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MyCareOhio
Connecting Medicare + Medicaid

AETNA BETTER HEALTH® OF OHIO
a MyCare Ohio plan

2015 Member Handbook

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

www.aetnabetterhealth.com/ohio

OH-14-09-02

H7172_15_013 CMS APPROVED

Helpful information

Member Services
1-855-364-0974 (toll free)

Services for Hearing Impaired (TTY)
Ohio Relay 7-1-1

Address
Aetna Better Health of Ohio
7400 W. Campus Rd.
New Albany, OH 43054-8725

Personal information

My member ID number

My PCP (primary care practitioner)

My PCP's phone number

My care manager's name and phone number

AETNA BETTER HEALTH OF OHIO, A MYCARE OHIO PLAN (MEDICARE-MEDICAID PLAN)

Member Handbook

January 1, 2015 – December 31, 2015

Your Health and Drug Coverage under Aetna Better Health of Ohio (Medicare-Medicaid Plan)

This handbook tells you about your coverage under Aetna Better Health of Ohio through December 31, 2015. It explains health care services, behavioral health coverage, prescription drug coverage, and home and community based waiver services (also called long-term services and supports). Long-term services and supports 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, Aetna Better Health of Ohio, My Care Ohio, is offered by Aetna Better Health, INC. (OH). When this *Member Handbook* says "we", "us" or "our", it means Aetna Better Health, INC. (OH). When it says "the plan" or "our plan" it means Aetna Better Health of Ohio, My Care Ohio.

You can get this handbook for free in other languages. Call **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. The call is free.

Puede obtener esta información en otros idiomas de manera gratuita. Llame al **1-855-364-0974**, Opción 1 y TTY al 711, 24 horas al dia, siete dias de la semana. Esta llamada es gratuita.

Waxaad macluumaadkaan oo lacag la'aan ah ku heli kartaa luqado kale. Wac **1-855-364-0974**, doorasho 1 (TTY: 711) 24 saac maalintii, 7 maalin halkii todobaad. Wicidda waa lacag la'aan.

You can ask for this handbook in other formats, such as Braille or large print. Call **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. The call is free.

→ If you have any problems reading or understanding this handbook or any other Aetna Better Health of Ohio information, please contact Member Services. We can explain the information or provide the information in your primary language. We may have the information printed in certain other languages or in other ways. If you are visually or hearing impaired, special help can be provided.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Disclaimers

Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

Benefits, *List of Covered Drugs*, pharmacy and provider networks may change from time to time throughout the year and on January 1 of each year.

Limitations and restrictions may apply. For more information, call Aetna Better Health of Ohio Member Services or read the Aetna Better Health of Ohio Member Handbook. This means that you may have to pay for some services and that you need to follow certain rules to have Aetna Better Health of Ohio pay for your services.

Chapter 1: Getting started as a member

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If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

A. Welcome to Aetna Better Health of Ohio

Aetna Better Health of Ohio, a MyCare Ohio Plan, offered by Aetna Better Health of Ohio, is a Medicare-Medicaid Plan. A Medicare-Medicaid plan is an organization made up of doctors, hospitals, pharmacies, providers of long-term services and supports, and other providers. It also has care managers 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 of Ohio was approved by the Ohio Department of Medicaid (ODM) and the Centers for Medicare & Medicaid Services (CMS) to provide you services as part of the MyCare Ohio program.

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

Aetna Better Health of Ohio is a Medicare-Medicaid Plan (MMP) in Ohio for the MyCare Ohio program. Our parent company, Aetna, is a leading national company that serves 44 million people, with more than 2 million of those Medicaid members. Aetna has more than 20 years of experience managing care for people enrolled in Medicaid and Medicare. We understand the needs of our members. We work with local Ohio providers and community groups to meet your needs.

B. What are Medicare and Medicaid?

You have both Medicare and Medicaid. Aetna Better Health of Ohio will make sure these programs work together to get you the care you need.

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).

Medicaid

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

Each state decides what counts as income and resources and who qualifies. They also decide what services are covered and the cost for services. States can decide how to run their programs, as long as they follow the federal rules.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Medicare and Ohio Medicaid must approve Aetna Better Health of Ohio each year. You can get Medicare and Medicaid services through our plan as long as:

- We choose to offer the plan, and
- Medicare and Ohio Medicaid approve the plan.

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

C. What are the advantages of this plan?

You will now get all your covered Medicare and Medicaid services from Aetna Better Health of Ohio, including prescription drugs. You do not pay extra to join this health plan.

Aetna Better Health of Ohio will help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You will have a care team that you helped put together. Your care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need.
- You will have a care manager. This is a person who works with you, with Aetna Better Health of Ohio, and with your care providers to make sure you get the care you need.
- You will be able to direct your own care with help from your care team and care manager.
- The care team and care manager will work with you to come up with a care plan specifically designed to meet your needs. The care team will be in charge of coordinating the services you need. This means, for example:
  - » Your care team will make sure your doctors know about all medicines you take so they can reduce any side effects.
  - » Your care team will make sure your test results are shared with all your doctors and other providers.

D. What is Aetna Better Health of Ohio's service area?

Aetna Better Health of Ohio is available only to people who live in our service area. To keep being a member of our plan, you must keep living in this service area.

Our service area includes these counties in Ohio: Butler, Clermont, Clinton, Delaware, Franklin, Fulton, Hamilton, Lucas, Madison, Ottawa, Pickaway, Union, Warren, and Wood.

If you move, you must report the move to your County Department of Job and Family Services office. If you move to a new state, you will need to apply for Medicaid in the new state.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

You are eligible for membership in our plan as long as:

- You live in our service area; **and**
- You have Medicare Parts A, B, and D; **and**
- You have full Medicaid coverage; **and**
- You are 18 years of age or older at time of enrollment.

Even if you meet the above criteria, you are not eligible to enroll in Aetna Better Health of Ohio if you:

- Have a delayed Medicaid spend down; **or**
- Have other third party creditable health care coverage; **or**
- Have intellectual or other developmental disabilities and receive services through a waiver or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICFIID); **or**
- Are enrolled in a Program of All-Inclusive Care for the Elderly (PACE).

Additionally, you have the option to not be a member if you:

- Are a member of a federally recognized Indian tribe; **or**
- Have been determined by the County Board of Developmental Disabilities to qualify for their services; **or**
- You are 18 years of age and receiving foster care or adoption assistance under Title IV-E, in foster care or an out-of-home placement, or receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMH).

→ If you believe that you meet any of the above criteria, please contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week for assistance.

F. What to expect when you first join a health plan

When you first join the plan, you will receive a health care needs assessment within the first 15 to 75 days of your enrollment effective date depending on your health status. A member of our care team will contact you and conduct a health care needs assessment. They will ask you questions to identify your immediate and long-term needs. You will be assigned a care manager who is part of your care team. Your care team is made up of you, your providers, your family, your care manager and whomever else you chose. The care team works together to develop a care plan to help you with your care and service needs.

If Aetna Better Health of Ohio is new for you, you can keep seeing the doctors you go to now for at least 90 days after you enroll. Also, if you already have approval to receive services, our plan will honor the approval until you get the services. This is called a "transition period." The New Member Letter included with your *Member Handbook* has more information on the transition periods. If you are on the MyCare Ohio Waiver, your Home & Community-Based Services Waiver Member Handbook also has more information on transition periods for waiver services.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

After the transition period, you will need to see doctors and other providers in the Aetna Better Health of Ohio network for most services. A network provider is a provider who works with the health plan. See Chapter 3 for more information on getting care.

If you are currently seeing a provider that is not a network provider or if you already have services approved and/or scheduled, it is important that you call Member Services at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week right away so we can arrange the services and avoid any billing issues.

G. What is a care plan?

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

After your health care needs 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.

Your care team will continuously work with you to update your care plan to address the health services you need and want.

H. Does Aetna Better Health of Ohio 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. You can also call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week or Medicare at 1-800-MEDICARE (1-800-633-4227).

The contract is in effect for months in which you are enrolled in Aetna Better Health of Ohio between January 1, 2015 and December 31, 2015.

J. What other information will you get from us?

You will also get an Aetna Better Health of Ohio member ID card, a New Member Letter with important information, information about how to access a *Provider and Pharmacy Directory*, and a *List of Covered Drugs*. Members enrolled in a home and community based waiver will also receive a supplement to their Member Handbook that gives information specific to waiver services. If you do not receive these items, please call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week for assistance.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Your Aetna Better Health of Ohio member ID card

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

If your card is damaged, lost, or stolen, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week right away and we will send you a new card.

As long as you are a member of our plan, this is the only card you need to get services. You will no longer get a monthly Medicaid card. You also do not need to use your red, white, and blue Medicare card. Keep your Medicare card in a safe place, in case you need it later.

New Member Letter

Please make sure to read the New Member Letter sent with your *Member Handbook* as it is a quick reference for some important information. For example, it has information on things such as when you may be able to receive services from providers not in our network, previously approved services, transportation services, and who is eligible for MyCare Ohio enrollment.

Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists the providers and pharmacies in the Aetna Better Health of Ohio network. While you are a member of our plan, you must use network providers and pharmacies to get covered services. There are some exceptions, including when you first join our plan and for certain services (see Chapter 3).

You can request a printed *Provider and Pharmacy Directory* at any time by calling Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. You can also see the *Provider and Pharmacy Directory* at **www.aetnabetterhealth.com/ohio**, 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 providers.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

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 Medicaid. For a full list of network providers, see the *Provider and Pharmacy Directory*.
- Network providers have agreed to accept payment from our plan for covered services as payment in full.

What are *"network pharmacies"*?

- *Network pharmacies* are the 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 in an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them. If it is not an emergency, you can ask us ahead of time to use a non-network pharmacy.

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 of Ohio.

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 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, you can visit the plan's website at **www.aetnabetterhealth.com/ohio** or call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

Member Handbook Supplement or "Waiver Handbook"

This supplement provides additional information for members enrolled in a home and community based waiver. For example, it includes information on member rights and responsibilities, service plan development, care management, waiver service coordination, and reporting incidents.

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).*

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

The Explanation of Benefits tells you 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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 are covered and any drug copay amounts for 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 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 you have to see a provider for an injury or illness that may have been caused by another person or business. For example, if you are hurt in a car wreck, by a dog bite, or if you slip and fall in a store, then another person or business may have to pay for your medical expenses. When you call we will need to know the name of the person or business at fault as well as any insurance companies or attorneys that are involved.

If any information changes, please let us know by calling Member Services at **1-855-364-0974,** Option 1 (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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Chapter 2: Important phone numbers and resources

This chapter provides you with a quick reference of contact information for Aetna Better Health of Ohio, the State of Ohio, Medicare, and other useful resources.

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If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

A. How to contact Aetna Better Health of Ohio Member Services

CALL	**1-866-600-2139** (Option 1). 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 of Ohio Attn: Member Services Department 7400 West Campus Road Mail Code: F494 New Albany, OH 43054 If you are sending us an appeal or complaint, you can use the form in Chapter 9. You can also write a letter telling us about your question, problem, complaint, or appeal.
WEBSITE	**www.aetnabetterhealth.com/ohio**

Contact Member Services about:

- **Questions about the plan**
- **Questions about claims or billing**
- **Member identification (ID) cards**
  Let us know if you didn't get your member ID card or you lost your member ID card.
- **Finding network providers**
  This includes questions about finding or changing your primary care provider (PCP).
- **Getting long-term services and supports**
  In some cases, you can get help with daily health care and basic living needs. If it is determined necessary by Ohio Medicaid and Aetna Better Health of Ohio, you may be able to receive assisted living, homemaker, personal care, meals, adaptive equipment, emergency response, and other services.
- **Understanding the information in your Member Handbook**
- **Recommendations for things you think we should change**

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- **Other information about Aetna Better Health of Ohio**
  You can ask for more information about our plan, including information regarding the structure and operation of Aetna Better Health of Ohio and any physician incentive plans we operate.

- **Coverage decisions about your health care and drugs**
  A coverage decision is a decision about:
  - » your benefits and covered services and drugs, **or**
  - » the amount we will pay for your health services and drugs.

  Call us if you have questions about a coverage decision.

  → To learn more about coverage decisions, see Chapter 9.

- **Appeals about your health care and drugs**
  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.

- **Complaints about your health care and drugs**
  You can make a complaint about us or any provider or pharmacy. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (see Section E).

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

  → You can send a complaint about Aetna Better Health of Ohio 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.

  → You can send a complaint about Aetna Better Health of Ohio directly to Ohio Medicaid. See page 19 for ways to contact Ohio Medicaid.

  → To learn more about making a complaint, see Chapter 9.

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

  → For more on how to ask us to assist you with a service you paid for or to pay a bill you have gotten, see Chapter 7.

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

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

B. How to contact your Care Manager

As an Aetna Better Health member, you will be assigned a care manager. This person works with you and your care providers to make sure you get the care and services you need. Your care manager will give you his or her phone number and email address so you can contact him or her. You can also contact your care manager by calling our Care Management line at **1-855-364-0974** (Option 5), 24 hours a day, 7 days a week. It is important that you have a good relationship with your care manager. If you want to change your care manager please call the Care Management line.

CALL	**1-855-364-0974** (Option 5). This call is free. The care management line is available 24 hours a day, 7 days a week, 365 days a year. 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, 365 days a year
WRITE	Aetna Better Health of Ohio Attn: Care Management 7400 West Campus Road Mail Code: F494 New Albany, OH 43054
WEBSITE	**www.aetnabetterhealth.com/ohio**

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

C. How to contact the 24-Hour Nurse Advice Call Line

Aetna Better Health of Ohio has a Nurse Advice Line available to help answer your medical questions, give advice on treatment options or other courses of action and confirm enrollment. The Nurse Advice Line does not take the place of your primary care provider but is available as another resource for you. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. You can contact the Nurse Advice Line at **1-855-364-0974** (TTY: 711), select Option 4.

CALL	**1-855-364-0974** (Option 4). This call is free. The Nurse Advice Line is available 24 hours a day, 7 days a week, 365 days a year. 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, 365 days a year

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

D. How to contact the 24-Hour Behavioral Health Crisis Line

Aetna Better Health of Ohio offers a Behavioral Health Crisis Line. If you need immediate behavioral health care and do not know who to call, you can call our Behavioral Health Crisis Line. It is staffed by qualified health professionals experienced in behavioral health and crisis intervention who can help get you the care you need when you need immediate help for a mental health or alcohol or drug addiction crisis. This number is available 24 hours a day, 7 days a week.

Some symptoms of a behavioral health crisis are:

- Hopelessness, feeling like there's no way out
- Anxiety, agitation, sleeplessness, or mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

CALL	**1-855-364-0974** (Option 9). This call is free. The Behavioral Health Crisis line is available 24 hours a day, 7 days a week, 365 days a year. 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, 365 days a year

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

Our state has an organization called KePRO. 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
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 Fax: 1-844-834-7130
WEBSITE	www.ohiokepro.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.

F. 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 of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

G. How to contact the Ohio Department of Medicaid

Medicaid helps with medical and long-term services and supports costs for people with limited incomes and resources. Ohio Medicaid pays for Medicare premiums for certain people, and pays for Medicare deductibles, co-insurance and copayments except for prescriptions. Medicaid covers long-term care services such as home and community-based "waiver" services and assisted living services and long-term nursing home care. It also covers dental and vision services.

You are enrolled in Medicare and in Medicaid. Aetna Better Health of Ohio provides your Medicaid covered services through a provider agreement with Ohio Medicaid. If you have questions about the help you get from Medicaid, call the Ohio Medicaid Hotline.

CALL	1-800-324-8680. This call is free. The Ohio Medicaid Hotline is available Monday through Friday from 7:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 5:00 p.m.
TTY	1-800-292-3572. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. The Ohio Medicaid TTY number is available Monday through Friday from 7:00 a.m. to 8:00 p.m., and Saturday from 8:00 a.m. to 5:00 p.m.
WRITE	Ohio Department of Medicaid Bureau of Managed Care 50 W. Town Street, Suite 400 Columbus, Ohio 43215
EMAIL	bmhc@medicaid.ohio.gov
WEBSITE	http://medicaid.ohio.gov/PROVIDERS/ManagedCare/IntegratingMedicareandMedicaidBenefits.aspx

You may also contact your local County Department of Job and Family Services if you have questions or need to submit changes to your address, income, or other insurance. Contact information is available online at: http://jfs.ohio.gov/County/County_Directory.pdf.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

H. How to contact the MyCare Ohio Ombudsman

The MyCare Ohio Ombudsman helps with concerns about any aspect of care. Help is available to resolve disputes with providers, protect rights, and file complaints or appeals with our plan. The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers receiving long-term services and supports.

CALL	**1-800-282-1206.** This call is free. The MyCare Ohio Ombudsman is available Monday through Friday from 8:00 a.m. to 5:00 p.m.
TTY	Ohio Relay Service: 1-800-750-0750. This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Ohio Department of Aging Attn: MyCare Ohio Ombudsman 50 W. Broad St., 9th Floor Columbus, Ohio 43215-3363
WEBSITE	http://aging.ohio.gov/services/ombudsman/ You can submit an online complaint at: http://aging.ohio.gov/contact/

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

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If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

Services are health care, long-term services and supports, 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 services and supports are listed in the Benefits Chart in Chapter 4.

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

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 pay nothing for covered services. The only exception is if you have a patient liability for nursing facility or waiver services. See Chapter 4 for more information.

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you receive. When you use a network pharmacy, you pay nothing for your prescription drugs. See Chapter 6 for more information.

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

Aetna Better Health of Ohio covers services covered by Medicare and Medicaid. This includes behavioral health, long term care, and prescription drugs.

Aetna Better Health of Ohio will generally pay for the health care and services you get if you follow the plan rules. To be covered:

- **The care you get must be a plan benefit.** See Chapter 4 for information regarding covered benefits, including the plan's Benefits Chart.
- **The care must be medically necessary.** Medically necessary means you need services, supplies, or drugs 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.
- **The care you receive must be prior authorized by Aetna Better Health of Ohio when required.** For some services, your provider must submit information to Aetna Better Health of Ohio and request approval for you to receive the service. This is called prior authorization. See the chart in Chapter 4 for more information.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- **You must choose a network provider** to be your primary care provider (PCP) to manage your medical care. 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.

  → To learn more about choosing a PCP, see page 26.

- **You must get your care from network providers.** Usually, the plan will not cover care from a provider who does not work with the plan (an out-of-network provider). 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 31.

  » If you need care that our plan covers and our network providers cannot give it to you, you can get this care from an out-of-network provider. The out-of-network provider must contact us for approval **before** seeing you. 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 27.

  » The plan covers services received at out-of-network Federally Qualified Health Centers, Rural Health Clinics and qualified family planning providers listed in the *Provider and Pharmacy Directory*.

  » If you are receiving assisted living waiver services or long-term nursing facility services from an out-of-network provider on and before the day you become a member, you can continue to receive the services from that out-of-network provider.

  » 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.

  » If you are new to our plan, you may be able to continue to see your current out-of-network providers for a period of time after you enroll. This is called a "transition period." For more information, go to Chapter 1 of this handbook and your *New Member Letter* .

C. Your care team and care manager

Your care team includes you, your family, caregivers, care manager, PCP, specialists, any other health or service providers who you actively work with and anyone else you want to include. Everyone on the care team works together to make sure your care is coordinated.

You will get a personalized care plan that is created to address your health care needs, the way you want. Your care team will also get a copy of your care plan to make sure you get the care and services you need. Your care team may ask you questions to learn more about your condition. That will also provide information to help you understand how to care for yourself and how to access a range of services, including local resources.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Your care manager helps you manage all of your providers and services. He or she works with your care team to make sure you get the care you need.

What is care management?

Care management is a process that coordinates and plans your care and services in order to get you what you need to reach your optimal health and functional levels. You are included in the care management process. You can also ask that we include other people such as your family or caregivers. We have a Care Management department at Aetna Better Health of Ohio staffed with care managers and other care management employees. You will have a care manager assigned to you.

When you first meet your care manager, he or she will give you his or her phone number. You can also call the 24-hour Care Management line at **1-855-364-0974**, Option 5 (TTY: 711) to reach your care manager.

How will the care manager and care team interact with you?

The care manager and care team work with you. Your care manager will give you his or her phone number. You may also meet in person. Your care team will have meetings and include you to discuss your care needs.

You can change your care manager at any time by calling the 24-hour Care Management line at **1-855-364-0974**, Option 5 (TTY: 711).

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 PCP is an individual physician or physician group practice who works with you and your care manager to direct and coordinate your health care. Your PCP handles your preventive care checkups and treats 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.

Your PCP may be trained in:

- Family practice
- General practice
- Geriatrics
- Certified nurse practitioner
- Internal medicine
- OB/GYN
- Pediatrics
- Physician assistant

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Sometimes a specialist may be your PCP. The specialist will have to first agree to do so. If you want a specialist to be your PCP, talk to your care manager. Your care manager will contact the specialist and work with him or her to become your PCP. A Rural Health Center (RHC) or a Federally Qualified Health Center (FQHC) can also serve as your PCP.

You can reach your PCP by calling the PCP's office. Your PCP's name and telephone number are printed on your Aetna Better Health of Ohio ID card.

How do you choose your PCP?

- Search for a PCP on our website **www.aetnabetterhealth.com/ohio**
- Call Member Services or your care manager at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week
- Look in your printed *Provider and Pharmacy Directory*, if you requested one

Changing your PCP

You may change your PCP for any reason. You can change your PCP to another network PCP as often as you like. There is no limit to the number of times you can change your PCP. Also, it's possible that your PCP might leave our plan's network. If your provider leaves the plan's network, we can help you find a new PCP.

If for any reason you want to change your PCP, you must first call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to ask for the change. The change will take effect immediately. We will issue you a new member ID card that you will get in the mail within 14 days. If you need to see your PCP before you get your new member ID card, your PCP's office can call us to verify your eligibility. If you are thinking about changing your PCP, talk to your care manager. Your care manager may help with any issues you are having.

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. You do not need a referral to see a network specialist. Your PCP or care manager can recommend a type of specialist to you. You can also call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. We will help you find a specialist near you. PCPs and specialists need to contact Aetna Better Health to get approval for certain services and drugs. This is called prior authorization. See the Benefits Chart in Chapter 4 and the Drug List for information about which services and drugs require prior authorization.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

What if a network provider leaves our plan?

A network provider you are using could leave our plan. Whenever possible we will notify you, by letter, in advance when we find out that your PCP or a hospital in your service area that you have had services within the prior 12 months is leaving our plan network.

The letter will tell you the last day that you can see the provider. It will also tell you how to contact us for help with finding a new provider and how to get services in urgent situations. If the provider is your PCP, the letter will also tell you who your new PCP is and also let you know how to change to a different PCP. In addition, you can call your care manager at any time if an urgent situation arises after one of your network providers leaves 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 45 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 a complaint.

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. You can contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week for assistance.

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 an out-of-network provider if:

- You need emergency services.
- You need urgent care.
- You are getting services at a Federally Qualified Health Center (FQHC) or Rural Health Clinic (RHC).
- You are getting services from a Qualified Family Planning provider.
- Aetna Better Health of Ohio approved you to see an out-of-network provider during or after your transition of care time period. The out-of-network provider must contact us to get approval to see you before your appointment.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

- A provider with a certain specialty is not available in-network. You can see an out-of-network provider with that specialty. The provider must get prior authorization before your appointment.

Services outside of the U.S. are not covered. Except for the out-of-network providers above, non-emergency care out of the service area is not covered. If you are out of the service area and need health care services, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711) 24 hours a day, 7 days a week or call your PCP. Your PCP's telephone number is on your member ID card.

→ **Please note:** If you go to an out-of-network provider, the provider must be eligible to participate in Medicare and/or Medicaid. We cannot pay a provider who is not eligible to participate in Medicare and/or Medicaid. If you go to a provider who is not eligible to participate in Medicare, you may have to 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 services and supports (LTSS)

As an Aetna Better Health of Ohio member, you may be able to get nursing facility or long-term care services and supports (LTSS) such as home health care, adult day services and specialized medical equipment. Long-term services and supports give assistance to help you stay at home instead of going to a nursing home or hospital. MyCare Ohio Waiver Services provided through Aetna Better Health of Ohio are designed to meet the needs of members eighteen years or older who are fully eligible for both Medicaid and Medicare, and enrolled in a MyCare Ohio Plan and who are determined by the state of Ohio, or its designee, to meet an intermediate or skilled level of care. These services help individuals to live independently.

A request for long-term services and supports can be made by the member or family member. Your care manager will be assigned by Aetna Better of Ohio to work with you and a team of professionals to make sure you receive the services that you need. If you have questions about LTSS or to see if you qualify, call your care manager.

F. How to get behavioral health services

If you have a behavioral health crisis, call the Behavioral Health Crisis Line at **1-855-364-0974**, Option 9 (TTY: 711), 24 hours a day, 7 days a week.

If you need mental health and/or substance abuse services, please talk to your care manager or call Member Services at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

You may also go directly to Ohio Department of Mental Health and Addiction Services (MHAS) certified community mental health centers, behavioral health professionals and other treatment centers that are part of the Aetna Better Health of Ohio network. Please see the provider directory or call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week for the names and telephone numbers of the facilities near you. Be sure to show your Aetna Better Health of Ohio member ID card when you get care.

You can find other Aetna Better Health of Ohio providers in the provider directory on our website **www.aetnabetterhealth.com/ohio**. You can also call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

G. How to get transportation services

If you must travel 30 miles or more from your home to receive covered health care services, Aetna Better Health of Ohio will provide transportation to and from the provider's office. Transportation by ambulette (wheelchair transport), non-emergency ambulance, emergency ambulance and waiver services are not limited to the 30 mile requirement.

Transportation for routine medical appointments

If you need a ride to your appointments, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711) 24 hours a day, 7 days a week. Member Services staff is trained to assist you with your transportation needs. You can also call LogistiCare directly at **1-866-799-4395** (TTY: 711), Monday through Friday, 8 a.m. – 5 p.m. (EST). You must call at least **3 days** before your appointment. If you need help, talk to your care manager or call Member Services. Member Services and LogistiCare will verify that the transportation request is for a covered health care service.

In addition to the transportation assistance that Aetna Better Health of Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.

Member Advisory Committee (MAC) transportation

Aetna Better Health of Ohio also provides transportation services for members who serve on the plan's Member Advisory Committee (MAC). Transportation to member advisory meetings for any member who serves on the MAC are provided when requested at least 3 days in advance by the member.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

H. 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, or other appropriate setting. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP or Aetna Better Health of Ohio.
- **Be sure to tell the provider that you are an Aetna Better Health of Ohio member.** Show the provider your Aetna Better Health of Ohio member ID card.
- **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. Also, if the hospital has you stay, please make sure Aetna Better Health of Ohio is called within 48 hours. The phone number is on your Aetna Better Health of Ohio member ID card.

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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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. If the provider that is treating you for an emergency takes care of the emergency but thinks you need other medical care to treat the problem that caused the emergency, the provider must call Aetna Better Health of Ohio at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week

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 or the health of your unborn child 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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/ohio** or by calling Member Services at **1-855-364-0974**, Option 1 (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 **1-855-364-0974**, Option 4 (TTY: 711).

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 or its territories.

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

Providers should bill us for providing you covered services. You should not receive a provider bill for services covered by the plan. If a provider sends you a bill for a covered service instead of sending it to the plan, you can ask us to pay the bill. Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week as soon as possible to give us the information on the bill.

→ You should not pay the bill yourself. If you do, the plan may not be able to pay you back.

If a provider or pharmacy wants you to pay for covered services, you have already paid for covered services, or if you have received a bill for covered services, see Chapter 7 to learn what to do.

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

Aetna Better Health of Ohio covers all services:

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

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

→ If you get services that aren't covered by our plan, **you may have to 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 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to learn more about your appeal rights.

We will pay for some services up to a certain limit. If you do not have prior approval from Aetna Better Health of Ohio to go over the limit, you may have to pay the full cost to get more of that type of service. Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to find out what the limits are, how close you are to reaching them, and what your provider must do to request to exceed the limit if they think it is medically necessary.

J. 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 *do* 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 manager should contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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. Ohio Medicaid does not cover clinical research studies.

Learning more

You can learn more about joining a clinical research study by reading "Medicare and Clinical Research Studies" on the Medicare website (http://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.

K. 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.

In some cases, Medicaid covers long-term care in a religious non-medical health care institution as long as the institution is a licensed nursing facility. The facility may need to contact us for prior authorization. If you have questions about this, talk to your care manager. To find nursing facilities in our network, use the provider search on our website **www.aetnabetterhealth.com/ohio** or call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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.

Inpatient hospital coverage limits apply (see the Benefits Chart in Chapter 4).

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

L. 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. Other types of durable medical equipment will be rented for you by Aetna Better Health of Ohio. Sometimes you will own the rented item after we pay the rental fee for a certain number of months, and sometimes you will not own the item no matter how long it is rented. Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to find out whether you will own your item or if it will be rented.

What happens if you switch to Medicare?

In Medicare, people who rent certain types of durable medical equipment own it after 13 months. 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

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If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

A. Understanding your covered services

This chapter tells you what services Aetna Better Health of Ohio covers, how to access services, and if there are any limits on services. You can also learn about services that are not covered. Information about drug benefits is in Chapter 5 and information about what you pay for drugs is in Chapter 6.

Because you get assistance from Medicaid, you generally pay nothing for the covered services explained in this chapter as long as you follow the plan's rules. See Chapter 3 for details about the plan's rules. However, you may be responsible for paying a "patient liability" for nursing facility or waiver services that are covered through your Medicaid benefit. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

If you need help understanding what services are covered or how to access services, please call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. You can also call the 24-hour Care Management line at **1-855-364-0974**, Option 5 or your care manager at his or her direct phone number.

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

Except as indicated above, we do not allow Aetna Better Health of Ohio providers to bill you for covered 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 covered service.

→ **You should never get a bill from a provider for a covered service. If you do, see Chapter 7.**

C. About the Benefits Chart

The following Benefits Chart is a general list of services the plan covers. It lists preventive services first and then categories of other services in alphabetical order. It also explains the covered services, how to access the services, and if there are any limits or restrictions on the services. If you can't find the service you are looking for, have questions, or need additional information on covered services and how to access services, contact Member Services or your care manager at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

We will cover the services listed in the Benefits Chart only when the following rules are met:

- Your Medicare and Medicaid covered services must be provided according to the rules set by Medicare and Ohio Medicaid.

- The services (including medical care, services, supplies, equipment, and drugs) must be a plan benefit and must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

→ If Aetna Better Health of Ohio makes a decision that a service is not medically necessary or not covered, you or someone authorized to act on your behalf may file an appeal. For more information about appeals, see Chapter 9.

- 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 has more information about using network and out-of-network providers.

- You have a primary care provider (PCP) or a care team that is providing and managing 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. Also, some of the services listed in the Benefits Chart are covered only if your doctor or other network provider writes an order or a prescription for you to receive the service. If you are not sure whether a service requires prior authorization, contact Member Services or visit our website at **www.aetnabetterhealth.com/ohio**

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above. The only exception is if you have a patient liability for nursing facility services or waiver services as determined by the County Department of Job and Family Services.

D. The Benefits Chart

Preventative Visits

Services covered by our plan	Limitations and exceptions
Annual checkup This is a visit to make or update a prevention plan based on your current risk factors. Annual checkups are covered 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.	
"Welcome to Medicare" visit If you have been in Medicare Part B for 12 months or less, you can get a one-time "Welcome to Medicare" preventive visit. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit. This 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.	
Well-child check-up (also known as Healthchek) Healthchek is Ohio's early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.	

Preventative Services and Screenings

Services covered by our plan	Limitations and exceptions
Abdominal aortic aneurysm screening The plan covers abdominal aortic aneurysm ultrasound screenings if you are at risk.	
Alcohol misuse screening and counseling The plan covers alcohol-misuse screenings for adults. This includes pregnant women. If you screen positive for alcohol misuse, you can get face-to-face counseling sessions with a qualified primary care provider or practitioner.	
Breast cancer screening The plan covers 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 ■ Women under the age of 35 who are at high risk for developing breast cancer may also be eligible for mammograms ■ Annual clinical breast exams	Prior authorization required for women under the age of 35
Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) The plan covers visits with your primary care provider to help lower your risk for heart disease. During this visit, your provider may: ■ Discuss aspirin use, ■ Check your blood pressure, or ■ Give you tips to make sure you are eating well.	

Preventative Services and Screenings (continued)

Services covered by our plan	Limitations and exceptions
Cardiovascular (heart) disease testing The plan covers blood tests to check for cardiovascular disease. These blood tests also check for defects due to high risk of heart disease.	Prior authorization may be required
Cervical and vaginal cancer screening The plan covers pap tests and pelvic exams annually for all women.	
Colorectal cancer screening For people 50 and older or at high risk of colorectal cancer, the plan covers: ■ Flexible sigmoidoscopy (or screening barium enema) ■ Fecal occult blood test ■ Screening colonoscopy 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).	
Counseling to stop smoking or tobacco use The plan covers tobacco cessation counseling.	Some services may require prior authorization
Depression screening The plan covers depression screening.	

Preventative Services and Screenings (continued)

Services covered by our plan	Limitations and exceptions
Diabetes screening The plan covers diabetes screening (includes fasting glucose tests). You may want to speak to your provider about this test if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, family history of diabetes, or history of high blood sugar (glucose).	
HIV screening The plan covers HIV screening exams for people who ask for an HIV screening test or are at increased risk for HIV infection.	
Immunizations The plan covers the following services: ■ Vaccines for children under age 21 ■ 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 Medicaid coverage rules ■ Other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more.	Some vaccines (other than your annual flu shot) may require prior authorization
Obesity screening and therapy to keep weight down The plan covers counseling to help you lose weight.	Some services may require prior authorization
Prostate cancer screening The plan covers the following services: ■ A digital rectal exam ■ A prostate specific antigen (PSA) test	

Preventative Services and Screenings (continued)

Services covered by our plan	Limitations and exceptions
Sexually transmitted infections (STIs) screening and counseling The plan covers screenings for sexually transmitted infections, including but not limited to chlamydia, gonorrhea, syphilis, and hepatitis B. The plan also covers face-to-face, high-intensity behavioral counseling sessions for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long.	Some services may require prior authorization

Other Services

Services covered by our plan	Limitations and exceptions
Ambulance and wheelchair van services Covered emergency ambulance transport 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 or, if you are pregnant, your unborn baby's life or health. In cases that are not emergencies, ambulance or wheelchair van transport services are covered when medically necessary.	Wheelchair van transportation requires that you notify Aetna Better Health of Ohio of your need to schedule van transport so we can make sure the correct vehicle is scheduled based on your individual transportation needs
Chiropractic services The plan covers: ■ Diagnostic x-rays ■ Adjustments of the spine to correct alignment	Prior authorization is required

Services covered by our plan	Limitations and exceptions
Dental services The plan covers the following services: ■ Comprehensive oral exam (one per provider-patient relationship) ■ Periodic oral exam once every 180 days for all members ■ Preventive services including prophylaxis, fluoride, sealants, and space maintainers ■ Routine radiographs/diagnostic imaging ■ Comprehensive dental services including non-routine diagnostic, restorative, endodontic, periodontic, prosthodontic, orthodontic, and surgery services	Some services may require prior authorization
Diabetic services The plan covers the following services for all people who have diabetes (whether they use insulin or not): ■ Training to manage your diabetes, in some cases ■ Supplies to monitor your blood glucose, including: » Blood glucose monitors and 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: » 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 also covers fitting the therapeutic custom-molded shoes or depth shoes.	Non-routine diabetic services such as those performed by a Podiatrist (foot specialist) may require prior authorization. See the Podiatry section below in this handbook. Therapeutic custom molded shoes, depth shoes and covered shoe inserts require a prescription from your provider.

Services covered by our plan	Limitations and exceptions
Durable medical equipment and related supplies Covered durable medical equipment includes, but is not limited to, the following: ■ Wheelchairs ■ Oxygen equipment ■ Canes, crutches, and walkers ■ IV infusion pumps ■ Hospital beds ■ Commodes ■ Nebulizers ■ Incontinence garments ■ Enteral nutritional products ■ Ostomy and urological supplies ■ Surgical dressings and related supplies For additional types of supplies that the plan covers, see the sections on diabetic services, hearing services, and prosthetic devices. The plan may also cover learning how to use, modify, or repair your item. Your Care Team will work with you to decide if these other items and services are right for you and will be in your Individualized Care Plan. We will cover all durable medical equipment that Medicare and Medicaid usually cover. 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.	Prior authorization may apply

Services covered by our plan	Limitations and exceptions
Emergency care (see also "urgently needed care") *Emergency care* means services that are: ■ Given by a provider trained to give emergency services, and ■ 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. In an emergency, call 911 or go to the nearest emergency room (ER) or other appropriate setting. If you are not sure if you need to go to the ER, call your PCP or the 24-hour toll-free nurse advice line. Your PCP or the nurse advice line can give you advice on what you should do. We will only cover emergency care within the United States and its territories.	If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must transfer 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.

Services covered by our plan	Limitations and exceptions
Family planning services The plan covers 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 (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) ■ Treatment for AIDS and other HIV-related conditions ■ 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.) ■ Screening, diagnosis and counseling for genetic anomalies and/or hereditary metabolic disorders ■ Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) **Note:** You can get family planning services from a network or out-of-network qualified family planning provider (for example Planned Parenthood) listed in the *Provider and Pharmacy Directory*. You can also get family planning services from a network certified nurse midwife, obstetrician, gynecologist, or primary care provider.	Certain diagnostic tests may require prior authorization. Prior authorization is required for genetic testing.

Services covered by our plan	Limitations and exceptions
Federally Qualified Health Centers The plan covers the following services at Federally Qualified Health Centers: ■ Office visits for primary care and specialists services ■ Physical therapy services ■ Speech pathology and audiology services ■ Dental services ■ Podiatry services ■ Optometric and/or optician services ■ Chiropractic services ■ Transportation services ■ Mental health services **Note:** You can get services from a network or out-of-network Federally Qualified Health Center.	Some services may require prior authorization
Health and wellness education programs These services will be coordinated by your care manager and integrated care team.	Some services may require prior authorization
Hearing services and supplies The plan covers the following: ■ Hearing and balance tests to determine the need for treatment (covered as outpatient care when you get them from a physician, audiologist, or other qualified provider) ■ Hearing aids, batteries, and accessories (including repair and/or replacement) » Conventional hearing aids are covered once every 4 years » Digital/programmable hearing aids are covered once every 5 years	Prior authorization may be required

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Services covered by our plan	Limitations and exceptions
Home and community-based waiver services The plan covers the following home and community-based waiver services: ■ Adult day health services ■ Alternative meals service ■ Assisted living services ■ Choices home care attendant ■ Chore services ■ Community transition ■ Emergency response services ■ Enhanced community living services ■ Home care attendant ■ Home delivered meals ■ Home medical equipment and supplemental adaptive and assistive devices ■ Home modification, maintenance, and repair ■ Homemaker services ■ Independent living assistance ■ Nutritional consultation ■ Out of home respite services ■ Personal care services ■ Pest control ■ Social work counseling ■ Waiver nursing services ■ Waiver transportation	These services are available only if your need for long-term care has been determined by Ohio Medicaid. You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

Services covered by our plan	Limitations and exceptions
Home health services The plan covers the following services provided by a home health agency: ■ Home health aide and/or nursing services ■ Physical therapy, occupational therapy, and speech therapy ■ Private duty nursing (may also be provided by an independent provider) ■ Home infusion therapy for the administration of medications, nutrients, or other solutions intravenously or enterally ■ Medical and social services ■ Medical equipment and supplies	Prior authorization is required

Services covered by our plan	Limitations and exceptions
Hospice care You can get care from any hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will cover the following: ■ Drugs to treat symptoms and pain ■ Short-term respite care ■ Home care ■ Nursing facility care ***For hospice services and services covered by Medicare Part A or B that relate to your terminal illness:*** ■ The hospice provider will bill Medicare for your services. Medicare will cover hospice services and any Medicare Part A or B services. You pay nothing for these services. ***For services covered by Medicare Part A or B that are not related to your terminal illness (except for emergency care or urgently needed care):*** ■ The provider will bill Medicare for your services. Medicare will cover the services covered by Medicare Part A or B. You pay nothing for these services. ***For services covered by Aetna Better Health of Ohio but not covered by Medicare Part A or B:*** ■ Aetna Better Health of Ohio will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to your terminal illness. Unless you are required to pay a patient liability for nursing facility services, you pay nothing for these services. **Note:** Except for emergency/urgent care, if you need non-hospice care, you should call your care manager to arrange the services. Non-hospice care is care that is not related to your terminal illness. Call your care manager directly or call the Care Management line at **1-855-364-0974** (Option 5) TTY: 711.	Prior authorization is required If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.

Services covered by our plan	Limitations and exceptions
Inpatient behavioral health services The plan covers the following services: ■ Inpatient psychiatric care in a private or public freestanding psychiatric hospital or general hospital » For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there is a 190-day lifetime limit ■ Inpatient detoxification care	Prior authorization is required
Inpatient hospital care The plan covers 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 for use in the hospital ■ Operating and recovery room services ■ Physical, occupational, and speech therapy ■ Inpatient substance abuse services ■ Blood, including storage and administration ■ Physician/provider 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 ***This benefit is continued on the next page***	Prior authorization is required

Services covered by our plan	Limitations and exceptions
Inpatient hospital care (continued) 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 of Ohio provides transplant services at a distant location outside the service area and you choose to get your transplant there, we will arrange or cover lodging and travel costs for you and one other person.	

Services covered by our plan	Limitations and exceptions
Inpatient services covered during a non-covered inpatient stay If your inpatient stay is not reasonable and needed, the plan will not cover it. However, in some cases the plan will cover services you get while you are in the hospital or a nursing facility. The plan will cover the following services, and maybe other services not listed here: ■ Doctor services ■ Diagnostic tests, like lab tests ■ X-ray, radium, and isotope therapy, including technician materials and services ■ Surgical dressings ■ Splints, casts, and other devices used for fractures and dislocations ■ Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that: » replace all or part of an internal body organ (including contiguous tissue), or » replace all or part of the function of an inoperative or malfunctioning internal body organ. ■ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient's condition ■ Physical therapy, speech therapy, and occupational therapy	Prior authorization is required

Services covered by our plan	Limitations and exceptions
Kidney disease services and supplies The plan covers the following services: ■ Kidney disease education services to teach kidney care and help you make good decisions about your care ■ Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3. ■ 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 **Note:** Your Medicare Part B drug benefit covers some drugs for dialysis. For information, please see "Medicare Part B prescription drugs" below.	Some services may require prior authorization
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 covers 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 cover 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.

Services covered by our plan	Limitations and exceptions
Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Aetna Better Health of Ohio covers 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 ■ 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 erythropoisis-stimulating agents (such as Procrit® or Aranesp®) ■ IV immune globulin for the home treatment of primary immune deficiency diseases → **Chapter 5 explains the outpatient prescription drug benefit.** It explains rules you must follow to have prescriptions covered. → **Chapter 6 explains what you pay for your outpatient prescription drugs through our plan.**	Prior authorization is required

Services covered by our plan	Limitations and exceptions
Mental health and substance abuse services at addiction treatment centers The plan covers the following services at addiction treatment centers: ■ Ambulatory detoxification ■ Assessment ■ Case management ■ Counseling » Limited to 30 hours per week ■ Crisis intervention ■ Intensive outpatient ■ Alcohol/drug screening analysis/lab urinalysis ■ Medical/somatic » Limited to 30 hours per week ■ Methadone administration ■ Office administered medications for addiction including vivitrol and buprenorphine induction See "Inpatient behavioral health services" and "Outpatient mental health care" for additional information.	Some services may require prior authorization

Services covered by our plan	Limitations and exceptions
Mental health and substance abuse services at community mental health centers The plan covers the following services at certified community mental health centers: ■ Mental health assessment/diagnostic psychiatric interview » Limited to 4 hours for non-physician assessment and 2 hours for physician interview per year ■ Community psychiatric supportive treatment (CPST) services ■ Counseling and therapy » Limited to 52 hours of combined individual/group therapy per year ■ Crisis intervention ■ Pharmacological management » Limited to 24 hours per year ■ Pre-hospital admission screening ■ Certain office administered injectable antipsychotic medications ■ Partial hospitalization » 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. See "Inpatient behavioral health services" and "Outpatient mental health care" for additional information.	Some services may require prior authorization

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility care The plan covers 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 ■ 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 ■ 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 Medicaid nursing facility care from the following place if it accepts our plan's amounts for payment: ■ A nursing home or continuing care retirement community where you lived on the day you became an Aetna Better Health of Ohio member. ***This benefit is continued on the next page***	Prior authorization is required You may be responsible for paying a patient liability for room and board costs for nursing facility services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability. Note that patient liability does not apply to Medicare-covered days in a nursing facility.

Services covered by our plan	Limitations and exceptions
Nursing and skilled nursing facility care (continued) You can get Medicare nursing facility 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	
Outpatient mental health care The plan covers mental health services provided by: ■ a state-licensed psychiatrist or doctor, ■ a clinical psychologist, ■ a clinical social worker, ■ a clinical nurse specialist, ■ a nurse practitioner, ■ a physician assistant, or ■ any other qualified mental health care professional as allowed under applicable state laws. The plan covers the following services and maybe other services not listed here: ■ Clinic services and general hospital outpatient psychiatric services ■ Day treatment ■ Psychological rehab services	Some services may require prior authorization

Services covered by our plan	Limitations and exceptions
Outpatient services The plan covers services you get in an outpatient setting for diagnosis or treatment of an illness or injury. The following are examples of covered services: ■ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ■ The plan covers outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers ■ Chemotherapy ■ Labs and diagnostic tests (for example urinalysis) ■ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it ■ Imaging (for example x-rays, CTs, MRIs) ■ Radiation (radium and isotope) therapy, including technician materials and supplies ■ Blood, including storage and administration ■ Medical supplies, such as splints and casts ■ Some screenings and preventive services ■ Some drugs that you can't give yourself	Some services may require prior authorization except in the case of an emergency

Services covered by our plan	Limitations and exceptions
Physician/provider services, including doctor's office visits The plan covers the following services: ■ Health care or surgery services given in places such as a physician's office, certified ambulatory surgical center, or hospital outpatient department ■ Consultation, diagnosis, and treatment by a specialist ■ Second opinion 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.	Prior authorization may be required
Podiatry services The plan covers the following services: ■ Diagnosis and medical or surgical treatment of injuries and diseases of the foot, the muscles and tendons of the leg governing the foot, and superficial lesions of the hand other than those associated with trauma ■ Routine foot care for members with conditions affecting the legs, such as diabetes	Prior authorization may be required for non-routine foot care services. Work with your Podiatrist (foot specialist) to obtain the correct authorization for these services.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Services covered by our plan	Limitations and exceptions
Prosthetic devices and related supplies *Prosthetic devices* replace all or part of a body part or function. The following are examples of covered prosthetic devices: ■ 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) ■ Dental devices The plan also covers some supplies related to prosthetic devices and the repair or replacement of prosthetic devices. The plan offers some coverage after cataract removal or cataract surgery. See "Vision Care" later in this section for details.	Some services may require prior authorization

Services covered by our plan	Limitations and exceptions
Rehabilitation services ■ Outpatient rehabilitation services » The plan covers physical therapy, occupational therapy, and speech therapy. » You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist/chiropractor/psychologist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. ■ Cardiac (heart) rehabilitation services » The plan covers cardiac rehabilitation services such as exercise, education, and counseling for certain conditions. » The plan also covers *intensive* cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. ■ Pulmonary rehabilitation services » The plan covers pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD).	Prior authorization may be required
Rural Health Clinics The plan covers the following services at Rural Health Clinics: ■ Office visits for primary care and specialists services ■ Clinical psychologist ■ Clinical social worker for the diagnosis and treatment of mental illness ■ Visiting nurse services in certain situations **Note:** You can get services from a network or out-of-network Rural Health Clinic.	Some services may require prior authorization

Services covered by our plan	Limitations and exceptions
Transportation for non-emergency services (see also "Ambulance and wheelchair van services") If you must travel 30 miles or more from your home to receive covered health care services, Aetna Better Health of Ohio will provide transportation to and from the provider's office. → In addition to the transportation assistance that Aetna Better Health of Ohio provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services. → For members who join our Member Advisory Committee, we will provide transportation to attend committee meetings. For more information about the Member Advisory Committee, call Member Services or talk to your care manager. Transportation requests must be made 3 business days in advance by calling Member Services **1-855-364-0974**, Option 1 (TTY: 711) and selecting the prompt for transportation.	
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.	

Services covered by our plan	Limitations and exceptions
Vision care The plan covers the following services: ■ One comprehensive eye exam, complete frame, and pair of lenses (contact lenses, if medically necessary) are covered: » Per 12-month period for members under 21 and over 59 years of age; ***or*** » Per 24-month period for members 21 through 59 years of age. ■ Vision training ■ Services for the diagnosis and treatment of diseases and injuries of the eye, including but not limited to: » Treatment for age-related macular degeneration » One glaucoma screening each year for members under the age of 20 or age 50 and older, members with a family history of glaucoma, and members with diabetes » 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 of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) The plan will also cover corrective lenses, and frames, and replacements if you need them after a cataract removal without a lens implant.	Some services may require prior authorization

E. Accessing services when you are away from home or outside of the service area

If you are away from home or outside of our service area (see Chapter 1) and need medical care Aetna Better Health of Ohio will cover emergency and urgent services only.

If you are out of the service area and you have a medical emergency, call 911 or go to the closest emergency room. Make sure you have your Aetna Better Health of Ohio member ID card. If you get services in the emergency room and you are admitted to the hospital while you are away from home, have the hospital call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

For urgent care, go to the nearest urgent care provider. Show the provider your Aetna Better Health of Ohio member ID card.

Routine care out of the service area or out of the country is not covered. If you are out of the service area and need health care services, call your care manager directly or your PCP. Your PCP's telephone number is on your member ID card. You can also call the 24-hour Care Management line at **1-855-364-0974**, Option 5, (TTY: 711) or the 24-hour Nurse Advice line at **1-855-364-0974**, Option 4 (TTY: 711).

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

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 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 pages 33-34 for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- Surgical treatment for morbid obesity, except when it is medically needed and Medicare covers it.
- A private room in a hospital, except when it is medically needed.
- Personal items in your room at a hospital or a nursing facility, such as a telephone or a television.
- Inpatient hospital custodial care.
- 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 cover reconstruction of a breast after a mastectomy and for treating the other breast to match it.
- Chiropractic care, other than diagnostic x-rays and manual manipulation (adjustments) of the spine to correct alignment consistent with Medicare and Medicaid coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare and Medicaid 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.
- Infertility services for males or females.
- Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Paternity testing.
- Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother.
- Acupuncture.
- Naturopath services (the use of natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities.
- Services to find cause of death (autopsy).

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Chapter 5: Getting your outpatient prescription drugs through the plan

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If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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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 Medicaid.

Aetna Better Health of Ohio 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.

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.
2. You generally must use a network pharmacy to fill your prescription.
3. 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 137 to learn about asking for an exception.
4. 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 Member Services or your care manager at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week if you have any questions. If you get a bill that you think you do not owe, or 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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 should **always** show the pharmacy your plan ID card when you fill a prescription to avoid any problems. 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 you need help getting a prescription filled, you can contact Member Services or Aetna Better Health's 24-hour medical advice line or your care manager at **1-855-364-0974**, (TTY: 711), 24 hours a day, 7 days a week.

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

If you change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new pharmacy.

→ If you need help finding a network pharmacy, you can contact Member Services or your care manager at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

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 Member Services or your care manager at **1-855-364-0974**, (TTY: 711), 24 hours a day, 7 days a week.

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 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 Member Services or your care manager at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

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" (not available at mail-order) in our Drug List.

Our plan's mail-order service allows you to order a minimum of a 30-day supply up to a 90-day supply.

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, talk to your care manager or call Member Services at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

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** (hearing impaired only, 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, 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best way to contact you. Contact us at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to tell them the best way to reach you. 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.

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 the same copay as a one-month supply. 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to tell them the best way to reach you. 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 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 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 conjunction with urgently needed care when network pharmacies are not available.
- If you are unable to get a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance 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 have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to see if there is a network pharmacy nearby.

If you use an out-of-network pharmacy, you may have to pay the full cost when you get your prescription.

→ If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7.

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 and products covered under your Medicaid benefits.

The Drug List includes both brand-name and *generic* drugs. Generic drugs have the same 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. Some over-the-counter drugs cost less than prescription drugs and work just as well. For more information, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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/ohio.** The Drug List on the website is always the most current one.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week, 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 of Ohio 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). Here are three general rules for excluded drugs:

- Our plan's outpatient drug coverage 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 Medicaid.

- Drugs used to promote fertility
- 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

Tier 2: Part D-eligible brand drugs

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Tier 3: Non-Part D-eligible generic drugs

- Non-Part D-eligible brand drugs
- Non-Part D-eligible over the counter drugs

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

→ Chapter 6 tells the amount you pay for drugs in each tier.

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 plan 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 thinks 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.

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. In most cases 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 of Ohio before you fill your prescription. If you don't get approval, Aetna Better Health of Ohio 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week or check our website at **www.aetnabetterhealth.com/ohio.**

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, 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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:**

- **You were in the plan last year 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 the calendar year.** This temporary supply will be for up to a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 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 30-day supply. 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 were in the plan last year and live in a long-term care facility.**

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

- **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 at least a 91-day supply and may be up to a 98-day supply depending on the dispensing increment. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 91-day supply 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 current members with changes to their level of care (e.g., you are discharged from a hospital to your home or admitted to, or discharged from, a long-term care facility), your pharmacy may obtain an override up to a 30-day supply.

→ To ask for a temporary supply of a drug, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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 at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week, 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.

→ If you need help asking for an exception, you can contact Member Services or your care manager at **1-855-364-0974,**(TTY: 711), 24 hours a day, 7 days a week.

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 an increase in your payments or 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.
- 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.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

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 copay. 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 at least a 91- to 98-day supply. The first supply will be for up to a 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.

If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan. If you are enrolled in a Medicare hospice and require a drug not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

If you leave hospice, our plan should cover all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify that you have left hospice. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D.

→ To learn more about the hospice benefit, see Chapter 4.

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 Member Services or your care manager at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

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Introduction

This chapter tells you about your outpatient prescription drugs. By "drugs," we mean:

- Medicare Part D prescription drugs, ***and***
- Drugs and items covered under Medicaid, ***and***
- Drugs and items covered at no cost to you by the plan as additional benefits.

Because you are eligible for 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. You can also find the Drug List on our website at **www.aetnabetterhealth.com/ohio.** The Drug List on the website is always the most current.

- **Chapter 5 of this Member Handbook.** Chapter 5 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your *out-of-pocket costs*. This is the amount of money you, or Medicare paying for you, pay for your prescriptions. If using a network pharmacy your out-of-pocket costs will be $0.
- Your *total drug costs*. This is the amount of money you, or others paying for you, pay for your prescriptions, plus the amount the plan pays. If using a network pharmacy your payment will be $0.

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, what the plan paid, and what you and others paying for you paid.
- **"Year-to-date" information.** This is your total drug cost and the total payments made since January 1.

→ We offer coverage of drugs not covered under Medicare. To find out which drugs our plan covers, see the Drug List.

B. Keeping track of your drug costs

To keep track of your drug costs and the payments you make, and that Medicare pays for you, 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, what you pay, and what Medicare pays for you.

2. Make sure we have the information we need.

Give us copies of receipts for drugs that you have paid for. You should give us copies of your receipts when you buy covered drugs at an out-of-network pharmacy.

→ If you were unable to use a network pharmacy and had to pay for your prescription, see Chapter 7 for information about what to do.

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 at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week. Be sure to keep these reports. They are an important record of your drug expenses.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

C. Vaccinations

Our plan covers Medicare Part D vaccines. 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 **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week whenever you are planning to get a vaccination.

- We can tell you about how your vaccination is covered by our plan
- We can tell you how to keep your costs down by using network pharmacies and providers. *Network pharmacies* are pharmacies that have agreed to work with our plan. A *network provider* is a provider who works with the health plan. A network provider should work with Aetna Better Health of Ohio to ensure that you do not have any upfront costs for a Part D vaccine.
- Some vaccines (such as your annual flu shot) are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, see the Benefits Chart in Chapter 4.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's Drug List.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine at a network pharmacy and get your shot at the pharmacy.
- You will pay nothing for the vaccine.

→ Some states do not allow pharmacies to give shots.

2. You get the Medicare Part D vaccination at your doctor's office and the doctor gives you the shot.
- You will pay nothing to the doctor for the vaccine.
- Our plan will pay for the cost of giving you the shot.
- The doctor's office should call our plan in this situation so we can make sure they know you have to pay nothing for the vaccine.

3. You get the Medicare Part D vaccine itself at a pharmacy and take it to your doctor's office to get the shot.
- You will pay nothing for the vaccine.
- Our plan will pay for the cost of giving you the shot.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

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

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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, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week or send the bill to us. To send us a bill, see page 12.

- If you have not paid the bill, we will pay the provider directly if the services or drugs are covered and you followed all the rules in the *Member Handbook*.
- If you have paid the bill, the services or drugs are covered, and you followed all the rules in the *Member Handbook*, we will work with the provider to refund your payment. 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 manager at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week if you have any questions. If you get a bill that you think you do not owe, or 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 some examples of times when you may need to ask our plan to assist you with a payment you made or a bill you got:

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

You should always tell the provider you are a member of Aetna Better Health of Ohio and ask the provider to bill the plan.

- If you pay the full amount when you get the care, you can ask to have the full amount refunded. 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 work with the provider to refund your payment.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

2. When a network provider sends you a bill

Network providers must always bill the plan for covered services.

- We do not allow providers to add separate charges, called "balance billing." This is true even if we pay the provider less than the provider charged for a service. If we decide not to pay for some charges, you still do not have to pay them.
- 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 work with the provider to refund your payment amount for your covered services.

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

We will cover prescriptions filled at out-of-network pharmacies in emergency situations only. We will pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- Prescriptions you get in connection with urgently needed care when network pharmacies are not available.
- If you are unable to get a covered prescription drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance 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 our 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.

You can always contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711) or your care manager at **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week if you are being asked to pay for services, get a bill, or have any questions. You can use the form on page 162 or ask Member Services to send you a form if you want to send us the information about the bill. You can also submit the information through our website at **www.aetnabetterhealth.com/ohio.**

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

B. How to avoid payment problems

1. Always ask the provider if the service is covered by Aetna Better Health of Ohio.

Except in an emergency or urgent situation, do not agree to pay for a service unless you have asked Aetna Better Health of Ohio for a coverage decision (see Chapter 9), received a final decision that the service is not covered, and decided that you still want the service even though the plan does not cover it.

2. Get plan approval before seeing an out-of-network provider.

An exception to this rule is if you need out-of-network emergency or urgent care services. Another exception is if you get services at Federally Qualified Health Centers, Rural Health Clinics, and qualified family planning providers listed in the *Provider and Pharmacy Directory*.

If you receive care from an out-of-network provider, ask the provider to bill Aetna Better Health of Ohio. If the out-of-network provider is approved by Aetna Better Health of Ohio, you should not have to pay anything. If the out-of-network provider will not bill Aetna Better Health of Ohio and you pay for the service, call Member Services at **1-855-364-0974**, Option 1 (TTY:711), 24 hours a day, 7 days a week as soon as possible to let us know.

→ Please remember that in most situations you must get plan approval before you can see an out-of-network provider. Therefore, unless you need emergency or urgent care, are in your transition of care period, or the provider does not require prior approval as indicated above, we may not pay for services you receive from an out-of-network provider. If you have questions about your transition of care period, whether you need approval to see a certain provider, or need help in finding a network provider, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

3. Follow the rules in the Member Handbook when receiving services.

See Chapter 3 for the rules about getting your health care, behavioral health, and other services. See Chapter 5 for the rules about getting your outpatient prescription drugs.

4. Use the *Provider and Pharmacy Directory* to find network providers.

If you do not have a *Provider and Pharmacy Directory*, you can call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week to request a copy or go online at **www.aetnabetterhealth.com/ohio** for the most up-to-date information.

5. Always carry your member ID card and show it to the provider or pharmacy when getting care.

If you forgot your member ID card, ask the provider to call Member Services. If your card is damaged, lost, or stolen, call Member Services right away at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week and we will send you a new card.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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. 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 and state laws about the Medicaid program. Other federal and state laws may apply too.

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

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

- To get information in a way that you can understand, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. Our plan has people who can answer questions in different languages. Written materials are available in Spanish and Somali upon request. We can also give you information in Braille or large print. Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week, to request written material in another format or language. This information is free to you.
- 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, 7 days a week. TTY users should call 1-877-486-2048. You can also contact the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call 711.

Cada año que está en nuestro plan, debemos informarle sobre los beneficios del plan y sus derechos de una manera que pueda entender.

- Para obtener información de una manera que pueda entender, llame a Servicios al Cliente. Nuestro plan tiene personas que pueden responder preguntas en diferentes idiomas. Hay material escrito en español y somalí si lo solicita. También damos información en braille o letra grande. Llame a Servicios al Cliente, al **1-855-364-0974**, Opción 1 (línea TTY para personas con dificultades de audición 711), para solicitar material escrito en otro formato o idioma. Esta información es gratis.
- Si le cuesta obtener información de nuestro plan, por problemas de idioma o incapacidad, y desea presentar una queja, llame a Medicare, al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. También puede llamar a la línea directa del programa Medicaid en Ohio al 1-800-324-8680, de lunes a viernes, de 7:00 a. m. a 8:00 p. m., y los sábados de 8:00 a. m. a 5:00 p. m. Los usuarios de la línea TTY para personas con dificultades de audición deben llamar al 711.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Sannad kasta oo aad ka tirsan tahay qorshahena, waa in aan kuu sheegno manaafacaadka qorshaha iyo xuquuqda aad leedahay anaga oo adeegsana siyaabo aad fahmi kartid.

- Si aad macluumaadka laguugu siiyo siyaabo aad fahmi kartid, wac Adeegyada Xubinta (Member Services). Qorshahena waxaa lagu heli karaa Isbanish iyo Soomaali. Waxaan kaloo macluumaadka kugu siin karnaa Braille ama far waaweyn. Wac Adeegyada Xubinta oo laga helo telefoonka **1-855-364-0974**, doorasho 1 (TTY 711) si aad u codsatid in qoraalada laguugu siiyo qaab kale ama luqad kale. Macluumaadkaan waa lacag la'aan.

- Haddii aad dhibaato ku qabtid in aad macluumaad ka heshid qorshahena maxaa yeelay waxaa jira dhibatooyin la xariira luqadda ama itaal darri, waxaadna rabtaa in aad soo gudbisid ashtako, wac Medicare, telefoonka 1-800-MEDICARE (1-800-633-4227). Waxaad soo wici kartaa 24 saac maalintii, todobada maalin halkii todobaad. Dadka isticmaala TTY waa in ay wacaan 1-877-486-2048. Waxaad kaloo la xariiri kartaa Telefoonka Medicaid ee Ohio 1-800-324-8680, Isniin ilaa Jimco, laga bilaabo 7:00 am ilaa 8:00 pm iyo Sabti laga bilaabo 8:00 am ilaa 5:00 pm. Dadka isticmaala TTY waa in ay wacaan 711.

C. 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
- National origin
- Religion
- Sexual orientation
- Veteran's status
- Behavior
- Need for health services
- Health status
- Use of services
- Appeals
- Genetic information
- Geographic location within the service area
- Ethnicity
- Ancestry
- Gender
- Age
- Mental ability
- Color
- Mental or physical disability
- Receipt of health care
- Claims experience
- Medical history
- Evidence of insurability

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. You have the right to be treated with respect and with regard for your dignity and privacy.

We cannot deny services to you or punish you for exercising your rights. Exercising your rights will not affect the way our plan, our network providers, or the Ohio Department of Medicaid treats you.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

→ 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 Ohio Department of Job and Family Services Bureau of Civil Rights at 1-866-227-6353 (TTY 1-866-221-6700).

→ If you have a disability and need help accessing care or a provider, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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

As a member of our plan:

- You have the right to receive all services that Aetna Better Health of Ohio must provide and to choose the provider that gives you care whenever possible and appropriate.
- If you cannot get services within a reasonable amount of time, we have to pay for out-of-network care.
- You have the right to be sure that others cannot hear or see you when you are getting medical care.
- 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.
  - » Call Member Services at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week or look in the *Provider and Pharmacy Directory* to learn which doctors are accepting new patients.
- You have the right to go to a network gynecologist or another network women's health specialist for covered women's health services without getting a referral. A *referral* is a written order from your primary care provider.
- 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

E. 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 the right to be ensured of confidential handling of information concerning your diagnoses, treatments, prognoses, and medical and social history.
- 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

- You have the right to be given information about your health. This information may also be available to someone who you have legally authorized to have the information or who you have said should be reached in an emergency when it is not in the best interest of your health to give it to you.
- 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 your health and drug information. If Medicare releases your information for research or other uses, it will be done according to federal laws. We are also required to give the Ohio Department of Medicaid (ODM), or another agency on its behalf, such information as ODM may require to meet ODM's obligations. If such information is shared, it will be done according to federal and state laws and our government contracts.

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 fee for making a copy of your medical records if it isn't to transfer the records to a new provider.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.
- 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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

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

- Your name
- Your date of birth
- Health care you received
- Amounts paid for your care

How we use and share your health information

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

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

If you are under 18 and don't want us to give your health information to your parents, call Member Services at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week. We can help in some cases if allowed by state law.

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

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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
- Care management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

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

Sharing with other businesses

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

Other reasons we might share your health information

We also may share your health information for these reasons:

- Public safety – Help with things like child abuse or threats to public health.
- Research – After we take care to protect your information.
- Business partners – People that provide services to us. They promise to keep your information safe.
- Industry regulation – State and federal agencies. They check to make sure we are doing a good job.
- Law enforcement – Federal, state and local enforcement people.
- Legal actions – 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.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

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 in a letter if we do this.

Call us toll free at **1-855-364-0974**, Option 1 (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.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

You also have the right to send us a complaint. If you think your rights were violated write to us at:
Aetna Better Health of Ohio
Attn: Privacy Officer
7400 W Campus Rd
New Albany, OH 43054-8725

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

Protecting your information

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

Will we change this notice?

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

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

As a member of Aetna Better Health of Ohio, 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 **1-855-364-0974**, Option 1 (TTY: 711) 24 hours a day, 7 days a week. This is a free service. Written materials are available in Spanish and Somali upon request. We can also give you information in Braille or large print.

If you want any of the following, call Member Services at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week.

- **Information about how to choose or change plans**
- **Information about our plan, including but not limited to:**
  - » Financial information
  - » How the plan has been rated by plan members
  - » The number of appeals made by members
  - » How to leave the plan

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- **Information about our network providers and our network pharmacies, including:**
  - How to choose or change primary care providers (PCP). You can change your PCP to another network PCP as often as you like. We must send you something in writing that says who the new PCP is and the date the change began.
  - 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 at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week, or visit our website at **www.aetnabetterhealth.com/ohio**

- **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

G. 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.

H. You have the right to get your Medicare and Part D coverage from original Medicare or another Medicare plan at any time by asking for a change

You have the right to get your Medicare 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. However, you must continue to get your Medicaid services from a MyCare Ohio plan. If you want to make a change, you can call the Ohio Medicaid Hotline at 1-800-324-8680 (TTY users should call 711), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. Calls to this number are free.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

I. 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, provided in a way appropriate to your condition and ability to understand.
- **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 qualified network provider before deciding on treatment. If a qualified network provider is not able to see you, we will arrange a visit with a non-network provider at no cost to you.
- **You can say "no."** You have the right to refuse any treatment or therapy. 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 say no to treatment, therapy or taking a drug, the doctor or Aetna Better Health of Ohio must talk to you about what could happen and they must put a note in your medical record. 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 tells how to ask the plan for a coverage decision.
- **Know of specific student practitioner roles.** You have the right to refuse treatment from a student.

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

Many people today worry about the medical care they would get if they became too sick to make their wishes known. Some people may not want to spend months or years on life support. Others may want every step taken to lengthen life.

You have a choice A growing number of people are acting to make their wishes known. You can state your medical care wishes in writing while you are healthy and able to choose. Your health care facility must explain your right to state your wishes about medical care. It also must ask you if you have put your wishes in writing.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

This section of your *Member Handbook* explains your rights under Ohio law to accept or refuse medical care. It will help you choose your own medical care. This section also explains how you can state your wishes about the care you would want if you could not choose for yourself. This section does not contain legal advice, but will help you understand your rights under the law.

For legal advice, you may want to talk to a lawyer. For information about free legal services, call 1-800-589-5888, Monday through Friday, 8:30 a.m. to 5 p.m.

What are my rights to choose my medical care?

You have the right to choose your own medical care. If you don't want a certain type of care, you have the right to tell your doctor you don't want it.

What if I'm too sick to decide? What if I can't make my wishes known?

Most people can make their wishes about their medical care known to their doctors. But some people become too sick to tell their doctors about the type of care they want.

Under Ohio law, you have the right to fill out a form while you're able to act for yourself. The form tells your doctors what you want done if you can't make your wishes known.

What kinds of forms are there?

Under Ohio law, there are four different forms, or advance directives, you can use. You can use either a:

- Living Will
- Declaration for Mental Health Treatment
- Durable Power of Attorney for medical care or
- Do Not Resuscitate (DNR) Order.

You fill out an advance directive while you're able to act for yourself. The advance directive lets your doctor and others know your wishes about medical care.

Do I have to fill out an advance directive before I get medical care?

No. No one can make you fill out an advance directive. You decide if you want to fill one out.

Who can fill out an advance directive?

Anyone 18 years old or older who is of sound mind and can make his or her own decisions can fill one out.

Do I need a lawyer?

No, you don't need a lawyer to fill out an advance directive. Still, you may decide you want to talk with a lawyer.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Do the people giving me medical care have to follow my wishes?

Yes, if your wishes follow state law. However, Ohio law includes a conscience clause. A person giving you medical care may not be able to follow your wishes because they go against his or her conscience. If so, they will help you find someone else who will follow your wishes.

Living Will

This form allows you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your wishes known. You can state when you would or would not want food and water supplied artificially.

How does a Living Will work?

A Living Will states how much you want to use life-support methods to lengthen your life. It takes effect only when you are:

- In a coma that is not expected to end, OR
- Beyond medical help with no hope of getting better and can't make your wishes known, OR
- Expected to die and can't make your wishes known.

The people giving you medical care must do what you say in your Living Will. A Living Will gives them the right to follow your wishes. Only you can change or cancel your Living Will. You can do so at any time.

Do-Not Resuscitate Order

State regulations offer a Do Not Resuscitate (DNR) Comfort Care and Comfort Care Arrest Protocol as developed by the Ohio Department of Health. A DNR Order means a directive issued by a physician or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist, which identifies a person and specifies that CPR should not be administered to the person so identified. CPR means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR. The DNR Comfort Care and Comfort Care Arrest Protocol lists the specific actions that paramedics, emergency medical technicians, physicians or nurses will take when attending to a patient with a DNR Comfort Care or Comfort Care Arrest order. The protocol also lists what specific actions will not be taken. You should talk to your doctor about the DNR Comfort Care and Comfort Care Arrest order and protocol options.

Durable Power of Attorney

A Durable Power of Attorney for medical care is different from other types of powers of attorney. This section talks only about a Durable Power of Attorney for medical care, not about other types of powers of attorney. A Durable Power of Attorney allows you to choose someone to carry out your wishes for your medical care. The person acts for you if you can't act for yourself. This could be for a short or a long while.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Who should I choose?

You can choose any adult relative or friend whom you trust to act for you when you can't act for yourself. Be sure to talk with the person about what you want. Then write down what you do or don't want on your form. You should also talk to your doctor about what you want. The person you choose must follow your wishes.

When does my Durable Power of Attorney for medical care take effect?

The form takes effect only when you can't choose your care for yourself, whether for a short or long while. The form allows your relative or friend to stop life support only in the following circumstances:

- If you are in a coma that is not expected to end, OR
- If you are expected to die.

Declaration for Mental Health Treatment

A Declaration for Mental Health Treatment gives more specific attention to mental health care. It allows a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can indicate medication and treatment preferences, and preferences concerning admission/retention in a facility.

The Declaration for Mental Health Treatment supersedes a Durable Power of Attorney for mental health care, but does not supersede a Living Will.

Advance Directives Questions

What is the difference between a Durable Power of Attorney for medical care and a Living Will?

Your Living Will explains, in writing, the type of medical care you would want if you couldn't make your wishes known. Your Durable Power of Attorney lets you choose someone to carry out your wishes for medical care when you can't act for yourself.

If I have a Durable Power of Attorney for medical care, do I need a Living Will, too?

You may want both. Each addresses different parts of your medical care. A Living Will makes your wishes known directly to your doctors, but states only your wishes about the use of life-support methods. A Durable Power of Attorney for medical care allows a person you choose to carry out your wishes for all of your medical care when you can't act for yourself. A Durable Power of Attorney for medical care does not supersede a Living Will.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

Can I change my advance directive?

Yes, you can change your advance directive whenever you want. If you already have an advance directive, make sure it follows Ohio's law (effective October 10, 1991). You may want to contact a lawyer for help. It is a good idea to look over your advance directives from time to time. Make sure they still say what you want and that they cover all areas.

If I don't have an advance directive, who chooses my medical care when I can't?

Ohio law allows your next-of-kin to choose your medical care if you are expected to die and can't act for yourself. If you are in a coma that is not expected to end, your next-of-kin could decide to stop or not use life support after 12 months.

Your next-of-kin may be able to decide to stop or not use artificially supplied food and water also (see below).

Other matters to think about

What about stopping or not using artificially supplied food and water?

Artificially supplied food and water means nutrition supplied by way of tubes placed inside you. Whether you can decide to stop or not use these depends on your state of health.

- If you are expected to die and can't make your wishes known, and your Living Will simply states you don't want life-support methods used to lengthen your life, then artificially supplied food and water can be stopped or not used.
- If you are expected to die and can't make your wishes known, and you don't have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water.
- If you are in a coma that is not expected to end, and your Living Will states you don't want artificially supplied food and water, then artificially supplied food and water may be stopped or not used.
- If you are in a coma that is not expected to end, and you don't have a Living Will, then Ohio law allows your next-of-kin to stop or not use artificially supplied food and water. However, he or she must wait 12 months and get approval from a probate court. By filling out an advance directive, am I taking part in euthanasia or assisted suicide? No, Ohio law doesn't allow euthanasia or assisted suicide.

Where do I get advance directive forms?

Many of the people and places that give you medical care have advance directive forms. Ask your care manager for an advance directive form – either a Living Will, a Durable Power of Attorney for medical care, a DNR Order, or a Declaration for Mental Health Treatment. A lawyer could also help you.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

What do I do with my forms after filling them out?

You should give copies to your doctor and health care facility to put into your medical record. Give one to a trusted family member or friend. If you have chosen someone in a Durable Power of Attorney for medical care, give that person a copy. Put a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends about what you have done. Don't just put these forms away and forget about them.

Organ and tissue donation

Ohioans can choose whether they would like their organs and tissues to be donated to others in the event of their death. By making their preference known, they can ensure that their wishes will be carried out immediately and that their families and loved ones will not have the burden of making this decision at an already difficult time. Some examples of organs that can be donated are the heart, lungs, liver, kidneys and pancreas. Some examples of tissues that can be donated are skin, bone, ligaments, veins and eyes.

There are two ways to register to become an organ and tissue donor:

- You can state your wishes for organ and/or tissue donation when you obtain or renew your Ohio driver's license or state I.D. card, or
- You can complete the Donor Registry Enrollment Form that is attached to the Ohio Living Will Form, and return it to the Ohio Bureau of Motor Vehicles. If you have questions about this information talk to your care manager.

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 living will and a power of attorney for health care.

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 Medicaid (such as the Ohio Department of Aging, Ohio State Bar Association and AARP) may also have advance directive forms. The forms are also currently available on the following website: **http://proseniors.org/Law_Library/Health/Advance_Dir.html.**

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- **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

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Ohio Department of Health by calling 1-800-342-0553 or emailing HCComplaints@odh.ohio.gov.

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

Chapter 9 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. We will also send you a notice when you can make an appeal directly to the Bureau of State Hearings within the Ohio Department of Job and Family Services.

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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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

You are free to exercise all of your rights knowing that Aetna Better Health of Ohio, our network providers, Medicare, and the Ohio Department of Medicaid will not hold it against you.

If you believe you have been treated unfairly – and it is *not* about discrimination for the reasons listed on page 96 you can get help in these ways:

- You can call **Member Services** at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.
- You can **call the Ohio Medicaid Consumer Hotline** at 1-800-324-8680 (TTY users call 711), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. Calls to this number are free.
- You can **call Medicare** at 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 MyCare Ohio Ombudsman in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 a.m. to 5:00 p.m. See Chapter 2 for more information about this organization.

How to get more information about your rights

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

- You can **call Member Services at 1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week.
- You can **call the Ohio Medicaid Consumer Hotline** at 1-800-324-8680 (TTY users call 711), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m.
- 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 MyCare Ohio Ombudsman** in the Office of the State Long-Term Care Ombudsman at 1-800-282-1206, Monday through Friday from 8:00 a.m. to 5:00 p.m. See Chapter 2 for more information about this organization.

K. 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

- **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 at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week 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.
- **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:
  - » Medicare Part A and Medicare Part B premiums. For nearly all Aetna Better Health of Ohio members, Medicaid pays the Part A premium and Part B premium. If you pay your Part A and/or part B premium and think Medicaid should have paid, you can contact your County Department of Job and Family Services and ask for assistance.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

» If you get any services or drugs that are not covered by our plan, you may have to pay for the service or drug.

→ If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

  » **If you move *outside* of our plan service area, you cannot be a member of our plan.** Chapter 1 tells about our service area. We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area. Also, be sure to let Medicare and Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and 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. You must also notify your County Caseworker at the local Department of Job and Family Services.

- Call Member Services at **1-855-364-0974,** Option 1 (TTY: 711), 24 hours a day, 7 days a week for help if you have questions or concerns.

L. 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 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 to ask for a coverage decision, an appeal or make a complaint. Read this chapter to find out what to do if for example:

- 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 services and supports

You should receive the health care, drugs, and nursing facility and home and community based waiver services (also called long-term services and supports) that your doctor and other providers determine are necessary for your care as a part of your care plan. However, sometimes you may run into a problem getting services, or you may be unhappy with how services were provided or how you were treated. This chapter will explain the different options you have for dealing with problems and complaints about our plan, our plan's providers, getting services, and payment of services.

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If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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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 contact any of the following resources for help.

Getting help from Aetna Better Health of Ohio's Member Services

Member Services can help you with any problems or complaints you may have getting health care, drugs, and long-term services and supports. We want to help with problems such as: understanding what services are covered; how to get services; finding a provider; being asked to pay for a service; asking for a coverage decision or appeal; or making a complaint (also called a grievance). To contact us you can:

- Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hour a day, 7 days a week. The call is free.
- Visit **www.aetnabetterhealth.com/ohio** to send a question, complaint, or appeal.
- Fill out the appeal/complaint form on page 162 of this chapter or call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. and ask us to mail you a form.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- Write a letter telling us about your question, problem, complaint, or appeal. Be sure to include your first and last name, the number from the front of your Aetna Better Health of Ohio member ID card, and your address and telephone number so we can contact you, if needed. You should also send any information that helps explain your problem.

Mail the form or your letter to:

Aetna Better Health of Ohio
Grievance and Appeals Manager
7400 West Campus Road
New Albany, OH 43054

Getting help from the Ohio Department of Medicaid

If you need help, you can always call the Ohio Medicaid Hotline. The hotline can answer your questions and direct you to staff that will help you understand what to do to handle your problem. The hotline is not connected with us or with any insurance company or health plan. You can call the Ohio Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572), Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. The call is free. You can also visit the Ohio Department of Medicaid website at www.medicaid.ohio.gov.

Getting help from the MyCare Ohio Ombudsman

You can also get help from the MyCare Ohio Ombudsman. The MyCare Ohio Ombudsman helps you resolve issues that you might have with our plan. They can help you file a complaint or an appeal with our plan. The MyCare Ohio Ombudsman is an independent advocate and is not connected with us or with any insurance company or health plan. You can call the MyCare Ohio Ombudsman at 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750), Monday through Friday from 8:00 a.m. to 5:00 p.m. You can also submit an online complaint at: http://aging.ohio.gov/contact. The services are free.

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 (http://www.medicare.gov).

Getting help from other resources

You may also want to talk to the following people about your problem and ask for their help.

- You can talk to your doctor or other provider. Your doctor or other provider can ask for a coverage decision. If you disagree with the coverage decision, the doctor or primary care practitioner that requested the service can submit a Level 1 appeal on your behalf.
  - » If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only or for a Medicaid State Hearing, you must name him or her as your representative in writing.
- You can talk to a friend or family member. A friend or family member can ask for a coverage decision, an appeal, or submit a complaint on your behalf if you name them as your "representative."
  - » If you want someone to be your representative, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week, and ask for the "Appointment of Representative" form. You can also get the form on the Medicare website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at **www.aetnabetterhealth.com/ohio**. The form will give the person permission to act for you. You must give us a copy of the signed form.
  - » We will also accept a letter or other appropriate form to authorize your representative.
- You can talk to a lawyer. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you want information on free legal help, you can contact your local legal aid office or call Ohio Legal Services toll free at 1-866-529-6446 (1-866-LAW-OHIO). If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form. Please note, **you do not need a lawyer** to ask for a coverage decision or to make an appeal or complaint.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Section 3: Problems with your Benefits

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, prescription drugs, or long-term services and supports are covered or not, the way in which they are covered, and problems related to the plan's denial of payment for items and services.)	
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 not 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 denials.

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 doctor 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 the doctor gives the service, item, or drug.

What is an appeal?

An *appeal* is a formal way of asking us to review our 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 medically necessary, not a covered benefit, or is no longer covered by Medicare or Medicaid. If you or your doctor disagrees with our decision, you can appeal.

How can I get help with coverage decisions and appeals?

If you need help, you can contact any of the resources that are listed in Section 2.1

Section 4.2: 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 to help you find the rules you need to follow. You only need to read the section that applies to your problem:

- **Section 5** gives you information if you have problems getting medical care, dental or vision services, behavioral health, long-term services and supports, items, and prescription drugs (but not Part D drugs). This includes if you are being told that coverage for care you have been getting will be reduced, suspended, or stopped and you disagree with our decision. For example, use this section if:
  - You are not getting medical care you want, and you believe that this care is covered by our plan.
  - We did not approve services, items, or drugs that your doctor wants to give you, and you believe that this care should be covered.

- **NOTE:** Only use Section 5 for problems with 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 services that you think should be covered, but we are not paying for this care.
  - You got and paid for medical services or items you thought were covered, and you want to ask us to pay for the services so your payment can be refunded.
  - 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 if you have problems 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 so your payment can be refunded. (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 Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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, dental or vision services, behavioral health, items, and long-term services and supports. 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 following situations:

1. You think the plan covers a benefit 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 for information on asking for a coverage decision.

2. You want the plan to cover a benefit that requires plan approval (also called prior authorization) before you receive the service.

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

NOTE: See the *Benefits Chart* in Chapter 4 for a general list of covered services as well as information on what services require prior authorization from Aetna Better Health of Ohio. See the *List of Covered Drugs* to see if any drugs **not** covered by Part D require prior authorization. You can also view the lists of benefits and drugs that require prior authorization at **www.aetnabetterhealth.com/ohio.**

3. The plan did not approve care your doctor 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 for information on making an appeal.

4. The plan did not approve your request to receive waiver services from a specific network non-agency or participant-directed provider.

What you can do: You can **appeal the plan's decision to not approve** the request. Go to section 5.3 for information on making an appeal.

5. 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 5.3 for information on making an appeal.

6. You got and paid for medical services or items you thought were covered, and you want the plan to work with the provider to refund your payment.

What you can do: You can **ask the plan to work with the provider** to refund your payment. Go to Section 5.6 for information on asking for payment.

7. Your coverage for a certain service or item is being reduced, suspended, or stopped, and you disagree with our decision.

What you can do: You **can appeal the plan's decision** to reduce, suspend, or stop the service or item. Go to Section 5.3 for information on making an appeal.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

NOTE: If we tell you that services or items you were approved to receive will be reduced, suspended, or stopped before you receive all of the services or items that were approved, you may be able to continue to receive the services and items during the appeal. Read *Will my benefits continue during Level 1 appeals* in Section 5.3.

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.

8. The plan did not make a coverage decision within the timeframes we should have.

What you can do: You can file a complaint or an appeal. Go to Section 10 for information on making a complaint. Go to Section 5.3 for information on making a Level 1 Appeal.

9. The plan did not make an appeal decision within the timeframes we should have.

What you can do: You can file a complaint. Go to Section 10 for information on making a complaint. Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you have not done so already. Go to Section 5.4 for information on requesting a State Hearing. Note that if your problem is about coverage for a Medicare service or item, we will automatically forward your appeal to Level 2 if we do not give you an answer within the required timeframe.

Section 5.2: Asking for a coverage decision

How to ask for a coverage decision to get a service, item, or Medicaid drug (go to Section 6 for Medicare Part D drugs)

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

- You can call us at: **1-855-364-0974,** Option 1, TTY: 711.
- You can fax us at: 1-855-734-9389
- You can to write us at:
  Aetna Better Health of Ohio
  Grievance and Appeals Manager
  7400 West Campus Road
  New Albany, OH 43054

→ Remember, you must complete the Appointment of Representative form to appoint someone as your authorized representative. We will also accept a letter or other appropriate form to authorize your representative. For more information, see Section 2 (page 117).

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

How long does it take to get a coverage decision?

We will make a standard coverage decision on Medicaid drugs within 72 hours after your request was received.

We will make a standard coverage decision on all other services and items within 14 calendar days after your request was received. If we don't give you our decision within 14 calendar days, you can appeal.

- You or your provider can ask for more time, or we may need more time to make a decision. If we need more time, 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"**

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, you should ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision **within 24 hours for Medicaid drugs and within 72 hours for all other services and items.**

- Except for fast coverage decisions for Medicaid drugs, you or your provider can ask for more time or we may need more time to make a decision. If we need more time, 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.

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 **1-855-364-0974**, Option 1 or fax us at 1-855-734-9389. For the details on how to contact us, go to Chapter 2 (page 12).
- You can also have your doctor or your authorized 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 for coverage for medical care or an item *you have not yet received.* (You cannot get a fast coverage decision if your request is about refunding your payment for medical care or an item you have already received.)
- You can get a fast coverage decision only if the standard deadlines could *cause serious harm to your health or hurt your ability to function.* The standard deadlines are 72 hours for Medicaid drugs and 14 calendar days for all other services and items.
  - → **If your doctor says that you need a fast coverage decision, we will automatically give you one.**
  - → If you ask for a fast coverage decision without your doctor's support, we will decide if you get a fast coverage decision.
- If we decide that your health does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard deadlines instead to make our decision.
- This letter will tell you that if your doctor 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.)

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

For standard coverage decisions, Aetna Better Health of Ohio will authorize the coverage within 72 hours for Medicaid drugs and 14 calendar days for all other services and items. For fast coverage decisions, Aetna Better Health of Ohio will authorize the coverage within 24 hours for Medicaid drugs and 72 hours for all other services and items. If we extended the time needed to make our coverage decision, we will authorize 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 Level 1 of the appeals process (see Section 5.3).
- You also have the right to ask for a State Hearing if the coverage decision was for a service or item that could be covered by Medicaid (see Section 5.4).

Section 5.3: Level 1 Appeal for services, items, and drugs (not Part D drugs)

What is an Appeal?

An *appeal* is a formal way of asking Aetna Better Health of Ohio to review our coverage decision and change it if you think we made a mistake. If you, your authorized representative, or your doctor or primary care practitioner that requested the service disagrees with our decision, you can appeal. You can also appeal our failure to make a coverage decision within the timeframes we should have. Aetna Better Health of Ohio will send you a notice in writing whenever we take an action or fail to take an action that you can appeal.

→ If you want your doctor or other provider to act on your behalf for an appeal of services covered by Medicaid only, you must name him or her as your representative in writing. See below or Section 2.1 for more information.

What is a Level 1 Appeal?

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.

→ **Please note:** You do not have to first appeal to the plan for services or items that are covered primarily by Medicaid or by both Medicare and Medicaid. You can appeal to the plan, the Bureau of State Hearings, or both. Aetna Better Health of Ohio will send you a notice of your right to appeal to the Bureau of State Hearings when the services or items are primarily covered by Medicaid or by both Medicare and Medicaid. Read below for information on filing an appeal with the plan, and go to Section 5.4 for information on filing an appeal with the Bureau of State Hearings.

How do I make a Level 1 Appeal?

- To start your appeal, you, your authorized representative, or your doctor or primary care practitioner that requested the service must contact us. You can call us at **1-855-364-0974**, Option 1 (TTY: 711) or write to us at the following address:

  Aetna Better Health of Ohio
  Grievance System Manager
  7400 West Campus Road
  New Albany, OH 43054

If you decide to write to us, you can draft your own letter or you can use the appeal/complaint form on page 162. Be sure to include your first and last name, the number from the front of your Aetna Better Health of Ohio member ID card, and your address and telephone number so we can contact you, if needed.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

You should also include any information that helps explain your problem.

- For additional details on how to reach us for appeals, see Chapter 2.
- You can ask us for a "standard appeal" or a "fast appeal."

Can someone else make the appeal for me?

Yes. Your doctor or primary care practitioner that requested the service can make the appeal for you. Also, someone else 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 at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week and ask for one, or visit the Medicare website at https://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or our website at **www.aetnabetterhealth.com/ohio.** We will also accept a letter or other appropriate form to authorize your representative.

→ If the appeal comes from someone besides you, your doctor, or the primary care practitioner that requested the service, we must receive your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf we must receive your written authorization.

How much time do I have to make an appeal?

You must ask for an appeal within 90 calendar days after 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 had a serious illness, or we gave you the wrong information about the deadline for requesting an appeal.

→ If you are appealing because we told you that medical care you have been getting will be reduced, suspended, or stopped before you receive all the services that were approved, read *Will my benefits continue during Level 1 appeals* below for additional information.

Can I get a copy of my case file?

Yes. Ask us for a copy.

Can my doctor give you more information about my appeal?

Yes, you and your doctor 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. 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" appeal decision?

We must give you our answer within 15 calendar days after we get your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you or your provider asks for more time, or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will write you to explain why more time is needed.
- 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 (see Section 10).
- If we do not give you an answer within 15 calendar days or by the end of the extra days (if we took them), you can file a complaint (see Section 10). Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4). If your problem is about coverage of a Medicare service or item, we will automatically send your case to Level 2 of the appeals process (see Section 5.5). You will be notified when this happens.

→ **If our answer is *Yes*** to part or all of what you asked for, we must approve the service within 15 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 sent your case to the Independent Review Entity for a Level 2 Appeal (see Section 5.5). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4).

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 all information needed to decide your appeal. We will give you our answer sooner if your health requires us to do so.

- However, if you or your provider asks for more time, or if we need to gather more information, we may take up to 14 more calendar days. If we take extra days to make the decision, we will write you to explain why more time is needed.
- If we do not give you an answer within 72 hours or by the end of the extra days (if we took them), you can file a complaint (see Section 10). Also, if your problem is about coverage of a Medicaid service or item, you can ask for a State Hearing if you haven't done so already (see Section 5.4). If your problem is about coverage of a Medicare service or item, we will automatically send your case to Level 2 of the appeals process (see Section 5.5). You will be notified when this happens.

→ **If our answer is *Yes*** to part or all of what you asked for, we must authorize 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 a Level 2 Appeal (see Section 5.5). If your problem is about coverage of a Medicaid service or item, the letter will remind you that you can also request a State Hearing (see Section 5.4).

Will my benefits continue during Level 1 appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You, your authorized representative, or your doctor or primary care practitioner that requested the service must ask for an appeal on or before the later of the following to continue the service during the appeal:

- Within 15 calendar days of the mailing date of the notice or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) 15 calendar days pass after we notify you that we said "no" to your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

→ **Note:** Sometimes your benefits may continue even if Aetna Better Health of Ohio says "no" to your appeal. If the service is covered by Medicaid and you also asked for a State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes a decision (see Section 5.4, page 131). If the service is covered by both Medicare and Medicaid, your benefits will continue during the Level 2 appeal process (see Section 5.5).

Section 5.4: State Hearings for services primarily covered by Medicaid or both Medicare and Medicaid

You should read this section if you disagree with our coverage decision on a service or item that is primarily covered by Medicaid or both Medicare and Medicaid. You can request a State Hearing in addition to or instead of appealing to Aetna Better Health of Ohio.

What is a State Hearing?

A ***State Hearing*** is a meeting with you or your authorized representative, Aetna Better Health of Ohio, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). You will explain why you think Aetna Better Health of Ohio did not make the right decision and we will explain why we made our decision. The hearing officer will listen and then decide who is right based on the information given and the rules.

Aetna Better Health of Ohio will send you a notice in writing of your right to request a State Hearing. If you are on the MyCare Ohio Waiver, you may have other State Hearing rights. Please refer to your Home & Community-Based Services Waiver *Member Handbook* regarding waiver eligibility and services.

How do I ask for a State Hearing?

To request a State Hearing, you or your authorized representative must contact the Bureau of State Hearings within 90 calendar days of receiving the notice of your State Hearing rights. The 90 calendar days begin on the day after the mailing date on the notice. If you miss the 90 calendar day deadline and have a good reason for missing it, the Bureau of State Hearings may give you more time to request a hearing. **Remember, you do not have to ask for a Level 1 Appeal before you can ask for a State Hearing.**

- If you want someone to act on your behalf, including your doctor, you must give the Bureau of State Hearings an authorized representative notice saying that you want that person to act on your behalf.

You can sign and return the State Hearing form to the address or fax number listed on the form, call the Bureau of State Hearings at 1-866-635-3748, or submit your request by e-mail to bsh@jfs.ohio.gov.

Can I get legal help for my State Hearing?

Yes. See Section 2.1 for information on free legal help. Please remember, you do not need a lawyer to ask for a State Hearing.

How long does it take to get a State Hearing decision?

State Hearing decisions are usually given no later than 70 calendar days after the request is received. However, if the Bureau of State Hearings agrees that this timeframe could cause serious harm to your health or hurt your ability to function, the decision will be given as quickly as needed but no later than three working days after the request is received.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

How will I find out about the decision?

The Bureau of State Hearings will send you a written hearing decision in the mail.

- **If the hearing decision is *Yes* (sustained)** to all or part of what you asked for, the decision will clearly explain what Aetna Better Health of Ohio must do to address the issue. If you do not understand the decision or have a question about getting the service or payment being made, contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week for assistance.
- **If the hearing decision is *No* (overruled)** to part or all of what you asked for, it means the Bureau of State Hearings agreed with Aetna Better Health of Ohio. The State Hearing decision will explain the Bureau of State Hearings' reasons for saying "no" and will tell you that you have the right to request an Administrative Appeal. The Bureau of State Hearings must receive your request for an Administrative Appeal within 15 calendar days of the date the hearing decision was issued. See Section 9.2 for more information.

Will my benefits continue during my State Hearing?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, we will send you a notice at least 15 days in advance of taking the action. You or your authorized representative must request a State Hearing before the later of the following to continue the service during the State Hearing:

- Within 15 calendar days of the mailing date of the notice or
- The intended effective date of the action.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the State Hearing request; 2) the Bureau of State Hearings decides "no" on your appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

- **Note:** Sometimes your benefits may continue even if the Bureau of State Hearings says "no" to your appeal. If you also asked for an appeal with Aetna Better Health of Ohio, you may be able to continue your benefits until the plan makes its decision (see Section 5.3). If the service is covered by both Medicare and Medicaid, your benefits will also continue during the Medicare Level 2 appeal process (see Section 5.5).

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Section 5.5: Level 2 Appeal for services, items, and drugs (not Part D drugs)

If the plan says *No* at Level 1, what happens next?

If we say "no" to part or all of your Level 1 Appeal, we will send you a letter. This letter will tell you if the service or item is primarily covered by Medicare and/or Medicaid.

- If your problem is about a **Medicare** service or item, you will automatically get a Level 2 Appeal with the Independent Review Entity (IRE) as soon as the Level 1 Appeal is complete.
- If your problem is about a **Medicaid** service or item, the letter will remind you that you may ask for a State Hearing if you have not done so already. Remember, you can request a State Hearing in addition to or instead of appealing to Aetna Better Health of Ohio. See Section 5.4 for information on State Hearings.
- If your problem is about a service or item that could be primarily **covered by both Medicare and Medicaid**, you will automatically get a Level 2 Appeal with the IRE. The letter will remind you that you may also ask for a State Hearing if you have not done so already. See Section 5.4 for information on State Hearings.

What is a Level 2 Appeal?

A Level 2 Appeal is the second appeal regarding a service or item that is covered by Medicare or both Medicare and Medicaid. The Level 2 Appeal is reviewed by an independent organization that is not connected to the plan.

What will happen at the Level 2 Appeal?

An Independent Review Entity will do a careful review of the Level 1 decision, and decide whether it should be changed.

- You do not need to request the Level 2 Appeal. We will automatically send any denials (in whole or in part) to the Independent Review Entity. You will be notified 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 Level 2 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 have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

- If you had a "fast appeal" at Level 1, you will automatically have a fast appeal at Level 2. 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.

Will my benefits continue during Level 2 appeals?

If we previously approved coverage for a service but then decided to change or stop the service before the authorization period expired, you can ask to continue your benefits during Medicare Level 2 appeals in some cases.

- If your problem is about a service primarily covered by **Medicare only**, your benefits for that service will **not** continue during the Level 2 appeal process with the IRE.

- If your problem is about a service primarily covered by both **Medicare and Medicaid**, your benefits for that service will continue during the Level 2 appeal process with the IRE.

If your benefits are continued, you can keep getting the service until one of the following happens: 1) you withdraw the appeal; 2) the IRE decides "no" on your Level 2 Appeal; or 3) the authorization expires or you receive all of the services that were previously approved.

- **Note:** If your problem is about a service primarily covered by both Medicare and Medicaid, sometimes your benefits may continue even if the IRE says "no" to your Medicare Level 2 Appeal. If you also asked for a Medicaid State Hearing, you may be able to continue your benefits until the Bureau of State Hearings makes its decision (see Section 5.4).

How will I find out about the decision?

The Independent Review Entity 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 medical care coverage within 72 hours or give you the service or item within 14 calendar days 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 Level 1 decision. This is called "upholding the decision." It is also called "turning down your appeal."

I appealed to both the Independent Review Entity and the Bureau of State Hearings for services covered by both Medicare and Medicaid. What if they have different decisions?

If either the Independent Review Entity or the Bureau of State Hearings decides "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?

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.

Section 5.6: Payment problems

We do not allow Aetna Better Health of Ohio providers to bill you for covered services. This is true even if we pay the provider less than the provider charges for a covered service.

If in the rare situation that you had to pay for your medical care and you want to ask us for payment, 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 us to assist you with payment you made to a provider 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. Chapter 7 also gives information to help you avoid payment problems in the future.

If you pay or receive a bill for services or items you think we should cover, contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week (see Section 2.1). Aetna Better Health of Ohio will contact the doctor or provider to discuss the service. It is possible that we will pay the provider so they can refund your payment or the provider will agree to stop billing you for the service.

Section 6: Part D drugs

Section 6.1: What to do if you have problems getting a Part D drug or you want your payment refunded 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.**

- T*he 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. Remember, you should not have to pay for any medically necessary services covered by Medicare and Medicaid. If you are being asked to pay for the full cost of a drug, call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week, for assistance.

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.

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

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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 get your money back for a drug you have already received and paid for? You can ask to have your money refunded. (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).

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).

- 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 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 **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

- 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 2 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 paid for a drug that you think should be covered, read Chapter 7 of this handbook. Chapter 7 tells how to call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week or send us the paperwork that asks us to cover the drug.

- 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.

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.

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 days.

- If you are asking for an exception, include the supporting statement from the 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 you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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

» 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 decision within 24 hours.

» If we decide that your medical 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).

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 and our decision.

→ **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 the decision.

→ **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 the decision.

→ **If our answer is *Yes*** to part or all of what you asked for, we will make payment to the pharmacy within 14 calendar days. The pharmacy will refund your money.

→ **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 **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.
- 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 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 of this chapter.

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 our decision.

→ **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*.

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

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 our decision.

→ **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 cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get your appeal request. The pharmacy will refund your money.

→ **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.

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 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.

- 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.

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 cover a drug you already paid for, we will pay the pharmacy within 30 calendar days after we get the decision. The pharmacy will refund your money.

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 at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week (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 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.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

- To look at a copy of this notice in advance, you can call Member Services at **1-855-364-0974** (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 **https://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.**

→ If you need help, please call Member Services at **1-855-364-0974** (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 (Ohio's Quality Improvement Organization) at: **1-855-408-8557** (TTY: 1-855-843-4776).

At a glance: How to make a Level 1 Appeal to change your discharge date

Call the Quality Improvement Organization in your state at 855-408-8557 and ask for a "fast review."

Call before you leave the hospital and before your planned discharge date.

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.

→ 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.

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 **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

The legal term for "fast review" is **"immediate review."**

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.

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.

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.

The legal term for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at **1-855-364-0974** (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/**

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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.

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.

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 KePRO (Ohio's Quality Improvement Organization) at: **855-408-8557** (TTY: 1-855-843-4776)

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

What happens if the answer is *No*?

It means the Quality Review 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 Review 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?

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 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.

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.

- 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.
- 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.

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

→ 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 of this chapter tells how to make a complaint.

***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.

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 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 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 Medicare 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 when they are covered by Medicare:*

- 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.

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.)

At a glance: How to make a Level 1 Appeal to ask the plan to continue your care

Call the Quality Improvement Organization in 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.

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

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 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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

The legal term for this written explanation is called the **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at **1-855-364-0974** (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.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

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.

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 in 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.

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.

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?

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.

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.

- 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.

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 of this chapter tells how to make a complaint.

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.

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 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 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: Taking your appeal beyond Level 2

Section 9.1: Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 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 MyCare Ohio Ombudsman at **1-800-282-1206.**

Section 9.2: Next steps for Medicaid services and items

If you had a State Hearing for services covered by Medicaid and your State Hearing decision was overruled (not in your favor), you also have the right to additional appeals. The State Hearing decision notice will explain how to request an Administrative Appeal by submitting your request to the Bureau of State Hearings. The Bureau of State Hearings must get your request within 15 calendar days of the date the hearing decision was issued. If you disagree with the Administrative Appeal decision, you have the right to appeal to the court of common pleas in the county where you live.

If you have any questions or need assistance with State Hearings or Administrative Appeals, you can contact the Bureau of State Hearings at **1-866-635-3748.**

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, receiving a bill, 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 of Ohio 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.

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.

The legal term for a "complaint" is a **"grievance."**
The legal term for "making a complaint" is "**filing a grievance."**

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about language access

- Your doctor or provider does not provide you with an interpreter during your appointment.

Complaints about receiving a bill

- Your doctor or provider is sending you a bill.

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 the provider for certain medical services so they can refund your money.
- You believe we did not forward your case to the Independent Review Entity on time.

Section 10.1: Details and deadlines

- Call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. Complaints related to Part D must be made within 60 calendar days after you had the problem you want to complain about. All other complaints 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 use the form on page 166 to submit the complaint.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

The legal term for "fast complaint" is "**expedited grievance."**

- 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.

- 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.

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.

- Complaints about access to care are answered in 2 business days. All other 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 Department of Health and Human Services. You can call **312-886-2359** (TTY: 312-353-5693) or send your complaint to:

Office of Civil Rights
United States Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, Illinois 60601

You may also have rights under the Americans with Disability Act. You can contact Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week or the Ohio Medicaid Hotline at **1-800-324-8680** (TTY: 1-800-292-3572) 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 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 call the Ohio Medicaid Hotline at 1-800-324-8680 or TTY 1-800-292-3572. The call is free. You can also e-mail your complaint to **bmhc@medicaid.ohio.gov.**

Request for Appeal Form

AETNA BETTER HEALTH® OF OHIO
7400 West Campus Road
New Albany, OH 43054
Tel: **1-855-364-0974**
TTY: **Ohio Relay 7-1-1**
www.aetnabetterhealth.com/ohio

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Request for Appeal

Because Aetna Better Health denied your request for coverage of (or payment for) an item or service, you have the right to ask us for an appeal of our decision. For Part D (drug) appeals you have 60 days from the date of the postmark on the written notice of a decision that was sent to you, for all other appeals you have 90 days from the date of the postmark on the written notice of a decision that was sent to you. To request an appeal in writing send us a letter telling us the details of what you are appealing and why or you may complete this form. Send your written request or this form by mail or fax:

Address:
Aetna Better Health of Ohio
Grievance System Manager
7400 West Campus Road
New Albany, OH 43054

Fax Number:
1-855-883-9555

You may also ask us for an appeal through our website at www.aetnabetterhealth.com/ohio.
Appeal requests can also be made by phone at **1-855-364-0974** (For Hearing Impaired call Ohio relay 7-1-1).

Who May Make a Request: You or another individual (such as a family member or friend) that you want to act for you can request an appeal. If the appeal comes from someone besides you, your doctor, or the primary care practitioner that requested the service, we must receive your written authorization before we can review the appeal. For services covered by Medicaid only, if you want your doctor, other provider, or anyone else to act on your behalf we must receive your written authorization. If you want someone to act for you they must be your representative. Contact us to learn how to name a representative.

OH-14-03-21 H7172_14_121
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New Albany, OH 43054
Tel: **1-855-364-0974**
TTY: **Ohio Relay 7-1-1**
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Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for appeal requests made by someone other than enrollee (if applicable see above under Who May Make a Request):

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted at the coverage determination level. For more information on appointing a representative, contact your plan at 1-855-364-0974 (For Hearing Impaired call Ohio relay 7-1-1) or 1-800-Medicare for Medicare covered items or services.

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Item or service being appealed

Description: _____

_____

_____

Date of the notice of denial you received _____

Did you receive the item pending appeal? ☐ Yes ☐ No

If "Yes":
Date of service: _____ Amount paid: $ _____ (attach copy of receipt)

Important Note: Fast Decisions, also called Expedited Decisions
If you or your doctor believe that waiting 7 calendar days for Part D (drug) or 15 calendar days for all other standard decisions could seriously harm your life or health, you can ask for an expedited (fast) decision. If your doctor indicates that waiting the timeframe for a standard decision could seriously harm your life or health, we will automatically give you a fast decision within 72 hours. If you do not obtain your prescriber's support for an expedited appeal, we will decide if your case requires a fast decision. You cannot request an expedited appeal if you are asking for an appeal for medical care or an item you already received.

☐ **CHECK THIS BOX IF YOU BELIEVE YOU NEED AN EXPEDITED APPEAL DECISION WITHIN 72 HOURS**

If you have a supporting statement from your doctor, attach it to this request.

Please explain your reasons for appealing. Attach additional pages, if necessary. Attach any additional information you believe may help your case, such as a statement from your doctor and relevant medical records. You may want to refer to the explanation we provided in the denial notice.

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_____
_____
_____
_____
_____

Signature of person requesting the appeal:

_____ ***Date:*** _____

Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other languages. Call 1-855-364-0974, TTY 711, 24 hours a day, 7 days a week. The call is free.

Puede obtener esta información en otros idiomas de manera gratuita. Llame al 1-855-364-0974 y TTY al 711, 24 horas al día, siete días de la semana. Esta llamada es gratuita.

OH-14-03-21

H7172_14_121
CMS APPROVED

Grievance Form

AETNA BETTER HEALTH® OF OHIO
7400 West Campus Road
New Albany, OH 43054
Tel: **1-855-364-0974**
TTY: **Ohio Relay 7-1-1**
www.aetnabetterhealth.com/ohio

aetna® | MyCareOhio Connecting Medicare + Medicaid

Submit a Grievance

We believe that the member grievance (complaint) processes are essential in protecting the rights and health of our members and in identifying ways to improve our program operations and management. For Part D (drug) grievances you have 60 days from when you became aware of the issue to submit your grievance, for all other grievances you have 90 days from when you became aware of the issue to submit your grievance. To submit a grievance in writing send us a letter telling us the details of your complaint or you may complete this form. Send your written request or this form by mail or fax:

Address:
Aetna Better Health of Ohio
Grievance System Manager
7400 West Campus Road
New Albany, OH 43054

Fax Number:
1-855-883-9555

You may also ask us submit a grievance through our website at www.aetnabetterhealth.com/ohio. Grievance requests can also be made by phone at **1-855-364-0974** (For Hearing Impaired call Ohio relay 7-1-1).

Who May Make a Request: Your or another individual (such as a family member or friend) that you want to act for you can submit a grievance. If you want someone to act for you they must be your representative. Contact us to learn how to name a representative.

Enrollee's Information

Enrollee's Name _____ Date of Birth _____

Enrollee's Address _____

City _____ State _____ Zip Code _____

Phone _____

Enrollee's Plan ID Number _____

Complete the following section ONLY if the person making this request is not the enrollee:

1

OH-14-03-22

H7172_14_120
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AETNA BETTER HEALTH® OF OHIO
7400 West Campus Road
New Albany, OH 43054
Tel: 1-855-364-0974
TTY: **Ohio Relay 7-1-1**
www.aetnabetterhealth.com/ohio

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Requestor's Name _____

Requestor's Relationship to Enrollee _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Representation documentation for grievance requests made by someone other than enrollee (if applicable see above under Who May Make a Request):

Attach documentation showing the authority to represent the enrollee (a completed Authorization of Representation Form CMS-1696 or a written equivalent) if it was not submitted previously. For more information on appointing a representative, contact your plan at 1-855-364-0974 (For Hearing Impaired call Ohio relay 7-1-1) or 1-800-Medicare for Medicare issues.

Grievance Details

Date Grievance happened _____

Grievance Description: _____

_____

_____

_____

_____

_____

_____

_____

2

OH-14-03-22 H7172_14_120
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AETNA BETTER HEALTH® OF OHIO
7400 West Campus Road
New Albany, OH 43054
Tel: **1-855-364-0974**
TTY: **Ohio Relay 7-1-1**
www.aetnabetterhealth.com/ohio

Important Note: Fast Decisions, also called Expedited Decisions
You have to right to an expedited grievance decision

- If you asked for a fast decision on a service or appeal and we decided to process it under our regular (non-expedited) time frame. If you have a supporting statement from your doctor, attach it to this request.
- If we took an extension to decide on your request for a service or an appeal.

☐ **CHECK THIS BOX IF YOU ARE REQUESTING AN EXPEDITED GRIEVANCE DECISION WITHIN 24 HOURS**

Signature of person requesting the grievance:

_____ ***Date:*** _____

Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees.

You can get this information for free in other languages. Call 1-855-364-0974, TTY 711, 24 hours a day, 7 days a week. The call is free.

Puede obtener esta información en otros idiomas de manera gratuita. Llame al 1-855-364-0974 y TTY al 711, 24 horas al día, siete días de la semana. Esta llamada es gratuita.

Chapter 10: Changing or ending your membership in our MyCare Ohio plan

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Introduction

This chapter tells about ways you can change or end your membership in our plan. You can change your membership in our plan by choosing to get your Medicare services separately (you will stay in our plan for your Medicaid services). You can end your membership in our plan by choosing a different MyCare Ohio plan.

A. When can you change or end your membership in our MyCare Ohio plan?

You can request to change or end your membership in Aetna Better Health of Ohio at any time.

If you change your membership in our plan by choosing to get Medicare services separately:

- You will keep getting Medicare services through our plan until the last day of the month that you make a request. Your new Medicare coverage will begin the first day of the next month. For example, if you make a request on January 18th to not have Medicare through our plan, your new Medicare coverage will begin February 1st.

If you end your membership in our plan by choosing a different MyCare Ohio plan:

- If you request to switch to a different MyCare Ohio plan before the last five days of a month, your membership will end on the last day of that same month. Your new coverage in the different MyCare Ohio plan will begin the first day of the next month. For example, if you make a request on January 18th, your coverage in the new plan will begin February 1st.

- If you request to switch to a different MyCare Ohio plan on one of the last five days of a month, your membership will end on the last day of the following month. Your new coverage in the different MyCare Ohio plan will begin the first day of the month after that. For example, if we get your request on January 30th, your coverage in the new plan will begin March 1st.

These are ways you can get more information about when you can change or end your membership:

- Call the Ohio Medicaid Hotline at **1-800-324-8680**, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711.
- Call Medicare at 1-800-MEDICARE (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

B. How do you change or end your membership in our plan?

If you decide to change or end your membership:

- Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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 173.

See Section A above for information on when your request to change or end your membership will take effect.

C. How do you join a different MyCare Ohio plan?

If you want to keep getting your Medicare and Medicaid benefits together from a single plan, you can join a different MyCare Ohio plan.

To enroll in a different MyCare Ohio plan:

- Call the Ohio Medicaid Hotline at **1-800-324-8680** Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711.

If you make a request to switch to a different MyCare Ohio plan before the last five days of a month, your coverage with Aetna Better Health of Ohio will end on the last day of that same month. If you make a request to switch to a different MyCare Ohio plan on one of the last five days of a month, your coverage with Aetna Better Health of Ohio will end on the last day of the following month. See Section A above for more information about when you can change or end your membership.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

D. If you do not want a different MyCare Ohio plan, how do you get Medicare and Medicaid services?

If you do not want to enroll in a different MyCare Ohio plan, you will go back to getting your Medicare and Medicaid services separately. Your Medicaid services will still be provided by Aetna Better Health of Ohio.

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 stop getting Medicare services from our plan.

1. You can change to: **A Medicare health plan, such as a Medicare Advantage plan**	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 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 Ohio Medicaid Hotline at 1-800-324-8680 Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711. You will automatically stop getting Medicare services through Aetna Better Health of Ohio 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, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: ■ Call the Ohio Medicaid Hotline at 1-800-324-8680, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711. You will automatically stop getting Medicare services through Aetna Better Health of Ohio when your Original Medicare and prescription drug plan coverage begins.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

3. You can change to:	Here is what to do:
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.	Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: ■ Call the Ohio Medicaid Hotline at 1-800-324-8680 Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711. You will automatically stop getting Medicare services through Aetna Better Health of Ohio when your new plan's coverage begins.

How you will get Medicaid services

You must receive your Medicaid benefits from a MyCare Ohio plan. Therefore, even if you do not want to receive your Medicare benefits through a MyCare Ohio plan, you must still get your Medicaid benefits from Aetna Better Health of Ohio or another MyCare Ohio managed care plan.

If you do not enroll in a different MyCare Ohio plan, you will remain in our plan to get your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care. Aetna Better Health of Ohio also offers members 21 and older an additional dental oral exam, cleaning, fluoride treatment and x-rays per year under your Medicaid benefit.

Once you stop getting Medicare services through our plan, you will get a new member ID card and a new *Member Handbook* for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to receive your Medicaid benefits, call the Ohio Medicaid Hotline at 1-800-324-8680**,** Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711.

E. Until your membership changes or ends, you will keep getting your Medicare and Medicaid services through our plan

If you change or end your enrollment with Aetna Better Health of Ohio, it will take time before your new coverage begins. See page 171 for more information. During this time, you will keep getting your Medicare and Medicaid services 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 changes or ends, your hospital stay will 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 Medicare and Medicaid must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage. Medicare services will end on the last day of the month that your Medicare Part A or Medicare Part B ends.
- If you no longer qualify for Medicaid or no longer meet MyCare Ohio eligibility requirements. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you are away from our service area for more than six months or you establish primary residence outside of Ohio.
  - » If you move or take a long trip, you need to call Member Services at **1-855-364-0974**, Option 1 (TTY 711), 24 hours a day, 7 days a week 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 ask Medicare and Medicaid to end your enrollment with our plan for the following reasons:

- If you intentionally give incorrect information when you are enrolling and that information affects your eligibility.
- 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.
- If you let someone else use your ID card to get medical care.
  - » If your membership ends for this reason, Medicare and/or Medicaid may have your case investigated by the Inspector General. Criminal and/or civil prosecution is also possible.

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, 7 days a week.

You should also call the Ohio Medicaid Hotline at **1-800-324-8680**, Monday through Friday from 7:00 a.m. to 8:00 p.m. and Saturday from 8:00 a.m. to 5:00 p.m. TTY users should call the Ohio Relay Service at 711.

H. You have the right to make a complaint if we ask Medicare and Medicaid to end your membership in our plan

If we ask Medicare and Medicaid to end your membership in our plan, we must tell you our reasons in writing. We must also explain how you can make a complaint about our request to end your membership. You can also see Chapter 9 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 Medicare and Medicaid can end your membership, you can call Member Services at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Chapter 11: Definitions of important words

Action: When Aetna Better Health of Ohio does one of the following:

- Denies or limits authorization of a requested service
- Reduces, suspends, or terminates of a previously authorized service prior to receipt of the services that were authorized by Aetna Better Health of Ohio
- Denies, in whole or in part, of payment for a service
- Fails to provide service in a timely manner
- Fails to respond to an Appeal in a timely manner

For more information see Chapter 9.

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. For more information, see Chapter 3.

Advance directive: A document that tells your health care provider and family the kind of medical care you want if you are too ill to make health care decisions for yourself. For more information, see Chapter 8.

Appeal: 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. See Chapter 9 for more information.

Care management: Care management is a way to coordinate and plan your care and services in order to get you what you need to reach your best health and functional levels. You are included in the care management process. You can also ask that we include other people such as your family or caregivers. See Chapter 3 for more information.

Care manager: This is a nurse, a social worker or other health care professional who works with you, Aetna Better Health of Ohio and your health care providers to make sure you get the care you need. See Chapter 3 for more information.

Care plan: The plan for what health services you will get and how you will get them. See Chapter 1 for more information.

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. See Chapter 3 for more information.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Coverage determination: An Aetna Better Health of Ohio decision about your benefits and covered services and drugs, or the amount we will pay for your health services and drugs. See Chapter 9 for more information.

Covered services: Health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services that our plan pays. Covered health care and long-term services and supports are listed in the Benefits Chart in Chapter 4.

Declaration for mental health treatment: This is a type of advance directive. It gives more specific attention to mental health care. It allows a person, while capable, to appoint a proxy to make decisions on his or her behalf when he or she lacks the capacity to make a decision. In addition, the declaration can set forth certain wishes regarding treatment. The person can give their medication and treatment preferences, and preferences about admission/retention in a facility. For more information see Chapter 8.

Do not resuscitate order (DNR): This is a type of advance directive that a doctor issues or, under certain circumstances, a certified nurse practitioner or clinical nurse specialist. It identifies a person and says that CPR should not be administered to that person. CPR means cardiopulmonary resuscitation or a component of cardiopulmonary resuscitation, but it does not include clearing a person's airway for a purpose other than as a component of CPR. For more information see Chapter 8.

Durable medical equipment (DME): These are 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. For more information see Chapter 3.

Durable power of attorney: This is a type of advance directive. A durable power of attorney for medical care is different from other types of powers of attorney. It lets you choose someone to carry out your wishes for your medical care. The person acts for you if you can't act for yourself. This could be for a short or a long while. For more information see Chapter 8.

Explanation of benefits: A document that tells you 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.

Grievance: Any written or verbal expression of dissatisfaction by you or your representative(including a provider authorized in writing to act on your behalf), including complaints, about any matter other than a coverage determination (action) regardless of whether any remedial action can be taken. For more information see Chapter 9.

List of covered drugs: Also called the "Drug List" for short. It tells what prescription drugs are covered by Aetna Better Health of Ohio. 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 1 for more information.

Living will: This is a type of advance directive. This form lets you to put your wishes about your medical care in writing. You can choose what you would want if you were too sick to make your wishes known. You can say when you would or would not want food and water supplied artificially. For more information see Chapter 8.

Medicaid: This is a program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. It covers extra services and drugs not covered by Medicare. See Chapter 1 for more information.

Medical emergency: 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.

For more information see Chapter 3.

Medically necessary: means you need services, supplies or drugs 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. See Chapter 3 for more information.

Medicare: This 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). See Chapter 1 for more information.

Medication therapy management (MTM): Programs developed by a team of pharmacists and doctors for people who meet certain requirements for their total covered drug costs, medical conditions they have, and how many different drugs they take. The programs can help be sure our members use the drugs that work best to treat their medical conditions. The programs also help members avoid potential drug-related problems. See Chapter 5 for more information.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

MyCare Ohio Ombudsman: The Ohio Department of Aging office or person that helps with concerns about any aspect of care. Help is available to resolve differences with providers, protect member rights and file complaints or appeals with our plan. The MyCare Ohio Ombudsman works together with the Office of the State Long-term Care Ombudsman, which advocates for consumers receiving long-term services and supports. See Chapter 2 for more information.

Network pharmacies: Pharmacies (drug stores) that have agreed to fill prescriptions for our plan members. Network pharmacies bill us directly for prescriptions you receive. When you use a network pharmacy, you pay nothing for your prescription drugs. See Chapter 6 for more information.

Network providers: These are providers who work with our 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 pay nothing for covered services. The only exception is if you have a patient liability for nursing facility or waiver services. See Chapter 4 for more information.

Notice of privacy practices: A written notice that tells you about your rights to get information and to control how your health information is used. It also explains how we protect the privacy of your health information. For more information see Chapter 8.

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 Medicaid. See Chapter 5 for more information.

Primary care provider (PCP): Your PCP is an individual physician or physician group who works with you and your care manager to direct and coordinate your health care. Your PCP does your preventive care checkups and treats 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. Your PCP may be trained in family practice, internal medicine, general practice, OB/GYN, geriatrics or pediatrics. Your PCP may also be a certified nurse practitioner or a physician assistant. For more information see Chapter 3.

Prior authorization: For some services, your provider must submit information to Aetna Better Health of Ohio and request approval for you to receive the service. This is called Prior Authorization. See Chapter 4 for more information.

Providers: Doctors, nurses and other people who deliver services and care. The term providers also include hospitals, home health agencies, clinics and other places that deliver health care services, medical equipment and long-term services and supports. See Chapter 2 for more information.

Provider and Pharmacy Directory: A document that lists the providers and pharmacies in the Aetna Better Health of Ohio network. See Chapter 1 for more information.

If you have questions, please call Aetna Better Health of Ohio at 1-855-364-0974, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call 1-855-364-0974, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit www.aetnabetterhealth.com/ohio.

Services: Health care, long-term services and supports, supplies, behavioral health, prescription and over-the-counter drugs, equipment and other services. See Chapter 4 for more information.

Specialist: A specialist is a doctor who provides health care for a specific disease or part of the body. For more information see Chapter 3.

Total drug costs: This is the amount of money you or others pay for your prescriptions, plus the amount the plan pays. See Chapter 6 for more information.

Transition period: If you are new to our plan, you may be able to continue to see your current out-of-network providers for a period of time after you enroll. This is called your transition period. See Chapter 1 for more information.

Urgently need 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. For more information see Chapter 3.

Notes

If you have questions, please call Aetna Better Health of Ohio at **1-855-364-0974**, Option 1 (TTY: 711), 24 hours a day, 7 days a week. If you need to speak to your care manager, please call **1-855-364-0974**, Option 5 (TTY: 711), 24 hours a day, 7 days a week. These calls are free. For more information, visit **www.aetnabetterhealth.com/ohio**.

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