Aetna Better Health® of Michigan

2024 - 2025 Member Handbook

AetnaBetterHealth.com/Michigan

aetna®

3258944-MI-EN (rev 10/24)

Aetna Better Health® of Michigan

Helpful Information

Our website
AetnaBetterHealth.com/Michigan

Member Services
1-866-316-3784 (TTY: 711)

Emergency
911

Vision (VSP)
1-800-877-7195

Dental
1-844-870-3976

Behavioral Health Services
1-866-827-8704

Personal Information

_____
My member ID number

_____
My PCP's phone number

_____
My Primary Care provider (PCP)

Contents

Welcome to Aetna Better Health® of Michigan

Aetna Better Health of Michigan has a contract with the Michigan Department of Health and Human Services to provide health care services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about Aetna Better Health of Michigan. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting Member Services at **1-866-316-3784 (TTY:711)**. You can also access this handbook on our website at **AetnaBetterHealth.com/Michigan**.

INTERPRETER SERVICES

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call Member Services at **1-866-316-3784** for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Aetna Better Health of Michigan complies with all applicable federal and state laws with this matter. ¿Habla español? Por favor contacte a al **1-866-316-3784 (TTY: 711)**.

HEARING AND VISION IMPAIRMENT

TTY/TDD services are available free of charge if you have hearing problems. The TTY/TDD line is open 24/7 by calling **TTY: 711**.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call Member Services at **1-866-316-3784 (TTY: 711)** to request materials in a different format to meet your needs.

Member Services Toll-Free Help Line	1-866-316-3784 Monday – Friday 8AM-5PM
Member Services Help Line TTY/TDD	711, 24 Hours a day / 7 days a week
Website	AetnaBetterHealth.com/Michigan
Address	28588 Northwestern Hwy, Ste 380B Southfield, MI 48034
24 Hour Toll-Free Emergency Line	1-844-711-6664 (TTY: 711)
24 Hour Toll-Free **Nurse** Line	1-844-711-6664 (TTY: 711)
Pharmacy Services	1-866-316-3784
Transportation Services (non-emergency)	1-866-316-3784 Option 6 1-844-610-3734
Dental Services	1-844-870-3976 Monday-Friday 8AM-8PM
Vision Services	1-800-877-7195 Monday-Saturday 9AM-8PM
Mental Health Services	1-866-827-8704 24 hours a day
To file a complaint about a health care facility	1-866-316-3784 (TTY: 711)
To file a complaint about Medicaid services	1-866-316-3784 (TTY: 711)
To request a Medicaid Fair Hearing	Michigan Office of Administrative Hearings and Rules (MOAHR) for the Department of Health and Human Services P.O. Box 30763 Lansing, MI 48909 For questions, call 1-800-648-3397 Fax: 517-763-0146
Grievance and Appeals	Phone 1-866-316-3784 Monday-Friday 8AM-5PM Aetna Better Health of Michigan Attn: Appeals Coordinator PO Box 81139 5801 Postal Rd, Cleveland, OH 44181 Phone: 1-866-316-3784 (TTY: 711) Fax: 1-866-889-7517 Email: MIAppealsandGrievances@Aetna.com
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	1-855-444-3911

To report Medicaid fraud and/or abuse	1-855-421-2082
To find out information about domestic violence	1-866-316-3784 (TTY: 711) Domestic Violence Hotline: 1-800-799-7233
To find information about urgent care	1-866-316-3784
Michigan ENROLLS	1-888-367-6557
Michigan Beneficiary Help Line	1-800-642-3195 or TTY: 866-501-5656
MIChild Program	1-888-988-6300
MDHHS office locations and phone numbers	https://www.michigan.gov/mdhhs/inside-mdhhs/county-offices
Women, Infants and Children (WIC)	1-800-942-1636
Free service to find local resources. Available 24/7	2-1-1
Social Security Administration	1-800-772-1213 TTY/TDD: 800-325-0778
In an emergency	9-1-1
Suicide and Crisis Lifeline	9-8-8

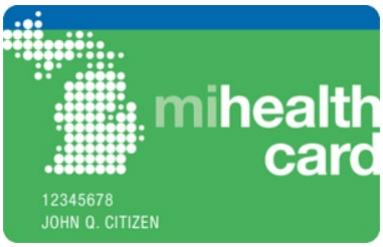
Aetna Better Health of Michigan makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency
- Of diverse cultural and ethnic backgrounds
- With a disability
- Regardless of gender, sexual orientation, or gender identity

Important Numbers and Contact Information
Identification Cards

YOUR STATE ISSUED MEDICAID ID CARD

When you have Medicaid, the Michigan Department of Health and Human Services (MDHHS) will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit. You may need your mihealth card to get services that Aetna Better Health of Michigan does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.

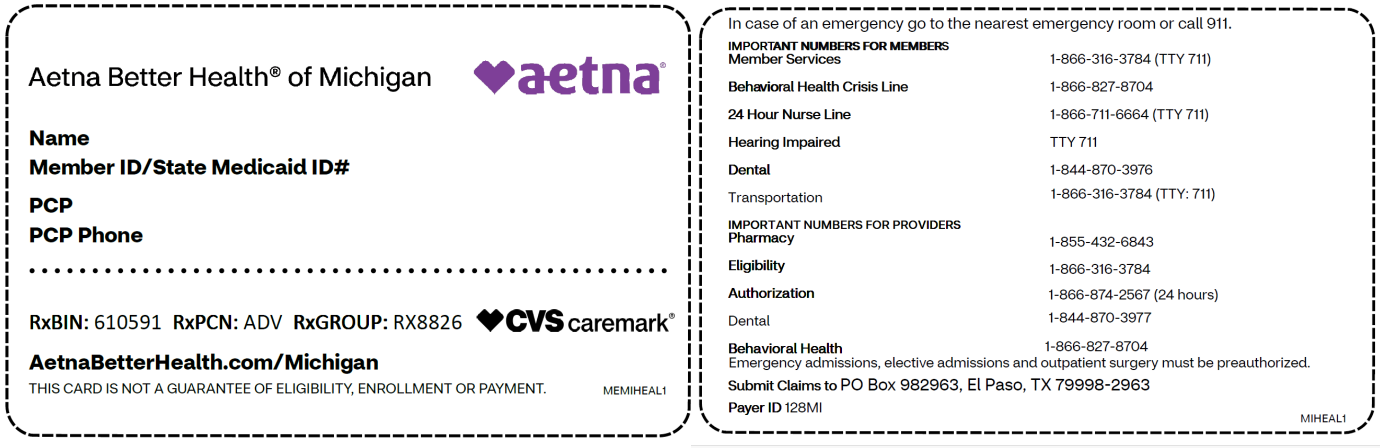


If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at **1-800-642-3195**. This number is located on the back of your mihealth card.

It is important to keep your contact information up to date so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting **www.michigan.gov/mibridges**. If you do not have an account, you can create one by selecting "Register". Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.

YOUR AETNA BETTER HEALTH OF MICHIGAN MEMBER ID CARD

You should have received your Aetna Better Health of Michigan ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.



If you have questions about this coverage or need a new Aetna Better Health of Michigan Member ID card, you should call Member Services at **1-866-316-3784 (TTY: 711)**.

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care
- Make sure all of your information is correct on both cards
- Call your local MDHHS office to change your records if your name or address changes
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card
- Do not let anyone else use your cards

Getting Help from Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

CONTACT US

You may call us at **1-866-316-3784 (TTY 711)**, Monday thru Friday 8am – 5pm.

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical Emergency Help Line for assistance. Call **1-866-316-3784 (TTY: 711)**.

OUR WEBSITE

You can visit our website at **AetnaBetterHealth.com/Michigan** to access online services such as:

- Provider network
- Frequently asked questions
- Contact phone numbers
- Email addresses

Aetna Better Health makes sure that all published electronic information works with assistive technology devices used by people with disabilities for information and communication. This applies to people with disabilities who use assistive technology to read and use electronic materials.

CONFIDENTIALITY

Your privacy is important to us. You have rights when it comes to protecting your health information. Aetna Better Health of Michigan recognizes the trust needed between you, your family, and your providers. Aetna Better Health of Michigan staff have been trained in keeping strict member confidentiality.

We respect your privacy. As required by the Health Insurance Portability and Accountability Act (HIPAA), Aetna and each member of the Aetna family of companies (an "Affiliate"), is giving you important information about how your medical and personal information may be used and about how you can access this information. Please review the following Notice of Privacy Practices carefully.

MANAGE YOUR DIGITAL HEALTH RECORDS/MEMBER MOBILE APPLICATION

Aetna Better Health of Michigan has a mobile app! It is easy to use right on your cell phone. Go to **AetnaBetterHealth.com/Michigan** or download the mobile app.

Through the mobile app you have access to:

- Find a provider
- View the member handbook
- Check claims

- Order a new ID card
- See your current medications

For iPhone users go to the Apple Store, for Android users go to the Google Play Store then search Aetna Better Health.

Transition of Care

If you're new to Aetna Better Health of Michigan, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through the pregnancy and post-partum period.

If you are a Aetna Better Health of Michigan member and your doctor no longer participates with us, you can continue to see your doctor if you are receiving treatment for certain chronic diseases.

We will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition
- The doctor has a restriction and you might be at risk
- The doctor is not willing to continue your care
- Care with the non-participating doctor was started after you enrolled with Aetna Better Health of Michigan
- The doctor does not meet Aetna Better Health of Michigan policies or criteria

Aetna Better Health of Michigan will help you choose new doctors and help you get services in our network. Your doctor may call **1-866-316-3784 (TTY: 711)** if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services.

Please contact us at **1-866-316-3784 (TTY: 711)** to request transition of care services or if you have any questions about your care.

Getting Care

CHOOSING A PRIMARY CARE PROVIDER

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the health care provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor
- Family practice doctor
- Nurse Practitioner
- Internal medicine doctor
- Pediatrician doctor
- OB/GYN doctor

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at **AetnaBetterHealth.com/find-provider** You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling **1-866-316-3784 (TTY: 711)**. Remember provider information changes often. Visit our website for the most up-to-date information. Call Member Services if you need help finding a doctor.

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

If you have certain health care needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Member Services at **1-866-316-3784 (TTY: 711)** for more information.

Make sure you ask the provider office if they participate in the Aetna Better Health network.

GETTING CARE FROM YOUR DOCTOR

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at **1-866-316-3784 (TTY: 711)**.

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

GETTING CARE FROM A SPECIALIST

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your doctor or call Member Services at **1-866-316-3784 (TTY: 711)** for more information. If you have special health care needs, you may not be required to obtain a referral or prior authorization as a condition to receive certain services from specialists in the network Contact Member Services or your Care Manager for more information.

OUT-OF-NETWORK SERVICES

You must get most of your care from providers in our provider network. Aetna Better Health Member Services **(1-866-316-3784 (TTY: 711)** can help you find a provider in our network.

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

If a member moves out of the service area after the effective date, the Aetna Better Health Coverage will remain in effect until the Member is disenrolled by MDHHS from the Plan. The Member may be required to return to the Aetna Better Health's Service Area to seek Medically Necessary Covered Services from Participating Providers, or the Aetna Better Health may Authorize the Member to seek Medically Necessary Covered Services outside of the Aetna's Service Area. Aetna may not pay for otherwise Covered Services provided outside of the Service Area if no Prior Authorization was obtained, except when Covered Services were rendered in response to an Emergency Medical Condition.

Out of State Services

Out of the state services provided by out-of-network providers require prior authorization.

Out of Country Services

Health care services provided outside the country are not covered by Aetna Better Health of Michigan.

PHYSICIAN INCENTIVE DISCLOSURE

Aetna has pay for quality incentive programs in place to improve health outcomes. For a copy of the Aetna Better Health Pay for Quality program, contact Member Services at **1-866-316-2784**.

PRIOR AUTHORIZATION

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve the service, we will notify the doctor and send you a written notice of the decision.

Aetna Better Health does not prevent our providers from:

- Speaking on our Member's behalf.
- Discussing treatment and services.
- Discussing payment arrangements between the Provider and the Plan.

We do not pay our providers or encourage them to withhold or deny medical care or services. Decisions about your health care are based on medical needs. If you have any questions, you can call Member Services at **1-866-316-3784 (TTY: 711)**.

Our utilization management (UM) program ensures you get the right care in the right setting when you need it. UM staff can help you and your doctors make decisions about your healthcare. Our UM program helps make sure you get the right services at the right place. When we make decisions, it's important for you to remember the following:

- We make UM decisions by looking at your benefits and clinical guidelines for the most appropriate care and service. We consider your needs, evidenced based practice, and availability of care. You also must have active coverage.
- We don't reward doctors or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services you get.

If you have questions about UM, you can speak to someone by calling Member Services toll-free at **1-866-316-3784 (TTY: 711)**, 24 hours a day, 7 days a week. If you need Language translation or assistance, you can contact Member Services toll-free at **1-866-316-3784 (TTY: 711).**

GETTING A SECOND OPINION

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from an Aetna Better Health of Michigan network provider. Second opinions do not require prior authorization from us. Please call Member Services at **1-866-316-3784 (TTY: 711)** to learn how to get a second opinion. Aetna Better Health will help you obtain a second opinion from an out-of-network provider at no additional cost if an appropriate in-network provider is not available.

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As an Aetna Better Health of Michigan member you do not have to pay co-pays for covered services under the Medicaid or Healthy Michigan Plan. See Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. The COC and Member Handbook are on our website at **AetnaBetterHealth.com/Michigan**.

Make sure a service is covered before the service is done. You may have to pay for services not covered by Aetna Better Health of Michigan under the Medicaid program.

Aetna Better Health of Michigan does not deny reimbursement or coverage for services on any moral or religious grounds.

TELEHEALTH/TELEMEDICINE SERVICES

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses and mental health needs without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, other illnesses, and mild to moderate mental health care, you can connect with a provider through your phone or computer to receive care where you are, when you need it. Providers can diagnose, treat, and even prescribe medicine, if needed. Call your provider's office to see if they offer telehealth services. Member Services can also assist you with virtual care options.

BENEFITS MONITORING PROGRAM

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency
- Seeing too many different doctors instead of your primary care doctor
- Getting more medicines than may be safe
- Activity that may indicate fraud

Using the right health services in the right amount helps us make sure you're getting the very best care.

Covered services include:

Aetna Better Health covers the following services. We will cover these services if they are medically needed. Some services may require a prior authorization.

Medically needed services include:

- The tests you need to find out if you are ill or injured
- The medical care to treat you if you are ill or injured
- Preventive care to help you avoid becoming ill or injured
- Medically needed services must:
- Be appropriate
- Meet your basic health care needs
- Begiven to you in an appropriate and cost-effective way
- Be the services that medical research and science guidelines recommend
- Be used to treat your health condition
- Not be experimental

Covered Services

- Ambulance and other emergency medical transportation
- Breast pumps; personal use, double-electric
- Blood lead testing in accordance with Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) policy
- Certified nurse midwife services
- Certified pediatric and family nurse practitioner services
- Chiropractic services
- Community Health Worker (CHW)/ Community Health Representative (CHR) services
- Dental services for adults
- Diagnostic laboratory, x-ray, and other imaging services
- Doula services

- Durable medical equipment (DME) and supplies
- Emergency services
- End Stage Renal Disease (ESRD) services
- Family planning services
- Health education
- Hearing aids
- Hearing and speech services
- Home Health services
- Hospice services
- Immunizations
- Inpatient and outpatient hospital services
- Intermittent or short-term restorative or rehabilitative services, in a nursing facility, up to 45 Days
- Long-term care acute hospital services (LTACH)
- Maternal and Infant Health Program (MIHP) services
- Medically Necessary weight reduction services
- Mental health assessment and certain services
- Non-emergency medical transportation
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Practitioners' services
- Preventive services required by the Patient Protection and Affordable Care Act as outlined by MDHHS.
- Prosthetics and orthotics
- Restorative or rehabilitative services in a place of service other than a nursing facility
- Sexually transmitted infections (STI) treatment
- Substance use disorder consult services
- Tobacco cessation treatment including pharmaceutical and behavioral support.

- Therapeutic services (speech, physical, occupational) Transplant services
- Vision services
- Well-child/EPSDT for persons under age 21

In addition to the services above Aetna Better Health of Michigan also offers the following benefits:

Asthma Support	Members with asthma can receive one set of hypoallergenic bedding and help to pay for carpet cleaning and pest control.
Active & Fit Gym Membership	Members have access to a fitness center, on-demand workout videos, and The Active&Fit Connected!™ tool for tracking activity.
Over-the-counter drugs and supplies	$25 per household per month.
Career & Life Skills Training & GED Support	Members ages 16 and older can get job skills training and a GED online prep course. Members passing the GED Prep test will get help to pay for the GED Exam.
Legal Supports and Services	Members ages 18+ may quality for $500 towards certain legal services.
Pyx Health	Members ages 18+ can talk to someone when they feel stressed or anxious. They can get help finding things like food or transportation. Pyx can also help you find a doctor or understand your benefits.
Healthy Food Card	Members aging out of foster care can receive $50 per month for 1 year to support access to healthy food.

PRESCRIPTION SERVICES

Your Aetna Better Health of Michigan benefits include coverage for prescriptions. We cover a wide range of prescription and over-the-counter (OTC) medications to help keep our members as healthy as they can be.

Aetna Better Health of Michigan uses the MDHHS Preferred Drug List (PDL) and Common Formulary, which means that only drugs listed on the PDL or Common Formulary are covered. Some medications require a prior authorization for coverage. Please visit our website at **AetnaBetterHealth.com/Michigan/pharmacy-prescription-drug-benefits.html** for the most up to date formulary coverage. If you would like more information on the formulary or drugs that require our prior authorization, Member Services can help by calling **1-866-316-3784 (TTY: 711)**.

Diabetes supplies are included in the Aetna Better Health of Michigan Pharmacy Benefit, for a detailed description on which supplies are covered, please visit our site for the most up to date information.

The Aetna Better Health of Michigan Pharmacy Benefit also includes coverage for some OTC medications on the PDL with a prescription from your provider and when you fill your OTC prescription at a pharmacy in our network.

In addition to the above pharmacy benefits, Aetna Better Health of Michigan members may also utilize a $25 per month OTC Card benefit. Members may purchase items found at a pharmacy without a prescription. Items include OTC drugs, baby items, shampoo, dental care items, food items and much more. Please visit our website for more information or contact our Member Services Department at **1-866-316-3784 (TTY: 711)**.

Aetna Better Health works with CVS Caremark, our pharmacy benefit manager. They help manage your prescription drug coverage. You can fill your prescriptions at over 2,000 pharmacies statewide. Our network also includes mail order services, please visit our website to get started with our mail order pharmacy.

CARE COORDINATION

Do you have a chronic health problem or disability? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through health care. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits

As a member of Aetna Better Health, you have your own care manager. This is part of our care management program. Your care manager is here to help you find the care and services you need. You'll get a call from your care manager soon after you are enrolled with Aetna Better Health Plan.

Do you have questions for your care manager? Just call your care manager directly or call the 24-hour Care Management line at **1-866-316-3784**, ask for Case Management **(TTY: 711)**, 24 hours a day, 7 days a week. Your care manager is there for you.

CARE MANAGEMENT

At times, you may not need much assistance from a care manager, but conditions can change and can be overwhelming. To offer you support, your doctor, hospital discharge planner or other provider or your caregiver may refer you to Care Management. A nurse on our health information line may also refer you. If you need help, do not wait for a referral. You can self-refer by calling us at **1-866-316-3784, (TTY: 711)** and ask for Care Management. Call Aetna Member Services for more information about the Care Management program.

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care manager about your health care. A care manager helps you:

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions
- Access community-based supports, services, and resources

If you are interested in joining this program, please call Member Services at **1-866-316-3784** to be connected with a care manager.

CHILDREN'S HEALTH

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight and BMI checked. Providers can talk about health, safety and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development. EPSDT can provide coverage for medically necessary services

even if these are not normally covered by Medicaid. For more information on EPSDT, go to the Bright Futures website **http://brightfutures.aap.org/**.

EPSDT checkups include:

Well-care visits	Physical and mental developmental/behavioral assessments
Health history and physical exam, including school and sports physicals	Crucial lab tests, including lead screening
Developmental screening	Nutrition assessment
Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children's Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children's Special Health Care Services (CSHCS).

CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from Aetna Better Health of Michigan.

There is no cost for this program. It doesn't change your child's Aetna Better Health of Michigan benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies.

MDHHS Family Center for Children and Youth with Special Health Care Needs:

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at **1-800-359-3722** from 8 AM to 5 PM Monday through Friday.

Local County Health Department:

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines and more. For help finding your local county health department, visit your county's website or **Michigan.gov**. Call Member Services at **1-866-316-3784 (TTY: 711)** for assistance.

Children's Special Needs Fund:

The Children's Special Needs fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts and mobility equipment. To see if you qualify for help from this fund call **517-241-7420**.

To see if you qualify for help from the CSN Fund, call **517-241-7420**. Examples of help include:

- Wheelchair ramps
- Van lifts and tiedowns
- Therapeutic tricycles
- Air conditioners
- Adaptive recreational equipment
- Electrical surge upgrades for eligible equipment

Services that are not covered by Aetna Better Health and are only covered by CSHCS include:

Orthodontia services provided for certain diagnosis*.

- Respite services*
- Certain over-the-counter medications
- Hemophilia drugs
- Certain orphan drugs

*These services will be coordinated by the local health department.

The CSN Fund also can help with adult transition services. You can get help from the Family Center for Child and Youth with Special Health Care Needs by:

- Calling the CSHCS toll-free Family Phone Line at **1-800-359-3722**, Monday – Friday from 8 AM to 5PM.
- Services can include:
    - Parent-to-parent support network.
    - Parent/professional training programs.
    - Financial help to go to CSHCS medical condition conferences

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services.

Aetna Better Health of Michigan CSHCS can help members with special health care needs transitioning from pediatric health care to adult health care services. We will help you by:

- Planning for members move to adult services early around 12 years old for better control of your condition
- Teaching members how to obtain health care and other services
- Members will get new doctors and need to tell them about their health
- Learn to ask for what they need
- Learn to have an active role in their health
- Understand their condition

When members turn 18 years old they are in charge of their own health care. There may be a need for guardianship. Some actions must be done through the courts so it's important to start looking at options well before 18 years of age.

Members 18 and older must give doctors and insurance companies approval to speak to their parents. Adult members give approval by allowing others to be:

- Partial guardian
- Full guardian
- Power of attorney (POA)
- Patient advocate

- Finding a new doctor
- Members should ask their current doctor who they want them to see
- Aetna Better Health of Michigan has a list of providers for members to choose from
- Members can change doctors anytime

COMMUNITY HEALTH WORKERS (CHW)

Community Health Workers are the front-line public health workers within the community, assisting members with navigating health care. CHWs serve as a bridge between health care and social services by building trusting relationships. CHWs full range of services include:

- Meeting face to face to improve your access to health care
- Helping others find providers and set up visits
- Finding local support like food and housing
- Teaching ways to live a healthy life
- Helping with provider follow-up visits after going to the hospital or emergency room
- Helping set up rides for medical or pharmacy visits

Contact Member Services at **1-866-316-3784 (TTY: 711)** for more information.

DENTAL SERVICES

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with DentaQuest to provide your dental benefits. If you have any questions about your dental services, please contact Dental Customer Service at **1-844-870-3976 (TTY users call 711)**.

Your dental care is important to your overall health. It is recommended that you see your dentist every 6 months for a check-up and cleaning. Your first call for any oral health concerns should be the dentist you see regularly, your dental home.

Covered dental services include:

- Routine exams and cleanings every six months
- Up to four bitewing X-rays every year

- Full-mouth X-rays once every five years
- One filling per tooth every 12 months
- Emergency exams, no more than twice a month
- Topical fluoride or fluoride varnish up to age 21, every 6 months
- Crowns, once every five years on the same tooth
- Root canal therapy
- Extractions
- Retreatment of previous root canal, once per tooth per lifetime
- Periodontal evaluation, once every 12 months
- Periodontal maintenance, once every six months
- Complete and partial dentures, once every five years per arch

Some of these services may require prior approval, please consult with your dentist prior to treatment. Written notice will be sent to the dentist and member if the requested treatment is denied.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at **1-800-642-3195** for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: **1-800-936-0935**

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (deltadentalmi.com)
Phone: **1-866-696-7441**

DURABLE MEDICAL EQUIPMENT

Some medical conditions need special equipment. Durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters and alcohol pads
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters and insulin pumps.
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed.

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call Member services at **1-866-316-3784 (TTY: 711)**.

EMERGENCY CARE

Emergency care is for a life-threating medical situation or injury that a reasonable person would seek care right away to avoid severe harm. Here are some examples of emergencies:

Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)
Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call **911** or go to the emergency room. You do not need an approval from Aetna Better Health of Michigan or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

FOOD SERVICES

(If approved by the federal government, in lieu of services will begin 1/1/2025) Michigan Medicaid and your Medicaid health plan are offering food services to improve your health. You may qualify for one of these services at no cost to you. The food service(s) include:

- Medically Tailored Home Delivered Meal
- Healthy Home Delivered Meal
- Healthy Food Pack
- Produce Prescription

It is up to you whether you use a food service if you qualify. Your Medicaid coverage and access to other medical services will stay the same if you use a food service or choose not to.

You can file a grievance or appeal about the food service, for example, if you are not approved for a food service. Information on how to file a grievance or appeal can be found on page 48.

Keep reading to learn more about your food service options and if you may qualify for a food service, or. If you have any questions, call Member Services at **1-866-316-3784 (TTY: 711)** for more information.

Medically Tailored Home Delivered Meal

Through the Medically Tailored Home Delivered Meal service, you will receive up to two healthy meals per day (or 14 per week) delivered to your home for up to 6 months, or longer if determined to be medically necessary.. These meals are tailored to your health needs.

You will also get help from a registered dietitian. This person is a nutrition expert and will give you guidance on choosing healthy foods.

This service is for members who cannot get enough food when they need it, cannot shop for and cook their own healthy meals, ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus

(HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, diabetes during pregnancy, other pregnancy complications, a substance use disorder or a mental health disorder;

- Have been in a hospital or skilled nursing facility in the last 90 days.

If you have any questions, call Member Services at **1- 866-316-3784 (TTY: 711)** for more information.

Healthy Home Delivered Meal

Through the Healthy Home Delivered Meal service, you will receive up to two healthy meals per day delivered to your home for up to 6 months, or longer if determined to be medically necessary.

This service is for members who cannot get enough food when they need it, cannot shop for and cook their own healthy meals ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder;
- Have been in a hospital or skilled nursing facility in the last 90 days;
- Are likely to end up in the hospital or another facility if they cannot access healthy food;
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, a mental health condition
- Used to be in foster care and is at risk of developing an illness;
- Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food;
- Are a child eligible for the Children's Special Health Care Services (CSHCS) program;
- Are an adult eligible for the Persons with Special Health Care Needs (PSHCN) program;
- Have a disability.

If you have any questions, call Member Services at **1- 866-316-3784 (TTY: 711)** for more information.

Healthy Food Pack

Through the Healthy Food Pack service, you will be able to pick up a mix of healthy foods or have them delivered to your home weekly for up to 6 months, or longer if determined medically necessary.

This service is for members who cannot get enough food when they need it, cannot shop for their own healthy foods ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder;
- Have been in a hospital or skilled nursing facility in the last 90 days;
- Are likely to end up in the hospital or another facility if they cannot access healthy food;
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, a mental health condition
- Used to be in foster care and is at risk of developing an illness;
- Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food
- Are a child eligible for the Children's Special Health Care Services (CSHCS) program;
- Are an adult eligible for the Persons with Special Health Care Needs (PSHCN) program;
- Have a disability.

If you have any questions, call Member Services at **1- 866-316-3784 (TTY: 711)** for more information.

Produce Prescription

Through the Produce Prescription service, you will receive a voucher to buy fruits and vegetables for up to 6 months, or longer if determined to be medically necessary.

This service is for members who cannot get enough food when they need it ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder; ***OR***
- Have been in a hospital or skilled nursing facility in the last 90 days; ***OR***
- Are likely to end up in the hospital or another facility if they cannot access healthy food; ***OR***
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, and a mental health condition ***OR***
- Used to be in foster care and is at risk of developing an illness; ***OR***
- Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food
- Are a child eligible for the Children's Special Health Care Services (CSHCS) program; ***OR***
- Are an adult eligible for the Persons with Special Health Care Needs (PSHCN) program; ***OR***
- Have a disability.

HEALTHY BEHAVIORS

You may be eligible to participate in a healthy behavior incentive program. Incentives can be earned for the following:

- Screenings
- Wellness Visits
- Pregnancy and Birth Care
- Healthy Actions

To get more information, visit our website at: **AetnaBetterHealth.com/Michigan/rewards-program.html** or call Member services at **1-866-316-3784 or (TTY: 711)**.

HEARING SERVICES

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams
- Medically necessary hearing aid evaluations and fittings
- Medically necessary hearing aids

If you need a hearing exam or think you need hearing aids, call Aetna Member Services **1-866-316-3784 (TTY: 711)**. You can also call a provider from our list of hearing providers.

HEPATITIS C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

HOME HEALTH CARE, SKILLED NURSING SERVICES AND HOSPICE CARE

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan)
- Home health care services for members who are homebound
- Supplies and equipment related to home health care
- Hospice care

HOSPITAL CARE

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more. Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. If you feel you have a substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY: 711)**.

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often
- Performing poorly at work or school
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.
- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down

- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substance's effects
- Giving up or reducing important social, work, or recreational activities because of substance use
- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits call Behavioral Health Services **1-866-827-8704** You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call 911. You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

OBSTETRICS AND GYNECOLOGY CARE

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network and some out-of-network providers such as public health departments and federally qualified health clinics. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:

Family Planning	Prenatal and postpartum care
Pregnancy testing	Midwife services in a health care setting
Birth control and birth control counseling	Delivery care
HIV/AIDS testing and treatment of sexually transmitted diseases	Parenting and birthing classes
Pregnancy and maternity care, including the Maternal Infant Health Program	Mammograms and breast cancer services, such as treatment and reconstruction
Doula Services	Pap tests
Depression Screening	

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact **Member Services at 1-866-316-3784 (TTY: 711)** as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
  (It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Member Services at **1-866-316-3784 (TTY: 711)** and ask for the Care Management department and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

Prenatal care and postpartum care are important for a healthy baby and mom. Aetna Better Health of Michigan offers prenatal and post-partum programs to help pregnant members have a healthy pregnancy and baby. It's important for you to visit your OB/GYN doctor as soon as you know that you are pregnant. Your doctor may have you come in for six or more visits during your pregnancy. Try to ensure that you make all of your visits.

Our Care Management staff can help you make prenatal and postpartum appointments. If you are high-risk you may want to talk to a Care Manager. If you want to learn more, call Member Services at **1-866-316-3784 (TTY: 711)** If you are pregnant, early and regular checkups can help protect you and your baby's health. Aetna Better Health of Michigan wants to make sure that you and your baby get the services you need. These services include:

- Routine pregnancy medical checkups
- Dental services
- Information about your hospital choices
- Information about pregnancy, labor and delivery
- HIV counseling and testing
- STI counseling, screening and support
- Support with accessing healthy food from GA Foods
- Help in applying for programs such as the Women, Infants and Children (WIC) program, low-or no-cost health insurance for your family
- Referrals for MIHP services
- Services after delivery
- Healthcare for your baby
- Family planning services
- Network Doulas and Midwives

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Member Services at **1-866-316-3784 (TTY: 711)** to report the change. This starts the process of signing your baby up for health care services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Member Services at **1-866-316-3784 (TTY: 711)** if you need help.

Change in Family Size

When you experience a change in family size, contact Member Services at **1-866-316-3784 (TTY: 711)** to let us know and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support, education, and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking
- Help with substance abuse
- Personal care or home help services

Call Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY: 711)** or visit **www.michigan.gov/mihp** for more information on how you can access these services.

PREVENTIVE HEALTH CARE FOR ADULTS

Preventive health care for adults is important to Aetna Better Health of Michigan. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early.

Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes

- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings

You can also ask your doctor about:

- Immunizations
- HIV/AIDS testing and treatment of sexually transmitted diseases

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you should and should not do to take control of your health are listed below.

Things you should do:	Things you should **not** do:
• Eat healthy • Exercise • Get enough sleep • Manage your stress • Don't smoke or use tobacco • Don't use drugs or drink alcohol • Go to the dentist for regular cleanings and preventive services • Visit your doctor each year for yearly preventive care	• Eat foods high in fat, sugar, and salt • Live an inactive lifestyle • Hold in your feelings or emotions if you're feeling stressed or depressed • Use drugs, alcohol, or tobacco • Forget to set up your dentist visits for regular cleanings and preventive services • Forget to set up a yearly visit to your doctor • Avoid going to the doctor

ROUTINE CARE

Routine care is for things like:

- Yearly wellness exams
- School physicals

- Health screenings
- Immunizations
- Vision and Hearing Exams
- Lab tests

Your doctor should set up a visit within 30 business days of request.

TRANSPORTATION SERVICES

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call Member Services at **1-866-316-3784 (TTY: 711)** available 24 hours per day, 7 days a week, 365 days per year for more information and to schedule a ride. Please call 3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

- Your name, Medicaid ID number and date of birth
- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.

If you are receiving services through the local Community Mental Health Services Program (CMHSP) agency, there may be some transportation services that you will continue to receive through the local CMHSP agency. Contact your local CMHSP agency for questions about this benefit.
Please be sure to call us as soon as possible if you need to cancel.

Emergency

If you need emergency transportation, call **911**.

Tobacco Cessation

URGENT CARE AND AFTER-HOURS CARE

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office.

VISION SERVICES

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 24 months
- One pair of glasses every 24 months
- Eye glass frames
- Contact lenses

You do not need a referral to get eye care. If you need glasses or an eye exam, call **1-800-877-7195** . You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources. It can be hard to focus on your health if you have problems with your housing or worry about having enough food to feed your family. Aetna Better Health can connect you to resources in your community to help you manage issues beyond your medical care. Call the Member REACH Team at **1-833-316-7010 (TTY: 711)** if you need:

- Financial assistance
- Food assistance
- Educational services
- Housing assistance
- Legal services
- Employment services
- Support groups
- Baby supplies
- Clothing

The Member REACH (Real Engagement And Community Help) team is dedicated to understanding and assisting with member's individual needs and can connect you to local community programs that may be able to offer the above services. Call **1-833-316-7010**, Monday through Friday, 9 AM-5 PM EST to talk to a Member REACH Coordinator.

Caring and helpful resources are just around the corner. Using the Community Resource Directory (CRD) tool, you can find support near you. From food and housing services to wellness and mental health support and more.

The CRD lets you:

- Search for resources
- Save your resources
- Share feedback
- Suggest new resources

How to get to the CRD:

- Log in to your Member Portal.
- Under the “Resources” column, go to “Community Resource Directory.”
- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors’ appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we can help. We know it’s difficult to get to your doctor for important health screenings or other care when you’re facing these challenges. If you’re struggling with a similar problem, or need assistance, reach out to your Care Manager. If you don’t have a Care Manager, and need help please call Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY: 711)**.

You can also access resources at the following:

- Online through our website: **AetnaBetterHealth.com/Michigan**
- Online through the State of Michigan portal: **https://newmibridges.michigan.gov**
- Online through the Michigan 2-1-1 website: **www.mi211.org**

Women, Infants, and Children (WIC) is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Call **1-800-262-4784** to find a WIC clinic near you or call Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY: 711)** for assistance.

Cost Sharing and Copayments

A copayment (sometimes called "co-pay") is a set dollar amount you are required to pay as your share of the cost for a medical service or supply. Aetna Better Health of Michigan does not require you pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan program.

You must go to a doctor in Aetna Better Health of Michigan Medicaid network, unless otherwise approved. If you go to a doctor that is not in Aetna Better Health of Michigan Medicaid network and did not get approval to do so, you may have to pay for those services. You should not receive a bill from your doctor for covered services within the plan's network. If you have questions about how co-pays may apply to you, contact Aetna Better Health of Michigan Member Services **1-866-316-3784 (TTY: 711)**.

Services Covered by Medicaid Not Aetna Better Health of Michigan

Aetna Better Health of Michigan does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at **1-800-642-3195**.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
    - Screening and assessment
    - Detox
    - Intensive outpatient counseling
    - Other outpatient care
    - Methadone treatment

Non-Covered Services

- Elective abortions and related services
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment
- Elective cosmetic surgery
- Services for the treatment of infertility

Rights and Responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you

- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations

- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of the Aetna Better Health of Michigan
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval

You have the Responsibility to:

- Review this handbook and Aetna Better Health of Michigan Certificate of Coverage
- Make and keep appointments with your Aetna Better Health of Michigan doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes

- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to **https://newmibridges.michigan.gov/.**

Grievances and Appeals

We want you to be happy with the services you get from Aetna Better Health of Michigan and our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help, call Member Services at **1-866-316-3784 (TTY: 711)**.

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. Aetna Better Health of Michigan has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

- Your provider or a(n) Aetna Better Health of Michigan staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a(n) Aetna Better Health of Michigan staff member was rude to you.
- Your provider or a(n) Aetna Better Health of Michigan staff member was insensitive to your cultural needs or other special needs you may have.

You can file your grievance on the phone by calling Member Services at **1-866-316-3784 (TTY: 711)**. You can also file your grievance in writing via mail or fax at:

Aetna Better Health of Michigan Attn: Appeals Coordinator
PO Box 81139
5801 Postal Rd,
Cleveland, OH 44181
Phone: **1-866-316-3784 (TTY: 711)**
Fax: **1-866-889-7517**
Email: MIAppealsandGrievances@Aetna.com

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling **1-866-316-3784] (TTY: 711)**. We will let you know when we have received your grievance. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, inform Aetna Better Health of Michigan in writing with the name of your representative and their contact information. Your grievance will be resolved within 90 - calendar days of submission. We will send you a letter of our decision.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an "Adverse Benefit Determination" letter from us. This letter will tell you the following:

- The adverse benefit determination the contractor has made or intends to make.
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it.
- Your right to file an appeal and how to do it.
- Your right to ask for a State Fair Hearing/External Review and how to do it.
- Your right in some circumstances to ask for an expedited appeal and how to do it.

- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services.

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not telling you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

You can file your appeal on the phone by calling Aetna Better Health at **1-866-316-3784 (TTY: 711)**. You can also file your appeal in writing via mail or fax at:

Aetna Better Health of Michigan Attn: Appeals Coordinator
PO Box 81139
5801 Postal Rd,
Cleveland, OH 44181
Phone: **1-866-316-3784 (TTY: 711)**
Fax: **1-866-889-7517**
Email: MIAppealsandGrievances@Aetna.com

You have several options for assistance. You may:

- Call Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY: 711)** and we will assist you in the filing process.
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either:
1. Send us a letter informing us that you want someone else to represent you and include in the letter their contact information or

2. Fill out the Authorized Representative Appeals form. You may call and request the form or find this form on our website at **AetnaBetterHealth.com/Michigan/medicaid-grievance-appeal-form.html**

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

Aetna Better Health of Michigan will send our decision in writing to you within 30 calendar days of the date we received your appeal request, or within 10 calendar days if you are receiving CSHCS benefits. Aetna Better Health of Michigan may request an extension up to 14 more days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If Aetna Better Health of Michigan's decision agrees with the Notice of Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If Aetna Better Health of Michigan's decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when Aetna Better Health of Michigan reviews your appeal.

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. Aetna Better Health of Michigan will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY: 711)**.

What Happens Next?

After you receive the Notice of Internal Appeal Decision in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a Notice of Internal Appeal Decision from us within the required time frame.

Call Aetna Better Health of Michigan Member Services at **1-866-316-3784** if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, 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.

If you have any questions, you can call MOAHR at **1-800-648-3397**.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can

also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send your request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Or call: **1-877-999-6442**
Fax: **517-284-8838**
Online: **https://difs.state.mi.us/Complaints/ExternalReview.aspx**

Make Your Wishes Known: Advance Directives

Aetna Better Health of Michigan supports your right to file an "Advance Directive" according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don't want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a *durable power of attorney for health care*. To create one, you will need to choose a patient advocate.

This person carries out your wishes and makes decisions for you when you cannot. It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Aetna Better Health of Michigan Member Services at **1-866-316-3784 (TTY:711)** for more information and the forms you need to write an advance directive.

If your wishes aren't followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170
Call: **517-373-9196**
Or click below:
https://www.michigan.gov/lara/bureau-list/bpl

If you have complaints about how Aetna Better Health of Michigan follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at **1-877-999-6442** or go to **https://www.michigan.gov/difs**.

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

Fraud

Fraud is purposefully misrepresenting facts. Here are some examples of fraud:

- Using someone else's member ID card
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from health care for people who need it. Here are some examples of waste:

- Using transportation services for non-medical appointments
- Doctors ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

- Using the emergency room for non-emergent health care reasons
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a doctor's office, hospital, or pharmacy
- Receiving services that are not medically necessary

You Can Help

We work to find, investigate, and prevent health care fraud. You can help. Know what to look for when you get health care services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you
- The type and date of service are the same type and date of service you received
- The diagnosis on your paperwork is the same as what your doctor told you

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name. If you'd like to report fraud, waste, or abuse, you can call any one of our helplines:

- SIU FWA Hotline: **1-855-421-2082 (TTY: 711)**
- Member Services: **1-866-316-3784 (TTY: 711)**
- Provider Relations: **1-866-316-3784 (TTY: 711)**
- Special Investigations Unit: **1-866-806-7020 (TTY: 711)**

You can also fill out our fraud, waste and abuse form on our website at **AetnaBetterHealth.com/Michigan/medicaid-fraud-abuse-form.html**.

You may also report or get more information about health care fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: **1-855-MI-FRAUD (1-855-643-7283)**
Or visit: **michigan.gov/fraud Information may be left anonymously**

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service
- A supply or item
- A prescription drug that you think you should be able to get

Reduces, limits, or denies coverage of:

- A healthcare service
- A supply or item
- A prescription drug you already got

Your plan stops providing or paying for all or part of:

- A service
- A supply or item

- A prescription drug you think you still need
- Does not provide timely medical services

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.

Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Medical services that your plan doesn't pay for or cover.

Grievance: A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

Habilitation Services and Devices: Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Services for people with disabilities

Health Insurance: Health insurance is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance.

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

Hospice Services: Hospice is a special way of caring for people who are terminally ill and provide support to the person's family.

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

Medical Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or
- Symptom

Medical Necessity for EPSDT: Services for children under 21 needed to help them grow and develop for their age. This means services to help them get better, stay healthy, or keep their current health the same.

Network: Health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that *does not* have a contract with the Medicaid Health Plan as a provider of care.

Physician Services: Healthcare services provided by a person licensed under state law to practice medicine.

Plan: A plan that offers health care services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment or
- Prescriptions

This is also called prior authorization, prior approval, or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

Premium: The amount paid for health care benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

Primary Care Physician: A licensed physician who provides and manages your health care services. (See Primary Care Provider.)

Primary Care Provider: A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a Primary Care Physician. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

Provider: A person, place or group that's licensed to provide health care like doctors, nurses, and hospitals.

Referral: A request from a PCP for his or her patient to see another provider for care.

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

Specialist: A licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

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.

This notice takes effect on October 1, 2015.

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 your:

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

How we use and share your health information
Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be 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 eighteen and don't want us to give your health information to your parents. Call us. We can help in some cases if allowed by state law.

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

[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.

also use your health information to look at the care your doctor gives you. We can also check your use of health services.

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

- Health promotion
- Case management
- Quality improvement
- Fraud prevention
- Disease prevention
- Legal matters

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

Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data

We may get information related to your race, ethnicity, language, sexual orientation and gender identity. We protect this information as described in this notice. We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Create health education information
- Let the doctors know about your language needs
- Address health care disparities
- Let member facing staff and doctors know about your pronouns

We do not use this information to:

- Determine benefits
- Pay claims
- Determine your cost or eligibility for benefits
- Discriminate against members for any reason
- Determine health care or administrative service availability or access

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.

Call us toll free at **1-866-316-3784 (TTY: 711**) to:

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

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

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079
FAX: **859-280-1272**

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address at **1-866-316-3784 (TTY: 711)**.

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 website at **AetnaBetterHealth.com/Michigan**.

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex, sexual orientation or gender identity.
Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex sexual orientation or gender identity, you can file a grievance with our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator
PO Box 818001, Cleveland OH 44181-8001
Telephone: **1-888-234-7358 (TTY: 711)**
Email: **MedicaidCRCoordinator@Aetna.com**

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal. hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, **1-800-368-1019**, **1-800-537-7697 (TDD)**.

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html.** Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE:注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**)

ALBANIAN: VINI RE: Nëse flisni shqip, janë në dispozicion për ju shërbime përkthimi, falas. Telefononi numrin në pjesën e pasme të kartës suaj ID ose **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수

있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

POLISH: UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer podany na odwrocie Twojego identyfikatora lub pod number **1-800-385-4104**(TTY: **711**).

GERMAN: ACHTUNG: Wenn Sie deutschen sprechen, können Sie unseren kostenlosen Sprachservicenutzen. Rufen Sie die Nummer auf der Rückseite Ihrer ID-Karte oder **1-800-385-4104** (TTY: **711**) an.

ITALIAN: ATTENZIONE: Nel caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuita. Chiamare il numero sul retro della tessera oppure il numero **1-800-385-4104** (utenti TTY: **711**).

JAPANESE:注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。 IDカード裏面の電話番号、または **1-800-385-4104** (TTY: **711**)までご連絡ください。

AetnaBetterHealth.com/Michigan

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