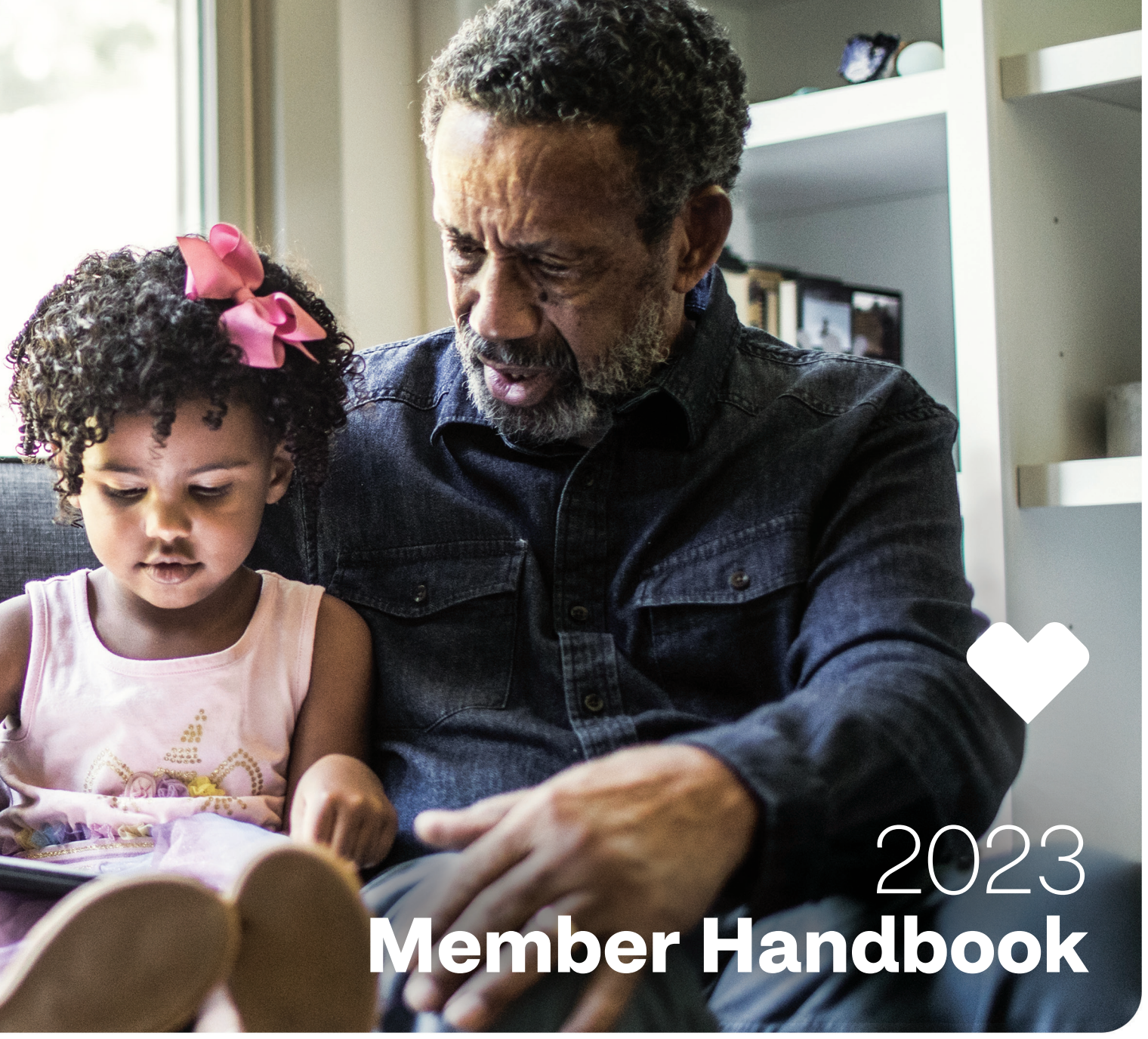

2023 Member Handbook

AETNA BETTER HEALTH℠ PREMIER PLAN

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

aetna®

MI HEALTH LINK
Linking Medicare and Medicaid for you

AetnaBetterHealth.com/Michigan

1036600-06-01 (4/23) Last updated: 4/23 H8026_23MBR HNDBK ACCEPTED

Aetna Better Health Premier Plan *Member Handbook*

January 1, 2023 – December 31, 2023

Your Health and Drug Coverage under the Aetna Better Health Premier Plan Medicare- Medicaid Plan

Member Handbook Introduction

This handbook tells you about your coverage under Aetna Better Health Premier Plan through December 31, 2023. It explains health care services, behavioral health coverage, prescription drug coverage, and long term supports and services. Long term supports and services help you stay at home instead of going to a nursing home or hospital. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

This is an important legal document. Please keep it in a safe place.

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

ATTENTION: If you speak Spanish or Arabic, language assistance services, free of charge, are available to you. Call **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. The call is free.

ATENCIÓN: Si habla español o árabe, tiene a su disposición servicios de idiomas gratuitos. Llame al **1-855-676-5772 (TTY: 711)**, las 24 horas del día, los 7 días de la semana. Esta llamada es gratuita.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل على الرقم **1-855-676-5772 (الهاتف النصي: 117)**، على مدار الساعة وطوال أيام الأسبوع. وتكون هذه المكالمة مجانية.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-855-676-5772 (TTY: 711), 24 hours a day, 7 days a week. The call is free.

If you wish to make or change a standing request to receive materials in a language other than English or in an alternate format, you can call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

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

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Disclaimers

- Aetna Better Health Premier Plan is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.
- Coverage under Aetna Better Health Premier Plan is qualifying health coverage called "minimum essential coverage." It satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Aetna Better Health Premier Plan, a health plan that covers all your Medicare and Michigan Medicaid services, and your membership in it. It also tells you what to expect and what other information you will get from Aetna Better Health Premier Plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

A. Welcome to Aetna Better Health Premier Plan

Aetna Better Health Premier Plan is a Medicare-Medicaid Plan. A Medicare-Medicaid Plan is an organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has care coordinators and care teams to help you manage all your providers and services. They all work together to provide the care you need.

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

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

Aetna Better Health is a division of Aetna — one of the nation's leading health care benefits companies. We are part of the CVS Health family.

Aetna has over 30 years of experience serving millions of members in managed care. We take a total approach to health and wellness. Because we understand that feeling healthy is more than just physical. We're here to help keep you healthy, not just be there for you when you're sick. Your health goals are unique to you. We want you to achieve every one of them so you can get the most out of life.

As part of our total approach to health, we're committed to helping you get the care you need when you need it. That means connecting you with providers and resources that will help you the most, both at and away from the doctor's office.

Source: AetnaBetterHealth.com. Visited July 21, 2022.

B. Information about Medicare and Michigan Medicaid

B1. Medicare

Medicare is the federal health insurance program for the following people:

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

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

B2. Michigan Medicaid

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

This means that each state decides:

- what counts as income and resources,
- who qualifies,
- what services are covered, **and**
- the cost for services.

States can decide how to run their own Medicaid programs, as long as they follow the federal rules.

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

- you are eligible to participate,
- we choose to offer the plan, **and**
- Medicare and the State of Michigan approve the plan.

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

C. Advantages of this plan

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

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

- You will be able to work with **one** health plan for **all** of your health insurance needs.
- You will not pay a deductible or copay when you get services from a provider or pharmacy in our health plan's provider network. (You will be required to keep paying any monthly Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.)

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

- You will have your own Care Coordinator who will ask you about your health care needs and choices and work with you to create a personal care plan based on your goals. We call this person-centered planning.
- Your Care Coordinator will help you get what you need, when you need it. This person will answer your questions and make sure that your health care issues get the attention they deserve.
- If you qualify, you will have access to home and community-based supports and services to help you live independently.

D. Aetna Better Health Premier Plan's service area

Our service area includes these counties in Michigan.

- Southwest Region: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties
- Southeast Region: Wayne and Macomb counties

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

If you move outside of our service area, you cannot stay in this plan. Refer to Chapter 8 for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as the following are true:

- you live in our service area (incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.), **and**
- you have Medicare Part A, Part B, and Part D, **and**
- you are eligible for full Michigan Medicaid benefits, **and**

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

- you are a United States citizen or are lawfully present in the United States, **and**
- you are not already enrolled in hospice, **and**
  - to learn more about the hospice benefit please look at Chapter 4 of the *Member Handbook*
- you are not enrolled in the MI Choice waiver program or the Program of All-inclusive Care for the Elderly (PACE). If you are enrolled in either of these programs, you need to disenroll before enrolling in the MI Health Link program through Aetna Better Health Premier Plan.

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

You will get a Level I Assessment within the first 60 days of joining our plan. One of our Care Coordinators will contact you within the first 60 days of enrolling with Aetna Better Health Premier Plan. The Care Coordinator will ask you a few questions to identify your immediate and long-term needs. The Care Coordinator will also work with you, your providers, your family and anyone else you choose to develop a care plan that will help you get all the services and care you need.

If Aetna Better Health Premier Plan is new for you, you can keep getting services and using the doctors and other providers you use now for at least 90 days from your enrollment start date.

The Habilitation Supports Waiver or Specialty Services and Supports Program services provided by the Prepaid Inpatient Health Plan (PIHP) that you may currently be receiving will not change due to your enrollment in Aetna Better Health Premier Plan. For all other services, you will be able to continue seeing the doctors and providers you use now for up to 180 days from your enrollment start date.

Your Care Coordinator will work with you to choose new providers and arrange services within this time period if your current provider is not part of Aetna Better Health Premier Plan's provider network. Call Aetna Better Health Premier Plan for information about nursing home services.

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

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

G. Your care plan

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

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

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

H. Aetna Better Health Premier Plan monthly plan premium

Aetna Better Health Premier Plan does not have a monthly plan premium.

I. 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, refer to Chapter 9, or call 1-800-MEDICARE (1-800-633-4227).

You can ask for a *Member Handbook* by calling Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. You can also refer to the *Member Handbook* at **AetnaBetterHealth.com/Michigan** or download it from this website.

The contract is in effect for the months you are enrolled in Aetna Better Health Premier Plan between January 1, 2023 and December 31, 2023.

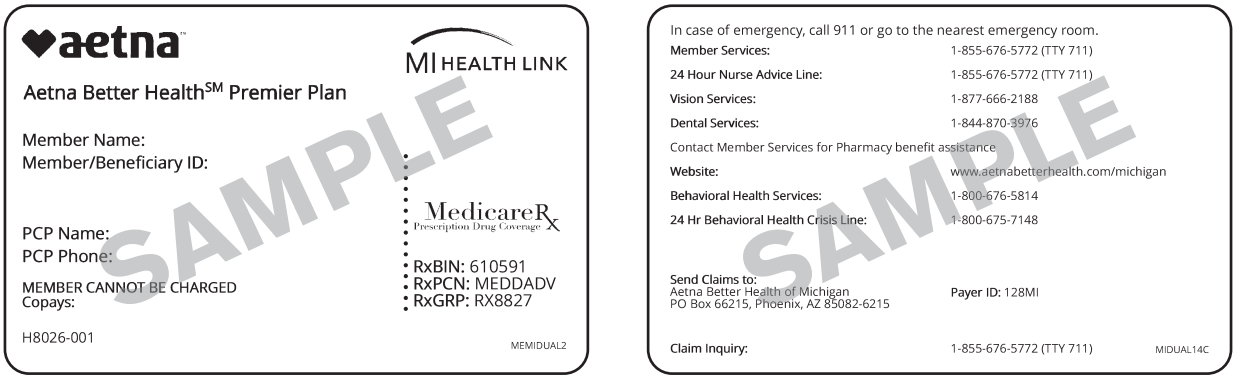
If you have questions, please call Aetna Better Health Premier Plan at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. This call is free. **For more information**, visit **AetnaBetterHealth.com/Michigan**.

J. Other important information will you get from us

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

J1. Your Aetna Better Health Premier Plan Member ID Card

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



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

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your Michigan Medicaid card to get services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Aetna Better Health Premier Plan Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to Chapter 7 to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

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

You can ask for a *Provider and Pharmacy Directory* by calling Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. You can also refer to the *Provider and Pharmacy Directory* at **AetnaBetterHealth.com/Michigan** or download it from this website.

The *Provider and Pharmacy Directory* has information about how to get care. It lists providers you may go to as an Aetna Better Health Premier Plan member.

- Health care providers, such as doctors and nurse practitioners
- Facilities, such as hospitals or clinics
- Support providers, such as home health providers

It also lists the pharmacies that you may use to get your prescription drugs.

- Retail and chain pharmacies
- Mail-order pharmacy
- Home infusion pharmacies
- Long-term pharmacies

Definition of network providers

- Aetna Better Health Premier Plan's network providers include:
    - Doctors, nurse practitioners, psychologists, hearing, dental, or vision specialists, nurses, pharmacists, therapists, and other health care professionals that you can use as a member of our plan;
    - Clinics, hospitals, nursing facilities, and other places that provide health services in our plan; and long term supports and services
    - Home health agencies, durable medical equipment suppliers, and others who provide goods and services that you get through Medicare or Michigan Medicaid.

Network providers have agreed to accept payment from our plan for covered services as payment in full.

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

Definition of network pharmacies

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

Call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week for more information. Both Member Services and Aetna Better Health Premier Plan's website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *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 Premier Plan.

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

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

J4. The *Explanation of Benefits*

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

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

An EOB is also available when you ask for one. To get a copy, contact Member Services.

K. How to keep your membership record up to date

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

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

Let us know the following:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage, such as from your employer, your spouse's employer or your domestic partner's employer, or workers' compensation
- Any liability claims, such as claims from an automobile accident
- Admission to a nursing home or hospital
- Care in an out-of-area or out-of-network hospital or emergency room
- Changes in who your caregiver (or anyone responsible for you) is
- You are part of or become part of a clinical research study (NOTE: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

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

K1. Privacy of personal health information (PHI)

The information in your membership record may include personal health information (PHI). Laws require that we keep your PHI private. We make sure that your PHI is protected. For more information about how we protect your PHI, refer to Chapter 8.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about Aetna Better Health Premier Plan and your health care benefits. You can also use this chapter to get information about how to contact your Care Coordinator and others that can advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

A. How to contact your Care Coordinator

A Care Coordinator is a health professional who will help you get care and services that affect your health and wellbeing. You are assigned a Care Coordinator when you enroll with Aetna Better Health Premier Plan. Your Care Coordinator will get to know you and will work with you, your doctors, and other care givers to make sure everything is working together for you. You can share your health history with your Care Coordinator and set goals for healthy living. Whenever you have a question or a problem about your health or services or care you are getting from us, you can call your Care Coordinator. **Your Care Coordinator is your "go-to" person** for Aetna Better Health Premier Plan.

Our goal in Aetna Better Health Premier Plan is to meet your needs in a way that works for you. This is why we call our program "person-centered." The person-centered planning process is when you work with your Care Coordinator to create a care plan that is about **your** goals, choices, and abilities. When you create your care plan, you are welcome to involve people you feel are key to your success, such as family members, friends, or legal representatives.

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week
WRITE	Aetna Better Health Premier Plan Attn: Care Management Dept. 7400 W. Campus, MC F499 New Albany, OH 43054
WEBSITE	**AetnaBetterHealth.com/Michigan**.

A1. When to contact your Care Coordinator

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

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

When you join Aetna Better Health Premier Plan, a Care Coordinator will meet with you to do an assessment. The assessment will help us learn about your health needs. It will also help us to see if you are eligible for LTSS. If you are eligible, we will re-evaluate you each year to see if your needs or eligibility have changed. To be eligible for LTSS, you must be at an institutional level of care. You may be eligible to receive some LTSS through a waiver.

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

- Skilled nursing care
- Physical therapy
- Occupational therapy
- Speech therapy
- Personal Care Services
- Home health care

Refer to Chapter 4 for additional information about Home and Community-Based waiver services.

B. How to contact Aetna Better Health Premier Plan Member Services

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. 24 hours a day, 7 days a week
FAX	1-855-259-2087
WRITE	Aetna Better Health Premier Plan Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998-2980
WEBSITE	**AetnaBetterHealth.com/Michigan**.

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

B1. When to contact Member Services

- Questions about the plan
- Questions about claims, billing, or Member ID Cards
- Coverage decisions about your health care
  - A coverage decision about your health care is a decision about:
    - your benefits and covered services, **or**
    - the amount we will pay for your health services.
  - Call us if you have questions about a coverage decision about health care.
  - To learn more about coverage decisions, refer to Chapter 9.
- Appeals about your health care
  - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.
  - To learn more about making an appeal, refer to Chapter 9.
- Complaints about your health care
  - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you got to us or to the Quality Improvement Organization (refer to Section F below).
  - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
  - You can send a complaint about Aetna Better Health Premier Plan right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - To learn more about making a complaint about your health care, refer to Chapter 9.

- Coverage decisions about your drugs
  - A coverage decision about your drugs is a decision about:
    - your benefits and covered drugs, **or**
    - the amount we will pay for your drugs.
  - This applies to your Part D drugs, Michigan Medicaid prescription drugs, and Michigan Medicaid over-the-counter drugs.
  - For more on coverage decisions about your prescription drugs, refer to Chapter 9.
- Appeals about your drugs
  - An appeal is a way to ask us to change a coverage decision.
  - You, your doctor/other provider, or your representative can send your appeal request to us in writing at:

    Aetna Better Health Premier Plan
    Part D Coverage Determination Pharmacy Department
    4500 E. Cotton Center Blvd
    Phoenix, AZ 85040

    You may also call us at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week, or fax the request to 1-844-242-0914.
  - Medicaid drugs are Tier 3 drugs on the *List of Covered Drugs*.
  - For more on making an appeal about your prescription drugs, refer to Chapter 9.
- Complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about Aetna Better Health Premier Plan right to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to Chapter 9.

- Payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to Chapter 7.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to Chapter 9 for more on appeals.
- Ask for more information about our plan, including information about the structure and operation of Aetna Better Health Premier Plan and any physician incentive plans.

C. How to contact the 24 Hour Nurse Advice Line

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

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week This call is free. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 24 hours a day, 7 days a week This call is free.

C1. When to contact the 24 Hour Nurse Advice Line

- Questions about your health care

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

Behavioral health services will be available to Aetna Better Health Premier Plan members. Members getting services through the PIHP will continue to get them according to their plan of care. Aetna Better Health Premier Plan will provide the personal care services previously provided by the Department of Health and Human Services (DHHS) Home Help program. Other medically necessary behavioral health, intellectual/developmental disability, and substance use disorder services, including psychotherapy or counseling (individual, family, and group) when indicated, are available and coordinated through the health plan and PIHP. There is no wrong door to receive these services.

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

If you have questions about your behavioral health services, contact Aetna Better Health Premier Plan. If you need immediate assistance, or are experiencing a behavioral health crisis, dial 988 to reach the Suicide and Crisis Lifeline or contact one of the crisis resources listed below.

Behavioral Health General Information Line:

Region 4 Behavioral Health General Information Line Serving: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties

CALL	**1-855-676-5772** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. 24 hours a day, 7 days a week

Region 7 PIHP General Information Line Serving: Wayne County

CALL	**1-800-241-4949** This call is free. 24 hours a day, 7 days a week We have free interpreter services for people who do not speak English.
TTY	**711** This call is free. 24 hours a day, 7 days a week

Region 9 Behavioral Health General Information Line Serving: Macomb County
Macomb County Community Mental Health

CALL	**1-855-996-2264** This call is free. 7 days a week, 8 AM to 8 PM
TTY	**711** This call is free. 7 days a week, 8 AM to 8 PM

This section is continued on the next page.

D1. When to contact the Behavioral Health General Information Line

- Questions about behavioral health services
- Where and how to get an assessment
- Where to go to get services
- A list of other community resources

Behavioral Health Crisis Line:

Region 4 Behavorial Health Crisis Lines Serving: Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren counties

Barry County - Barry County Community Mental Health (CMH) Services Authority

CALL	1-866-266-4781 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. 24 hours a day, 7 days a week

Berrien County - Berrien Mental Health Authority

CALL	1-800-336-0341 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. 24 hours a day, 7 days a week

Branch County - Pines Behavioral Health

CALL	1-888-725-7534 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. 24 hours a day, 7 days a week

This section is continued on the next page.

Calhoun County - Summit Pointe

CALL	1-800-632-5449 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. 24 hours a day, 7 days a week

Cass County - Woodlands Behavioral Healthcare Network

CALL	1-800-323-0335 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. 24 hours a day, 7 days a week

Kalamazoo County - Integrated Services of Kalamazoo

CALL	1-888-373-6200 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. 24 hours a day, 7 days a week

St. Joseph County - CMH & Substance Abuse Services of St. Joseph County

CALL	1-800-622-3967 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. 24 hours a day, 7 days a week

Van Buren County - Van Buren Community Mental Health Authority

CALL	1-800-922-1418 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. 24 hours a day, 7 days a week

This section is continued on the next page.

Region 7 Behavioral Health Crisis Line Serving: Wayne County

CALL	1-844-623-4357 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. 24 hours a day, 7 days a week

Region 9 Behavioral Health Crisis Line Serving: Macomb County

Macomb County Community Mental Health

CALL	**(586) 307-9100** This call is not 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. 24 hours a day, 7 days a week

This section is continued on the next page.

D2. When to contact the Behavioral Health Crisis Line

- Suicidal thoughts
- Information on mental health/illness
- Substance abuse/addiction
- To help a friend or loved one
- Relationship problems
- Abuse/violence
    - If you are subject to or suspect abuse, neglect or ill treatment, you can **call Adult Protective Services (APS) at 1-855-444-3911 any time day or night** to make a report. APS will investigate within 24 hours after you report it.
- Economic problems causing anxiety/depression
- Loneliness
- Family problems
- If you are experiencing a life or death emergency, please call 9-1-1 or use the nearest hospital.

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

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

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

CALL	1-800-803-7174 This call is free. Hours of operation are: Monday through Friday, 8 AM to 5 PM.
TRS	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	6105 St Joe Hwy #204 Lansing Charter Township, MI 48917
EMAIL	info@mmapinc.org
WEBSITE	mmapinc.org/

E1. When to contact MMAP

- Questions about your Medicare and Michigan Medicaid health insurance
    - MMAP counselors can answer your questions about changing to a new plan and help you:
        - understand your rights,
        - understand drug coverage, such as prescription and over-the-counter drugs,
        - understand your plan choices,
        - make complaints about your health care or treatment, **and**
        - straighten out problems with your bills.

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

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

CALL	1-888-524-9900 This call is free.
TTY	1-888-985-8775 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WRITE	Livanta 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701
WEBSITE	www.livantaqio.com

F1. When to contact Livanta

- Questions about your health care
  - You can make a complaint about the care you got if you:
    - have a problem with the quality of care,
    - think your hospital stay is ending too soon, **or**
    - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

G. How to contact Medicare

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

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

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
WEBSITE	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, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has booklets you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website, print it out, and send it to you.

H. How to contact Michigan Medicaid

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

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

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

Michigan Medicaid eligibility is determined by the Michigan Department of Health and Human Services. If you have questions about your Michigan Medicaid eligibility or yearly renewal, contact your Department of Health and Human Services Specialist. For general questions about Department of Health and Human Services assistance programs, call 1-855-275-6424 Monday through Friday, 8 AM to 5 PM.

I. How to contact the MI Health Link Ombudsman program

The MI Health Link Ombudsman program helps people enrolled in MI Health Link. They work as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The MI Health Link Ombudsman also helps people enrolled in Michigan Medicaid with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-888-746-6456
TTY	711 This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it.
EMAIL	help@mhlo.org
WEBSITE	www.mhlo.org

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

J. How to contact the Michigan Long Term Care Ombudsman Program

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

CALL	1-866-485-9393
WRITE	State Long Term Care Ombudsman 15851 South US 27, Suite 73 Lansing, MI 48906
EMAIL	mltcop.org/contact
WEBSITE	mltcop.org/

K. How to report fraud and abuse

If you suspect that fraud, waste or abuse is occurring, please let us know.

CALL	**1-866-806-7020** – Aetna's Special Investigations Unit 1-855-MI-FRAUD (643-7283) – Michigan Department of Health and Human Services, Office of Inspector General
WRITE	Office of Inspector General PO Box 30062 Lansing, MI 48909
EMAIL	MDHHS-OIG@michigan.gov
WEBSITE	**AetnaBetterHealth.com/Michigan/fraud-abuse** Michigan.gov/mdhhs/doing-business/providers/providers/medicaid/billingreimbursement/fraud - Michigan Department of Health and Human Services, Office of Inspector General

L. Other resources

LOCAL AREA AGENCY	CALL	WEBSITE AND AREA SERVED
Area Agency on Aging 1A	1-313-446-4444	DetroitSeniorSolution.org County served: Wayne (Detroit area)
Area Agency on Aging 1B	1-800-852-7795	AAA1b.org Counties served: Livingston, Macomb, Monroe, Oakland, St. Clair and Washtenaw
The Senior Alliance - Area Agency on Aging 1C	1-800-815-1112	TheSeniorAlliance.org Counties served: Southern and Western Wayne
Area Agency on Aging 3A	1-269-373-5200	Kalcounty.com/AAA County served: Kalamazoo
Carewell Services Area Agency on Aging 3B	1-269-966-2450 1-800-626-6719 (outside Calhoun County)	CarewellServices.org Counties served: Barry and Calhoun
Area Agency on Aging 3C	1-888-615-8009	BHSJ.org/AAA Counties served: Branch and St. Joseph
Area Agency on Aging Region IV	1-800-654-2810	AreaAgencyonAging.org Counties served: Berrien, Cass and Van Buren

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

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with Aetna Better Health Premier Plan. It also tells you about your Care Coordinator, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do when you are billed directly for services covered by our plan, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Information about "services," "covered services," "providers," and "network providers"

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

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

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

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

Aetna Better Health Premier Plan covers all services covered by Medicare and Michigan Medicaid. This includes behavioral health services, long term support and services, and prescription drugs.

Aetna Better Health Premier Plan will generally pay for the health care and other supports and services you get if you follow the plan rules. The only exceptions are that you pay any Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services or any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

To be covered by our plan:

- The care you get must be a **plan benefit**. This means that it must be included in the plan's Benefits Chart. (The chart is in Chapter 4 of this handbook).
- The care must be **medically necessary**. Medically necessary means you need services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing home. It also means the services, supplies, equipment or drugs meet accepted standards of medical practice.
- You must have a network **primary care provider (PCP)** who has ordered the care or has told you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
    - In most cases, your network PCP must give you approval before you can use someone that is not your PCP or use other providers in the plan's network. This is called a **referral**. If you don't get approval, Aetna Better Health Premier Plan may not cover the services. You don't need a referral for certain specialists, such as women's health specialists. To learn more about referrals, refer to page 34.
    - You do not need a referral from your PCP for emergency care or urgent care or for a woman's health provider. You can get other kinds of care without having a referral from your PCP. To learn more about this, refer to page 38.
    - To learn more about choosing a PCP, refer to page 36.
- **You must get your care from network providers**. Usually, the plan will not cover care from a provider who does not work with the health plan. Here are some cases when this rule does not apply:
    - The plan covers emergency or urgent care from an out-of-network provider. To learn more and find out what emergency or urgent care means, refer to Section I, page 41.
    - If you need care that our plan covers and our network providers cannot give it to you, you can get the care from an out-of-network provider. The out-of-network provider must first get prior authorization from Aetna Better Health Premier Plan. In this situation, we will cover the care as if you got it from a network provider. To learn about getting approval for an out-of-network provider, refer to Section D, page 36.

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

- The plan covers kidney dialysis services when you are outside the plan's service area or when your provider for this service is unavailable or inaccessible for a short time. You can get these services at a Medicare-certified dialysis facility.
- When you first join the plan, you can keep getting services and using the doctors and other providers you use now for at least 90 days from your enrollment start date. The Habilitation Supports Waiver or Specialty Services and Supports Program services provided by the Prepaid Inpatient Health Plan (PIHP) that you may currently be receiving will not change due to your enrollment in Aetna Better Health Premier Plan. For all other services, you will be able to continue seeing the doctors and providers you use now for up to 180 days from your enrollment start date. Your Care Coordinator will work with you to choose new providers and arrange services within this time period. Call Aetna Better Health Premier Plan for information about nursing home services.

C. Information about your Care Coordinator

C1. What a Care Coordinator is

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

C2. How you can contact your Care Coordinator

When you first meet with your Care Coordinator, they will give you their phone number. You can also reach your Care Coordinator by calling Member Services.

C3. How you can change your Care Coordinator

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

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

D1. Care from a primary care provider

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

Definition of "PCP," and what does the PCP do for you

What is a PCP?

- Your primary care provider (PCP) works with you and your Care Coordinator to direct and coordinate your health care. A PCP may be a doctor, a nurse practitioner, or in some cases, a specialist. 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. Although you do not need approval (called a referral) from your PCP to go to other providers, it is important to contact your PCP before you go to a specialist or before going to another doctor for a non-emergent condition. You should also contact your PCP for follow-up after any urgent or emergency department visit or hospital stay as well as after any visit to a specialist.
- You should share any changes in your care or recommendations the specialist made with your PCP. This allows your PCP to manage your care for the best outcomes.

What types of providers may act as a PCP?

- General Practice
- Family Practice
- Internal Medicine
- OB/GYN
- Geriatrics

There are times when doctors other than the types above may serve as a PCP. If you have a chronic health condition like diabetes, you may need a specialist to take care of you as your PCP. Member Services or your Care Coordinator can help you with this decision. If you want a specialist to be your PCP, the specialist must agree to do so and must contact us first to make arrangements.

Your PCP and your other providers are responsible for following Aetna Better Health Premier Plan's prior authorization requirements, and for getting an authorization number.

When can a clinic be your primary care provider (RHC/FQHC)?

If a clinic in which you receive most of your primary care services is a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC), then the clinic may be assigned as your primary care provider.

Your choice of PCP

When choosing your PCP, consider the following:

- Do you have a PCP you would like to continue to go to?
- Is your PCP's office close to your home?
- Does your PCP practice at a hospital close to your home?
- Does your PCP's office hours meet your needs?
- Do you go to a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) for your care?

Ways to find a PCP in our network:

- Go to **AetnaBetterHealth.com/Michigan** and select "Find a Provider / Pharmacy."
- Call your Care Coordinator or Member Services.
- Look in your printed *Provider and Pharmacy Directory*, if you requested one.

Option to change your PCP

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

To find a new PCP, use our provider search tool on our website at **AetnaBetterHealth.com/Michigan**.

To change your PCP, call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. The change will take effect immediately upon request.

D2. Care from specialists and other network providers

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

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

You can go to any specialist in our network. Your PCP or Care Coordinator can recommend a specialist to you. Member Services can also help you find a specialist near you. You do not need a referral to go to a network specialist however the specialist may have to contact us to get approval to see you before your appointment. This is called prior authorization. Aetna Better Health Premier Plan clinicians and Medical Directors review the services to make sure they are what you need.

Your providers must get prior authorization from the plan before you can get certain services. Refer to the Benefits Chart in Chapter 4 for information about which services require prior authorization.

The benefits that require prior authorization include footnotes in the Benefits Chart.

D3. What to do when a provider leaves our plan

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

- Even though our network of providers may change during the year, we must give you uninterrupted access to qualified providers.
- We will make a good faith effort to give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.

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

- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If we cannot find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care.
- 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 make an appeal of our decision. Refer to Chapter 9 for information about making an appeal.

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

D4. How to get care from out-of-network providers

Generally, you must go to providers that are in our network. There are times when you can go to an out-of-network provider, such as:

- You need emergency services.
- You need urgent care.
- You are out of the service area and need dialysis.
- Aetna Better Health Premier Plan has approved you to go to an out-of-network provider during your first 90 days from your enrollment start date in Aetna Better Health Premier Plan (or 180 days if you get services through the Habilitation Supports Waiver or the Specialty Services and Supports Program through the PIHP). The out-of-network provider must contact us to get approval to see you before your appointment.
- When a provider with a certain specialty is not available in network, the provider must get prior authorization before your appointment. Out-of-network providers are responsible for getting prior authorization. A prior authorization request can be made by calling **1-855-676-5772** or faxing the request to 1-844-241-2495. The prior authorization form is available on our website at **AetnaBetterHealth.com/Michigan**.

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Michigan Medicaid.

- We cannot pay a provider who is not eligible to participate in Medicare and/or Michigan Medicaid.
- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

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

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

As an Aetna Better Health Premier Plan member, you may qualify to receive long-term supports and services (LTSS) in a nursing facility or at home. LTSS provides assistance to help you stay at home instead of going to a nursing home or hospital, or may assist you to transition from the nursing facility to the community. LTSS can provide assistance with bathing, dressing and other basic activities of daily living. LTSS may also include home modification, adaptive equipment and supplies, and chore services.

To qualify for these services, you must meet nursing facility level of care. Your Care Coordinator will meet with you and assess your needs. Once you qualify for these services, we will re-assess you each year to see if the services are meeting your needs. If you have questions about LTSS or to see if you qualify, call your Care Coordinator.

F. How to get behavioral health services

All behavioral health services are available to Aetna Better Health Premier Plan members through the local Pre-paid Inpatient Health Plan (PIHP) provider network. These services are available and coordinated through your Care Coordinator and the PIHP.

If you currently receive services through the PIHP, you will continue to receive those services according to their plan of care. If you need behavioral health services, talk to your Care Coordinator. To contact the PIHP directly, refer to the contact information in Chapter 2.

G. How to participate in self-determination arrangements

G1. What arrangements that support self-determination are

Self-determination is an option available to enrollees getting services through the MI Health Link HCBS home and community-based waiver program. It is a process that allows you to design and exercise control over your own life.

- This includes managing a fixed amount of dollars to cover your authorized supports and services. Often, this is referred to as an "individual budget."
- If you choose to do so, you would also have control over the hiring and management of providers.

G2. Who can get arrangements that support self-determination

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

G3. How to get help in employing providers

You may work with your Care Coordinator to get help employing providers.

H. How to get transportation services

If you need a ride to your appointments, call us at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week and choose the transportation option. You can also call MTM directly at 1-844-549-8347 (TTY: 711) Monday – Friday, 6 a.m. – 10 p.m. and Saturday 8 a.m. – 4 p.m. for scheduling. You must call 3 days before your appointment. If you need help, call your Care Coordinator or Member Services.

Transportation providers and members may be reimbursed for mileage, tolls, parking fees, approved meals and lodging expenses, and caregivers. Plan covers services that follow the MI HealthLink program and IRS mileage reimbursement. Reimbursement is permitted for medically necessary caregivers.

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

I1. Care when you have a medical emergency

Definition of a medical emergency

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

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**
- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
  - there is not enough time to safely transfer you to another hospital before delivery.
  - a transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

What to do if you have a medical emergency

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories from any provider with an appropriate state license.
- **As soon as possible, make sure that you tell our plan about your emergency.** We need to follow up on your emergency care. You or someone should call to tell us about your emergency care, usually within 48 hours. However, you will not have to pay for emergency services because of a delay in telling us. Call your Care Coordinator or Member Services at the toll-free phone number on the back of your Member ID Card.

Covered services in 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, refer to the Benefits Chart in Chapter 4.

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in Chapter 4.

The providers who give emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

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

What to do if you have a behavioral health emergency

If you have a behavioral health emergency, call 911 or go to the nearest hospital emergency room.

An emergency means a behavioral health condition that is life threatening and requires immediate medical attention. You need to get care right away! If you don't get care immediately, the emergency could result in death or harm to yourself or others. You may have a mental health, drug or alcohol use emergency.

Some examples of problems that are probably emergencies:

- Thinking about or looking for ways for hurting or killing yourself or others
- Experiencing serious reactions to or side effects from medication
- Having severe impairment or symptoms of withdrawal from alcohol or other drugs
- Feeling disoriented, distraught or having rage and aggressive behavior toward others for no reason

At the hospital emergency room, the provider will evaluate you and determine if you should be admitted to a hospital for treatment, or if you are stable enough to be discharged from the emergency room.

After you visit the emergency room:

- Call your behavioral health provider as soon as you can.
- If you don't have a current behavioral health provider, call Aetna Better Health Premier Plan at **1-855-676-5772**, 24 hours a day, 7 days a week, and ask for help in finding a provider.
- It is important that you receive the follow-up care you need to keep your condition stable.

Getting emergency care if it wasn't an emergency

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

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

- you use a network provider, **or**
- the additional care you get is considered "urgent care" and you follow the rules for getting this care. (Refer to the next section.)

I2. Urgent Care

Definition of urgent care

Urgent care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need to have it treated.

Urgent care when you are in the plan's service area

In most situations, we will cover urgent care only if:

- you get this care from a network provider, **and**
- you follow the other rules described in this chapter.

However, if it is not possible or reasonable to get to a network provider, we will cover urgent care you get from an out-of-network provider.

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 **AetnaBetterHealth.com/Michigan** by clicking on "Find a Provider / Pharmacy" or by calling Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

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

Urgent care when you are outside the plan's service area

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

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

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

I3. Care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from Aetna Better Health Premier Plan.

Please visit our website for information on how to obtain needed care during a declared disaster: **AetnaBetterHealth.com/Michigan**.

During a declared disaster, if you cannot use a network provider, we will allow you to get care from out-of-network providers at no cost to you. If you cannot use a network pharmacy during a declared disaster, you will be able to fill your prescription drugs at an out-of-network pharmacy. Please refer to Chapter 5 for more information.

J. What to do if you are billed directly for services covered by our plan

If a provider sends you a bill instead of sending it to the plan, you can ask us to pay the bill.

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

If you have paid for your covered services or if you have gotten a bill for covered medical services, refer to Chapter 7 to learn what to do.

J1. What to do if services are not covered by our plan

Aetna Better Health Premier Plan covers all services:

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

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

If you want to know if we will pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. 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 to learn more about your appeal rights.

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

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

K. Coverage of health care services when you are in a clinical research study

K1. Definition of 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. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study will contact you. That person will tell you about the study and find out 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.

While you are in the study, you may stay enrolled in our plan. That way you continue to get care from our plan not related to the study.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or 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.

We encourage you to tell us before you start participating in a clinical research study. If you plan to be in a clinical research study, you or your Care Coordinator should contact Member Services to let us know you will be in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you will pay nothing for the services covered under the study and Medicare will pay for services covered under the study as well as routine costs associated with your care. 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.

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

K3. Learning more about clinical research studies

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

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

L1. Definition of 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.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Getting care from a religious non-medical health care institution

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.
- 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.

Our plan will cover unlimited inpatient hospital days in a network hospital when medically necessary with prior authorization.

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

M. Durable Medical Equipment (DME)

M1. DME as a member of our plan

DME includes certain items ordered by a provider such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You will always own certain items, such as prosthetics.

In this section, we discuss DME you must rent. As a member of Aetna Better Health Premier Plan, you usually will not own DME, no matter how long you rent it.

Even if you had the DME for up to 12 months in a row under Medicare before you joined our plan, you will not own the equipment.

M2. DME ownership when you switch to Original Medicare or Medicare Advantage

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and Medicare Advantage Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2023* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the Medicare Advantage plan, to own the DME item if:

- you did not become the owner of the DME 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 DME item under Original Medicare or a Medicare Advantage plan before you joined our plan, **those Original Medicare or Medicare Advantage plan payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the Medicare Advantage plan to own the DME item.
- There are no exceptions to this when you return to Original Medicare or a Medicare Advantage plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you are a member of our plan, we will cover the following:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or Medicare Advantage

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you will rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**:

- your supplier must provide the oxygen equipment, supplies, and services for another 24 months.
- your supplier must provide oxygen equipment and supplies for up to 5 years if medically necessary.

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- a new 5-year period begins.
- you will rent from a supplier for 36 months.
- your supplier must then provide the oxygen equipment, supplies, and services for another 24 months.
- a new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to a Medicare Advantage plan**, the plan will cover at least what Original Medicare covers. You can ask your Medicare Advantage plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits Chart

Introduction

This chapter tells you about the services Aetna Better Health Premier Plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. Your covered services

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

You pay nothing for your covered services as long as you follow the plan's rules. Refer to Chapter 3 for details about the plan's rules. The only exceptions are that you pay any:

- Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services.
- Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

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

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

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

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

A1. During public health emergencies

Aetna Better Health Premier Plan is required to loosen restrictions to your health care during a declared public health emergency or for those living in an emergency area. These changes to the restrictions are available only during the declared emergency. This means you may be able to get your prescriptions filled at any pharmacy and prior authorizations may be waived in part or in full. In such emergencies, you can visit **AetnaBetterHealth.com/Michigan** for more information.

B. Rules against providers charging you for services

We do not allow Aetna Better Health Premier Plan 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 service.

You should never get a bill from a provider for covered services. If you do, refer to Chapter 7 or call Member Services.

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

C. Our plan's Benefits Chart

The Benefits Chart in Section D tells you which services the plan pays for. It lists categories of services in alphabetical order and explains the covered services. It is broken into two sections:

- General Services
  - Offered to all enrollees
- Home and Community-Based Services (HCBS) Waiver
  - Offered only to enrollees who:
    - require nursing facility level of care but are not residing in a nursing facility, **and**
    - have a need for covered waiver services

We will pay for the services listed in the Benefits Chart only when the following rules are met. You do not pay anything for the service listed in the Benefits Chart, as long as you meet the coverage requirements described below. The only exceptions are that you pay any Patient Pay Amount (PPA) you have for nursing facility services as determined by the local Department of Health and Human Services or any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

- Your Medicare and Michigan Medicaid covered services must be provided according to the rules set by Medicare and Michigan Medicaid.
- The services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition 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.
- 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) that is providing your care.
- Some of the services listed in the Benefits Chart are covered only if your doctor or other network provider gets approval from us first. This is called prior authorization (PA). Covered services that need PA are marked in the Benefits Chart by a footnote. In addition, you must get PA for the following services that are not listed in the Benefits Chart:
  - Outpatient Blood Services

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

- **Important Benefit Information for Members with Certain Chronic Conditions**. If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits.
- The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

  How to be eligible
  In order to be eligible for this benefit you must have:

  - 1 qualifying chronic condition and 1 inpatient hospital stay within the last 12 months; OR
  - 1 qualifying chronic condition and 1 emergency room visit within the last 12 months; OR
  - 2 qualifying chronic conditions listed below

  Your eligibility must be determined through medical claims submission. You cannot self-attest. Only medical claims that your provider submits with a diagnosis supporting the conditions above will qualify you for eligibility. Contact the plan if you need help scheduling a visit with your provider.

  If you have one of the conditions listed below, you may be eligible for additional benefits under our plan:

  - Autoimmune disorders limited to:
    - Polyarteritis nodosa
    - Polymyalgia rheumatica
    - Polymyositis
    - Rheumatoid arthritis
    - Systemic lupus erythematosus
  - Cancer
  - Cardiovascular disorders limited to:
    - Cardiac arrhythmias
    - Coronary artery disease
    - Peripheral vascular disease
    - Chronic venous thromboembolic disorder

- Chronic alcohol and other drug dependence
- Chronic and disabling mental health conditions limited to:
  - Bipolar disorders
  - Major depressive disorders
  - Paranoid disorder
  - Schizophrenia
  - Schizoaffective disorder
- Chronic heart failure
- Chronic lung disorders limited to:
  - Asthma
  - Chronic bronchitis
  - Chronic obstructive pulmonary disease (COPD)
  - Emphysema
  - Pulmonary fibrosis
  - Pulmonary hypertension
- Dementia
- Diabetes
- End-stage liver disease
- End-stage renal disease (ESRD) requiring dialysis;
- HIV/AIDS
- Hyperlipidemia
- Hypertension

- Neurologic disorders limited to:
  - Amyotrophic lateral sclerosis (ALS)
  - Epilepsy
  - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia)
  - Huntington's disease
  - Multiple sclerosis (MS)
  - Parkinson's disease
  - Polyneuropathy
  - Spinal stenosis
  - Stroke-related neurologic deficit
- Severe hematologic disorders limited to:
  - Aplastic anemia
  - Hemophilia
  - Immune thrombocytopenic purpura
  - Myelodysplastic syndrome
  - Sickle-cell disease (excluding sickle-cell trait)
  - Chronic venous thromboembolic disorder
- Stroke

  Please refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information.
- All preventive services are free. You will find this apple next to preventive services in the Benefits Chart. The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.

D. The Benefits Chart

General Services that our plan pays for		What you must pay
	Abdominal aortic aneurysm screening The plan will pay for a one-time ultrasound screening for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	$0
	Acupuncture for chronic low back pain The plan will pay for up to 12 visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. The plan will pay for an additional 8 sessions if you show improvement. You may not get more than 20 acupuncture treatments each year. Acupuncture treatments must be stopped if you don't get better or if you get worse.	$0

General Services that our plan pays for		What you must pay
	Adaptive Medical Equipment and Supplies The plan covers devices, controls, or appliances that enable you to increase your ability to perform activities of daily living or to perceive, control, or communicate with the environment in which you live. Services might include: • shower chairs/benches • lift chairs • raised toilet seats • reachers • jar openers • transfer seats • bath lifts/room lifts • swivel discs • bath aids such as long handle scrubbers • telephone aids • automated/telephone or watches that assist with medication reminders • button hooks or zipper pulls • modified eating utensils • modified oral hygiene aids • modified grooming tools • heating pads • sharps containers • exercise items and other therapy items • voice output blood pressure monitor • nutritional supplements such as Ensure Prior authorization may be required.	$0

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

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

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

	General Services that our plan pays for	What you must pay
	Cell phone benefit Aetna Better Health Premier Plan members who are interested in the Lifeline, federal free cell phone program, are provided our contracted Lifeline vendor's website, phone number or application to complete in order to determine if they qualify. The vendor notifies Aetna Better Health Premier Plan of those members who are approved and opt-in to the program. Qualified members are eligible to receive a smartphone with talk time and data. Aetna Better Health Premier Plan members receive unlimited free calls to the plan's Member Services toll-free number that do not apply to their monthly minute allotment. As appropriate, the plan will send free health-related texts and other free texts.	$0
	Cervical and vaginal cancer screening The plan will pay for the following services: • For all women: Pap tests and pelvic exams once every 24 months • For women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • For women who have had an abnormal Pap test within the last 3 years and are of childbearing age: one Pap test every 12 months	$0
	Chiropractic services The plan will pay for the following services: • Adjustments of the spine to correct alignment • Diagnostic x-rays Prior authorization may be required.	$0

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

General Services that our plan pays for		What you must pay
	Colorectal cancer screening For people 50 and older, the plan will pay for the following services: • Flexible sigmoidoscopy (or screening barium enema) every 48 months • Fecal occult blood test, every 12 months • Guaiac-based fecal occult blood test or fecal immunochemical test, every 12 months • DNA based colorectal screening, every 3 years For people at high risk of colorectal cancer, the plan will pay for one screening colonoscopy (or screening barium enema) every 24 months. For people not at high risk of colorectal cancer, the plan will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy).	$0

	General Services that our plan pays for	What you must pay
	Community Transition Services The plan will pay for one-time expenses for you to transition from a nursing home to another residence where you are responsible for your own living arrangement. Covered services may include: • housing or security deposits • utility hook-ups and deposits (excludes television and internet) • furniture (limited) • appliances (limited) • moving expenses (excludes diversion or recreational devices) • cleaning including pest eradication, allergen control, and over-all cleaning This service does not include ongoing monthly rental or mortgage expense, regular utility charges, or items that are intended for purely diversional or recreational purposes. Coverage is limited to once per year. Prior authorization is required.	$0
	Counseling to stop smoking or tobacco use If you use tobacco but do not have signs or symptoms of tobacco-related disease: • The plan will pay for two counseling quit attempts in a 12 month period as a preventive service. This service is free for you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: • The plan will pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. The plan covers up to 42 additional smoking cessation counseling sessions over Medicare.	$0

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

General Services that our plan pays for		What you must pay
	Dental services Aetna Better Health Premier Plan will pay for the following services: Preventive dental services • Examinations and evaluations are covered once every six months • Cleaning is a covered benefit once every six months • Silver diamine fluoride treatment is covered with a maximum of six applications per lifetime • X-rays ◦ Bitewing x-rays are a covered benefit only once in a 12-month period ◦ A panoramic x-ray is a covered benefit once every five years ◦ A full mouth or complete series of x-rays is a covered benefit once every five years • Fillings • Tooth extractions • Complete or partial dentures are covered once every five years • Sealants are covered once every three years, if criteria are met • Indirect restorations (crowns) are covered once every 5 years per tooth, if criteria are met • Root canal therapy/re-treatment of previous root canal • Comprehensive periodontal evaluation • Scaling in presence of inflammation • Periodontal scaling and root planning • Other periodontal maintenance The Plan covers one dental planing and scaling treatment per year with referral by physician and/or dental provider. Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Depression screening The plan will pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals, which include referrals to your primary care provider or the Prepaid Inpatient Health Plan (PIHP) for further assessment and services.	$0
	Diabetes screening The plan will pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • High blood pressure (hypertension) • History of abnormal cholesterol and triglyceride levels (dyslipidemia) • Obesity • History of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.	$0

General Services that our plan pays for		What you must pay
	Diabetic self-management training, services, and supplies The plan will pay for the following services for all people who have diabetes (whether they use insulin or not): • Supplies to monitor your blood glucose, including the following: ◦ A blood glucose monitor ◦ Blood glucose test strips ◦ Lancet devices and lancets ◦ Glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease, the plan will pay for the following: ◦ One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, **or** ◦ One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) The plan will also pay for fitting the therapeutic custom-molded shoes or depth shoes. • The plan will pay for training to help you manage your diabetes, in some cases. The plan exclusively covers blood glucose monitors and diabetic test strips manufactured by OneTouch / LifeScan, such as OneTouch Verio® or OneTouch Ultra® systems, test strips and supplies. Prior authorization is required for more than one blood glucose monitor per year and more than 100 test strips per 30 days. ◦ Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Doula services The plan will pay for different types of doula services, including community-based doulas, prenatal doulas, labor and birth doulas, and postpartum doulas. The plan will pay for six total visits during the prenatal and postpartum periods and one visit for attendance at labor and delivery. Additional visits may be requested. Doula support during the perinatal period may include, but is not limited to: • Prenatal services • Labor and delivery services • Postpartum services **A recommendation for doula services must come from any licensed healthcare provider.** Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (For a definition of "Durable medical equipment (DME)," refer to Chapter 12 as well as Chapter 3, Section M of this handbook.) The following items are covered: • Wheelchairs • Crutches • Powered mattress systems • Diabetic supplies • Hospital beds ordered by a provider for use in the home • Intravenous (IV) infusion pumps • Speech generating devices • Oxygen equipment and supplies • Nebulizers • Walkers **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (continued) The following items are also covered: • Breast Pumps • Canes • Commodes • CPAP Device • Enteral Nutrition • Home Uterine Activity Monitor • Incontinence Supplies • Insulin Pump and Supplies • Lifts, Slings and Seats • Lymphedema Pump • Negative Pressure Wound Therapy • Orthopedic Footwear • Orthotics • Osteogenesis Stimulator • Ostomy Supplies • Parenteral Nutrition • Peak Flow Meter • Pressure Gradient Products • Pressure Reducing Support Surfaces • Prosthetics • Pulse Oximeter • Surgical Dressings • Tracheostomy Care Supplies • Transcutaneous Electrical Nerve Stimulator • Ventilators • Wearable Cardioverter-Defibrillators **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Durable medical equipment (DME) and related supplies (continued) Other items may be covered. Some DME is provided based on Michigan Medicaid policy. Requirements for referral, physician order, and assessment apply along with limitations on replacement and repair. Other items may be covered, including environmental aids or assistive/adaptive technology. Aetna Better Health Premier Plan may also cover you learning how to use, modify, or repair your item. Your Integrated Care Team will work with you to decide if these other items and services are right for you and will be in your Plan of Care. Some items may also be covered through the Prepaid Inpatient Health Plan (PIHP) based on eligibility criteria. These items should be paid for by either our plan or the PIHP, not by both. We will pay for all medically necessary DME that Medicare and Michigan Medicaid usually pay for. If our supplier in your area does not carry a particular brand or maker, you may ask them if they can special-order it for you. Prior authorization is required.	$0

General Services that our plan pays for		What you must pay
	Emergency 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: • serious risk to your health or to that of your unborn child; **or** • serious harm to bodily functions; **or** • serious dysfunction of any bodily organ or part; **or** • in the case of a pregnant woman in active labor, when: ◦ there is not enough time to safely transfer you to another hospital before delivery. ◦ a transfer to another hospital may pose a threat to your health or safety or that of your unborn child. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you may need to return to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if the plan approves your stay. Emergencies are only covered within the United States and its territories.	$0

General Services that our plan pays for		What you must pay
	Family planning services The law lets you choose any provider to get certain family planning services from. This means any doctor, clinic, hospital, pharmacy or family planning office. The plan will pay for the following services: • Family planning exam and medical treatment • Family planning lab and diagnostic tests • Family planning methods (birth control pills, patch, ring, IUD, injections, implants) • Counseling and diagnosis of infertility, and related services • Counseling and testing for sexually transmitted infections (STIs), HIV/AIDS, and other HIV-related conditions • Treatment for sexually transmitted infections (STIs) • Voluntary sterilization (You must be age 21 or older, and you must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.) • Genetic counseling The plan will also pay for some other family planning services. However, you must use a provider in the plan's network for the following services: • Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • Treatment for AIDS and other HIV-related conditions • Genetic testing Prior authorization may be required for genetic counseling and testing.	$0

General Services that our plan pays for		What you must pay
	Fitness Aetna Better Health Premier Plan offers SilverSneakers® membership to members at no additional cost. SilverSneakers is the nation's leading community fitness program specifically designed for older adults. It promotes greater health engagement and accountability by providing members with regular exercise (strength training, aerobics, flexibility) and social opportunities. Benefit includes • Access to thousands of participating fitness locations • Use of basic amenities (weights, treadmills, pools, etc.) • Fitness classes • Group activities and classes outside the traditional gym setting (Community FLEX classes) • One Home kit or Steps kit available each calendar year Online resources include • Member portal • Live classes • On-demand classes • SilverSneakers app with reminders to move and more SilverSneakers is a registered trademark of Tivity Health, Inc. © 2022 Tivity Health, Inc. All rights reserved.	$0
	Health and wellness education programs The plan offers a wide array of health and nutrition education tools and programs available to members at no additional cost, including educational member materials, use of educational tools and support systems.	$0

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

General Services that our plan pays for		What you must pay
	Hearing services The plan pays for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. For adults aged 21 and older, the plan pays for evaluation and fitting for a hearing aid twice per year and pays for a hearing aid once every five years. Referral and authorization are required. Prior authorization may be required.	$0
	Help with certain chronic conditions For members who qualify under Special Supplemental Benefits for the Chronically Ill, the plan offers a flex card with a $150 allowance every three months to help with utilities and healthy foods If you have the below chronic condition(s) and meet certain medical criteria, you may be eligible for this additional benefit: **How to be eligible** In order to be eligible for this benefit you must have: ◦ 1 qualifying chronic condition and 1 inpatient hospital stay within the last 12 months; OR ◦ 1 qualifying chronic condition and 1 emergency room visit within the last 12 months; OR ◦ 2 qualifying chronic conditions listed below Your eligibility is only determined through submitted medical claims. You cannot self-attest. You can only qualify for this benefit through medical claims that your provider submits. AND the claims must have a diagnosis that support the qualifying conditions. **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Help with certain chronic conditions (continued) If you have one of the conditions listed below, you may be eligible for additional benefits under our plan: • Autoimmune disorders limited to: ◦ Polyarteritis nodosa ◦ Polymyalgia rheumatica ◦ Polymyositis ◦ Rheumatoid arthritis ◦ Systemic lupus erythematosus • Cancer • Cardiovascular disorders limited to: ◦ Cardiac arrhythmias ◦ Coronary artery disease ◦ Peripheral vascular disease ◦ Chronic venous thromboembolic disorder • Chronic alcohol and other drug dependence • Chronic and disabling mental health conditions limited to: ◦ Bipolar disorders ◦ Major depressive disorders ◦ Paranoid disorder ◦ Schizophrenia ◦ Schizoaffective disorder **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Help with certain chronic conditions (continued) • Chronic heart failure • Chronic lung disorders limited to: ◦ Asthma ◦ Chronic bronchitis ◦ Chronic obstructive pulmonary disease (COPD) ◦ Emphysema ◦ Pulmonary fibrosis ◦ Pulmonary hypertension • Dementia • Diabetes • End-stage liver disease • End-stage renal disease (ESRD) requiring dialysis; • HIV/AIDS • Hyperlipidemia • Hypertension • Neurologic disorders limited to: ◦ Amyotrophic lateral sclerosis (ALS) ◦ Epilepsy ◦ Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia) ◦ Huntington's disease ◦ Multiple sclerosis (MS) ◦ Parkinson's disease ◦ Polyneuropathy ◦ Spinal stenosis ◦ Stroke related neurologic deficit **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Help with certain chronic conditions (continued) • Severe hematologic disorders limited to: ◦ Aplastic anemia ◦ Hemophilia ◦ Immune thrombocytopenic purpura ◦ Myelodysplastic syndrome ◦ Sickle cell disease (excluding sickle cell trait) ◦ Chronic venous thromboembolic disorder • Stroke The benefits mentioned are a part of special supplemental program for the chronically ill. Not all members qualify.	$0
	HIV screening The plan pays for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, the plan pays for up to three HIV screening tests during a pregnancy.	$0

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General Services that our plan pays for		What you must pay
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. The plan will pay for the following services, and maybe other services not listed here: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Home health aide when provided with a nursing service Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Home infusion therapy The plan will pay for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • The drug or biological substance, such as an antiviral or immune globulin; • Equipment, such as a pump; **and** • Supplies, such as tubing or a catheter. The plan will cover home infusion services that include but are not limited to: • Professional services, including nursing services, provided in accordance with your care plan; • Member training and education not already included in the DME benefit; • Remote monitoring; **and** • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find a hospice program certified by Medicare. Your hospice doctor can be a network provider or an out-of-network provider. The plan will pay for the following while you are getting hospice services: • Drugs to treat symptoms and pain • Short-term respite care • Home care **Hospice services and services covered by Medicare Part A or B are billed to Medicare.** • Refer to Section E of this chapter for more information. **For services covered by Aetna Better Health Premier Plan but not covered by Medicare Part A or B:** • Aetna Better Health Premier Plan 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 prognosis. You pay nothing for these services. **For drugs that may be covered by Aetna Better Health Premier Plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. **Note:** If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Call your Care Coordinator at **1-855-676-5772 (TTY: 711)**, 8 a.m. to 5 p.m., Monday – Friday. Prior authorization is required.	$0

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General Services that our plan pays for		What you must pay
	Immunizations The plan will pay for the following services: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B or Michigan Medicaid coverage rules The plan will pay for other vaccines that meet the Medicare Part D coverage rules. Read Chapter 6 to learn more. Prior authorization may be required.	$0
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) The plan will pay for the following services, and maybe other services not listed here: • Semi-private room (or a private room if it is medically necessary) • Meals, including special diets • Regular nursing services • Costs of special care units, such as intensive care or coronary care units • Drugs and medications • Lab tests • X-rays and other radiology services • Needed surgical and medical supplies **This benefit is continued on the next page**	$0 You must get approval from the plan to keep getting inpatient care at an out-of-network hospital after your emergency is under control.

General Services that our plan pays for		What you must pay
	Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) (continued) • Appliances, such as wheelchairs • Operating and recovery room services • Physical, occupational, and speech therapy • Inpatient substance use disorder services • Blood, including storage and administration ◦ The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. ◦ The plan will pay for all other parts of blood beginning with the first pint used. • Physician services • In some cases, the following types of transplants: corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If Aetna Better Health Premier Plan provides transplant services outside the pattern of care for your community and you choose to get your transplant there, we will arrange or pay for lodging and travel costs for you and one other person. Prior authorization is required.	
	Inpatient services in psychiatric hospital Contact the plan or your Care Coordinator to determine if the services will be provided through the plan or the Prepaid Inpatient Health Plan (PIHP). Refer to Section F in this chapter for more information. Prior authorization is required.	$0

General Services that our plan pays for		What you must pay
	Kidney disease services and supplies The plan will pay for the following services: • Kidney disease education services to teach kidney care and help members make good decisions about their care. You must have stage IV chronic kidney disease, and your doctor must refer you. The plan will cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible. • 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 Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, please refer to "Medicare Part B prescription drugs" in this chart. Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Lung cancer screening The plan will pay for lung cancer screening every 12 months if you: • Are aged 50-77, **and** • Have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • Have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer *or* smoke now or have quit within the last 15 years. After the first screening, the plan will pay for another screening each year with a written order from your doctor or other qualified provider.	$0
	Meal benefit The plan will pay for 20 home-delivered meals after inpatient hospitalization. Prior authorization is required.	$0
	Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. The plan will pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. (This includes our plan, any other Medicare Advantage plan, or Medicare.) We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if your treatment is needed in the next calendar year. Prior authorization is required.	$0

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General Services that our plan pays for		What you must pay
	Medicare Diabetes Prevention Program (MDPP) The plan will pay for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle. Prior authorization is required.	$0

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General Services that our plan pays for		What you must pay
	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Aetna Better Health Premier Plan will pay for the following drugs: • Drugs you don't usually give yourself and are injected or infused while you are getting doctor, hospital outpatient, or ambulatory surgery center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Osteoporosis drugs that are injected. These drugs are paid for if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically necessary), topical anesthetics, and erythropoiesis-stimulating agents (such as Procrit® or Aranesp®) • IV immune globulin for the home treatment of primary immune deficiency diseases The following link will take you to a list of Part B drugs that may be subject to step therapy: **AetnaBetterHealth.com/Michigan/formulary**. We also cover some vaccines under our Medicare Part B and Part D prescription drug benefit. 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.	$0

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General Services that our plan pays for		What you must pay
	Non-emergency medical transportation The plan will cover transportation for you to travel to or from your medical appointments and the pharmacy if it is a covered service. Types of non-emergency transportation include: • Wheelchair equipped van • Service car • Taxicab Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Nursing facility care The plan will pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically needed • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's 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 or significant other lives at the time you qualify for nursing facility care • The nursing home where you were living when you enrolled in Aetna Better Health Premier Plan This service is intended to be long term custodial care and does not overlap with skilled nursing facility care. You must meet Michigan Medicaid Nursing Facility Level of Care standards to get this service. Prior authorization is required.	When your income exceeds an allowable amount, you must contribute toward the cost of your nursing facility care. This contribution, known as the Patient Pay Amount (PPA), is required if you live in a nursing facility. However, you might not end up having to pay each month. Patient pay responsibility does not apply to Medicare-covered days in a nursing facility.

General Services that our plan pays for		What you must pay
	Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, the plan will pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	$0
	Opioid treatment program (OTP) services The plan will pay for the following services to treat opioid use disorder (OUD): • Intake activities • Periodic assessments • Medications approved by the Food and Drug Administration (FDA) and, if applicable, managing and giving you these medications • Substance use counseling • Individual and group therapy • Testing for drugs or chemicals in your body (toxicology testing) Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Outpatient diagnostic tests and therapeutic services and supplies The plan will pay for the following services, and maybe other services not listed here: • X-rays • Radiation (radium and isotope) therapy, including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used for fractures and dislocations • Lab tests • Blood, beginning with the first pint of blood that you need, including storage and administration. • Other outpatient diagnostic tests Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Outpatient hospital services The plan pays for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. The plan will pay for the following services, and maybe other services not listed here: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services ◦ Observation services help your doctor know if you need to be admitted to the hospital as an "inpatient." ◦ Sometimes you can be in the hospital overnight and still be an "outpatient." ◦ You can get more information about being an inpatient or an outpatient in this fact sheet: www.medicare.gov/media/11101 • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Preventive screenings and services listed throughout the Benefits Chart • Some drugs that you can't give yourself Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Outpatient mental health care The plan will pay for mental health services provided by a state-licensed: • psychiatrist or doctor, • clinical psychologist, • clinical social worker, • clinical nurse specialist, • nurse practitioner, • physician assistant, **or** • any other Medicare or Michigan Medicaid-qualified mental health care professional as allowed under applicable state laws. Contact the plan or your Care Coordinator to determine if the services will be provided through the plan or the Prepaid Inpatient Health Plan (PIHP). The plan will pay for the following services, and maybe other services not listed here: • Clinic services • Day treatment • Psychosocial rehab services Prior authorization may be required.	$0
	Outpatient rehabilitation services The plan will pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	Outpatient substance use disorder services Contact the plan or your Care Coordinator to determine if the services will be provided through the plan or the Prepaid Inpatient Health Plan (PIHP). Refer to Section F in this chapter for more information. Prior authorization may be required.	$0
	Outpatient surgery The plan will pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. Prior authorization is required.	$0
	Over-the-counter supplies As an added benefit, the plan offers you $105 in certain over-the-counter (OTC) supplies every three months. Products must be purchased through the approved OTC catalog or in participating store locations. For more information, talk to your Care Coordinator or call Member Services.	$0
	Partial hospitalization services Contact the plan or your Care Coordinator to determine if the services will be provided through the plan or the Prepaid Inpatient Health Plan (PIHP). Refer to Section F in this chapter for more information. Prior authorization is required.	$0

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

General Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits The plan will pay for the following services: • Medically necessary health care or surgery services given in places such as: ◦ physician's office ◦ certified ambulatory surgical center ◦ hospital outpatient department • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams given by your primary care provider, if your doctor orders them to find out whether you need treatment • Telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke • Telehealth services for members with a substance use disorder or co-occurring mental health disorder • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ◦ You have an in-person visit within 6 months prior to your first telehealth visit ◦ You have an in-person visit every 12 months while receiving these telehealth services ◦ Exceptions can be made to the above for certain circumstances **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Physician/provider services, including doctor's office visits (continued) • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ◦ you're not a new patient **and** ◦ the check-in isn't related to an office visit in the past 7 days **and** ◦ the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: ◦ you're not a new patient **and** ◦ the evaluation isn't related to an office visit in the past 7 days **and** ◦ the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient **This benefit is continued on the next page**	$0

	General Services that our plan pays for	What you must pay
	Physician/provider services, including doctor's office visits (continued) • Second opinion by another network provider before surgery • 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.	$0
	Podiatry services The plan will pay for the following services: • Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • Routine foot care for members with conditions affecting the legs, such as diabetes The plan also covers 3 preventive, routine foot care visits per year. Prior authorization may be required.	$0
	Prostate cancer screening exams For men age 50 and older, the plan will pay for the following services once every 12 months: • A digital rectal exam • A prostate specific antigen (PSA) test	$0

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

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

General Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care The plan will pay for the following services, and maybe other services not listed here: • A semi-private room, or a private room if it is medically necessary • Meals, including special diets • Nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • Blood, including storage and administration: ◦ The plan will pay for whole blood and packed red cells beginning with the first pint of blood you need. ◦ The plan will pay for all other parts of blood beginning with the first pint used. • Medical and surgical supplies given by nursing facilities • Lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • Appliances, such as wheelchairs, usually given by nursing facilities • Physician/provider services **This benefit is continued on the next page**	$0

General Services that our plan pays for		What you must pay
	Skilled nursing facility (SNF) care (continued) A hospital stay is not required to get SNF care. You will usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • A nursing home or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • A nursing facility where your spouse or domestic partner lives at the time you leave the hospital Prior authorization is required.	
	Stipend for maintenance costs of a service animal The plan will pay up to $20 per month for maintenance costs of a service animal if: • You are receiving personal care services, **and** • You are certified as disabled due to a specific condition defined by the Americans with Disabilities Act, such as arthritis, blindness, cerebral palsy, polio, multiple sclerosis, deafness, stroke or spinal cord injury, **and** • The service animal is trained to meet your specific needs relative to your disability. Your service plan must document that the service animal will be used primarily to meet your personal care needs. Prior authorization is required.	

General Services that our plan pays for		What you must pay
	Supervised exercise therapy (SET) The plan will pay for SET for members with symptomatic peripheral artery disease (PAD). The plan will pay for: • Up to 36 sessions during a 12-week period if all SET requirements are met • An additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • In a hospital outpatient setting or in a physician's office • Delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • Under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques Prior authorization may be required.	$0
	Urgent care Urgent 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 urgent 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 (for example, when you are outside the plan's service area or during the weekend).	$0

General Services that our plan pays for		What you must pay
	Vision care Routine eye examinations are covered once every two years. The plan will pay for an initial pair of eye glasses. Replacement glasses are offered once every year. The plan will pay for contact lenses for people with certain conditions. The plan will pay for basic and essential low vision aids (such as telescopes, microscopes, and certain other low vision aids). The plan will pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration. For people at high risk of glaucoma, the plan will pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma, • people with diabetes, • African-Americans who are age 50 and older, **and** • Hispanic Americans who are 65 or older. The plan will pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. (If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.) Prior authorization may be required.	$0

General Services that our plan pays for		What you must pay
	"Welcome to Medicare" Preventive Visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it. **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
Adult Day Program The plan covers structured day activities at a program of direct care and supervision if you qualify. This service: • provides personal attention, **and** • promotes social, physical and emotional well-being Prior authorization is required.	$0
Assistive Technology The plan covers technology items used to increase, maintain, or improve functioning and promote independence if you qualify. Some examples of services include: • van lifts • hand controls • computerized voice system • communication boards • voice activated door locks • power door mechanisms • specialized alarm or intercom • assistive dialing device Prior authorization is required.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
Chore Services The plan covers services needed to maintain your home in a clean, sanitary, and safe environment if you qualify. Examples of services include: • heavy household chores (washing floors, windows, and walls) • tacking loose rugs and tiles • moving heavy items of furniture • mowing, raking, and cleaning hazardous debris such as fallen branches and trees The plan may cover materials and disposable supplies used to complete chore tasks. Prior authorization is required.	$0
Environmental Modifications The plan covers modifications to your home if you qualify. The modifications must be designed to ensure your health, safety and welfare or make you more independent in your home. Modifications may include: • installing ramps and grab bars • widening of doorways • modifying bathroom facilities • installing specialized electric systems that are necessary to accommodate medical equipment and supplies Prior authorization is required.	$0

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
Expanded Community Living Supports To get this service, you **must** have a need for prompting, cueing, observing, guiding, teaching, and/or reminding to help you complete activities of daily living (ADLs) like eating, bathing, dressing, toileting, other personal hygiene, etc. If you have a need for this service, you can also get assistance with instrumental activities of daily living (IADLs) like laundry, meal preparation, transportation, help with finances, help with medication, shopping, go with you to medical appointments, other household tasks. This may also include prompting, cueing, guiding, teaching, observing, reminding, and/or other support to complete IADLs yourself. Prior authorization is required.	$0
Fiscal Intermediary Services The plan will pay for a fiscal intermediary (FI) to assist you to live independently in the community while you control your individual budget and choose the staff to work with you. The FI helps you to manage and distribute funds contained in the individual budget. You use these funds to purchase home and community-based services authorized in your plan of care. You have the authority to hire the caregiver of your choice. Prior authorization is required.	$0
Home delivered meals The plan covers up to two prepared meals per day brought to your home if you qualify. Prior authorization is required.	$0
Non-medical Transportation The plan covers transportation services to enable you to access waiver and other community services, activities, and resources, if you qualify. Prior authorization is required.	$0

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

Home and Community-Based Services (HCBS) Waiver that our plan pays for	What you must pay
Preventive Nursing Services The plan covers nursing services provided by a registered nurse (RN) or licensed practical nurse (LPN). You must require observation and evaluation of skin integrity, blood sugar levels, prescribed range of motion exercises, or physical status to qualify. You may get other nursing services during the nurse visit to your home. These services are not provided on a continuous basis. Prior authorization is required.	$0
Private Duty Nursing (PDN) The plan covers skilled nursing services on an individual and continuous basis, up to a maximum of 16 hours per day, to meet your health needs directly related to a physical disability. PDN includes the provision of nursing assessment, treatment and observation provided by licensed nurse, consistent with physician's orders and in accordance with your plan of care. You must meet certain medical criteria to qualify for this service. Prior authorization is required.	$0
Respite Care Services You may get respite care services on a short-term, intermittent basis to relieve your family or other primary caregiver(s) from daily stress and care demands during times when they are providing unpaid care. Relief needs of hourly or shift staff workers should be accommodated by staffing substitutions, plan adjustments, or location changes and not by respite care. Respite is not intended to be provided on a continuous, long-term basis where it is a part of daily services that would enable an unpaid caregiver to work elsewhere full time. Prior authorization is required.	$0

E. Benefits covered outside of Aetna Better Health Premier Plan

The following services are not covered by Aetna Better Health Premier Plan but are available through Medicare or Michigan Medicaid.

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in Section D of this chapter for more information about what Aetna Better Health Premier Plan pays for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or B that relate to your terminal prognosis:

- The hospice provider will bill Medicare for your services. Medicare will pay for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or B that are not related to your terminal prognosis:

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or B. You pay nothing for these services.

For drugs that may be covered by Aetna Better Health Premier Plan's Medicare Part D benefit:

- Drugs are never covered by both hospice and our plan at the same time. For more information, please refer to Chapter 5. You pay nothing for these drugs.

For services covered by Michigan Medicaid:

- The provider will bill Aetna Better Health Premier Plan for your services. Aetna Better Health Premier Plan will pay for the services covered by Michigan Medicaid. You pay nothing for these services.

Note: If you need non-hospice care, you should call your Care Coordinator to arrange the services. Non-hospice care is care that is not related to your terminal prognosis. Contact your Care Coordinator at **1-855-676-5772 (TTY: 711)**, 8 a.m. to 5 p.m., Monday – Friday.

E2. Services covered by the plan or Prepaid Inpatient Health Plan (PIHP)

The following services are covered by Aetna Better Health Premier Plan.

Inpatient behavioral health care

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

Outpatient substance use disorder services

- We will pay for treatment services that are provided in the outpatient department of a hospital if you, for example, have been discharged from an inpatient stay for the treatment of drug substance abuse or if you require treatment but do not require the level of services provided in the inpatient hospital setting. Refer to coverage for Opioid treatment program (OTP) services in The Benefits Chart in Section D.

Partial hospitalization services

- Partial hospitalization is a structured program of active psychiatric treatment. It is offered as hospital outpatient service 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.

If you are receiving services through the PIHP, please refer to the separate PIHP *Member Handbook* for more information and work with your Care Coordinator to get services provided through the PIHP.

F. Benefits not covered by Aetna Better Health Premier Plan, Medicare, or Michigan Medicaid

This section tells you what kinds of benefits are excluded by the plan. Excluded means that the plan does not pay for these benefits. Medicare and Michigan Medicaid will not pay for them either.

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

The plan will not pay for the excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under the specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that we should pay for a service that is not covered, you can file an appeal. For information about filing an appeal, refer to Chapter 9.

In addition to any exclusions or limitations described in the Benefits Chart, **the following items and services are not covered by our plan, Medicare, or Michigan Medicaid**:

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

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

- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy and LASIK surgery. However, the plan will pay for glasses after cataract surgery.
- Reversal of sterilization procedures and non-prescription contraceptive supplies.
- Naturopath services (the use of natural or alternative treatments).
- Non-emergency services provided to veterans in Veterans Affairs (VA) facilities.

Chapter 5: Getting your outpatient prescription drugs through the plan

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and Michigan Medicaid. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

- Drugs covered by Medicare Part A. These include some drugs given to you while you are in a hospital or nursing facility.
- Drugs covered by Medicare Part B. These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to 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, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care.
2. Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
3. You generally must use a network pharmacy to fill your prescription.
4. 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.
    - Refer to Chapter 9 to learn about asking for an exception.
5. 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 medical references. Medicaid-covered drugs must also be used for medically accepted indications meaning approved by the Food and Drug Administration or supported by certain medical references.

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

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

A. Getting your prescriptions filled

A1. Filling 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 use any of our network pharmacies.

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

A2. Using your Member ID Card when you fill a prescription

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

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

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

- To learn how to ask us to pay you back, refer to Chapter 7.
- If you need help getting a prescription filled, you can contact your Care Coordinator or Member Services.

A3. What to do if you change to a different network pharmacy

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

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

A4. What to do if your pharmacy leaves the network

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

For up-to-date information about Aetna Better Health Premier Plan network pharmacies in your area, you can look in the *Provider and Pharmacy Directory*, visit our website, or call Member Services. Your Care Coordinator can also help you find a new pharmacy.

A5. Using 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. If you are a resident of a long-term care facility, we must make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have any difficulty accessing your drug benefits in a long-term care facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

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

A6. Using mail-order services to get your drugs

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

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

How do I fill my prescriptions by mail?

To get order forms and information about filling your prescriptions by mail, go to our website at **AetnaBetterHealth.com/Michigan**. You can also talk to your Care Coordinator or call Member Services at **1-855-676-5772**.

Usually, a mail-order prescription will get to you within 10 – 15 days. In the unlikely event there is a significant delay in your order, our mail order service will work with you and a network pharmacy to provide a temporary supply of your mail-order prescription drug.

Mail-order processes

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 gets from you**

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

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

   The pharmacy will automatically fill and deliver new prescriptions it gets from health care providers, without checking with you first, if either:

   - You used mail-order services with this plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by calling CVS Caremark Customer Care at 1-844-843-6264 (TTY: 1-800-231-4403).

   If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact CVS Caremark Customer Care at 1-844-843-6264 (TTY: 1-800-231-4403) and let them know how you would like to receive your mail order prescriptions or register online with CVS Caremark at Caremark.com. You can change your mail order preference at any time.

   If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel 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.

To opt out of automatic deliveries of new prescriptions you got directly from your health care provider's office, please contact CVS Caremark Customer Care at 1-844-843-6264 (hearing impaired only, TTY 1-800-231-4403). You can also change your preferences by registering online with CVS Caremark at Caremark.com.

3. Refills on mail-order prescriptions

For refills, please contact your pharmacy 15 days before your current prescription will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. Contact CVS Caremark Customer Care at 1-844-843-6264 (TTY: 1-800-231-4403) to tell them the best way to reach you. You can also register online with CVS Caremark at Caremark.com to specify how you would like to be contacted. 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.

A7. Getting a long-term supply of drugs

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

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

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

A8. Using 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:

- The prescription is for a medical emergency or urgent care.
- You are unable to get a covered drug in a time of need because there are no 24-hour network pharmacies within a reasonable driving distance.
- The prescription is for a drug that is out-of-stock at an accessible network retail or mail service pharmacy (including high-cost and unique drugs).
- If you are evacuated or otherwise displaced from your home because of a Federal disaster or other public health emergency declaration.

A vaccine or drug administered in your doctor's office. Note: Out-of-network supply is limited to 29 days-supply. Paper claims should be submitted for reimbursement.

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

A9. Paying you back if you pay for a prescription

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

To learn more about this, refer to 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.

B1. Drugs on the Drug List

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

The Drug List includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the Drug List, when we refer to "drugs," this could mean a drug or a biological product such as vaccines or insulin.

Generic drugs have the same active ingredients as brand name drugs. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as brand name drugs or biological products and usually cost less. There are generic drug substitutes or biosimilar alternatives available for many brand name drugs and some biological products.

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

B2. How to find a drug 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 **AetnaBetterHealth.com/Michigan**. The Drug List on the website is always the most current one.
- Call Member Services to find out if a drug is on the plan's Drug List or to ask for a copy of the list.

B3. Drugs that are 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 Premier Plan will not pay for the drugs listed in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you must pay for it yourself. If you think we should pay for an excluded drug because of your case, you can file an appeal. (To learn how to file an appeal, refer to Chapter 9.)

Here are three general rules for excluded drugs:

1. Our plan's outpatient drug coverage (which includes Part D and Michigan Medicaid drugs) cannot pay for a drug that would already be covered under Medicare Part A or Part B. Drugs covered under Medicare Part A or Part B are covered by Aetna Better Health Premier Plan for free, but they are not considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. The use of the drug must be either approved by the Food and Drug Administration or supported by certain medical references as a treatment for your condition. Your doctor might prescribe a certain drug to treat your condition, even though it was not approved to treat the condition. This is called off-label use. Our plan usually does not cover drugs when they are prescribed for off-label use.

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

- Drugs used to promote fertility
- Drugs used for 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 says that you have to have tests or services done only by them

B4. Drug List tiers

Every drug on the plan's Drug List is in one of three (3) tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or over-the-counter drugs).

- Tier 1: Part D prescription brand name and generic drugs
- Tier 2: Part D prescription brand name and generic drugs
- Tier 3: Non-Part D prescription and over-the-counter drugs

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

C. Limits on some drugs

Why do some drugs have limits?

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

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

To learn more about asking for exceptions, refer to 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 Premier Plan before you fill your prescription. If you don't get approval, Aetna Better Health Premier Plan may not cover the drug.

3. **Trying a different drug first**

   In general, the plan wants you to try lower-cost drugs (that often are as effective) before the plan covers drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, the plan may require you to try Drug A first.

   If Drug A does not work for you, the plan will then cover Drug B. This is called step therapy.

4. **Quantity limits**

   For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, the plan might limit how much of a drug you can get each time you fill your prescription.

Do any of these rules apply to your drugs?

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

D. Reasons 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.

D1. Getting a temporary supply

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

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

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

    For Medicare Part D Drugs:

    - You are new to the plan.
        - 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 days in an outpatient setting and 31 days in a long-term facility.
        - If your prescription is written for fewer days, we will allow multiple refills to provide up to a maximum of 30 days of medication in an outpatient setting and 31 days of medication in a long-term care facility. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your prescription drug in small 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 temporary supply.

- If you are a current member with a change in level of care:
    - We will cover a one-time temporary 31-day supply if you are discharged from a hospital or a long-term care facility to your home:
    - You need a drug that is not on our drug list, or
    - Your ability to get the drug is limited
    - We will cover a one-time temporary 31-day supply (see the note below for exceptions) if you are admitted to a long-term care facility and:
    - You need a drug that is not on our drug list, or
    - Your ability to get the drug is limited

Note: Certain dosage forms such as oral tablets or capsules are limited to 14-day fills with exceptions as required by Medicare Part D rules.

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

For Michigan Medicaid drugs:

- You are new to the plan.
    - We will cover a supply of your Michigan Medicaid drug for up to 90 calendar days after enrollment and will not terminate it at the end of the 90 calendar days without advance notice to you and a transition to another drug, if needed.
    - To ask for a temporary supply of a drug, call Member Services.

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

- You can change to another drug.

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

  OR

- You can ask for an exception.

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

If a drug you are taking will be taken off the Drug List or limited in some way for next year, we will allow you to ask for an exception before next year.

- We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year.
- We will answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to Chapter 9.

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

E. Changes in coverage for your drugs

Most changes in drug coverage happen on January 1, but Aetna Better Health Premier Plan may add or remove drugs on the Drug List during the year. We may also change our rules about drugs. For example, we could:

- Decide to require or not require prior approval (PA) for a drug. (PA is permission from Aetna Better Health Premier Plan before you can get a drug.)
- Add or change the amount of a drug you can get (called quantity limits).
- Add or change step therapy restrictions on a drug. (Step therapy means you must try one drug before we will cover another drug.)

For more information on these drug rules, refer to Section C earlier in this chapter.

If you are taking a drug that was covered at the **beginning** of the year, we will generally not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on the Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when the Drug List changes, you can always:

- Check Aetna Better Health Premier Plan's up to date Drug List online at **AetnaBetterHealth.com/Michigan or**
- Call Member Services to check the current Drug List at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

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

Some changes to the Drug List will happen **immediately**. For example:

- **A new generic drug becomes available**. Sometimes, a new generic drug comes on the market that works as well as a brand name drug on the Drug List now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we will send you information about the specific change we made once it happens.
  - You or your provider can ask for an "exception" from these changes. We will send you a notice with the steps you can take to ask for an exception. Please refer to Chapter 9 of this handbook for more information on exceptions.

- **A drug is taken off the market**. If the Food and Drug Administration (FDA) says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we will take it off the Drug List. If you are taking the drug, we will let you know. Your prescriber will also know about this change, and can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We will tell you in advance about these other changes to the Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we will:

- Tell you at least 30 days before we make the change to the Drug List **or**
- Let you know and give you a 30-day supply of the drug in an outpatient setting and a 31-day supply of the drug in a long-term care facility after you ask for a refill.

This will give you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on the Drug List you can take instead **or**
- Whether to ask for an exception from these changes. To learn more about asking for exceptions, refer to Chapter 9.

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

We may make changes that do not affect the drugs you take now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change will not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. 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.

F2. 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.

F3. If you are in a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- If you are enrolled in a Medicare hospice and require a pain medication, anti-nausea, laxative, or antianxiety drug not covered by your hospice because it is unrelated to your terminal prognosis and related conditions, our plan must get 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 getting 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 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. Refer to 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, refer to Chapter 4.

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

G. Programs on drug safety and managing drugs

G1. Programs to help members use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- May not be needed because you are taking another drug that does the same thing
- May not be safe for your age or gender
- Could harm you if you take them at the same time
- Have ingredients that you are or may be allergic to
- Have unsafe amounts of opioid pain medications

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

G2. Programs to help members manage their drugs

If you take medications for different medical conditions and/or you are in a Drug Management Program to help you use your opioid medications safely, 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. In addition, you'll get information about safe disposal of prescription medications that are controlled substances.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

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

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

G3. Drug management program to help members safely use their opioid medications

Aetna Better Health Premier Plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications **from a certain pharmacy** and/or **from a certain doctor**
- **Limiting the amount** of those medications we will cover for you

If we think that one or more limitations should apply to you, we will send you a letter in advance. The letter will explain the limitations we think should apply.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we will send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can file an appeal. If you file an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we will automatically send your case to an Independent Review Entity (IRE). (To learn how to file an appeal and to find out more about the IRE, refer to Chapter 9.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

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

Introduction

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

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

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

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Other key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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 three (3) tiers each drug is in
    - Whether there are any limits on the drugs
  - If you need a copy of the Drug List, call Member Services. You can also find the Drug List on our website at **AetnaBetterHealth.com/Michigan**. 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.

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A. The *Explanation of Benefits* (EOB)

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

When you get prescription drugs through the plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB has more information about the drugs you take. The EOB includes:

- **Information for the month.** The summary tells what prescription drugs you got for the previous month. It shows the total drug costs and what the plan paid, and what others paying for you paid.
- **"Year-to-date" information.** This is your total drug costs and the total payments made for you since January 1.
- **Drug price information.** This is the total price of the drug and the percentage change in the drug price since the first fill.
- **Lower cost alternatives.** When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs will not count towards your Part D total out-of-pocket costs.
- To find out which drugs our plan covers, refer to the Drug List.

B. How to keep track of your drug costs

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

1. **Use your Member ID Card.**

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

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

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

3. Check the EOBs we send you.

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

C. A summary of your drug coverage

As an Aetna Better Health Premier Plan member, you pay nothing for covered prescription and over-the-counter (OTC) drugs as long as you follow Aetna Better Health Premier Plan's rules.

C1. The plan's tiers

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

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

C2. Getting a long-term supply of a drug

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

For details on where and how to get a long-term supply of a drug, refer to Chapter 5 or the *Provider and Pharmacy Directory*.

C3. Drug coverage summary

Your coverage for a one-month or long-term supply of a covered prescription drug

	A network pharmacy A one-month or up to a 90-day supply	**The plan's mail-order service** A one-month or up to a 90-day supply	**A network long-term care pharmacy** Up to a 31-day supply	**An out-of-network pharmacy** Up to a 29-day supply. Coverage is limited to certain cases. Refer to Chapter 5 for details.
Tier 1 (Part D prescription brand name and generic drugs)	$0	$0	$0	$0
Tier 2 (Part D prescription brand name and generic drugs)	$0	$0	$0	$0
Tier 3 (Non-Part D prescription and over-the-counter drugs)	$0	Mail-order is not available for drugs in Tier 3.	$0	$0

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

D. Vaccinations

Important Message About What You Pay for Vaccines — Our plan covers most Medicare Part D vaccines at no cost to you. 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 vaccine**. For example, sometimes you may get the vaccine as a shot given to you by your doctor.

D1. What you need to know before you get a vaccination

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

- We can tell you about how your vaccination is covered by our plan.
- 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 Premier Plan to ensure that you do not have any upfront costs for a Part D vaccine
- As an Aetna Better Health Premier Plan member, you pay nothing for covered vaccinations.

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

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Asking 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 the services and drugs you already got. A network provider is a provider who works with the health plan.

If you get a bill for health care or drugs, send the bill to us. To send us a bill, refer to page 141.

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

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

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

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

   You should ask the provider to bill the plan.

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

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

   Network providers must always bill the plan. Show your Aetna Better Health Premier Plan Member ID Card when you get any services or prescriptions. Improper/inappropriate billing occurs when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. **Call Member Services if you get any bills you do not understand.**

   - Because Aetna Better Health Premier Plan pays the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.

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

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

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

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

4. When you pay the full cost for a prescription because you do not have your Member ID Card with you

If you do not have your Member ID Card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

- If the pharmacy cannot get the information they need right away, you may have to pay the full cost of the prescription yourself.
- Send us a copy of your receipt when you ask us to pay you back.

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

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

- The drug may not be on the plan's *List of Covered Drugs* (Drug List), or it could have a requirement or restriction that you did not know about or do not think should apply to you. If you decide to get the drug, you may need to pay the full cost for it.
    - If you do not pay for the drug but think it should be covered, you can ask for a coverage decision (refer to Chapter 9).
    - If you and your doctor or other prescriber think you need the drug right away, you can ask for a fast coverage decision (refer to Chapter 9).

- Send us a copy of your receipt when you ask us to pay you back. In some situations, we may need to get more information from your doctor or other prescriber in order to pay you back for the drug.

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

To learn how to make an appeal, refer to Chapter 9.

B. Sending a request for payment

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

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

Aetna Better Health Premier Plan
Aetna Duals COE Member Correspondence
PO Box 982980
El Paso, TX 79998-2980

You must submit your claim to us within 12 months of the date you got the service, item, or drug.

Prescription Drugs

Send us your request for payment, along with your bill and documentation of any payment you have made. It is a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You do not have to use the form, but it will help us process the information faster.

Either download a copy of the form from the member forms section of our website at **AetnaBetterHealth.com/Michigan** or call Member Services and ask for the form.

For Part D prescription drug claims: Mail your request for payment together with any bills or paid receipts to us at this address:

Medicare Part D Paper Claim
PO Box 52066
Phoenix, AZ 85072-2066

You must submit your pharmacy claim to us within three (3) years of the date you received the pharmacy service, item, or drug.

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

C. Coverage decisions

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

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

Chapter 3 explains the rules for getting your services covered. Chapter 5 explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter explaining why not. The letter will also explain your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9.

D. Appeals

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

The appeals process is a formal process with detailed procedures and important deadlines. To learn more about appeals, refer to Chapter 9.

- If you want to make an appeal about getting paid back for a health care service, refer to page 183.
- If you want to make an appeal about getting paid back for a drug, refer to page 185.

Chapter 8: Your rights and responsibilities

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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

A. Your right to get services and information in a way that meets your needs

You have the right to be treated with dignity and respect. You have the right to have a voice in the governance and operation of the integrated system, provider, and health plan. We must ensure that **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week or your Care Coordinator at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. Materials are available in Spanish.
- If you wish to make or change a standing request to receive materials in your preferred language other than English or in an alternate format, you can call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

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 may also file a complaint with Michigan Medicaid. Please refer to Chapter 9 for more information.
- Office of Civil Rights at 1-800-368-1019 or TTY 1-800-537-7697.

Usted tiene derecho a que lo traten con dignidad y respeto. Debemos garantizar que **todos** los servicios se brinden de forma culturalmente competente y accesible. También debemos informarle sobre los beneficios del plan y sus derechos de una manera que usted pueda comprender. Debemos informarle sobre sus derechos cada año que se encuentre en nuestro plan.

- Para obtener información de una manera que usted pueda comprender, llame al Departamento de Servicios para Miembros al **1-855-676-5772 (TTY: 711)**, durante las 24 horas, los 7 días de la semana, o a su coordinador de atención al **1-855-676-5772 (TTY: 711)**, durante las 24 horas, los 7 días de la semana. Nuestro plan cuenta con servicios de interpretación gratuitos disponibles para responder preguntas en distintos idiomas.
- Nuestro plan también puede brindarle materiales en otros idiomas además del inglés y en formatos como letra grande, braille o audio. Los materiales están disponibles en español.
- Si desea realizar o modificar una solicitud permanente para recibir los materiales en el idioma que prefiera o en otro formato, puede llamar al Departamento de Servicios para Miembros al **1-855-676-5772 (TTY: 711)**, durante las 24 horas, los 7 días de la semana.

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

Si tiene dificultad para obtener información de nuestro plan debido a problemas relacionados con el idioma o una discapacidad, y desea presentar un reclamo, llame a:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar durante las 24 horas, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.
- También puede presentar un reclamo ante Medicaid de Michigan. Para obtener más información, consulte el capítulo 9.
- Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

يحق لك أن تُعامَل بكرامة واحترام؛ يجب أن نتأكد من تقديم جميع الخدمات لك بطريقة مختصة ثقافيًا ويمكن الوصول إليها. يجب علينا إخبارك أيضًا بمزايا الخطة وبالحقوق الخاصة بك بالطريقة التي تفهمها. ويجب أن نخبرك عن حقوقك سنويًا طالما أنك مسجل في خطتنا.

- للحصول على معلومات بطريقة يمكنك فهمها، اتصل بخدمات الأعضاء على **1-855-676-5772 (TTY: 711)**، على مدار 24 ساعة في اليوم، 7 أيام في الأسبوع أو منسق الرعاية الخاص بك على **1-855-676-5772 (TTY: 711)**، على مدار 24 ساعة في اليوم، 7 أيام في الأسبوع. تحتوي خطتنا على خدمات ترجمة مجانية متاحة للإجابة على الأسئلة بلغات مختلفة.
- وتمنحك خطتنا المواد بلغات أخرى غير اللغة الإنجليزية وبتنسيقات أخرى مثل الطباعة بأحرف كبيرة أو طريقة برايل أو ملفات صوتية. تتوفر المواد باللغة الإسبانية.
- إذا كنت ترغب في تقديم أو تغيير طلب دائم لتلقي المواد بلغتك المفضلة غير الإنجليزية أو بتنسيق بديل، يمكنك الاتصال بخدمات الأعضاء على الرقم **1-855-676-5772 (TTY: 711)**، على مدار 24 ساعة في اليوم، 7 أيام في الأسبوع.

إذا كنت تواجه مشكلة في الحصول على معلومات من خطتنا بسبب مشكلات لغوية أو إعاقة وتريد تقديم شكوى، اتصل بـ:

- Medicare على الرقم (1-800-633-4227) 1-800-MEDICARE. يمكنك الاتصال على مدار 24 ساعة و7 أيام في الأسبوع. ويجب على مستخدمي الهاتف النصي الاتصال على الرقم 1-877-486-2048.
- يمكنك أيضًا تقديم شكوى من خلال Michigan Medicaid. يُرجى مراجعة الفصل 9 للحصول على مزيد من المعلومات.
- مكتب الحقوق المدنية على الرقم 1-800-368-1019 أو TTY 1-800-537-7697.

B. Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You also have the right to change the PCP within your health plan. You can find more information about choosing a PCP in Chapter 3.
    - Call Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to use a women's health specialist without getting a referral. A referral is approval from your PCP to use someone that is not your PCP.
- 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.
    - 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 get emergency services or care that is urgently needed without prior approval (PA).
- 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 use an out-of-network provider. To learn about out-of-network providers, refer to Chapter 3.

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.

C. Our responsibility to protect your personal health information (PHI)

You have the right to privacy and confidentiality about all of your care and of all health information, unless otherwise required by law. We protect your personal health information (PHI) as required by federal and state laws.

Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

You have rights related to your information and to control how your PHI 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 PHI.

C1. How we protect your PHI

We make sure that unauthorized people do not look at or change your records.

Except for the cases noted below, we do not give your PHI 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 PHI to government agencies that are checking on our quality of care.
- We are required to give Medicare and Michigan Medicaid your PHI. If Medicare or Michigan Medicaid releases your information for research or other uses, it will be done according to Federal and State laws.

C2. You have a right to look at your medical records

You have the right to look at your medical records and to get a copy of your records.

- We provide the first copy of your medical records free of charge.
- We are allowed to charge you a reasonable fee for making additional copies of your medical records.

You have the right to amend or correct information in your medical records. The correction will become part of your record.

You have the right to know if and how your PHI has been shared with others.

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

D. Our responsibility to give you information about the plan, its network providers, and your covered services

You have the right to have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed. As a member of Aetna Better Health Premier Plan, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. This is a free service. You can get written materials in Spanish. You can also get interpretation services in any other non-English primary language spoken. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:
  - Financial information
  - How the plan has been rated by plan members
  - The number of appeals made by members
  - How to leave the plan
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers
  - Qualifications of our network providers and pharmacies
  - How we pay providers in our network
  - A list of providers and pharmacies in the plan's network, in the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Member Services, or visit our website at **AetnaBetterHealth.com/Michigan**.
- Covered services (refer to Chapter 3 and 4) and drugs (refer to Chapter 5 and 6) 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

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

- Why something is not covered and what you can do about it (refer to Chapter 9), including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

E. Inability of network providers to 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, refer to Chapter 7.

F. Your right to leave the plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- Refer to Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- If there is another MI Health Link plan in your service area, you may also change to a different MI Health Link plan and continue to get coordinated Medicare and Michigan Medicaid benefits.
- You can get your Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.

G. Your right to make decisions about your health care

G1. Your right to know your treatment options and make decisions about your health care

You have the right to participate in all aspects of care, including the right to refuse treatment, and to exercise all rights of appeal. You have the right to be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulations on the use of restraints and seclusion. You have the right to get full information from your doctors and other health care providers. Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **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.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask the plan for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

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

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

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

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

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

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

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

G3. What to do if your instructions are not followed

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

H. Your 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.

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.

H1. What to do if you believe you are being treated unfairly or you would like more information about your rights

You have the right to exercise your member rights. Exercising your rights will not adversely affect the way the ICO and the network providers or MDHHS treat you. If you believe you have been treated unfairly – and it is **not** about discrimination for the reasons listed in Chapter 11 – or you would like more information about your rights, you can get help by calling:

- Member Services.
- The State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Medicare/Medicaid Assistance Program (MMAP). For details about this organization and how to contact it, refer to Chapter 2.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The MI Health Link Ombudsman program. For details about this organization and how to contact it, refer to Chapter 2.

I. Your responsibilities as a member of the plan

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

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, refer to 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.
  - Covered drugs, refer to Chapters 5 and 6.

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

- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member 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 almost all Aetna Better Health Premier Plan members, Michigan Medicaid pays for your Part A premium and for your Part B premium.
    - Chapter 4 provides additional information about the Patient Pay Amount (PPA) for nursing facility services.
    - Any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.

- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Member Services.
    - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get Aetna Better Health Premier 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 Michigan Medicaid know your new address when you move. Refer to Chapter 2 for phone numbers for Medicare and Michigan Medicaid.
    - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- Call Member Services for help if you have questions or concerns.
- Enrollees age 55 and older who are getting long-term care services may be subject to estate recovery upon their death. For more information, you may:
    - Contact your Care Coordinator, **or**
    - Call the Beneficiary Helpline at 1-800-642-3195, **or**
    - Visit the website at www.michigan.gov/estaterecovery, **or**
    - Email questions to MDHHS-EstateRecovery@michigan.gov

J. Member Advisory Committee

You have a right to have a voice in the governance and operation of the integrated system, provider or health plan.

As an Aetna Better Health Premier Plan member, you are invited to attend our Member Advisory Committee meetings. Caregivers and health aides are also welcome to share their thoughts about Aetna Better Health Premier Plan.

Your feedback on our program is important. We use your opinions to make our program and your experience better.

Call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week for more information.

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

K. Your opinions and recommendations

You have the right as a member to contact us at any time to voice your opinions and submit recommendations about Aetna Better Health Premier Plan's Rights and Responsibilities Policy. Call **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week to speak to a Member Services representative or contact your care coordinator.

L. New technologies

Aetna Better Health reviews new technologies to see if they can be used for our members. Our doctors look at new treatments as they become available to see if they should be added to our benefit plan. Aetna Better Health reviews the following areas below at least once a year:

- Medical services
- Behavioral health services
- Pharmacy
- Medical equipment

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

Introduction

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

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

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

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

You should get the health care, drugs, and other supports and services that your doctor and other providers determine are necessary for your care as a part of your care plan. You should try to work with your providers and Aetna Better Health Premier Plan first. **If you are still having a problem with your care or our plan, you can call the MI Health Link Ombudsman at 1-888-746-6456.** This chapter explains the different options you have for different problems and complaints, but you can always call the MI Health Link Ombudsman to help guide you through your problem. For additional resources to address your concerns and ways to contact them, refer to Chapter 2 for more information on ombudsman programs.

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

A. What to do if you have a problem

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

A1. 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," "benefit determination," "at-risk 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.

B. Where to call for help

B1. Where to get more information and help

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

You can get help from the MI Health Link Ombudsman

If you need help getting answers to your questions or understanding what to do to handle your problem, you can call the MI Health Link Ombudsman. The MI Health Link Ombudsman is not connected with us or with any insurance company. They can help you understand which process to use. The phone number for the MI Health Link Ombudsman is 1-888-746-6456. The services are free. Refer to Chapter 2 for more information on ombudsman programs.

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

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

Getting help from Medicare

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

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

Getting help from Michigan Medicaid

You can also call Michigan Medicaid for help with problems. Call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service. You can also email beneficiarysupport@michigan.gov.

C. Which process to use to help with your problem

C1. Using the process for coverage decisions and appeals or for making 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, long term supports and services, or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care, long term supports and services, or prescription drugs.)	
Yes. My problem is about benefits or coverage. Refer to **Section D: "Coverage decisions and appeals"** on page 164.	**No.** My problem is not about benefits or coverage. Skip ahead to **Section J: "How to make a complaint"** on page 209.

D. Coverage decisions and appeals

D1. 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.

NOTE: Behavioral health services are covered by your plan or Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your plan or Care Coordinator for information about coverage decisions and appeals on behavioral health services.

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. We are also making a coverage decision whenever you ask us to increase or change the amount of a service, item, or drug that you are already receiving.

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

What is an appeal?

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

D2. Getting help with coverage decisions and appeals

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

You can ask any of these people for help:

- Call your **Care Coordinator** at **1-855-676-5772 (TTY: 711)**.
- Call **Member Services** at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.
- Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- Call the **MI Health Link Ombudsman** for free help. The MI Health Link Ombudsman can help you with questions about or problems with MI Health Link or our plan. The MI Health Link Ombudsman is an independent program, and is not connected with this plan. The phone number is 1-888-746-6456.
- Call the **Michigan Medicare/Medicaid Assistance Program (MMAP)** for free help. MMAP is an independent organization. It is not connected with this plan. The phone number is 1-800-803-7174.

- Talk to a **friend or family member** and ask them to act for you. You can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal. Your designated representative will have the same rights as you do in asking for a coverage decision or making an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form.
    - You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. The form gives the person permission to act for you. You must give us a copy of the signed form.
- **You also have the right to ask a lawyer** to act for you. You may call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. If you choose to have a lawyer, you must pay for those legal services. However, some legal groups will give you free legal services if you qualify. If you want a lawyer to represent you, you will need to fill out the Appointment of Representative form.
    - However, you do not need a lawyer to ask for any kind of coverage decision or to make an appeal.

D3. Using the section of this chapter that will help you

There are four different types of situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We separate this chapter into different sections to help you find the rules you need to follow. **You only need to read the section that applies to your problem:**

- **Section E on page 168** gives you information if you have problems about services, items, and certain drugs (**not** Part D drugs). For example, use this section if:
    - You are not getting medical care or other supports and services that you want, and you believe our plan covers this care.
    - We did not approve services, items, or drugs that your doctor wants to give you, and you believe this care should be covered and is medically necessary.
        - **NOTE:** Only use Section E if these are drugs **not** covered by Part D. Drugs in the *List of Covered Drugs*, also known as the Drug List, with an asterisk (*) are **not** covered by Part D. Refer to Section F on page 185 for Part D drug appeals.

- You got medical care or other supports and services you think should be covered, but we are not paying for this care.
- You got and paid for medical care or other supports and services you thought were covered, and you want to ask us to pay you back.
- You are being told that coverage for care you have been getting will be reduced or stopped, and you disagree with our decision.
  - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Refer to Sections G and H on pages 195 and 202.
- Your request for a coverage decision might be dismissed, which means we won't review the request. Examples of when we might dismiss your request are: if your request is incomplete, if someone makes the request for you but hasn't given us proof that you agreed to allow them to make the request, or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why, and how to ask for a review of the dismissal. This review is a formal process called an appeal.

- **Section F on page 185** gives you information about Part D drugs. For example, use this section if:
  - You want to ask us to make an exception to cover a Part D drug that is not on our 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 authorization (PA) or approval.
  - We did not approve your request or exception, and you or your doctor or other prescriber thinks we should have.
  - You want to ask us to pay for a prescription drug you already bought. (This is asking for a coverage decision about payment.)
- **Section G on page 195** 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 H on page 202** 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 use, please call your Care Coordinator at **1-855-676-5772 (TTY: 711)** or Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

If you need other help or information, please call the MI Health Link Ombudsman at 1-888-746-6456.

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

E. Problems about services, items, and drugs (not Part D drugs)

E1. When to use this section

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

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

1. You think we cover a medical service or other supports and services you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to Section E2 on page 169 for information on asking for a coverage decision.

2. We did not approve care your provider wants to give you, and you think we should have.

   What you can do: You can appeal our decision to not approve the care. Refer to Section E3 on page 171 for information on making an appeal.

3. You got services or items that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to Section E3 on page 171 for information on making an appeal.

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

   What you can do: You can ask us to pay you back. Refer to Section E5 on page 183 for information on asking us for payment.

5. We reduced or stopped your coverage for a certain service, and you disagree with our decision.

   What you can do: You can appeal our decision to reduce or stop the service. Refer to Section E3 on page 171 for information on making an appeal.

   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 G or H on pages 195 and 202 to find out more.

E2. Asking for a coverage decision

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

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

- You can call us at: **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.
- You can write to us at:

  Aetna Better Health Premier Plan
  7400 W. Campus, MC F499
  New Albany, OH 43054

- **NOTE:** Your plan or Prepaid Inpatient Health Plan (PIHP) will make coverage decisions for behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your plan or Care Coordinator for more information.

How long does it take to get a coverage decision?

It usually takes up to 14 calendar days after you, your representative, or your provider asked unless your request is for a Medicare Part B prescription drug. If your request is for a Medicare Part B prescription drug, we will give you a decision no more than 72 hours after we receive your request. If we don't give you our decision within 14 calendar days (or 72 hours for a Medicare Part B prescription drug), you can appeal.

Sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

Can I get a coverage decision faster?

Yes. If you need a response faster because of your health, ask us to make a "fast coverage decision." If we approve the request, we will notify you of our decision within 72 hours (or within 24 hours for a Medicare Part B prescription drug).

However, sometimes we need more time, and we will send you a letter telling you that we need to take up to 14 more calendar days. The letter will explain why more time is needed. We can't take extra time to give you a decision if your request is for a Medicare Part B prescription drug.

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

Asking for a fast coverage decision:

- If you request a fast coverage decision, start by calling our plan to ask us to cover the care you want.
- You can call us at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. For details on how to contact us, refer to Chapter 2.
- You can also have your doctor or your representative call us.

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

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

1. You can get a fast coverage decision only if you are asking about coverage for services or items you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care or an item you already got.)
2. You can get a fast coverage decision only if the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) could cause serious harm to your health or hurt your ability to function.
    - If your provider says that you need a fast coverage decision, we will automatically give you one.

- If you ask for a fast coverage decision without your provider's support, we will decide if you get a fast coverage decision.
    - If we decide that your condition does not meet the requirements for a fast coverage decision, we will send you a letter. We will also use the standard 14 calendar day deadline (or the 72 hour deadline for Medicare Part B prescription drugs) instead.
    - This letter will tell you that if your provider asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about the process for making complaints, including fast complaints, refer to Section J on page 209.

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

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

If the coverage decision is 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 change this decision by making an appeal. Making an appeal means asking us to review our decision to deny coverage.
- If you decide to make an appeal, it means you are going on to the Internal Appeals process (read the next section for more information).

E3. Internal Appeal for services, items, and drugs (not Part D drugs)

What is an appeal?

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

NOTE: Your plan or Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. Contact your plan or Care Coordinator for more information.

If you need help during the appeals process, you can call the MI Health Link Ombudsman at 1-888-746-6456. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan.

What is an adverse action?

An adverse action is an action, or lack of action, by our plan that you can appeal. This includes:

- We denied or limited a service or item your provider requested;
- We reduced, suspended, or ended coverage that was already approved;
- We did not pay for a service or item that you think is covered;
- We did not resolve your authorization request within the required timeframes;
- You could not get a covered service or item from a provider in our network within a reasonable amount of time; **or**
- We did not act within the timeframes for reviewing a coverage decision and giving you a decision.

What is an Internal Appeal?

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

You must ask for an Internal Appeal before you can ask for an External Appeal under Section E4 below.

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

How do I make an Internal Appeal?

- To start your appeal, you, your representative, or your provider must contact us. You can call us at **1-855-364-0974 (TTY: 711)**, 24 hours a day, 7 days a week. For additional details on how to reach us for appeals, refer to Chapter 2.
- You can ask us for a "standard appeal" or a "fast appeal."
- If you are asking for a standard appeal or fast appeal, make your appeal in writing or call us.
    - You can submit a request to the following address:

  Aetna Better Health Premier Plan
  Attn: Grievance & Appeals Department
  5801 Postal Rd.
  P.O. Box 818070
  Cleveland, OH 44181

    - You may also ask for an appeal by calling us at **1-855-364-0974 (TTY: 711)**, 24 hours a day, 7 days a week.

At a glance: How to make an Internal Appeal

You, your doctor, 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.
- If you appeal because we told you that a service you currently get will be changed or stopped, you have fewer days to appeal if you want to keep getting that service while your appeal is processing.
- Keep reading this section to learn about what deadline applies to your appeal.

The legal term for "fast appeal" is **"expedited econsideration."**

Can someone else make the appeal for me?

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

If we don't get this form, and someone is acting for you, your appeal request will be dismissed. If this happens, you have a right to have someone else review our dismissal. We will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

To get an Appointment of Representative form, call Member Services and ask for one, or visit www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

We must get the completed Appointment of Representative form before we can review the appeal.

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

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

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

NOTE: If you appeal because we told you that a service you currently get will be changed or stopped, **you have fewer days to appeal** if you want to keep getting that service while your appeal is processing. Read "Will my benefits continue during Internal Appeals" on page 176 for more information.

Can I get a copy of my case file?

Yes. Ask us for a free copy by calling Member Services at **1-855-364-0974** (TTY: 711), 24 hours a day, 7 days a week.

Can my provider give you more information about my appeal?

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

How will we make the appeal decision?

We take a careful look at all of the information about your request for coverage of medical care or other supports and services. Then, we check 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 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug). We will give you our decision sooner if your condition requires us to.

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide we need to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.
- 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. For more information about the process for making complaints, including fast complaints, refer to Section J on page 209.
- If we do not give you an answer to your appeal within 30 calendar days (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug) or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Michigan Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 177.

If our answer is Yes to part or all of what you asked for, we must approve or give the coverage within 30 calendar days after we get your appeal (or within 7 calendar days after we get your appeal for a Medicare Part B prescription drug).

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we automatically sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Michigan Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 177.

When will I hear about a "fast" appeal decision?

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

- However, if you ask for more time or if we need to gather more information, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will send you a letter that explains why we need more time. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- 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. For more information about the process for making complaints, including fast complaints, refer to Section J on page 209.
- If we do not give you an answer to your appeal within 72 hours or by the end of the extra days (if we took them), we will automatically send your case for an External Appeal if your problem is about coverage of a Medicare service or item. You will be notified when this happens. If your problem is about coverage of a Michigan Medicaid service or item, you can file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 177.

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

If our answer is No to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the Independent Review Entity for an External Appeal. If your problem is about coverage of a Michigan Medicaid service or item, the letter will tell you how to file an External Appeal yourself. For more information about the External Appeal process, refer to Section E4 on page 177.

Will my benefits continue during Internal Appeals?

If we decide to change or stop coverage for a service that was previously approved, we will send you a notice before taking the proposed action. If you file your Internal Appeal within 10 calendar days of the date on our notice or prior to the intended effective date of the action, we will continue your benefits for the service while the Internal Appeal is pending.

If you are appealing to get a new service from our plan, then you would not get that service unless your appeal is finished and the decision is that the service is covered.

E4. External Appeal for services, items, and drugs (not Part D drugs)

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

You must ask for an Internal Appeal and get a decision from us before you can ask for an External Appeal.

If we say No to part or all of your Internal Appeal, we will send you an appeal denial notice. This notice is called the Notice of Appeal Decision. This notice will tell you if the service or item is usually covered by Medicare and/or Michigan Medicaid.

- If your problem is about a Medicare service or item, you will automatically get an External Appeal with the Independent Review Entity (IRE) as soon as the Internal Appeal is complete.
- If your problem is about a Michigan Medicaid service or item, you can file an External Appeal yourself with the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or a request for an External Review with the Michigan Department of Insurance and Financial Services (DIFS). The Notice of Appeal Decision will tell you how to do this. Information is also on page 177.
- If your problem is about a service or item that could be covered by both Medicare and Michigan Medicaid, you will automatically get an External Appeal with the IRE. You can also ask for an External Appeal with MOAHR and/or External Review with DIFS.

What is an External Appeal?

An External Appeal (also called a Level 2 Appeal) is the second appeal, which is done by an independent organization that is not connected to the plan. Medicare's External Appeal organization is called the Independent Review Entity (IRE). The IRE is an independent organization hired by Medicare. It is not a government agency. Medicare oversees its work.

Michigan Medicaid's External Appeal is a Fair Hearing through the Michigan Office of Administrative Hearings and Rules (MOAHR). You also have the right to request an External Review of Michigan Medicaid service denials through the Michigan Department of Insurance and Financial Services (DIFS).

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

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

1. Fair Hearing

You have the right to ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR). A Fair Hearing is an impartial review of a decision made by our plan. You may ask for a Fair Hearing after the Internal Appeal with our plan. In addition, if you do not receive a notice about your appeal, or a decision on your appeal within the time frame the plan has to respond on your appeal, you may ask for a Michigan Medicaid Fair Hearing.

You must ask for a Fair Hearing **within 120 calendar days** from the date on the Notice of Appeal Decision.

NOTE: If you ask for a Fair Hearing because we told you that a service you currently get will be changed or stopped, **you have fewer days to file your request** if you want to keep getting that service while your Fair Hearing is pending. Read "Will my benefits continue during External Appeals" on page 181 for more information.

To ask for a Fair Hearing from MOAHR, you must complete a Request for Hearing form. We will send you a Request for Hearing form with the Notice of Appeal Decision. You can also get the form by calling the Michigan Medicaid Beneficiary Help Line at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service, Monday through Friday from 8:00 AM to 7:00 PM. Complete the form and send it to:

Michigan Office of Administrative Hearings and Rules (MOAHR)
PO Box 30763
Lansing, MI 48909

FAX: 517-763-0146

You can also start the Fair Hearing by calling 800-648-3397. You can ask for an expedited (fast) Fair Hearing by calling that number or writing to the address or faxing to the number listed above.

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

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

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

2. External Review

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

Your request for an External Review must be submitted **within 127 calendar days** of your receipt of our Internal Appeal decision.

NOTE: If you qualified for continuation of benefits during the Internal Appeal and you ask for an External Review **within 10 calendar days** from the date of the Internal Appeal decision, you can continue to get the disputed service during the review. Read "Will my benefits continue during External Appeals" on page 181 for more information.

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

DIFS
Office of Research, Rules, and Appeals – Appeals Section
PO Box 30220
Lansing, MI 48909-7720

Email: DIFS-HealthAppeal@Michigan.gov

DIFS Consumer Hotline: 877-999-6442

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

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

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

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

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

An Independent Review Entity (IRE) will carefully review the Internal Appeal decision and decide whether it should be changed.

- You do not need to ask for the External Appeal. We will automatically send any denials (in whole or in part) to the IRE. You will be told when this happens.
- The IRE is hired by Medicare and is not connected with this plan.
- You may ask for a copy of your file by calling Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

The IRE must give you an answer to your External Appeal within 30 calendar days of when it gets your appeal (or within 7 calendar days of when it gets your appeal for a Medicare Part B prescription drug). This rule applies if you sent your appeal before getting medical services or items.

- However, if the IRE 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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

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

- However, if the IRE 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. The IRE can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

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

If your problem is about a service or item that could be covered by both Medicare and Michigan Medicaid, we will automatically send your External Appeal to the Independent Review Entity. You can also submit an External Appeal to the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or an External Review to the Michigan Department of Insurance and Financial Services (DIFS). Follow the instructions on page 177.

Will my benefits continue during External Appeals?

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

- If the service is covered by Medicare and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the External Appeal process with the Independent Review Entity (IRE).
- If the service is covered by Michigan Medicaid, your benefits for that service will continue if you qualified for continuation of benefits during your Internal Appeal and you ask for a Fair Hearing from MOAHR or an External Review from DIFS within 10 calendar days from the date of the Notice of Appeal Decision.
- If the service could be covered by both Medicare and Michigan Medicaid and you qualified for continuation of benefits during the Internal Appeal, your benefits for that service will automatically continue during the IRE review. You may also qualify for continuation of benefits during MOAHR and/or DIFS review if you submit your request within the timeframes listed above.

If your benefits are continued, you can keep getting the service until one of the following happens: (1) you withdraw the appeal; or (2) all entities that got your appeal (the IRE, MOAHR, and/or DIFS) decide "no" to your request. If any of the entities decide "yes" to your request, your services will continue.

How will I find out about the decision?

If your External Appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision.

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

If your External Appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision.

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

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

- If the IRE says **Yes** to part or all of what you asked for, we must authorize the coverage as quickly as your condition requires, but no later than 72 hours from the date we get the IRE's decision.
- If the IRE says **Yes** to part or all of what you asked for in your standard appeal for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug within 72 hours after we get the IRE's decision. If you had a fast appeal, we must authorize or provide the Medicare Part B prescription drug within 24 hours from the date we get the IRE's decision.
- If the IRE says **No** to part or all of what you asked for, it means they agree with the Internal Appeal decision. This is called "upholding the decision." It is also called "turning down your appeal."

What if I had different types of External Appeals and they have different decisions?

If any of the External Appeal organizations (MOAHR, DIFS, and/or the IRE) decide **Yes** for all or part of what you asked for, we will give you the approved service or item that is closest to what you asked for in your appeal.

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

If your External Appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, you can appeal the decision within 30 days to the Circuit Court. You may also request a rehearing or reconsideration by MOAHR within 30 days.

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

If your External Appeal went to the Independent Review Entity (IRE), 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 MOAHR, DIFS, or IRE will explain additional appeal rights you may have. Refer to Section I on page 208 for more information on additional levels of appeal.

NOTE: Your benefits for the disputed service will not continue during the additional levels of appeal.

E5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill. The only amount you should be asked to pay is any required Patient Pay Amount (PPA) for nursing home care.

If you get a bill for covered services and items, send the bill to us. **You should not pay the bill yourself.** We will contact the provider directly and take care of the problem.

For more information, start by reading Chapter 7: "Asking us to pay a bill you have gotten for covered services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Can I ask you to pay me back for a service or item I paid for?

Remember, if you get a bill for covered services and items, you should not pay the bill yourself. But if you do pay the bill, you can get a refund if you followed the rules for getting services and items.

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

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request. If you haven't paid for the service or item yet, we will send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item is not covered, or you did not follow all the rules, we will send you a letter telling you we will not pay for the service or item, and explaining why.

What if we say we will not pay?

If you do not agree with our decision, **you can make an appeal**. Follow the appeals process described in Section E3 on page 171. When you follow these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we get your appeal.
- If you are asking us to pay you back for a service or item you already got and paid for yourself, you cannot ask for a fast appeal.

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

- If the IRE reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after review by the IRE, we must send the payment you asked for to you or to the provider within 60 calendar days.
- If the IRE says **No** to your appeal, it means they agree with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.") The letter you get will explain additional appeal rights you may have. You can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. Refer to Section I on page 208 for more information on additional levels of appeal.

If we answer **No** to your appeal and the service or item is usually covered by Michigan Medicaid, you can ask for a Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) or an External Review from the Michigan Department of Insurance and Financial Services (refer to Section E4 on page 177).

F. Part D drugs

F1. What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

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

The 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 E on page 168.

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 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).

NOTE: If your pharmacy tells you that your prescription cannot be filled, you will get a notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is asking for a coverage decision about payment.

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

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

Use the chart below to help you decide which section 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?	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?	Do you want to ask us to pay you back for a drug you already got and paid for?	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 ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you are asking us to reconsider.)
Start with **Section F2** on page 186. Also refer to Sections F3 and F4 on pages 187 and 188.	Skip ahead to **Section F4** on page 188.	Skip ahead to **Section F4** on page 188.	Skip ahead to **Section F5** on page 191.

F2. What an exception is

An exception is permission to get coverage for a drug that is not normally on our Drug List or to use the drug without certain rules and limitations. If a drug is not on our Drug List 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 Drug List.
    - If we agree to make an exception and cover a drug that is not on the Drug List, you will not be charged.

2. Removing a restriction on our coverage. There are extra rules or restrictions that apply to certain drugs on our Drug List (for more information, refer 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 "PA.")
        - 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, we limit 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."**

F3. 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 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 F5 on page 191 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.

F4. How to ask for a coverage decision about a Part D drug or reimbursement for a Part D drug, including an exception

What to do

- Ask for the type of coverage decision you want. Call, write, or fax us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can call us at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. Include your name, contact information, and information about the claim.
- 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 D on page 164 to find out how to give permission to someone else to act as your representative.
- You do not need to give your doctor or other prescriber written permission to ask us for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, read Chapter 7 of this handbook. Chapter 7 describes times when you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

At a glance: How to ask for a coverage decision about a drug or payment

Call, write, or fax us to ask, or ask your representative or doctor or other prescriber to ask. We will give you an answer on a standard coverage decision within 72 hours. We will give you an answer on reimbursing you for a Part D drug you already paid for within 14 calendar days.

- If you are asking for an exception, include the supporting statement from your doctor or other prescriber.
- You or your doctor or other prescriber may ask for a fast decision. (Fast decisions usually come within 24 hours.)
- Read this section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- If you are asking for 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.
- A **fast coverage decision** means we will give you an answer within 24 hours after we get your doctor's statement.

> **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 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 that your medical condition does not meet the requirements for a fast coverage decision, we will use the standard deadlines instead.
    - We will send you a letter telling you that. The letter will tell you how to make a complaint about our decision to give you a standard decision.
    - You can file a "fast complaint" and get a response to your complaint within 24 hours. For more information about the process for making complaints, including fast complaints, refer to Section J on page 209.

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, this means within 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 it.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.

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

- **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, this means within 72 hours after we get your doctor's or prescriber's supporting statement. We will give you our answer sooner if your health requires it.
- If we do not meet this deadline, we will send your request on to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must approve or give the coverage within 72 hours after we get your request or, if you are asking for an exception, your doctor's or prescriber's supporting statement.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

Deadlines for a "standard coverage decision" about payment for a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we do not meet this deadline, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we will make payment to you within 14 calendar days.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No**. The letter will also explain how you can appeal our decision.

F5. Level 1 Appeal for Part D drugs

- To start your appeal, you, your doctor or other prescriber, or your representative must contact us. Include your name, contact information, and information regarding your claim.
- If you are asking for a standard appeal, you can make your appeal by sending a request in writing. You may also ask for an appeal by calling us at **1-855-676-5772 (TTY: 711)**, 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 your 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 section to make sure you qualify for a fast decision! Read it also to find information about decision deadlines.

- You have the right to ask us for a copy of the information about your appeal. To ask for a copy, call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

The legal term for an appeal to the plan about a Part D drug coverage decision is plan **"redetermination."**

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 F4 on page 188.

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

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 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. The reviewer will be someone who did not make the original coverage decision.

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we will give you our answer within 72 hours after we get your appeal, or sooner if your health requires it.
- If we do not give you an answer within 72 hours, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for, we must give the coverage within 72 hours after we get your appeal.
- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and how to appeal our decision.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we get your appeal, or sooner if your health requires it, except if you are asking us to pay you back for a drug you already bought. If you are asking us to pay you back for a drug you already bought, we must give you our answer within 14 calendar days after we get your appeal. 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, or 14 calendar days if you asked us to pay you back for a drug you already bought, we will send your request to Level 2 of the appeals process. At Level 2, an Independent Review Entity will review your request.
- **If our answer is Yes** to part or all of what you asked for:
    - If we approve a request for coverage, we must give you the coverage as quickly as your health requires, but no later than 7 calendar days after we get your appeal or 14 calendar days if you asked us to pay you back for a drug you already bought.

- If we approve a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get your appeal request.

- **If our answer is No** to part or all of what you asked for, we will send you a letter that explains why we said **No** and tells how to appeal our decision.

F6. Level 2 Appeal for Part D drugs

If we say **No** to part or all of your appeal, you can choose whether to accept this decision or make another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Entity (IRE) will review our decision.

- If you want the IRE 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 IRE, we will send them your case file. You have the right to ask us for a copy of your case file by calling Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.
- You have a right to give the IRE other information to support your appeal.
- The IRE is an independent organization that is hired by Medicare. It is not connected with this plan and it is not a government agency.
- Reviewers at the IRE will take a careful look at all of the information related to your appeal. The organization will send you a letter explaining its decision.

At a glance: How to make a Level 2 Appeal

If you want the Independent Review Entity to review your case, your appeal request must be in writing.

- Ask **within 60 calendar days** of the decision you are appealing. If you miss the deadline for a good reason, you may still appeal.
- You, your doctor or other prescriber, or your representative can request the Level 2 Appeal.
- Read this section 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 IRE about a Part D drug is **"reconsideration."**

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Entity (IRE) for a "fast appeal."
- If the IRE 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 IRE 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 (IRE) must give you an answer to your Level 2 Appeal within 7 calendar days after it gets your appeal, or 14 calendar days if you asked us to pay you back for a drug you already bought.
- If the IRE 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 IRE approves a request to pay you back for a drug you already bought, we will send payment to you within 30 calendar days after we get the decision.

What if the Independent Review Entity says No to your Level 2 Appeal?

No means the Independent Review Entity (IRE) agrees with our decision not to approve your request. This is called "upholding the decision." It is also called "turning down your appeal."

If you want to go to Level 3 of the appeals process, the drugs you are requesting must meet a minimum dollar value. If the dollar value is less than the minimum, you cannot appeal any further. If the dollar value is high enough, you can ask for a Level 3 appeal. The letter you get from the IRE will tell you the dollar value needed to continue with the appeal process.

G. 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 covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day when you 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."
- 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.

G1. 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 **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. 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 rights 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.
- Be a part of any decisions about the length of your hospital stay.
- Know where to report any concerns you have about the quality of your hospital care.
- Appeal if you think you are being discharged from the hospital too soon.

You should sign the Medicare notice to show that you got it and understand your rights. Signing the notice does **not** mean you agree to the discharge date that may have been told to you by your doctor or hospital staff.

Keep your copy of the signed notice so you will have the information in it if you need it.

- To look at a copy of this notice in advance, you can call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. 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 find the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.
- If you need help, please call Member Services or Medicare at the numbers listed above.

G2. 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 find out if your planned discharge date is medically appropriate for you.

In Michigan, the Quality Improvement Organization is called Livanta. To make an appeal to change your discharge date, call Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

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, refer to Section G4 on page 200.

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

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for a "fast review."

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

We want to make sure you understand what you need to do and what the deadlines are.

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. You can also call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174. You can also get help from the MI Health Link Ombudsman by calling 1-888-746-6456.

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 the organization to use the fast deadlines for an appeal instead of using the standard deadlines.

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

What happens during the fast review?

- The reviewers at the Quality Improvement Organization will ask you or your representative why you think coverage should continue after the planned discharge date. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will look at your medical record, talk with your doctor, and review all of the information related to your hospital stay.
- By noon of the day after the reviewers tell us about your appeal, you will get a letter that gives your planned discharge date. The letter explains the reasons why your doctor, the hospital, and we think it is right for you to be discharged on that date.

The legal term for this written explanation is called the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. 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 find a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices

What if the answer is Yes?

- If the Quality Improvement Organization says **Yes** to your appeal, we must keep covering your hospital services for as long as they are medically necessary.

What if the answer is No?

- If the Quality Improvement 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 Quality Improvement Organization says **No** and you decide to stay in the hospital, then you may have to pay for your continued stay at the hospital. The cost of the hospital care that you may have to pay begins at 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.

G3. Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. You will need to contact the Quality Improvement Organization again and ask for another review.

Ask for the Level 2 review **within 60 calendar days** after the day when the Quality Improvement Organization said **No** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775).

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.
- Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will make a decision.

At a glance: How to make a Level 2 Appeal to change your discharge date

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for another review.

What happens if the answer is Yes?

- We must pay you back for our share of the costs of hospital care you got since noon on the day after the date of your first appeal decision. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

What happens if the answer is No?

It means the Quality Improvement Organization agrees with the Level 1 decision and will not change it. The letter you get will tell you what you can do if you wish to continue with the appeal process.

If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

G4. What happens if you miss an appeal deadline

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

NOTE: Your plan or Prepaid Inpatient Health Plan (PIHP) handles appeals about behavioral health, intellectual/developmental disability, and substance use disorder services and supports. This includes Alternate Appeals for inpatient mental health care. Contact your plan or Care Coordinator for more information.

Level 1 Alternate Appeal to change your hospital discharge date

If you miss the deadline for contacting the Quality Improvement Organization (which is within 60 days or no later than your planned discharge date, whichever comes first), you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

- During this review, we take a look at all of the information about your hospital stay. We check 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. This means 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 got 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.

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.

- If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you got after the planned discharge date.
- To make sure we were following all the rules when we said **No** to your fast appeal, we will send your appeal to the "Independent Review Entity." When we do this, it means that your case is automatically going to Level 2 of the appeals process.

The legal term for "fast review" or "fast appeal" is **"expedited appeal."**

Level 2 Alternate Appeal to change your hospital discharge date

We will send the information for your Level 2 Appeal to the Independent Review Entity (IRE) 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 J on page 209 tells how to make a complaint.

During the Level 2 Appeal, the IRE reviews the decision we made when we said **No** to your "fast review." This organization decides whether the decision we made should be changed.

At a glance: How to make a Level 2 Alternate Appeal

You do not have to do anything. The plan will automatically send your appeal to the Independent Review Entity.

- The IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE 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 IRE will take a careful look at all of the information related to your appeal of your hospital discharge.
- If the IRE says **Yes** to your appeal, then we must pay you back for our share of the costs of hospital care you got since the date of your planned discharge. We must also continue our coverage of your hospital services for as long as it is medically necessary.
- If the IRE 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 IRE 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.

H. What to do if you think your home health care, skilled nursing care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

This section is about the following types of care only:

- Home health care services.
- Skilled nursing care in a skilled nursing facility.
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation.
    - With any of these three types of care, you have the right to keep getting covered services for as long as the doctor says you need it.
    - When we decide to stop covering any of these, we must tell you before your services end. When your coverage for that care ends, we will stop paying for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

H1. We will tell you in advance when your coverage will be ending

You will get a notice at least two calendar days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The written notice tells you the date we will stop covering your care and how to appeal this decision.

You or your representative should sign the written notice to show that you got it. Signing it does **not** mean you agree with the plan that it is time to stop getting the care.

When your coverage ends, we will stop paying for your care.

H2. Level 1 Appeal to continue your care

If you think we are ending coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Before you start your appeal, 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 J on page 209 tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. Or call the Michigan Medicare/Medicaid Assistance Program (MMAP) at 1-800-803-7174.

During a Level 1 Appeal, a Quality Improvement Organization will review your appeal and decide whether to change the decision we made. In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). Information about appealing to the Quality Improvement Organization is also in the Notice of Medicare Non-Coverage. This is the notice you got when you were told we would stop covering your care.

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

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for a "fast-track appeal."

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

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 a "fast-track appeal." This is 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, refer to Section H4 on page 206.

The legal term for the written notice is **"Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week 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 find a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices

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 to you and the Quality Improvement Organization 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.

H3. 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.

During the Level 2 Appeal, the Quality Improvement Organization will 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.

In Michigan, the Quality Improvement Organization is called Livanta. You can reach Livanta at: 1-888-524-9900 (TTY: 1-888-985-8775). 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 of receipt of your appeal request.

At a glance: How to make a Level 2 Appeal to require that the plan cover your care for longer

Call the Quality Improvement Organization for your state at 1-888-524-9900 and ask for another review.

Call before you leave the agency or facility that is providing your care and before your planned discharge date.

What happens if the review organization says Yes?

- We must pay you back for our share of the costs of care you got 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.

H4. What happens if you miss the deadline for making your Level 1 Appeal

You can appeal to us instead

If you miss appeal deadlines, there is another way to make Level 1 and Level 2 Appeals, called Alternate Appeals. But the first two levels of appeal are different.

Level 1 Alternate Appeal to continue your care for longer

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

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 home health care, skilled nursing facility care, or care you are getting at a Comprehensive Outpatient Rehabilitation Facility (CORF). We check 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 got 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 (IRE) 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 J on page 209 tells how to make a complaint.

During the Level 2 Appeal, the IRE 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 IRE does a "fast review" of your appeal. The reviewers usually give you an answer within 72 hours.
- The IRE 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 IRE will take a careful look at all of the information related to your appeal.

At a glance: How to make a Level 2 Alternate 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 Entity.

- **If the IRE says Yes** to your appeal, then we must pay you back for our share of the costs of care. We must also continue our coverage of your services for as long as it is medically necessary.
- **If the IRE 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 IRE will tell you what you can do if you wish to continue with the review process. It will give you details about how to go on to a Level 3 Appeal, which is handled by a judge.

I. Appeal options after Level 2 or External Appeals

I1. Next steps for Medicare services and items

If you made a Level 1 or Internal Appeal and a Level 2 or External Appeal for Medicare services or items, and both your appeals have been turned down, you may have the right to additional levels of appeal. The letter you get from the Independent Review Entity will tell you what to do if you wish to continue the appeals process.

Level 3 of the appeals process is an Administrative Law Judge (ALJ) hearing. The person who makes the decision in a Level 3 appeal is an ALJ or an attorney adjudicator. If you want an ALJ or attorney adjudicator to review your case, the item or medical service you are requesting must 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 or attorney adjudicator to hear your appeal.

If you do not agree with the ALJ or attorney adjudicator's decision, you can use the Medicare Appeals Council. After that, you may have the right to ask a federal court to look at your appeal.

If you need assistance at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

I2. Next steps for Michigan Medicaid services and items

You also have more appeal rights if your appeal is about services or items that might be covered by Michigan Medicaid.

If your appeal went to the Michigan Office of Administrative Hearings and Rules (MOAHR) for a Fair Hearing, MOAHR will send you a letter explaining its decision. If you disagree with the MOAHR final decision, you have 30 calendar days from the date of the decision to file a request for rehearing/reconsideration and/or to file an appeal with the Circuit Court. Please call MOAHR at 517-335-2484 for information about requirements you must meet to qualify for a rehearing/reconsideration.

If your appeal went to the Michigan Department of Insurance and Financial Services (DIFS) for an External Review, DIFS will send you a letter explaining the Director's decision. If you disagree with the decision, you have the right to appeal to Circuit Court in the county where you live or the Michigan Court of Claims within 60 calendar days from the date of the decision.

If you need help at any stage of the appeals process, you can contact the MI Health Link Ombudsman. The phone number is 1-888-746-6456.

J. How to make a complaint

J1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy, or shared information about you that is confidential.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Aetna Better Health Premier Plan staff treated you poorly.
- You think you are being pushed out of the plan.

At a glance: How to make a complaint

You can make an internal complaint with our plan and/or an external complaint with an organization that is not connected to our plan.

To make an internal complaint, call Member Services or send us a letter.

There are different organizations that handle external complaints. For more information, read Section J3 on page 212.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- Your provider does not give you a reasonable accommodation you need such as an American Sign Language interpreter.

Complaints about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other plan staff.

Complaints about cleanliness

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

Complaints about language access

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

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.

Complaints about the timeliness of our actions related to coverage decisions or appeals

- You believe that we are not meeting our deadlines for making a coverage decision or answering your appeal.
- You believe that, after getting a coverage or appeal decision in your favor, we are not meeting the deadlines for approving or giving you the service or paying you back for certain medical services.
- You believe we did not forward your case to the Independent Review Entity on time.

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

Are there different types of complaints?

Yes. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization that is not affiliated with our plan. If you need help making an internal and/or external complaint, you can call the MI Health Link Ombudsman at 1-888-746-6456.

NOTE: Behavioral health services are covered by your Prepaid Inpatient Health Plan (PIHP). This includes mental health, intellectual/developmental disability, and substance use disorder services and supports. Contact your plan or Care Coordinator for information about internal complaints on behavioral health services.

J2. Internal complaints

To make an internal complaint, call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week. You can make the complaint at any time unless it is about a Part D drug. If the complaint is about a Part D drug, you must make it **within 60 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.

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

If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- We answer most complaints within 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 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 took extra time to make a coverage decision or appeal, we will automatically give you a "fast complaint" and respond to your complaint within 24 hours.

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.

J3. External complaints

You can tell Medicare about your complaint

You can send your complaint to Medicare. The Medicare Complaint Form is available at: 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 users can call 1-877-486-2048. The call is free.

You can tell Michigan Medicaid about your complaint

You can also send your complaint to Michigan Medicaid. You can call the Beneficiary Help Line Monday through Friday from 8:00 AM to 7:00 PM at 1-800-642-3195 (TTY: 1-866-501-5656), or 1-800-975-7630 if calling from an internet-based phone service.

You can file a complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the Office for Civil Rights is 1-800-368-1019. TTY users should call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.

You may also contact the local Office for Civil Rights at:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave. Suite 240
Chicago, IL 60601

Phone: 1-800-368-1019
Fax: (202) 619-3818
TDD: (800) 537-7697

You can also contact the Michigan Department of Civil Rights by phone at 1-800-482-3604 or online at www.michigan.gov/lara/about/contact-us. TTY users should call 1-877-878-8464. You can also email MDCRServiceCenter@michigan.gov

You may also have rights under the Americans with Disability Act and under ADA Michigan. You can contact the MI Health Link Ombudsman for assistance. The phone number is 1-888-746-6456.

You can file a complaint with 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 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. To learn more about the Quality Improvement Organization, refer to Chapter 2.

In Michigan, the Quality Improvement Organization is called Livanta. The phone number for Livanta is 1-888-524-9900 (TTY: 1-888-985-8775).

You can tell the MI Health Link Ombudsman about your complaint

The MI Health Link Ombudsman also helps solve problems from a neutral standpoint to make sure that our members get all the covered services that we are required to provide. The MI Health Link Ombudsman is not connected with us or with any insurance company or health plan. The phone number is 1-888-746-6456. The services are free.

You can tell the State of Michigan about your complaint

If you have a problem with Aetna Better Health Premier Plan, you can contact the Michigan Department of Insurance and Financial Services (DIFS) at 1-877-999-6442, Monday through Friday from 8:00 AM to 5:00 PM. The call is free. You can email difs-HICAP@michigan.gov or fax 517-284-8838. You can also write to:

DIFS – Office of Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

For complaints about how your provider follows your wishes, call 517-373-9196, go online at www.michigan.gov/lara/bureau-list/bpl/complaint or write to:

Michigan Department of Licensing and Regulatory Affairs
Bureau of Professional Licensing
Enforcement Division
P.O. Box 30670
Lansing, MI 48909
E-mail: BPL-Complaints@Michigan.gov

Send overnight deliveries to:

Department of Licensing and Regulatory Affairs
Mail Services
2407 N. Grand River Avenue
Lansing, MI 48906

You can also call 517-241-0205 or fax 517-241-2389.

To a file a complaint against a licensed nurse, visit:
www.michigan.gov/lara/bureau-list/bpl/complaint

To file a complaint against all other licensed health professionals, visit:
www.michigan.gov/documents/lara/lara_ED_200PKT_AllegationPkt_477156_7.pdf

Chapter 10: Ending your membership in Aetna Better Health Premier Plan

Introduction

This chapter tells you when and how you can end your membership in our plan and what your health coverage options are after you leave our plan. If you leave our plan, you will still be in the Medicare and Michigan Medicaid programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

Table of Contents

A. When can you end your membership in our Medicare-Medicaid Plan

You can end your membership in Aetna Better Health Premier Plan Medicare-Medicaid Plan at any time during the year by enrolling in another Medicare Advantage Plan, enrolling in another Medicare-Medicaid Plan, or moving to Original Medicare.

The change will be effective the first day of the next month after we get your request. If you leave our plan, you can get information about your:

- Medicare options, refer to the table on page 217.
- Michigan Medicaid services, refer to page 220.

You can get more information about when you can end your membership by calling:

- Michigan ENROLLS at 1-800-975-7630 Monday through Friday, 8 AM to 7 PM. TTY users should call 1-888-263-5897.
- The State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). MMAP can be reached at 1-800-803-7174.
- 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.

NOTE: If you're in a drug management program, you may not be able to change plans. Refer to Chapter 5 for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership, tell Michigan Medicaid or Medicare that you want to leave Aetna Better Health Premier Plan:

- Call Michigan ENROLLS at 1-800-975-7630 Monday through Friday, 8 AM to 7 PM. TTY users should call 1-888-263-5897; **OR**
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty hearing or speaking) 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 218.

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

C. How to join a different Medicare-Medicaid Plan

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

To enroll in a different Medicare-Medicaid Plan:

- Call Michigan ENROLLS at 1-800-975-7630 Monday through Friday, 8 AM to 7 PM. TTY users should call 1-888-263-5897. Tell them you want to leave Aetna Better Health Premier Plan and join a different Medicare-Medicaid Plan. If you are not sure what plan you want to join, they can tell you about other plans in your area.

Your coverage with Aetna Better Health Premier Plan will end on the last day of the month that we get your request.

D. How to get Medicare and Michigan Medicaid services separately

If you do not want to enroll in a different Medicare-Medicaid Plan after you leave Aetna Better Health Premier Plan, you will return to getting your Medicare and Michigan Medicaid services separately.

D1. Ways to get your Medicare services

You will have a choice about how you get your Medicare benefits.

You have three options for getting your Medicare services. By choosing one of these options, you will automatically end your membership in our plan.

1. You can change to:	**Here is what to do:**
A Medicare health plan (such as a Medicare Advantage Plan or Program of All-inclusive Care for the Elderly (PACE))	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 State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). You will automatically be disenrolled from Aetna Better Health Premier Plan when your new plan's coverage begins.

This section is continued on the next page.

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 State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). You will automatically be disenrolled from Aetna Better Health Premier Plan when your Original Medicare coverage begins.
3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you tell Medicare you don't want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call MMAP at 1-800-803-7174.	**Here is what to do:** Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-803-7174. Persons with hearing and speech disabilities may call 711. The call is free. Office hours are Monday through Friday, 8 AM to 5 PM. In Michigan, the SHIP is called the Michigan Medicare/Medicaid Assistance Program (MMAP). You will automatically be disenrolled from Aetna Better Health Premier Plan when your Original Medicare coverage begins.

D2. How to get your Michigan Medicaid services

If you leave the Medicare-Medicaid Plan, you will get your Michigan Medicaid services through fee-for-service.

Your Michigan Medicaid services include most long term supports and services and behavioral health care. If you leave the Medicare-Medicaid Plan, you can use any provider that accepts Michigan Medicaid.

E. Keep getting your medical services and drugs through our plan until your membership ends

If you leave Aetna Better Health Premier Plan, it may take time before your membership ends and your new Medicare and Michigan Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan.

- Use our network providers to receive medical care.
- **Use our network pharmacies** including through our mail-order pharmacy services **to get your prescriptions filled**.
- **If you are hospitalized on the day that your membership in Aetna Better Health Premier Plan ends, our plan will cover your hospital stay until you are discharged.** This will happen even if your new health coverage begins before you are discharged.

F. Other situations when your membership ends

These are the cases when Aetna Better Health Premier Plan must end your membership in the plan:

- If there is a break in your Medicare Part A and Part B coverage.
- If you no longer qualify for Michigan Medicaid. Our plan is for people who qualify for both Medicare and Michigan Medicaid. MI Health Link program allows you to remain enrolled in the MI Health Link program for up to three months after the loss of Medicaid eligibility to give you a chance to get your redetermination paperwork sorted out with your caseworker. This is called “deeming.” (Refer to Chapter 12 for more information on “deeming.”)

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

- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
    - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
    - The Centers for Medicare & Medicaid Services will notify us if you aren't eligible to remain a member on this basis.
    - We must disenroll you if you don't meet this requirement.
- If you knowingly fail to complete and submit any necessary consent or release allowing the ICO and/or providers to access necessary health care and service information.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Michigan Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
- If you let someone else use your Member ID Card to get medical care.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

G. Rules against asking you to leave our plan for any health-related reason

Aetna Better Health Premier Plan may not request disenrollment or ask you to leave our plan for any of the following reasons:

- A change in your health and/or because of your use of medical services
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from special needs (unless the behavior makes it very hard for us to provide services to you or other members).
- You want to make treatment decisions that we or any of your health care providers associated with our plan disagree with.

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 can also call the Beneficiary Help Line at 1-800-642-3195 (or 1-866-501-5656 for TTY users) Monday through Friday, 8 AM to 7 PM. You should also call the MI Health Link Ombudsman program at 1-888-746-MHLO (1-888-746-6456) Monday through Friday, 8 AM to 5 PM. TTY users can call 711. Or, you can send an email to help@MHLO.org.

H. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to Chapter 9 for information about how to make a complaint.

I. How to get more information about ending your plan membership

If you have questions or would like more information on when we can end your membership, you can call Member Services at **1-855-676-5772 (TTY: 711)**, 24 hours a day, 7 days a week.

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

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in **AetnaBetterHealth.com/Michigan**. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

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A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws are not included or explained in this handbook. The main laws that apply to this handbook are federal laws about the Medicare and Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

Every company or agency that works with Medicare and Michigan Medicaid must obey laws that protect you from discrimination or unfair treatment. We don't discriminate or treat you differently because of your age, claims experience, color, ethnicity, evidence of insurability, gender, genetic information, geographic location within the service area, health status, medical history, mental or physical disability, national origin, race, religion, sex, or sexual orientation.

If you want more information or 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 users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- You can also call the Michigan Department of Civil Rights at 1-800-482-3604.

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

C. Notice about Medicare as a second payer

Sometimes someone else has to pay first for the services we provide you. For example, if you are in a car accident or if you are injured at work, insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

D. Out-of-network providers

Out-of-network/non-contracted providers are under no obligation to treat plan members, except in emergency situations. Please call our customer service number or see your *Member Handbook* for more information, including the cost-sharing that applies to out-of-network services.

E. Provider, hospital, pharmacy networks

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

F. Fraud, Waste and Abuse

Health care fraud affects all of us. It impacts the quality of health care. Aetna Better Health Premier Plan is dedicated to fight fraud, abuse and waste through its Fraud Prevention Program. This program is designed to detect and eliminate health care fraud, abuse and waste.

What can you do?

Know what to look for. It can help you protect your identity and benefits. Be suspicious of:

- People trying to sell you health care items or services door-to-door or over the phone
- People who offer money or gifts for health care services
- Bills for services or equipment you didn't get
- Shipments of medical supplies you didn't order
- Someone using your ID card to get medical care, supplies or equipment
- People offering you free gifts or services in exchange for your ID number
- Falsifying timesheets for services not provided or only partially provided
- Incorrectly stating a diagnosis to get higher payments
- Performing unnecessary services to get higher payments

Know Who You're Sharing Information With

Don't be afraid to ask questions if someone asks for your personal information. Never give out your Social Security number, health plan numbers, or banking information to anyone you don't know.

It's important to be able to identify these issues and protect your identity and benefits.

Online theft of personal Information

People may try to steal your personal or Medicare-Medicaid information online. They can harm you financially and may disrupt your benefits. It's not always easy to distinguish an important email about your benefits from an online scam. An email may say there's a problem with your account or ask for updated information to continue your coverage.

You can help support our mission to reduce and eliminate fraud in the health care industry by following a few simple guidelines:

- Be careful when providing your health care information, including your Member ID number.
- Be cautious of "free" medical treatments where you are required to provide them with your health care information.
- Understand your benefit plan and what types of treatments, drugs, services, etc., are covered.

Telemarketing Scams

Many legitimate businesses use telemarketing. But criminals can also use live or recorded calls to try to steal your identity. Aetna won't call to ask for your bank account number, Social Security number, Member ID number.

What you can do:

- Hang up on recorded messages that ask you to verify your personal information.
- Don't press any keys or numbers when prompted - even if it's to take your name off their list.
- Never give your personal information to someone you don't know.

Online Pharmacy Scams

Most online pharmacies aren't safe or legal. They might send you medicine that is tampered with, expired, or fake. They could use your personal information to steal your identity.

What you can do:

- Only order from online pharmacies in your health plan's pharmacy network.
- Don't click on links in emails or pop-up advertisements on the internet.
- Don't order from pharmacies outside of the United States.
- Report pharmacies that
  - Offer prescription drugs without a prescription.
  - Won't accept your prescription insurance card as a form of payment.

Lab Test Fraud

Your doctor must order genetic tests for Aetna to cover them. Some labs try to offer a free test in order to get your Aetna information. They may try to steal your identity or submit a fraudulent bill.

What to do before you agree to genetic testing:

- Make sure your doctor ordered the test.
- Make sure the test is medically necessary and that we cover it.

Report concerns to us

You can complete the form at **AetnaBetterHealth.com/Michigan**. Call Member Services if you have questions about the form.

You do not need to give us your name or contact information. But if you do, we will keep it confidential. You can also give us just your contact information and not your name.

If you choose not to give your contact information, our review will be only about the information you are reporting. It is important that you give us as much information as you can. It will help us do a complete and correct investigation.

G. Notice of Privacy Practices

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

What do we mean when we use the words "health information" [1]

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

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

How we use and share your health information

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

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

If you are under 18 and don't want us to give your health information to your parents. Call us. We can help in some cases if allowed by state law.

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

[1] For purposes of this notice, "Aetna" and the pronouns "we," "us" and "our" refer to all the HMO and licensed insurer subsidiaries of Aetna Inc. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

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 coordination
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

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

Sharing with other businesses

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

Other reasons we might share your health information

We also may share your health information for these reasons:

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

Reasons that we will need your written okay

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

- For marketing reasons that have nothing to do with your health plan.

- Before sharing any psychotherapy notes.
- For the sale of your health information.
- For other reasons as required by law.

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

What are your rights

You have the right to look at your health information.

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

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

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

You have the right to get a list of people or groups that we have shared your health information with.

You have the right to ask for a private way to be in touch with you.

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

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

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

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

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

Aetna, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity and sexual orientation. Aetna, Inc. does not exclude people or treat them different because of race, color national origin, age, disability, gender identity and sexual orientation.

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

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

You also have the right to send us a complaint. If you think your rights were violated, or you were discriminated against on the basis of race, color, national origin, age, disability, gender identity and sexual orientation, you can write to us at:

Aetna Better Health Premier Plan
Attn: Privacy Officer
28588 Northwestern Hwy, Suite 380B
Southfield, MI 48034

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

If you are unhappy and tell the Office 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, such as:

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

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

Will we change this notice

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

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

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout the *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living: The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing the teeth.

Aid paid pending: You can continue getting your benefits while you are waiting for a decision about an appeal or fair hearing. This continued coverage is called "aid paid pending."

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. Chapter 9 explains appeals, including how to make an appeal.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need. Refer to Chapter 2 for more information.

Care plan: A plan for what supports and services you will get and how you will get them. Refer to Chapter 1 for more information.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan. Refer to Chapter 1 for more information.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. Chapter 2 explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, network providers, or network pharmacies. The formal name for "making a complaint" is "filing a grievance." Refer to Chapters 8 and 9 for more information.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services. Refer to Chapter 9 for more information.

Co-payment: A payment that you are required to pay for health services, in addition to the payment made by Aetna Better Health Premier Plan. You should not be required to pay any co-payments. If you receive a bill for a co-payment, you should contact your care coordinator. Refer to Chapter 1 for more information.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription drugs covered by our plan. Refer to Chapter 1 for more information.

Covered services: The general term we use to mean all of the health care, long term supports and services, supplies, prescription and over-the-counter drugs, equipment, and other services covered by our plan. Refer to Chapter 4 for more information.

Cultural Competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Refer to Chapter 10 for more information.

Drug Tiers: Groups of drugs on our Drug List. Generic, brand, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of three (3) tiers. Refer to Chapter 5 for more information.

Durable medical equipment (DME): Certain items your doctor or other health care provider orders for use in your home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers. (Refer to Chapters 3 and 4 for more information.

Emergency care / Emergency room care / Emergency services: Covered services that are given by a provider trained to give emergency services and needed to treat a medical emergency. Emergency care includes emergency room care and emergency medical transportation. Refer to Chapters 3 and 4 for more information.

Emergency Medical Condition: A medical emergency is when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be a serious injury or severe pain.

Emergency medical transportation: Transportation taking 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 health or, if you are pregnant, your unborn baby's life or health. Refer to Chapter 4 for more information. Refer to Chapters 3 and 4 for more information.

Exception: Permission to get coverage for a drug that is not normally covered or to use the drug without certain rules and limitations. Refer to Chapters 5 and 9 for more information.

Excluded Services: Services that are not covered by this health plan. Refer to Chapter 4 for more information.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D drug costs, such as premiums, deductibles, and copays. Extra Help is also called the "Low-Income Subsidy," or "LIS."

Fair hearing: A chance for you to tell your problem in a formal hearing and show that a decision we made is wrong. Refer to Chapter 9 for more information.

Freedom to Work: A program that provides health coverage to working people with disabilities in Michigan who are not otherwise eligible for Medicaid. People in the Freedom to Work program get full Medicaid coverage in exchange for a monthly premium. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html. Refer to Chapter 1 for more information.

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same active ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug. Refer to Chapter 5 for more information.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care. Refer to Chapter 9 for more information.

Habilitation Services/Devices: Health care services/devices that help you keep, learn, or improve skills and functioning for daily living.

Health Insurance: A type of insurance that pays for health and medical expenses. Refer to Chapter 1 for more information.

Health plan (also called Plan): An organization made up of doctors, hospitals, pharmacies, providers of long term supports and services, and other providers. It also has Care Coordinators to help you manage all your providers and services. They all work together to provide the care you need. Refer to Chapter 1 for more information.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future. Refer to Chapters 1 and 2 for more information.

Home health aide: A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care: Health care services that can be given in your home for an illness or injury. Refer to Chapter 2 for more information.

Hospice Services: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has a terminal illness and is expected to have six months or less to live. Refer to Chapter 4 for more information.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- Aetna Better Health Premier Plan must give you a list of hospice providers in your geographic area.

Hospitalization: When you are admitted to a hospital for health services/treatment.

Hospital Outpatient Care: Any health service/treatment that you get at a hospital that does not require hospitalization. Refer to Chapter 4 for more information.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than the plan's cost sharing amount for services. Show your Aetna Better Health Premier Plan Member ID Card when you get any services or prescriptions. Call Member Services if you get any bills you do not understand. Because Aetna Better Health Premier Plan pays the entire cost for your services, you do not owe any cost sharing. Providers should not bill you anything for these services. Refer to Chapter 7 for more information.

Inpatient: A term used when you have been formally admitted to the hospital for skilled medical services. If you were not formally admitted, you might still be considered an outpatient instead of an inpatient even if you stay overnight.

***List of Covered Drugs* (Drug List):** A list of prescription drugs covered by the plan. The plan chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary." Refer to Chapter 1 for more information.

Long term supports and services (LTSS): Long term supports and services are services that help improve a long term condition. LTSS includes nursing home services as well as home and community-based services. The home and community-based services help you stay in your home so you don't have to go to a nursing home or hospital. Refer to Chapter 3 for more information.

Low-income subsidy (LIS): Refer to "Extra Help."

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a 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 must meet accepted standards of medical practice. A specific service is determined medically (clinically) appropriate, necessary to meet needs, consistent with your diagnosis or health issue, is the most cost-effective option in the least restrictive environment, and is consistent with clinical standards of care. Medical necessity includes those supports and services designed to assist you to attain or maintain a sufficient level of functioning to enable you to live in your community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to "Health plan"). Refer to Chapter 10 for more information.

Medicare Advantage Plan: A Medicare program, also known as "Medicare Part C" or "MA Plans," that offers plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare-covered services: Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and Part B.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a "dually eligible individual." Refer to Chapter 1 for more information.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health and hospice care.

Medicare Part B: The Medicare program that covers services (like lab tests, surgeries, and doctor visits) and supplies (like wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program that lets private health insurance companies provide Medicare benefits through a Medicare Advantage Plan.

Medicare Part D: The Medicare prescription drug benefit program. (We call this program "Part D" for short.) Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Part B or Medicaid. Aetna Better Health Premier Plan includes Medicare Part D.

Medicare Part D drugs: Drugs that can be covered under Medicare Part D. Congress specifically excluded certain categories of drugs from coverage as Part D drugs. Medicaid may cover some of these drugs.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state. Refer to Chapter 1 for more information.

***Member Handbook* and Disclosure Information:** This document, along with your enrollment form and any other attachments or riders, which explains your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. Refer to Chapter 2 for information about how to contact Member Services.

Michigan Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long term supports and services and medical costs. It covers extra services and drugs not covered by Medicare. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Michigan Medicaid. Refer to Chapter 2 for information about how to contact Michigan Medicaid.

Network: The group of doctors, hospitals, and other healthcare providers that provide covered services to our members.

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they have agreed to work with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for health care professionals and support providers such as doctors, nurse practitioners, psychologists, hearing, dental, or vision specialists, nurses, pharmacists, therapists, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services; medical equipment; behavioral health, substance use disorder, intellectual/developmental disability, and long term supports and services.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with the health plan and accept our payment and not charge our members an extra amount.
- While you are a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers."

Non-participating provider: A provider that is not a part of our network.

Nursing home or facility: A place that provides care for people who cannot get their services at home but who do not need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsman's services are free. You can find more information about the ombudsman in Chapters 2 and 9 of this handbook.

Organization determination: The plan has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this handbook. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (traditional Medicare or fee-for-service Medicare): Original Medicare is offered by the government. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers amounts that are set by Congress.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you do not want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or Out-of-network facility (also called non-participating provider or facility): A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. Chapter 3 explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs refers to any drug or medicine that a person can buy without a prescription from a healthcare professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Participating provider: A provider that is included in our network.

Patient Pay Amount (PPA): The amount of money you may be asked to pay for the time you stay in a nursing home. This amount is based on your income and set by the state.

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits and medical history. Refer to Aetna Better Health Premier Plan's Notice of Privacy Practices for more information about how Aetna Better Health Premier Plan protects, uses, and discloses your PHI, as well as your rights with respect to your PHI. Refer to Chapter 8 for more information.

Person-centered Planning Process: A process for planning and supporting a person getting services. The process builds on the individual's desire to engage in activities that promote community life and that honor the individual's preferences, choices, and abilities. The individual leads the person-centered planning process, and it involves families, friends, legal representatives, and professionals as the individual desires or requires.

Primary care provider (PCP): Your primary care provider is the doctor or other provider you use first for most health problems.

- They make sure you get the care you need to stay healthy. They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to Chapter 3 for information about getting care from primary care providers.

Physician Services: Health services provided by a doctor.

Premium: The amount that you are required to pay for a health insurance policy. You do not have to pay a premium for your insurance with Aetna Better Health Premier Plan.

Prescription Drugs: A drug that requires medical prescription from a qualified health professional.

Prescription drug coverage: Drugs the health plan covers under Medicare Parts A, B and D, Medicaid that your provider orders for you. You get these drugs from a pharmacy or by mail-order. Refer to Chapters 4 and 5 for more information.

Primary Care Physician (also called Primary Care Provider, PCP or provider): A doctor that provides and coordinates general healthcare services for patients.

Prior authorization (PA) (also called preauthorization): An approval from Aetna Better Health Premier Plan you must get before you can get a specific service or drug or use an out-of-network provider. Aetna Better Health Premier Plan may not cover the service or drug if you don't get approval.

Some network medical services are covered only if your doctor or other network provider gets PA from our plan.

- Covered services that need our plan's PA are marked in the Benefits Chart in Chapter 4.

Some drugs are covered only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. They are paid by the federal government to check and improve the care given to patients. Refer to Chapter 2 for information about how to contact the QIO for your state.

Quantity limits: A limit on the amount of a drug you can have. Limits may be on the amount of the drug that we cover per prescription.

Referral: A referral means that your primary care provider (PCP) must give you approval before you can use someone that is not your PCP. If you don't get approval, Aetna Better Health Premier Plan may not cover the services. You don't need a referral for certain specialists, such as women's health specialists. You can find more information about referrals in Chapter 3 and about services that require referrals in Chapter 4.

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

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to Chapter 4 to learn more about rehabilitation services.

Rehabilitation devices: Certain equipment that help meet clinical or functional needs such as walkers, canes, and crutches, glucose monitors and infusion pumps.

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

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it is also generally the area where you can get routine (non-emergency) services. Only people who live in our service area can get Aetna Better Health Premier Plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Medicaid agency: The Michigan Department of Health and Human Services. This is the agency that runs Michigan's Medicaid program, helping people with limited incomes and resources pay for medical care and long term supports and services.

Step therapy: A coverage rule that requires you to first try another drug before we will cover the drug you are asking for.

Supplemental Security Income (SSI): A monthly benefit paid by Social Security to people with limited incomes and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgent care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-855-676-5772 (TTY: 711) 24 hours a day, 7 days a week**. Someone who speaks English/ Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llámenos al **1-855-676-5772 (TTY: 711) durante las 24 horas, los 7 días de la semana**. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 **1-855-676-5772 (TTY: 711)**，服务时间为每周 **7** 天，每天 **24**小时。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 **1-855-676-5772 (TTY: 711)**，服務時間為每天 **24** 小時，每週 **7** 天。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-855-676-5772 (TTY: 711) 24 na oras sa isang araw, 7 araw sa isang linggo**. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-855-676-5772 (TTY : 711). Ce service est disponible 24h/24, 7j/7**. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời bất kỳ câu hỏi nào quý vị có thể có về chương sức khỏe và chương trình thuốc men. Để được thông dịch, chỉ cần gọi theo số i **1-855-676-5772 (TTY: 711) 24 giờ/ngày, 7 ngày/tuần**. Người nói ngôn ngữ của quý vị có thể trợ giúp quý vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie **täglich rund um die Uhr unter 1-855-676-5772 (Schreibtelefon/TTY: 711).** Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-855-676-5772 (TTY: 711)**번으로 주 **7**일 하루 **24**시간 언제든 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно плана медицинского обслуживания или обеспечения лекарственными препаратами, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру **1-855-676-5772 (TTY: 711) в любое время суток и в любой день недели**. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على الرقم **1-855-676-5772 (TTY: 711) على مدار 24 ساعة في اليوم خلال 7 أيام في الأسبوع** . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं। एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-855-676-5772 (TTY: 711)** पर **24** घंटे एक दिन, सप्ताह में **7** दिन कॉल करें। कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है।

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-855-676-5772 (TTY: 711), attivo 24 ore al giorno, sette giorni alla settimana.** Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-855-676-5772 (TTY: 711), 24 horas por dia, 7 dias por semana**. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan sante ak plan medikaman nou yo. Pou jwenn yon entèprèt, jis rele nou nan **1-855-676-5772 (TTY: 711) 24 è sou 24, 7 jou sou 7**. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-855-676-5772 (TTY: 711) dostępny 24 godziny na dobę, 7 dni w tygodniu**. Ta usługa jest bezpłatna.

Japanese: 当社の健康保険と処方薬プランに関するご質問にお答えするため に、無料の通訳サービスをご用意しています。通訳をご希望の方は、**1**日**24**時間、週**7**日、**1-855-676-5772 (TTY: 711)**にお電話ください。日本語を話す人者が支援いたします。これは無料のサー ビスです。

Aetna Better Health Premier Plan Member Services

CALL	**1-855-676-5772** Calls to this number are free. 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 24 hours a day, 7 days a week.
WRITE	Aetna Better Health Premier Plan Aetna Duals COE Member Correspondence PO Box 982980 El Paso, TX 79998-2980
WEBSITE	**AetnaBetterHealth.com/Michigan**

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AetnaBetterHealth.com/Michigan

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