or ask your representative or doctor to ask us for a decision.

- You can call us at: **1-855-676-5772** (TTY **711**).
- You can fax us at: 1-844-321-9567
- You can to write us at:

  Aetna Better Health[SM] Premier Plan
  Appeal and Grievance Department
  1333 Gratiot Ave, Suite 400
  Detroit, MI 48207

➔ **Please note:** Your Prepaid Inpatient Health Plan (PIHP) will make coverage decisions for behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information. See Chapter 2, Section D, page 20 for the contact information for the PIHP in your region.

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you, your representative, or your provider asked. If we don't give you our decision within 14 calendar days, you can appeal.

➔ Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you, your representative, or your provider should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 72 hours**.

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed.

> ***The legal term*** *for "fast coverage decision" is* ***"expedited determination."***

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling or faxing our plan to ask us to cover the care you want.
- You can call us at **1-855-676-5772** (TTY **711**) or fax us at 1-855-321-9567. For the details on how to contact us, go to Chapter 2, page 15.
- You can also have your doctor or your representative call us.

Here are the rules for asking for a fast coverage decision:

You must meet the following two requirements to get a fast coverage decision:

- You can get a fast coverage decision *only* if you are asking about coverage for services or items *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care or an item you have already received.)
- You can get a fast coverage decision *only* if the standard 14 calendar day deadline could *cause serious harm to your health or hurt your ability to function.*
  - **If your provider says that you need a fast coverage decision, we will automatically give you one.**
  - If you ask for a fast coverage decision, without your provider's support, we will decide if you get a fast coverage decision.
    - If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline instead.
    - This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage

decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

How will I find out the plan's answer about my coverage decision?

We will send you a letter telling you whether or not we approved coverage.

If the coverage decision is *Yes*, when will I get the service or item?

You will be approved (pre-authorized) to get the service or item within 14 calendar days (for a standard coverage decision) or 72 hours (for a fast coverage decision) of when you asked. If we extended the time needed to make our coverage decision, we will approve the coverage by the end of that extended period.

If the coverage decision is *No*, how will I find out?

If the answer is *No*, we will send you a letter telling you our reasons for saying *No*.

- If we say no, you have the right to ask us to reconsider – and change – this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to the Internal appeals process (see Section 5.3 below). You also have the right to ask for a Fair Hearing if the coverage decision was for a service or item that could be covered by Medicaid (see Section 5.4).

Section 5.3: Internal Appeal for covered services, items, and drugs (not Part D drugs)

What is an appeal?

An *appeal* is a formal way of asking us to review a coverage decision (denial) or any adverse action that we took. If you or your provider disagrees with our decision, you can appeal.

➔ **Please note:** Your Prepaid Inpatient Health Plan (PIHP) handles appeals regarding behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for more information. See Chapter 2, Section D, page 20 for the contact information for the PIHP in your region.

What is an adverse action?

An adverse action is an action, or lack of action, by Aetna Better Health[SM] Premier Plan that you can appeal. This includes:

- We denied or limited a service your provider requested;
- We reduced, suspended, or ended coverage that was already approved;

- We did not pay for an item or service that you think is covered;
- We did not resolve your service authorization request within the required timeframes;
- You could not get a covered service from a provider in our network within a reasonable amount of time; or
- We did not act within the timeframes for reviewing a coverage decision and giving you a decision.

What is an Internal Appeal?

An Internal Appeal (also called a Level 1 Appeal) is the first appeal to our plan. We will review your coverage decision to see if it is correct. The reviewer will be someone who did not make the original coverage decision. When we complete the review, we will give you our decision in writing and tell you what you can do next if you disagree with the decision.

You can ask for a "standard appeal" or a "fast appeal."

➔ **Please note:** If your problem is about a Medicaid service or item, you can also file a request for a Fair Hearing with the Michigan Administrative Hearing System (MAHS) before, during, after, or instead of the Internal Appeal to Aetna Better Health[SM] Premier Plan. You must ask for a Fair Hearing within 90 days from the date on the letter that told you the service was denied, reduced, or stopped. For more information on the Medicaid Fair Hearings process, see Section 5.4.

How do I make an Internal Appeal?

- To start your appeal, you, your representative, or your provider must contact us. You can call us at **1-855-676-5772** (TTY **711**). For additional details on how to reach us for appeals, see Chapter 2, page 15.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.

  - You can submit a request to the following address:

    Aetna Better Health[SM] Premier Plan
    Appeal and Grievance Department
    1333 Gratiot Ave, Suite 400
    Detroit, MI 48207

  - You may also ask for an appeal by calling us at **1-855-676-5772** (TTY **711**).

> ***The legal term*** *for "fast appeal" is* ***"expedited reconsideration."***

Can someone else make the appeal for me?

Yes. Your doctor or other provider can make the appeal for you. Also, someone besides your doctor or other provider can make the appeal for you, but first you must complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services and ask for one, or visit the Medicare website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or our website at **www.aetnabetterhealth.com/michigan**.

➔ If the appeal comes from someone besides you or your doctor or other provider, we must receive the completed Appointment of Representative form before we can review the appeal.

How much time do I have to make an Internal Appeal?

You must ask for an Internal Appeal within 60 calendar days from the date on the letter we sent to tell you our decision.

If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of a good reason are: you were in the hospital, or we gave you the wrong information about the deadline for requesting an appeal.

➔ **Please note:** If you are appealing because you were told that a service you are getting will be changed or stopped, you must ask for your appeal within 12 calendar days or prior to the date of action if you want your benefits for that service to continue while the appeal is pending. Read *"Will my benefits continue during Internal Appeals"* on page 141 for more information.

Can I get a copy of my case file?

Yes. Ask us for a copy.

Can my provider give you more information about my appeal?

Yes. Both you and your provider may give us more information to support your appeal.

How will the plan make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care or other supports and services. Then, we check to see if we were following all the rules when we said *No* to your request. The reviewer will be someone who did not make the original decision.

If we need more information, we may ask you or your doctor for it.

When will I hear about a "standard" Internal Appeal decision?

We must give you our answer within 30 calendar days after we get your appeal. We will give you our decision sooner if your condition requires us to.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours.
- If we do not give you an answer to your appeal within 30 calendar days or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 of this chapter.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we automatically sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 of this chapter.

What happens if I ask for a fast appeal?

If you ask for a fast appeal, we will give you your answer within 72 hours after we get your appeal. We will give you our answer sooner if your condition requires us to do so.

- However, if you ask for more time, or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time.
- If we do not give you an answer within 72 hours or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 of this chapter.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must authorize or provide the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, go to Section 5.4 of this chapter.

Will my benefits continue during Internal appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the proposed action. If you file your Internal Appeal (or External Appeal with MAHS on a Medicaid benefit) within 12 calendar days of the date on our notice or prior to the intended effective date of the action, we will continue your benefits for the service while the Internal Appeal is pending.

If you are appealing to get a new service from Aetna Better Health[SM] Premier Plan, then you would not get that service unless your appeal is finished and the decision is that the service is covered.

Section 5.4: External Appeal for covered services, items, and drugs (not Part D drugs)

If the plan says *No* to the Internal Appeal, what happens next?

If we say no to part or all of your Internal Appeal, we will send you a letter. This letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get an External Appeal with the Independent Review Entity (IRE) as soon as the Internal Appeal is complete.
- If your problem is about a **Medicaid** service or item, you can file an External Appeal yourself with the Michigan Administrative Hearings System (MAHS) and/or a request for an External Review with the Michigan Department of Insurance and Financial Services (DIFS). The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you will automatically get an External Appeal with the IRE. You can also ask for an External Appeal with MAHS and/or External Review with DIFS.

What is an External Appeal?

An External Appeal (also called a Level 2 Appeal) is the second appeal, which is done by an independent organization that is not connected to the plan. Medicare's External Appeal organization is called the Independent Review Entity (IRE). Medicaid's External Appeal is a Fair Hearing through the Michigan Administrative Hearings System (MAHS). You also have the right to request an External Review of Medicaid service denial through the Michigan Department of Insurance and Financial Services (DIFS).

My problem is about a Medicaid covered service or item. How can I make an External Appeal?

There are two ways to make an External Appeal for Medicaid services and items: 1) Fair Hearing and/or 2) External Review.

1) Fair Hearing

You have the right to request a Fair Hearing from the Michigan Administrative Hearings System (MAHS). A Fair Hearing is an impartial review of a decision made by Aetna Better Health[SM] Premier Plan. You may request a Fair Hearing before, during, after, or instead of the Internal Appeal with Aetna Better Health[SM] Premier Plan.

You must ask for a Fair Hearing within 90 calendar days from the date on the letter that told you that a Medicaid covered service was denied, reduced, or stopped. If you are asking for Fair Hearing because the plan decided to reduce or stop a service you were already getting, you must file your appeal within 12 calendar days from the date of the adverse action notice or prior to the date of action if you want your benefits for that service to continue while the appeal is pending (see page 141 for more information).

To ask for a Fair Hearing from MAHS, you must complete a Request for Hearing form. We will send you a Request for Hearing form with the coverage decision letter. You can also get the form by calling

the Medicaid Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656), open Monday through Friday from 8:00 AM to 7:00 PM. Complete the form send it to:

Michigan Administrative Hearing System
Department of Community Health
PO Box 30763
Lansing, MI 48909

FAX: 517-373-4147

You can also ask for an expedited (fast) Fair Hearing by writing to the address or faxing to the number listed above.

After your Fair Hearing request is received by MAHS, you will get a letter telling you the date, time, and place of your hearing. Hearings are usually conducted over the phone, but you can request that your hearing be conducted in person.

MAHS must give you an answer in writing within 90 calendar days of when it gets your request for a Fair Hearing. If you qualify for an expedited Fair Hearing, MAHS must give you an answer within 72 hours. However, if MAHS needs to gather more information that may help you, it can take up to 14 more calendar days.

Following receipt of the MAHS final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court.

2) External Review

You also have the right to request an External Review through the Michigan Department of Insurance and Financial Services (DIFS). You must go through our Internal Appeals process first before you can ask for this type of External Appeal.

Your request for an External Review must be submitted within 60 days of your receipt of our Internal Appeal decision. If you qualified for continuation of benefits during the Internal Appeal and you submit your request for an External Review within 12 calendar days from the date of the Internal Appeal decision, you can continue to receive the disputed service during the review (see page 141 for more information).

To ask for an External Review from DIFS, you must complete the Health Care Request for External Review form. We will send you this form with our appeal decision letter. You can also get a copy of the form by calling DIFS at 1-877-999-6442. Complete the form and send it with all supporting documentation to:

DIFS - Office of General Counsel
Health Care Appeals Section
PO Box 30220
Lansing, MI 48909-7720

FAX: 517-241-4168

If your request does not involve reviewing medical records, the External Review will be conducted by the Director of DIFS. If your request involves issues of medical necessity or clinical review criteria, it will be sent to a separate Independent Review Organization (IRO).

If the review is conducted by the Director and does not require review by an IRO, the Director will issue a decision within 14 calendar days after your request is accepted. If the review is referred to an IRO, the IRO will give its recommendation to DIFS within 14 calendar days after it is assigned the review. The Director will then issue a decision within 7 business days after it receives the IRO's recommendation.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited (fast) review. An expedited review is completed within 72 hours after your request. To qualify for an expedited review, you must have your doctor verify that the timeframe for a standard review would jeopardize your life or health.

If you disagree with the External Review decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision.

My problem is about a Medicare covered service or item. What will happen at the External Appeal?

An Independent Review Entity will do a careful review of the Internal Appeal decision, and decide whether it should be changed.

- You do not need to ask for the External Appeal. We will automatically send any denials (in whole or in part) to the Independent Review Entity. You will be told when this happens.
- The Independent Review Entity is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file.

➔ The Independent Review Entity must give you an answer to your External Appeal within 30 calendar days of when it gets your appeal. This rule applies if you sent your appeal before getting medical services or items.

» However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

➔ If you had "fast appeal" at the Internal Appeal, you will automatically have a fast appeal at the External Appeal. The review organization must give you an answer within 72 hours of when it gets your appeal.

» However, if the Independent Review Entity needs to gather more information that may benefit you, it can take up to 14 more calendar days. If the IRE needs extra days to make a decision, it will tell you by letter.

What if my service or item is covered by both Medicare and Medicaid?

If your problem is about a service or item that could be covered by both Medicare and Medicaid, we will automatically send your External Appeal to the Independent Review Entity. You can also submit an External Appeal to MAHS and/or an External Review to DIFS. Follow the instructions on page 141.

Will my benefits continue during External Appeals?

If we previously approved coverage for a service but then decided to reduce or stop the service before the authorization expired, you can continue your benefits during External Appeals in some cases.

- If the service is covered by **Medicare** and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the External Appeal process with the IRE.
- If the service is covered by **Medicaid**, your benefits for that service will continue if:
  - » You ask for an External Appeal from MAHS within 12 calendar days from the date of the letter that told you that the service would be reduced or stopped; OR
  - » You qualified for continuation of benefits during your Internal Appeal and you ask for an External Appeal from MAHS or External Review from DIFS within 12 calendar days from the date of our Internal Appeal decision.
- If the service could be covered by **both Medicare and Medicaid** and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the IRE review. You may also qualify for continuation of benefits during MAHS and/or DIFS review if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) all entities that got your appeal (the IRE, MAHS, and/or DIFS) decide "no" to your request; or 3) the authorization expires or you receive all of the services that were previously approved.

How will I find out about the decision?

If your External Appeal went to MAHS for a Fair Hearing, MAHS will send you a letter explaining its decision.

- If MAHS says *Yes* to part or all of what you asked for, we must approve the service for you as quickly as your condition requires, but no later than 72 hours from the date we receive MAHS' decision.
- If MAHS says *No* to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal."

If your External Appeal went to DIFS for an External Review, DIFS will send you a letter explaining the Director's decision.

- If DIFS says *Yes* to part or all of what you asked for, we must approve the service for you as quickly as your condition requires.
- If DIFS says *No* to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision" or "turning down your appeal."

If your External Appeal went to the Independent Review Entity, it will send you a letter explaining its decision.

- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize the coverage as quickly as your condition requires, but no later than 72 hours from the date we receive the IRE's decision.
- If the Independent Review Entity says *No* to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision."
  It is also called "turning down your appeal."

What if I appealed to MAHS, DIFS, and/or the IRE and they have different decisions?

If MAHS, DIFS, and/or the IRE decide "yes" for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

If the decision is *No* for all or part of what I asked for, can I make another appeal?

If your External Appeal went to MAHS for a Fair Hearing, you can appeal the decision within 30 days to the Circuit Court. You may also request a rehearing or reconsideration by MAHS within 30 days.

If your External Appeal went to DIFS for an External Review, you can appeal to the Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision.

If your External Appeal went to the Independent Review Entity, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. The letter you get from the IRE will explain additional appeal rights you may have.

See Section 9 of this chapter for more information on additional levels of appeal.

➔ **Please note:** Your benefits for the disputed service will not continue during the additional levels of appeal.

Section 5.5: Payment problems

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay a bill you have gotten for covered services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

How do I ask the plan to pay me back for medical services or items I paid for?

If you are asking to be paid back, you are asking for a coverage decision. We will see if the service or item you paid for is a covered service or item, and we will check to see if you followed all the rules for using your coverage.

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for your medical care within 60 calendar days after we get your request.

  Or, if you haven't paid for the services or items yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying *Yes* to your request for a coverage decision.

- If the medical care is *not* covered, or you did *not* follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if the plan says they will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section 5.3. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.

➔ If we answer "no" to your appeal and the service or item is usually covered by Medicare, we will automatically send your case to the Independent Review Entity. We will notify you by letter if this happens.

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is *Yes* at any stage of the process after review by the IRE, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says *No* to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. See Section 9 of this chapter for more information on additional levels of appeal.

➔ If we answer "no" to your appeal and the service or item is usually covered by Medicaid, you can file an External Appeal with MAHS or External Review with DIFS yourself (see Section 5.4 of this chapter).

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these drugs are "Part D drugs." There are a few drugs that Medicare Part D does not cover but that Medicaid may cover. **This section only applies to Part D drug appeals.**

- The *List of Covered Drugs (Drug List)*, includes some drugs with an asterisk (*). These drugs are **not** Part D drugs. Appeals or coverage decisions about drugs with an asterisk (*) symbol follow the process in **Section 5.**

Can I ask for a coverage decision or make an appeal about Part D prescription drugs?

Yes. Here are examples of coverage decisions you can ask us to make about your Part D drugs:

- You ask us to make an exception such as:
  - » Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs* (Drug List)
  - » Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us if a drug is covered for you (for example, when your drug is on the plan's Drug List but we require you to get approval from us before we will cover it for you).
  - » *Please note:* If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

> ***The legal term** for a coverage decision about your Part D drugs is **"coverage determination."***

If you disagree with a coverage decision we have made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to request an appeal.

Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover? You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter. Also see Sections 6.3 and 6.4.	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need? You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.	Do you want to ask us to pay you back for a drug you have already received and paid for? You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2: What is an exception?

An *exception* is permission to get coverage for a drug that is not normally on our List of Covered Drugs, or to use the drug without certain rules and limitations. If a drug is not on our List of Covered Drugs, or is not covered in the way you would like, you can ask us to make an "exception."

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception.

Here are examples of exceptions that you or your doctor or another prescriber can ask us to make:

1. Covering a Part D drug that is not on our *List of Covered Drugs* (Drug List).
   - If we agree to make an exception and cover a drug that is not on the Drug List, you will not be charged.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, go to Chapter 5, Section C, page 94).

   - The extra rules and restrictions on coverage for certain drugs include:
     - » Being required to use the generic version of a drug instead of the brand name drug.
     - » Getting plan approval before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
     - » Being required to try a different drug first before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
     - » Quantity limits. For some drugs, the plan limits the amount of the drug you can have.

> ***The legal term*** *for asking for removal of a restriction on coverage for a drug is sometimes called asking for a* ***"formulary exception."***

Section 6.3: Important things to know about asking for exceptions

Your doctor or other prescriber must tell us the medical reasons

Your doctor or other prescriber must give us a statement explaining the medical reasons for requesting an exception. Our decision about the exception will be faster if you include this information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are asking for, and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We will say* Yes *or* No *to your request for an exception

- If we say *Yes* to your request for an exception, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say *No* to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 (page 155) tells how to make an appeal if we say *No*.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4: How to ask for a coverage decision about a Part D drug or reimbursement for a Part D Drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-855-676-5772** (TTY **711**).
- You or your doctor (or other prescriber) or someone else who is acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.

  Read Section 4 (page 131) to find out how to give permission to someone else to act as your representative.

  → You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7, Section A, page 107 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are requesting an exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception. We call this the "supporting statement."

  Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone, and then fax or mail a statement.

***At a glance:* How to ask for a coverage decision about a drug or payment**

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)

→ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

If your health requires it, ask us to give you a "fast coverage decision"

We will use the "standard deadlines" unless we have agreed to use the "fast deadlines."

- A standard coverage decision means we will give you an answer within 72 hours after we get your doctor's statement.
- A fast coverage decision means we will give you an answer within 24 hours.
  - » You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - » You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
  - » If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision, and the letter will tell you that.

    If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether you get a fast coverage decision.

    If we decide to give you a standard decision, we will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision. You can file a "fast complaint" and get a response to the complaint within 24 hours.
  - » If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

> ***The legal term*** *for "fast coverage decision" is* ***"expedited coverage determination."***

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours. This means within 24 hours after we get your request. Or, if you are asking for an exception, 24 hours after we get your doctor's or prescriber's statement supporting your request. We will give you our answer sooner if your health requires us to.

- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an outside independent organization will review your request.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give you the coverage within 24 hours after we get your request or your doctor's or prescriber's statement supporting your request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours after we get your request or, if you are asking for an exception, after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is *Yes*** to part or all of what you asked for, we will make payment to you within 14 calendar days.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No*. This statement will also explain how you can appeal our decision.

Section 6.5: Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-855-676-5772** (TTY **711**).
- If you want a fast appeal, you may make your appeal in writing or you may call us.
- Make your appeal request within 60 calendar days from the date on the notice we sent to tell you our decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make you appeal. For example, good reasons for missing the deadline would be if you have a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for requesting an appeal.

***At a glance:* How to make a Level 1 Appeal**

You, your doctor or prescriber, or your representative may put your request in writing and mail or fax it to us. You may also ask for an appeal by calling us.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or prescriber, or your representative can call us to ask for a fast appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

The legal term** for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."

- You can ask for a copy of the information in your appeal and add more information.
- You have the right to ask us for a copy of the information about your appeal.
  - » If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 (page 152) of this chapter.

> ***The legal term** for "fast appeal" is **"expedited reconsideration."***

Our plan will review your appeal and give you our decision

- We take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said *No* to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is *Yes*** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it. If you think your health requires it, you should ask for a "fast appeal."
- If we do not give you a decision within 7 calendar days, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

➔ **If our answer is *Yes*** to part or all of what you asked for:

» If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

» If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

➔ **If our answer is *No*** to part or all of what you asked for, we will send you a letter that explains why we said *No* and tells how to appeal our decision.

Section 6.6: Level 2 Appeal for Part D drugs

If we say *No* to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity will review our decision.

- If you want the Independent Review Entity to review your case, your appeal request must be in writing. The letter we send about our decision in the Level 1 Appeal will explain how to request the Level 2 Appeal.
- When you make an appeal to the Independent Review Entity, we will send them your case file. You have the right to ask us for a copy of your case file.
- You have a right to give the Independent Review Entity other information to support your appeal.
- The Independent Review Entity is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

***At a glance:* How to make a Level 2 Appeal**

If you want the Independent Review Organization to review your case, your appeal request must be in writing.

- Ask within 60 calendar days of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.

➔ Read this chapter to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," it must give you an answer to your Level 2 Appeal within 72 hours after getting your appeal request.
- If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 24 hours after we get the decision.

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the Independent Review Entity must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal.
  - » If the Independent Review Entity says *Yes* to part or all of what you asked for, we must authorize or give you the drug coverage within 72 hours after we get the decision.
  - » If the Independent Review Entity approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If the dollar value of the drug coverage you want meets a certain minimum amount, you can make another appeal at Level 3. The letter you get from the Independent Review Entity will tell you the dollar amount needed to continue with the appeals process. The Level 3 Appeal is handled by an administrative law judge.

Section 7: Asking us to cover a longer hospital stay

When you are admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for any care you may need after you leave.

- The day you leave the hospital is called your "discharge date." Our plan's coverage of your hospital stay ends on this date.
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay. This section tells you how to ask.

Section 7.1: Learning about your Medicare rights

Within two days after you are admitted to the hospital, a caseworker or nurse will give you a notice called *An Important Message from Medicare about Your Rights.* If you do not get this notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Read this notice carefully and ask questions if you don't understand. The *Important Message* tells you about your rights as a hospital patient, including:

- Your right to get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be a part of any decisions about the length of your hospital stay.
- Your right to know where to report any concerns you have about the quality of your hospital care.
- Your right to appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does ***not*** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at **1-855-676-5772** (TTY **711**). You can also call **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week. **TTY** users should call **1-877-486-2048**. The call is free.

  You can also see the notice online at **www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.**

➔ If you need help, please call Member Services at **1-855-676-5772** (TTY **711**). You can also call **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. The call is free.

Section 7.2: Level 1 Appeal to change your hospital discharge date

If you want us to cover your inpatient hospital services for a longer time, you must request an appeal. A Quality Improvement Organization will do the Level 1 Appeal review to see if your planned discharge date is medically appropriate for you.

To make an appeal to change your discharge date, call KePRO (Michigan's Quality Improvement Organization) at: **1-855-408-8557** (**TTY: 1-855-843-4776**).

Call right away!

Call the Quality Improvement Organization ***before*** you leave the hospital and no later than your planned discharge date. *An Important Message from Medicare about Your Rights* contains information on how to reach the Quality Improvement Organization.

- If you call before you leave, you are allowed to stay in the hospital *after* your planned discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not call* to appeal, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you get after your planned discharge date.

***At a glance:* How to make a Level 1 Appeal to change your discharge date**

Call the Quality Improvement Organization for your state at 1-855-408-8557 and ask for a "fast review".

Call before you leave the hospital and before your planned discharge date.

If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details, see Section 7.4 (page 163).

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at **1-855-676-5772** (TTY **711**). You can also call the Michigan Medicare/Medicaid Assistance Program (MMAP) at **1-800-803-7174**. Starting in mid-2015, you can also get help from the MI Health Link Ombudsman. For information about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**).

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people with Medicare.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

> ***The legal** term for "fast review" is **"immediate review."***

What happens during the review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

> ***The legal term*** *for this written explanation is called the* ***"Detailed Notice of Discharge."*** *You can get a sample by calling Member Services at* ***1-855-676-5772*** *(TTY* ***711****). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/*

What if the answer is *Yes*?

- If the review organization says *Yes* to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is *No*?

- If the review organization says *No* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day *after* the Quality Improvement Organization gives you its answer.
- If the review organization says No and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer.
- If the Quality Improvement Organization turns down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal.

Section 7.3: Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

You can reach the KePRO at: **1-855-408-8557.**

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

At a glance: **How to make a Level 2 Appeal to change your discharge date**

Call the Quality Improvement Organization in your state and ask for another review.

- Within 14 calendar days, the Quality Improvement Organization reviewers will make a decision.

What happens if the answer is *Yes*?

- We must pay you back for our share of the costs of hospital care you have received since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is *No*?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Section 7.4: What happens if I miss an appeal deadline?

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

➔ **Please note:** Your Prepaid Inpatient Health Plan (PIHP) handles appeals regarding behavioral health, intellectual/developmental disability, and substance use disorder services and supports. This includes Alternate Appeals for inpatient mental health care. Contact your PIHP for more information. See Chapter 2, Section D, page 20 for the contact information for the PIHP in your region.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when you should leave the hospital was fair and followed all the rules.

***At a glance:* How to make a Level 1 Alternate Appeal**

Call our Member Services number and ask for a "fast review" of your hospital discharge date.

We will give you our decision within 72 hours.

- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes* to your fast review,** it means we agree that you still need to be in the hospital after the discharge date. We will keep covering hospital services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.
- **If we say *No* to your fast review,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends on the day we said coverage would end.
  - » If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you got after the planned discharge date.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term** for "fast review" or "fast appeal" is **"expedited appeal."***

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 (page 173) of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.

***At a glance:* How to make a Level 2 Alternate Appeal**

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the Independent Review Entity says *Yes* to your appeal, then we must pay you back for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary.
- If this organization says *No* to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.

  The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Section 8: What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care *only*:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.

  ➔ With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.

  ➔ When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, *we will stop paying for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.1: We will tell you in advance when your coverage will be ending

The agency or facility that is providing your care will give you a notice at least two days before we stop paying for your care.

- The written notice tells you the date when we will stop covering your care.
- The written notice also tells you how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does not mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying for your care.

Section 8.2: Level 1 Appeal to continue your care

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start, understand what you need to do and what the deadlines are.

- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at **1-855-676-5772** (TTY **711**). Or call the Michigan Medicare/Medicaid Assistance Program (MMAP) at **1-800-803-7174**.

During a Level 1 Appeal, The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage*.

What is a Quality Improvement Organization?

It is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. They are paid by Medicare to check on and help improve the quality of care for people

***At a glance:* How to make a Level 1 Appeal to ask the plan to continue your care**

Call the Quality Improvement Organization for your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

with Medicare.

What should you ask for?

Ask them for an independent review of whether it is medically appropriate for us to end coverage for your services.

What is your deadline for contacting this organization?

- You must contact the Quality Improvement Organization *no later than noon of the day after you got the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.4 (page 169).

> ***The legal term** for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at **1-855-676-5772** (TTY **711**) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or see a copy online at http://www.cms.hhs.gov/BNI/*

What happens during the Quality Improvement Organization's review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- When you ask for an appeal, the plan must write a letter explaining why your services should end.
- The reviewers will also look at your medical records, talk with your doctor, and review information that our plan has given to them.
- **Within one full day after reviewers have all the information they need, they will tell you their decision.** You will get a letter explaining the decision.

> ***The legal term** for the letter explaining why your services should end is **"Detailed Explanation of Non-Coverage."***

What happens if the reviewers say *Yes*?

- If the reviewers say *Yes* to your appeal, then we must keep providing your covered services for as long as they are medically necessary.

What happens if the reviewers say *No*?

- If the reviewers say *No* to your appeal, then your coverage will end on the date we told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date your coverage ends, then you will have to pay the full cost of this care yourself.

Section 8.3: Level 2 Appeal to continue your care

If the Quality Improvement Organization said *No* to the appeal **and** you choose to continue getting care after your coverage for the care has ended, you can make a Level 2 Appeal.

You can ask the Quality Improvement Organization to take another look at the decision they made at Level 1. If they say they agree with the Level 1 decision, you may have to pay the full cost for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end. The Quality Improvement Organization will review your appeal and decide whether to change the decision we made. You can find out how to call them by reading the *Notice of Medicare Non-Coverage.*

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said *No* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- The Quality Improvement Organization will make its decision within 14 calendar days.

***At a glance:* How to make a Level 2 Appeal to require that the plan cover your care for longer**

Call the Quality Improvement Organization for your state and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says *Yes*?

- We must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary.

What happens if the review organization says *No*?

- It means they agree with the decision they made on the Level 1 Appeal and will not change it.
- The letter you get will tell you what to do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Section 8.4: What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the *first two levels of appeal are different.*

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check to see if the decision about when your services should end was fair and followed all the rules.
- We will use the fast deadlines rather than the standard deadlines for giving you the answer to this review. We will give you our decision within 72 hours after you ask for a "fast review."
- **If we say *Yes*** to your fast review, it means we agree that we will keep covering your services for as long as it is medically necessary.

  It also means that we agree to pay you back for our share of the costs of care you have received since the date when we said your coverage would end.

> ***At a glance:* How to make a Level 1 Alternate Appeal**
>
> Call our Member Services number and ask for a "fast review."
>
> We will give you our decision within 72 hours.

- **If we say *No*** to your fast review, we are saying that stopping your services was medically appropriate. Our coverage ends as of the day we said coverage would end.
  - » If you continue getting services after the day we said they would stop, **you may have to pay the full cost** of the services.

➔ To make sure we were following all the rules when we said *No* to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is *automatically* going to Level 2 of the appeals process.

> ***The legal term*** *for "fast review" or "fast appeal" is* ***"expedited appeal."***

Level 2 Alternate Appeal to continue your care for longer

We will send the information for your Level 2 Appeal to the Independent Review Entity within 24 hours of when we give you our Level 1 decision. If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 (page 173) of this chapter tells how to make a complaint.

During the Level 2 Appeal, the **Independent Review Entity** reviews the decision we made when we said *No* to your "fast review." This organization decides whether the decision we made should be changed.

- The Independent Review Entity does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The Independent Review Entity is an independent organization that is hired by Medicare. This organization is not connected with our plan, and it is not a government agency.
- Reviewers at the Independent Review Entity will take a careful look at all of the information related to your appeal.
- **If this organization says *Yes*** to your appeal, then we must pay you back for our share of the costs of care. We must also continue the plan's coverage of your services for as long as it is medically necessary.
- **If this organization says *No*** to your appeal, it means they agree with us that stopping

> ***At a glance:*** **How to make a Level 2 Appeal to require that the plan continue your care**
>
> You do not have to do anything. The plan will automatically send your appeal to the Independent Review Organization.

coverage of services was medically appropriate.

The letter you get from the Independent Review Entity will tell you what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

> ***The formal name*** *for "Independent Review Organization" is* ***"Independent Review Entity."*** *It is sometimes called the* ***"IRE."***

Section 9: Appeal options after Level 2 or External Appeals

Section 9.1: Next steps for Medicare services and items

If you made a Level 1or Internal Appeal and a Level 2 or External Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. If you want an ALJ to review your case, the item or medical service you are requesting will have to meet a minimum dollar amount. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, you can ask an ALJ to hear your appeal.

If you do not agree with the ALJ's decision, you can go to the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The MI Health Link Ombudsman will be available starting in mid-2015. For information about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**).

Section 9.2: Next steps for Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Medicaid.

If your appeal went to the Michigan Administrative Hearings System (MAHS) for a Fair Hearing, MAHS will send you a letter explaining its decision. If you disagree with the MAHS final decision, you have

30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MAHS at **1-877-833-0870** for information about requirements you must meet to qualify for a rehearing/reconsideration.

If your appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision. If you disagree with the decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 days from the date of the decision. If you need help at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The MI Health Link Ombudsman will be available starting in mid-2015. For information about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**).

Section 10: How to make a complaint

What kinds of problems should be complaints?

The complaint process is used for certain types of problems *only,* such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is *confidential.*

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Aetna Better Health[SM] Premier Plan staff treated you poorly.
- You think you are being pushed out of the plan.

Complaints about physical accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

***At a glance:* How to make a complaint**

Call Member Services or send us a letter telling us about your complaint.

➔ If your complaint is about *quality of care*, you have more choices. You can:

1. Make your complaint to the Quality Improvement Organization,
2. Make your complaint to Member Services and to the Quality Improvement Organization, or
3. Make your complaint to Medicare.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

> ***The legal term*** *for a "complaint" is a* ***"grievance."***
>
> ***The legal term*** *for "making a complaint" is* ***"filing a grievance."***

Section 10.1: Details and deadlines

You can make an Internal Complaint and/or an External Compliant. An Internal Complaint is reviewed by Aetna Better Health[SM] Premier Plan. An External Complaint is reviewed by an organization that is not affiliated with our plan. Read this section for more information about Internal Complaints. The different types of External Complaints are described in the sections that follow.

➔ **Please note:** Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your PIHP for information about Internal Complaints on behavioral health services. See Chapter 2, Section D, page 20 for the contact information for the PIHP in your region.

How to file an Internal Complaint with Aetna Better Health[SM] Premier Plan

- Call Member Services at **1-855-676-5772** (TTY **711**). Complaints related to Part D must be made within 60 calendar days after you had the problem you want to complain about. If you are requesting action regarding any other Medicare issue, the complaint must be made within 90 calendar days after you had the problem you want to complain about.
- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- You can also send us your complaint by filling out the "Submit a Grievance" form on the website at **www.aetnabetterhealth.com/michigan**
- If you can show good cause in writing why you are filing later than the 60 calendar days for Part D or 90 calendars days for all other issues, Aetna Better Health[SM] Premier Plan will extend the timeframe for you to make a complaint. If you sent us your complaint in writing we will send you a letter within 3 business days telling you that we received it.
- We will review your complaint within 30 calendar days and send you a letter telling you our decision within 2 business days after the decision is made.
- At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, tell Aetna Better Health[SM] Premier Plan in writing by completing the Appointment of Representative (AOR) form. You or your representative may ask Aetna Better Health[SM] Premier Plan to see any information relevant to your grievance. You may also send information that you have about your grievance to Aetna Better Health[SM] Premier Plan at:

  Aetna Better Health[SM] Premier Plan
  Appeal and Grievance Department
  1333 Gratiot Avenue, Suite 400
  Detroit, MI 48207

  Phone: **1-855-676-5772** (TTY **711**) Fax: 1-844-321-9567

- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

> ***The legal term*** *for "fast complaint" is* ***"expedited grievance."***

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest, or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. We will tell you in writing why we need more time.
- **If we do not agree** with some or all of your complaint we will tell you and give you our reasons. We will respond whether we agree with the complaint or not.

Section 10.2: You can file complaints with the Office of Civil Rights

If you have a complaint about disability access or about language assistance, you can file a complaint with the Office of Civil Rights at the United States Department of Health and Human Services. The contact information for the Office of Civil Rights is:

233 N. Michigan Ave., Suite 240
Chicago, IL 60601
Phone: **1-800-368-1019**
Fax: 312-886-1807
TDD: 1-800-537-7697

You can also contact the Michigan Department of Civil Rights at:

110 W. Michigan Ave., Suite 800
Lansing, MI 48933
Phone: **517-335-3165**
Fax: 517-241-0546
TTY: 517-241-1965

You may also have rights under the Americans with Disability Act and under ADA Michigan; **http://www.adamich.org.** Starting mid-2015, you can contact the MI Health Link Ombudsman for assistance.

Section 10.3: You can make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you also have two choices:

- If you prefer, you can make your complaint about the quality of care directly to the Quality Improvement Organization (*without* making the complaint to us).

- Or you can make your complaint to us *and also* to the Quality Improvement Organization. If you make a complaint to this organization, we will work with them to resolve your complaint.

The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

The phone number for the Quality Improvement Organization is 1-855-408-8557 (TTY: 1-855-843-4776).

Section 10.4: You can tell Medicare about your complaint

You can also send your complaint to Medicare. The Medicare Complaint Form is available at: https://www.medicare.gov/MedicareComplaintForm/home.aspx

Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your problem, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048. The call is free.

Section 10.5: You can tell Medicaid about your complaint

You can also send your complaint to Medicaid. You can call the Beneficiary Help Line at **1-800-642-3195 (TTY 1-866-501-5656**), open Monday through Friday from 8 a.m. to 7 p.m.

Section 10.6: You can tell the MI Health Link Ombudsman about your complaint

The MI Health Link Ombudsman also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we are required to provide. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan. The MI Health Link Ombudsman will be available starting mid-2015.

To find out about the MI Health Link Ombudsman, visit **www.aetnabetterhealth.com/michigan** or call **1-855-676-5772** (TTY **711**). The services are free.

Section 10.7: You can tell the State of Michigan if you have a problem with your provider

For complaints about how your provider follows your wishes, call **517-373-9196** or write to:

Michigan Department of Licensing and Regulatory Affairs

Bureau of Health Care Services
Enforcement Division
P.O. Box 30454
Lansing, MI 48909-9897

Section 10.8: You can tell the State of Michigan if you have a problem with Aetna Better Health[SM] Premier Plan

If you have a problem with Aetna Better Health[SM] Premier Plan, you can contact the Michigan Department of Insurance and Financial Services (DIFS) at **1-877-999-6442**, Monday through Friday from 8 a.m. to 5 p.m.. The call is free. You can also send an email to DIFS at: **difs-HICAP@michigan.gov**.

Chapter 10: Ending your membership in Aetna Better Health[SM] Premier Plan

Table of Contents

Introduction

This chapter tells about ways you can end your membership in our plan and your health coverage options after you leave the plan. You will still qualify for both Medicare and Medicaid benefits if you leave our plan.

A. When can you end your membership in Aetna Better Health[SM] Premier Plan?

- You can end your membership in Aetna Better Health[SM] Premier Plan ICO at any time. The change will be effective the first day of the next month after we get your request. For information on Medicare options when you leave our plan, see the table on page 182.
- For information about your Medicaid services when you leave our plan, see page 183.

These are ways you can get more information about when you can end your membership:

- Call Michigan ENROLLS at **1-800-975-7630**, Monday through Friday 8 a.m. to 7 p.m. TTY users should call **1-888-263-5897**.
- Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at **1-800-803-7174.**
- Call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, seven days a week. **TTY** users should call **1-877-486-2048**.

B. How do you end your membership in our plan?

If you decide to end your membership, tell Michigan Medicaid or Medicare that you want to leave Aetna Better Health[SM] Premier Plan:

- Call Michigan ENROLLS at **1-800-975-7630**, Monday through Friday 8 a.m. to 7 p.m. **TTY** users should call **1-888-263-5897**; OR
- Call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, seven days a week. TTY users (people who are deaf, hard of hearing, or speech disabled) should call **1-877-486-2048**. When you call **1-800-MEDICARE**, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 182.

C. How do you join a different plan?

If you want to keep getting your Medicare and Michigan Medicaid benefits together from a single plan, you can join a different Medicare-Medicaid Plan.

To enroll in a different Medicare-Medicaid Plan:

- Call Michigan ENROLLS at **1-800-975-7630**, Monday through Friday 8 a.m. to 7 p.m. **TTY** users should call **1-888-263-5897**. Tell them you want to leave Aetna Better Health[SM] Premier Plan and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with Aetna Better Health[SM] Premier Plan will end on the last day of the month that we get your request.

D. If you leave our plan and you do not want a different Medicare-Medicaid Plan, how do you get Medicare and Michigan Medicaid services?

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave Aetna Better Health[SM] Premier Plan, you will go back to getting your Medicare and Michigan Medicaid services separately.

How you will get Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan or Program of All-inclusive Care for the Elderly (PACE)**	**Here is what to do:** Call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048** to enroll in the new Medicare-only health plan. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at **1-800-803-7174**. You will automatically be disenrolled from Aetna Better Health[SM] Premier Plan when your new plan's coverage begins.
2. You can change to: **Original Medicare *with* a separate Medicare prescription drug plan**	**Here is what to do:** Call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at **1-800-803-7174**. You will automatically be disenrolled from Aetna Better Health[SM] Premier Plan when your Original Medicare coverage begins.

3. You can change to: **Original Medicare *without* a separate Medicare prescription drug plan** **NOTE**: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you get drug coverage from an employer, union or other source. If you have questions about whether you need drug coverage, call your Michigan Medicare/Medicaid Assistance Program (MMAP) at **1-800-803-7174**.	**Here is what to do:** Call Medicare at **1-800-MEDICARE** (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call **1-877-486-2048**. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at **1-800-803-7174**. You will automatically be disenrolled from Aetna Better Health[SM] Premier Plan when your Original Medicare coverage begins.

How you will get Michigan Medicaid services

If you leave the Medicare-Medicaid Plan, you will get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long term supports and services and behavioral health care. If you leave the Medicare-Medicaid Plan, you can see any provider that accepts Michigan Medicaid.

E. Until your membership ends, you will keep getting your medical services and drugs through our plan

If you leave Aetna Better Health[SM] Premier Plan, it may take time before your membership ends and your new Medicare and Michigan Medicaid coverage begins. See page 181 for more information. During this time, you will keep getting your health care and drugs through our plan.

- **You should use our network pharmacies to get your prescriptions filled.** Usually, your prescription drugs are covered only if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Your membership will end in certain situations

These are the cases when Aetna Better Health[SM] Premier Plan must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Michigan Medicaid. Our plan is for people who qualify for both Medicare and Michigan Medicaid
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - » If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to prison.
- If you lie about or withhold information about other insurance you have for prescription drugs.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Michigan Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your ID card to get medical care.
  - » If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. We *cannot* ask you to leave our plan for any reason related to your health

If you feel that you are being asked to leave our plan for a health-related reason, you should call Medicare at **1-800-MEDICARE** (1-800-633-4227). **TTY** users should call **1-877-486-2048**. You may call 24 hours a day, seven days a week.

You can also call the Beneficiary Help Line at **1-800-642-3195** (or **1-866-501-5656 for TTY** users), Monday through Friday, 8 a.m. to 7 p.m. You should also call the MI Health Link Ombudsman program.

H. You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also see Chapter 9, Section 10, page 173 for information about how to make a complaint.

I. Where can you get more information about ending your plan membership?

If you have questions or would like more information on when we can end your membership, you can call Member Services at **1-855-676-5772** (TTY **711**), 24 hours a day, 7 days a week.

Chapter 11: Legal notices

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare must obey the law. You cannot be treated differently because of your race, color, national origin, disability, age, religion, or sex. If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit http://www.hhs.gov/ocr for more information. You can also call the Michigan Department of Civil Rights at 1-800-482-3604.

C. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

Chapter 12: Definitions of important words

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than the plan's cost sharing amount for services. We do not allow providers to "balance bill" you. Because Aetna Better Health[SM] Premier Plan pays the entire cost for your services, you should not get any bills from providers. Call Member Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: A plan for what supports and services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2, Section G, page 26 explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, network providers, or network pharmacies.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9, Section 4, page 131 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long term supports and services, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Tier: A group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs). Every drug on the List of Covered Drugs is in one of three tiers.

Durable medical equipment (DME): Certain items your doctor or other health care provider orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of function of a body part. The medical symptoms may be a serious injury or severe pain.

Emergency care: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations.

Extra Help: A Medicare program that helps people with limited incomes and resources pay for Medicare Part D prescription drugs. Extra help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in court and show that a decision we made is wrong.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice: A program of care and support for people who are terminally ill to help them live comfortably. A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs. An enrollee who has six months or less to live has the right to elect hospice. Aetna Better Health[SM] Premier Plan must give you a list of hospice providers in your geographic area.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

List of Covered Drugs (Drug List): A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Long term supports and services (LTSS): Long term supports and services are services that help improve a long term condition. LTSS includes nursing home services as well as home and community-based services. The home and community-based services help you stay in your home so you don't have to go to a nursing home or hospital.

Low-income subsidy (LIS): See "Extra Help."

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term supports and services and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section H, page 27 for information about how to contact Medicaid in your state.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. The services, supplies, or drugs must meet accepted standards of medical practice. A specific service is determined medically (clinically) appropriate, necessary to meet needs, consistent with your diagnosis or health issue, is the most cost-effective

option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity includes those supports and services designed to assist you to attain or maintain a sufficient level of functioning to enable you to live in your community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (see "Health plan").

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dual eligible beneficiary."

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Aetna Better Health[SM] Premier Plan includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected documents, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2, Section A, page 15 for information about how to contact Member Services.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services; medical equipment; behavioral health, substance use disorder, intellectual/developmental disability, and long term supports and services . They are licensed or certified by Medicare and by the state to provide health care services. We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our members an extra amount. While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Nursing home or facility: A place that provides care for people who cannot get their services at home but who do not need to be in the hospital.

Ombudsman: An office in your state that helps you if you are having problems with our plan. The ombudsman's services are free.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9, Section 4, page 131 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance). Original Medicare is available everywhere in the United States. If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3, Section D, page 32 explains out-of-network providers or facilities.

Part A: See "Medicare Part A."

Part B: See "Medicare Part B."

Part C: See "Medicare Part C."

Part D: See "Medicare Part D."

Part D drugs: See "Medicare Part D drugs."

Primary care provider (PCP): Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to stay healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section D, page 32 for information about getting care from primary care providers.

Patient Pay Amount (PPA): The amount of money you may be asked to pay for the time you stay in a nursing home. This amount is based on your income and set by the state.

Prior authorization: Approval needed before you can get certain services or drugs. Some network services are covered only if your doctor or other network provider gets prior authorization from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4, Section D, page 46. Some drugs are covered only if you get prior authorization from us. Covered drugs that need prior authorization are marked in the *List of Covered Drugs*.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. See Chapter 2, Section F, page 25 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription or how many refills you can get.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. See Chapter 4, Section D, page 69 to learn more about rehabilitation services.

Self-Determination: Self-determination is an option available to enrollees receiving services through the MI Health Link HCBS home and community based waiver program. It is a process that allows you to design and exercise control over your own life. This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget." If you choose to do so, you would also have control over the hiring and management of providers.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. The plan may drop you if you move out of the plan's service area.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The Michigan Department of Community Health, Medical Services Administration. This is the agency that runs Michigan's Medicaid program, helping people with limited incomes and resources pay for medical care and long term supports and services.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.