Medallion 4.0 Member Handbook

Learn about your health care benefits

Aetna Better Health® of Virginia

aetna®

AetnaBetterHealth.com/Virginia

Last reviewed/revised:
August 2023

For contract year:
July 1, 2023 – June 30, 2024

Helpful Information

Our website
AetnaBetterHealth.com/Virginia

Mailing Address
Aetna Better Health of Virginia
9881 Mayland Drive
Richmond, VA 23233

Member Services
1-800-279-1878
24 hours a day, 7 days a week

Services for the Hearing and Speech Impaired
711

Language Translation/Interpretation Services
1-800-279-1878

Behavioral Health and Substance Use Services and 24-Hour Helpline
1-800-279-1878

Care Management
1-800-279-1878

24-Hour Nurse Line
1-877-878-8940

Dental (Smiles for Children)
1-888-912-3456

Transportation
1-800-734-0430

Interpreter service and alternative formats

Call **1-800-279-1878** (**TTY: 711**) if you need help in another language or format. We'll get you an interpreter in your language. You can ask for a verbal or sign language interpreter if you need help talking to your doctor during your visit. You won't need to pay for these services.

If you have a hard time seeing, or you don't read English, you can get information in other formats such as large print or audio. These services are at no cost to you.

Grievance and Appeals
Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
1-800-279-1878

Report Fraud and Abuse
1-844-317-5825

Virginia Managed Care Helpline
1-800-643-2273
(TTY: 1-800-817-6608)
virginiamanagedcare.com

Cover Virginia
833-5CALLVA
(TDD: 1-888-221-1590)
www.coverva.org

Department of Medical Assistance Services (DMAS)
www.dmas.virginia.gov

Department of Social Services
www.dss.virginia.gov

Personal Information

_____
My member ID number

_____
My primary care provider (PCP)

_____
My PCP's phone number

VIRGINIA'S MEDICAID PROGRAM

DMAS

INNOVATION • QUALITY • VALUE

FAMIS

Covering Children With Affordable Health Insurance

MEDALLION 4.0

Aetna Better Health® of Virginia

Medicaid Managed Care Member Handbook

Effective December 1, 2022

Help in Other Languages or Alternate Formats

This handbook is available for free in other languages and formats including on-line, large print, braille or audio CD. To request this handbook in an alternate format and/or language, contact our Member Services staff at **1-800-279-1878** (TTY: **711**). Alternate formats will be provided within 5 business days.

If you are having difficulty understanding this information, please contact our Member Services staff at **1-800-279-1878** (TTY: **711**) for help at no cost to you.

Additionally, Members with alternative hearing or speech communication needs can dial **711** to reach a Telecommunications Relay Services (TRS) operator who will help you reach Aetna Better Health's Member Services staff. Voice and TRS users can make a 711 call from any telephone anywhere in the United States free of charge.

If you do not speak English, call us at **1-800-385-4104** (TTY: **711**). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language free of charge.

Spanish: Si no habla inglés, llámenos a **1-800-385-4104** (TTY: **711**).
Tenemos acceso a servicios de intérprete y podemos ayudar a responder sus preguntas en su idioma de forma gratuita. También podemos ayudarle a encontrar un proveedor de atención médica que pueda comunicarse con usted en su idioma.

Korean: 영어로 말할 수 없다면 **1-800-385-4104** (TTY: **711**).로 전화하십시오. 저희는 통역 서비스를 이용할 수 있으며 귀하의 언어로 된 질문에 무료로 답변 할 수 있습니다. 우리는 또한 귀하의 언어로 의사 소통 할 수있는 의료 서비스 제공자를 찾도록 도울 수 있습니다.

Vietnamese: Nếu bạn không nói được tiếng Anh, hãy gọi cho chúng tôi tại **1-800- 385-4104** (TTY: **711**). Chúng tôi có quyền truy cập vào các dịch vụ phiên dịch và có thể giúp trả lời câu hỏi của bạn trong ngôn ngữ của bạn miễn phí. Chúng tôi
cũng có thể giúp bạn tìm thấy một nhà cung cấp chăm sóc sức khỏe người có thể giao tiếp với bạn bằng ngôn ngữ của bạn.

Chinese: **如果您不会**说英语，请致电 **1-800-385-4104** (TTY: **711**).。 **我**们可以使用翻译服务，并可以用您的语言免费回答您的问题。 **我**们还可以帮助您找到一个能用您的语言与您沟通的医疗保健提供者。

Arabic: **1-800-385-4104**الثالثون-الثالثون1- >على بنا اتصل اإلنكليزية، يتكلمون ال كنت إذا باللغة أسئلتك على اإلجابة في تساعد أن **711** معك التواصل يمكن الذين الصحية الرعاية موفر على العثور مساعدتك أيضا يمكننا :TTY) .(ويمكن شفوي، مترجم خدمات على الحصول
بك الخاصة.
بك الخاصة باللغة.

Tagalog: kung ikaw ay hindi nagsasalita ng ingles , mo sa amin & lt ; **1-800-385-4104** (TTY: **711**). & gt ; . kami ay ng interpreter paglilingkod at makakatulong ang sagot sa tanong na ang wika ng katungkulan . at kami ay tulungan ka ng ng pangangalaga sa kalusugan nagkakaloob na ang pamamahagi sa inyo sa inyong mga wika.

Farsi:

اگر انگلیسی صحبت با ما تماس بگیرید در **1-800-385-4104 (TTY: 711)**. ما دسترسی به خدمات مترجم شفاهی و سئوالات زبان شما می تواند کمک کند. ما همچنین می توانید کمک ارائه دهنده مراقبت های بهداشتی است که می تواند ارتباط با شما زبان خود را پیدا کنید.

Amharic: እንግሊዝኛ መናገር የማይችሉ ከሆነ, **1-800-385-4104 (TTY: 711).** ይደውሉልን. እኛ የአስተርጓሚ አገልግሎቶች መዳረሻ ያላቸው እና ከክፍያ ነጻ በራስዎ ቋንቋ ውስጥ የእርስዎን ጥያቄዎች መልስ ለማግኘት ይችላሉ. እኛ ደግሞ እንደ እናንተ የእርስዎን ቋንቋ ከአንተ ጋር መገናኘት የሚችል የጤና እንክብካቤ አቅራቢ እንዲያገኙ ሊረዱዎት ይችላሉ.

Urdu: اگر آپ انگریزی نہیں، تو بولتے **1-800-385-4104 (TTY: 711).** پر ہمیں کال کریں. ہم مترجم کی مدد میں دینے جواب کا سوالات کے آپ میں زبان اپنی انچارج کے مفت اور بے حاصل رسائی تک خدمات کی سکتے. ہم نے بھی آپ جو آپ کی زبان کی آپ میں کے کر چیت بات ساتھ کے آپ میں زبان کی صحت ایک سکتے کر فراہم بھال دیکھ ہیں سکتے کر مدد میں تلاش.

French: Si vous ne parlez pas anglais, appelez-nous à **1-800-385-4104** (TTY: **711**). Nous avons accès à des services d'interprètes et pouvons vous aider à répondre à vos questions dans votre langue gratuitement. Nous pouvons également vous aider à trouver un fournisseur de soins de santé qui peut communiquer avec vous dans votre langue.

Russian: Если вы не говорите по-английски, позвоните нам по телефону **1-800- 385-4104** (TTY: **711**). Мы имеем доступ к услугам переводчика и может помочь ответить на ваши вопросы на вашем языке бесплатно. Мы также можем помочь вам найти поставщика медицинских услуг, которые могут общаться с вами на вашем языке.

Hindi: आप अग्र ेजी नह ं बोलते हैं, तो **1-800-385-4104** (TTY: **711**). पर कॉल करें। हम दभु ाषिया सेवाओं के ललए उपयोग ककया है और नन: शुल्क अपनी भाि ा में आपके सवालों के जवाब कर सकते हैं। हम यह भी मदद कर सकता है आप एक स्वास्् य देखभाल प्रदाता जो आपकी भाि ा में आप के साथ संवाद कर सकते हैं।

German: Wenn Sie kein Englisch sprechen, rufen Sie uns unter **1-800-385-4104** (TTY: **711**). an. Wir haben Zugang zu Dolmetscherdiensten und können Ihnen helfen, Ihre Fragen in Ihrer Sprache kostenlos zu beantworten. Wir können Ihnen auch helfen, einen Arzt zu finden, der mit Ihnen in Ihrer Sprache kommunizieren kann.

Bengali: আপনি ইংরেজি বলতে পারি না, তাহলে **1-800-385-4104 (TTY: 711).** আমাদের সঙ্গে যোগাযোগ করুন. আমরা দোভাষীর পরিষেবাগুলিতে অ্যাক্সেস আছে এবং নিখরচা আপনার ভাষায় আপনার প্রশ্নের উত্তর সাহায্য করতে পারেন. আমরা সাহায্য করতে পারেন একটি স্বাস্থ্যের যত্ন প্রদানকারী যারা আপনার ভাষায় আপনার সাথে যোগাযোগ করতে পারেন.

Portuguese: Se você não fala inglês, ligue para **1-800-385-4104 (TTY: 711).** Temos acesso a serviços de intérprete e podemos ajudar a responder às suas perguntas no seu idioma gratuitamente. Também podemos ajudá-lo a encontrar um profissional de saúde que possa se comunicar com você em seu idioma.

Important Information Related to Coronavirus (COVID-19)

To our members,

The COVID-19 pandemic has affected us all in ways we could have never imagined. For some, this may mean the loss or illness of loved ones. For others, difficult changes in our daily routines, less socialization, and higher stress than normal – adults and children alike.

I encourage you to read this section related to COVID-19 in full. You will find answers to frequently asked questions related to the COVID-19 vaccine, as well as ways we will reach out to you and how you can reach us 24 hours a day, 7 days a week. I encourage you to store this document in an easy-to-find place when you finish reading it.

As always, if you or a family member are showing symptoms of COVID-19, call your doctor right away. COVID-19 is a serious and potentially life-threatening illness. It's important to get help as soon as possible. Aetna Better Health covers COVID-19 testing and vaccines at no cost to you.

As your partner in health, we're committed to keeping you up to date on the latest COVID-19 information as it becomes available. Below are some of the ways we will reach out to you:

- **By mail.** If you receive a mailing from us — letter, postcard, or our member newsletter — please be sure to open and read it as soon as you can.
- **By phone or text.** Phone and text message are the quickest way for us to get you the information you need without delay. If you have changed your phone number recently and want us to be able to contact you with important updates, you can let us know your new phone number by calling **1-800-279-1878 (TTY: 711)**.
- **On our website.** Visit **AetnaBetterHealth.com/Virginia** and select "For Members," where you can find important member announcements related to COVID-19, including benefit changes meant to help you take care of your health and wellness needs during this time.

COVID-19 Vaccine Frequently Asked Questions

There is no cost for the vaccine for Aetna Better Health members. It is completely free. Transportation is available to any member who does not have a ride.

Where do I go to get vaccinated?
COVID-19 vaccinations are available at CVS and other pharmacies, as well as doctors' offices, local health departments, and other clinical sites of care. If you choose to go to your primary care physician, please call first and confirm they have the vaccine. You may also visit **vaccines.gov** to find a location near you that offers the vaccine.

Why should I get vaccinated?
By getting the COVID-19 vaccine, you are helping protect yourself and those around you. If you have a medical condition, it can help prevent serious illness or even death.

Are there any side effects from the vaccine?
You may experience mild side effects from the COVID-19 vaccine. These may include pain at the injection site, fatigue, headache, chills, fever, and joint and muscle pain. These are temporary. If your side effects become moderate to severe, please call your doctor right away. After you get the COVID-19 vaccine, you can enroll in the v-safe program. This program is an app-based tool that checks in on you after your COVID-19 vaccination. To register, visit **vsafe.cdc.gov**.

Do I need a second shot?
Certain COVID-19 vaccines are one-time only. Others may require a second shot. The provider or pharmacist administering the shot will give you a vaccine tracker card to make sure you get the second shot, if needed. Talk to your health care provider who gives you the vaccine to confirm.

I don't have transportation. How can I get a ride?
If you don't have transportation of your own, we will cover your ride at no cost to you through ModivCare. To schedule your ride, call **1-800-734-0430 (TTY: 711)**. Or, book your ride online at **member.logisticare.com**.

Common myths associated with the vaccine

I can get COVID-19 from the COVID-19 vaccine. You cannot get COVID-19 from the COVID-19 vaccine. The COVID-19 vaccine does not contain a live virus.

I already had COVID-19 and I have recovered, so I don't need to get a COVID-19 vaccine. You still need to get the vaccine, even if you have already had COVID-19. Talk to your health care provider about when you should get the vaccine if you are in recovery.

I am allergic to eggs or have another allergy. I shouldn't get the COVID-19 vaccine. Those with allergies to eggs can take the COVID-19 vaccine. It does not contain eggs. Before you get the vaccine, let your health care provider know of any and all allergies you have.

I have a question not answered here. Who can I talk to?

Member Services
Aetna Better Health is here for you 24 hours a day, 7 days a week. Call **1-800-279-1878 (TTY: 711)**. We can also help you schedule an appointment or find a provider or pharmacy giving the vaccine.

Your health care provider
Your health care provider can also talk to you if you have any questions or concerns about the COVID-19 vaccine.

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1. Medicaid Managed Care Plan

Welcome to Aetna Better Health of Virginia

Thank you for choosing Aetna Better Health of Virginia (Aetna Better Health) as your preferred Medicaid Managed Care plan. If you are a new member, we will get in touch with you by phone in the next few weeks to go over some very important information with you. If you receive a call from us, please do your best to answer or return our message. Understanding how your health care plan works is very important.

You can also ask us any questions you may have or get help making appointments. If you need to speak with us right away or before we contact you, call Aetna Better Health Member Services at **1-800-279-1878** (TTY: **711**), visit our website at **AetnaBetterHealth.com/Virginia**, or call the Virginia Medicaid Managed Care Helpline at **1-800-643-2273** (TTY: **1-800-817-6608**), Monday – Friday, 8:30 a.m. – 6:00 p.m. for help. This handbook is also available on our website at **AetnaBetterHealth.com/Virginia**.

If you are a FAMIS member (see logo on your ID card), please refer to Chapter 16 of this handbook. There is a special insert that gives you program facts and how to access information about the FAMIS program.

We have built a strong network of area physicians, hospitals, and other health care providers to offer a broad range of services for your medical needs. We start by recognizing that our providers are essential for improving the effectiveness and efficiency of our programs and services. We also believe that our members should have the opportunity to be leaders in their care. We work with you, your providers, and caregivers to achieve your goals.

Please take some time to read these materials to learn more about your Aetna Better Health coverage. Our Member Services Department is here to answer any questions you may have about your coverage and services. You can reach us at **1-800-279-1878** (TTY: **711**), 24 hours a day, 7 days a week.

On behalf of all of those associated with Aetna Better Health, we welcome you. We look forward to serving you and your family.

How to Use This Handbook

This handbook will help you understand your benefits and how you can get help from Aetna Better Health. This handbook is a health care and Aetna Better Health member guide that explains health care services, behavioral health coverage, prescription drug coverage, and other services and supports covered under the program. This guide will help you take the best steps to make our health plan work for you.

Feel free to share this handbook with a family member or someone who knows your health care needs. When you have a question or need guidance, please check this handbook, call Aetna Better Health Member Services at **1-800-279-1878** (TTY: **711**), visit our website at **AetnaBetterHealth.com/Virginia**, or call the Virginia Medicaid Managed Care Helpline free of charge at **1-800-643-2273** (TTY: **1-800-817-6608**), Monday – Friday, 8:30 a.m. – 6:00 p.m.

You may also find this handbook on our website at **AetnaBetterHealth.com/Virginia**.

Your Welcome Packet

Member ID Card

You should have already received a welcome packet and your Aetna Better Health Member ID card. Your Aetna Better Health ID card is used to access Medicaid managed care program health care services and supports at doctor visits and when you pick up prescriptions. You must show this card to get services or prescriptions. Below is a sample card to show you what yours will look like:

Sample Medallion 4.0 Member ID card


aetna

Aetna Better Health® of Virginia

Name LASTNAME, FIRSTNAME

Medicaid/Member ID # XXXXXXXXXXX DOB 00/00/0000 Sex X

PCP LASTNAME, FIRSTNAME

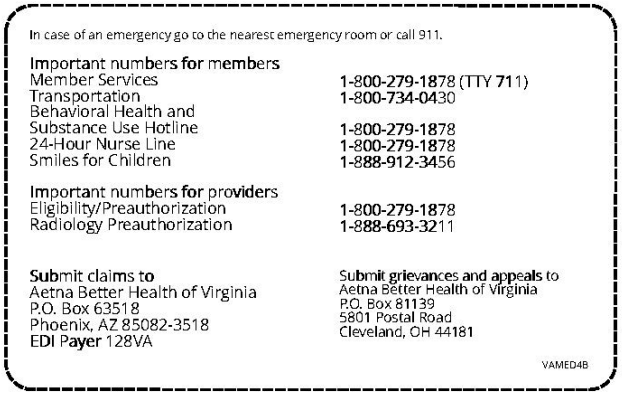
PCP Phone 1-000-000-0000 Effective Date 00/00/0000

RxBIN: 610591 RxPCN: ADV RxGROUP: RX8837

Pharmacist Use Only: 1-855-270-2365 CVS caremark

AetnaBetterHealth.com/Virginia

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. VAMED4


In case of an emergency go to the nearest emergency room or call 911.

Important numbers for members

Member Services	1-800-279-1878 (TTY 711)
Transportation	1-800-734-0430
Behavioral Health and Substance Use Hotline	1-800-279-1878
24-Hour Nurse Line	1-800-279-1878
Smiles for Children	1-888-912-3456

Important numbers for providers

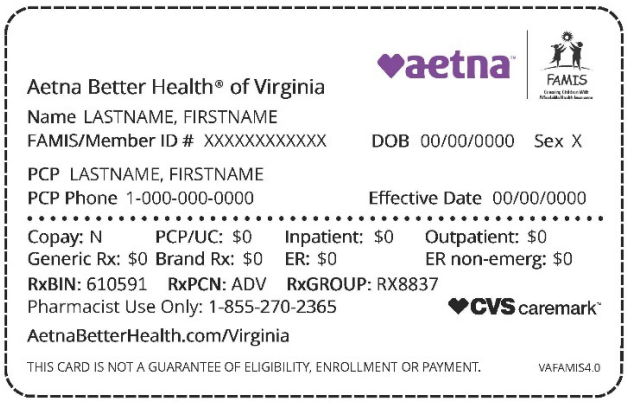
Eligibility/Preauthorization	1-800-279-1878
Radiology Preauthorization	1-888-693-3211

Submit claims to
Aetna Better Health of Virginia
P.O. Box 63518
Phoenix, AZ 85082-3518
EDI Payer 128VA

Submit grievances and appeals to
Aetna Better Health of Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181

VAMED4B

Sample FAMIS Member ID card


aetna

FAMIS

Aetna Better Health® of Virginia

Name LASTNAME, FIRSTNAME

FAMIS/Member ID # XXXXXXXXXXX DOB 00/00/0000 Sex X

PCP LASTNAME, FIRSTNAME

PCP Phone 1-000-000-0000 Effective Date 00/00/0000

Copay: N PCP/UC: $0 Inpatient: $0 Outpatient: $0

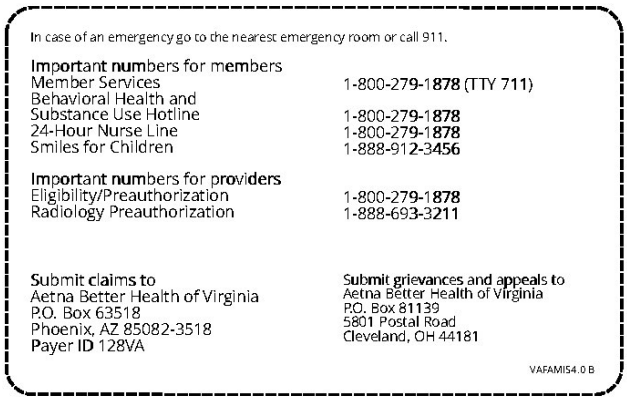
Generic Rx: $0 Brand Rx: $0 ER: $0 ER non-emerg: $0

RxBIN: 610591 RxPCN: ADV RxGROUP: RX8837

Pharmacist Use Only: 1-855-270-2365 CVS caremark

AetnaBetterHealth.com/Virginia

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. VAFAMIS4.0


In case of an emergency go to the nearest emergency room or call 911.

Important numbers for members

Member Services	1-800-279-1878 (TTY 711)
Behavioral Health and Substance Use Hotline	1-800-279-1878
24-Hour Nurse Line	1-800-279-1878
Smiles for Children	1-888-912-3456

Important numbers for providers

Eligibility/Preauthorization	1-800-279-1878
Radiology Preauthorization	1-888-693-3211

Submit claims to
Aetna Better Health of Virginia
P.O. Box 63518
Phoenix, AZ 85082-3518
Payer ID 128VA

Submit grievances and appeals to
Aetna Better Health of Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181

VAFAMIS4.0 B

If you haven't received your card, or if your card is damaged, lost, or stolen, call the Member Services number located at the bottom of this page right away, and we will send you a new card.

Keep your Commonwealth of Virginia Medicaid ID card to access services that are covered through the State, under the Medicaid fee-for-service program. These services are described in Services Covered through Medicaid Fee-For-Service, in Section 10 of this handbook.

Provider and Pharmacy Directories

You should have received information about Aetna Better Health Provider and Pharmacy Directories in your welcome packet. These directories list the providers and pharmacies that participate in the Aetna Better Health network. While you are a member of our plan, and in most cases, you must use one of our network providers to get covered services.

You may ask for a paper copy of the Provider and Pharmacy Directory by calling Member Services at the number at the bottom of the page. If you need help finding a provider in your area, Member Services can help with that too. You can also see or download the Provider and Pharmacy Directory at **AetnaBetterHealth.com/Virginia**.

Access our online provider search

1. Visit **AetnaBetterHealth.com/Virginia**
2. Select **"Find a Provider"** to access our online provider search tool

Our online provider search engine is updated daily. You can also download a PDF version of our full directory by visiting **AetnaBetterHealth.com/Virginia/Members/Provider-Directory**.

The Provider and Pharmacy Directories provide information on health care professionals such as:

- Doctors, nurse practitioners, specialists.
- Behavioral health providers, including psychologists and counselors.
- Dental and vision providers.
- Facilities (hospitals, urgent care clinics, outpatient clinics, nursing facilities, etc.)
- Support providers (such as adult day health, home health providers, etc.)
- Pharmacies in the Aetna Better Health network.

While you are a member of our plan, you generally must use one of our network providers and pharmacies to get covered services. There are some exceptions, however, including:

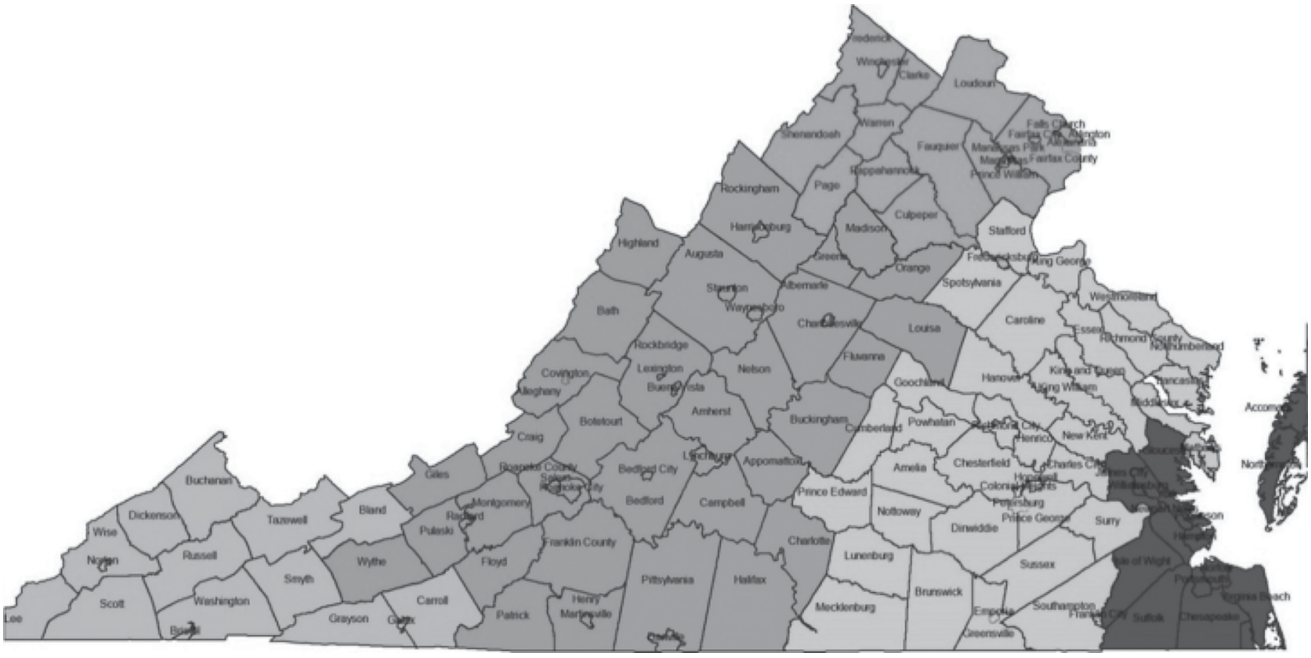
- When you first join our plan (see Transition of Care Period in Section 3 of this handbook),
- If you have other insurance in addition to Aetna Better Health (see How to Get Care From Your Primary Care Physician in Section 6 of this handbook), and
- In several other circumstances (see How to Get Care From Out-of-Network Providers in Section 6 of this handbook.)

Refer to the List of Covered Drugs in Section 9 of this handbook.

The Provider & Pharmacy Directory gives you information on how to obtain care and lists health care professionals that you may see as an Aetna Better Health member. It also lists the pharmacies that you may use to get your prescription drugs. The online listing has the most up-to-date information. If you need assistance finding a provider or scheduling an appointment, Member Services can help. Call **1-800-279-1878** (TTY **711**).

What Is Aetna Better Health's Service Area?

Aetna Better Health is a statewide Medicaid health plan, which means you can access services throughout the Commonwealth of Virginia with one of our contracted providers or facilities. Aetna Better Health's service area includes the entire Commonwealth of Virginia—all 95 counties and 38 independent cities.



Counties

Accomack
Albemarle
Alleghany
Amelia
Amherst
Appomattox
Arlington
Augusta
Bath
Bedford
Bland
Botetourt
Brunswick
Buchanan
Buckingham
Campbell
Caroline
Carroll
Charles City
Charlotte
Chesterfield
Clarke
Craig
Culpeper
Cumberland
Dickenson
Dinwiddie
Essex
Fairfax
Fauquier
Floyd
Fluvanna
Franklin
Frederick
Giles
Gloucester
Goochland
Grayson
Greene
Greensville
Halifax
Hanover
Henrico
Henry
Highland
Isle of Wight
James City
King and Queen
King George
King William
Lancaster
Lee
Loudoun
Louisa
Lunenburg
Madison
Mathews
Mecklenburg
Middlesex
Montgomery
Nelson
New Kent
Northampton
Northumberland
Nottoway
Orange
Page
Patrick
Pittsylvania
Powhatan
Prince Edward
Prince George
Prince William
Pulaski
Rappahannock
Richmond
Roanoke
Rockbridge
Rockingham
Russell
Scott
Shenandoah
Smyth
Southampton
Spotsylvania
Stafford
Surry
Sussex
Tazewell
Warren
Washington
Westmoreland

Wise	Wythe	York	

Cities

Alexandria	Falls Church	Manassas Park	Roanoke
Bristol	Franklin	Martinsville	Salem
Buena Vista	Fredericksburg	Newport News	Staunton
Charlottesville	Galax	Norfolk	Suffolk
Chesapeake	Hampton	Norton	Virginia Beach
Colonial Heights	Harrisonburg	Petersburg	Waynesboro
Covington	Hopewell	Poquoson	Williamsburg
Danville	Lexington	Portsmouth	Winchester
Emporia	Lynchburg	Radford	
Fairfax	Manassas	Richmond	

Only people who live in our service area can enroll with Aetna Better Health. If you move outside of our service area (to another state other than Virginia, for example), you cannot stay in this plan. If this happens, you will receive a letter from Department of Medical Assistance Services (DMAS) asking you to choose a new plan. You can also call the Managed Care Helpline if you have any questions about your health plan enrollment. Contact the Managed Care Helpline at **1-800-643-2273** or visit the website at **virginiamanagedcare.com**.

When you select Aetna Better Health, you will have access to extra benefits, such as:

- Adult vision
- Adult hearing
- Asthma prevention
- Better Breathing
- Diabetes Care for Life
- Home-delivered meals
- Weight management
- No-cost cell phones
- Expanded Member Services call center hours 24 hours a day, 7 days a week
- Non-traditional medicine
- General Educational Development (GED) Incentive
- Swimming lessons
- Ted E. Bear, M.D. Wellness Club for children
- Monthly stipend for menstrual care products
- Youth sports physicals

List of Covered Drugs

You can see a list of covered drugs at **AetnaBetterHealth.com/Virginia/Members/Pharmacy-Benefits**. You can access or download the Provider and Pharmacy Directory at **AetnaBetterHealth.com/Virginia/Members/Provider-Directory** or receive a printed copy by calling Member Services at **1-800-279-1878** (TTY **711**).

List of Covered and Non-Covered Services

See Section 8 of this handbook or you can access or download Aetna Better Health's Covered Services at **AetnaBetterHealth.com/Virginia/Members/Medicaid/Medicaid-Benefits** or receive a printed copy by calling **1-800-279-1878** (TTY **711**). See Transition of Care Period in Section 2 of this handbook.

Information About Eligibility

If you have questions about your Medicaid eligibility, contact your case worker at the Department of Social Services in the city or county where you live. If you have questions about the services you get under Aetna Better Health, please call the Member Services number listed at the bottom of this page. You may also visit Cover Virginia at **www.coverva.org** or call **833-5CALLVA** (TDD **1-888-221-1590**). **These calls are free.**

Getting Help Right Away

Aetna Better Health's Member Services

Our Member Services staff are available to help you if you have any questions about your benefits, services, or procedures or have a concern about Aetna Better Health.

How To Contact Aetna Better Health Member Services

CALL	**1-800-279-1878**. **This call is free.** 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY **711**. **This call is free.** 24 hours a day, 7 days a week This number is for people who have hearing or speaking problems. You must have special equipment to call this number.
FAX	**1-866-207-8901**
WRITE	Aetna Better Health of Virginia 9881 Mayland Drive Richmond, VA 23233
EMAIL	Please visit the contact page on our website at **AetnaBetterHealth.com/Virginia/Contact-Us** to send us a secure message. You may send email directly to **vamedicaidmemberservices@aetna.com**
WEBSITE	**AetnaBetterHealth.com/Virginia**

How Aetna Better Health's Member Services Representatives Can Help You:

- Answer questions about Aetna Better Health
- Answer questions about claims, billing, or member ID cards
- Assist with finding or checking to see if a doctor is in Aetna Better Health's network
- Assist with changing your Primary Care Provider (PCP)
- Understand your benefits and covered services including the amount that we will pay so that you can make the best decisions about your health care
- File an appeal about your health care services (including drugs). An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake.

- File a complaint about your health care services (including prescriptions). You can make a complaint about us or any provider (including a network or non-network provider). A network provider is a provider who works with the health plan. You can also make a complaint about the quality of the care you received to us or to the Managed Care Helpline at **1-800-643-2273**.
- Get in touch with an Aetna Better Health Care Manager

How to Contact an Aetna Better Health Care Manager/Coordinator

If you have a chronic condition, a history of health problems, or need assistance getting health care, we want to work with you and your doctor to meet your health care needs. Care Management helps you get the best care in the most efficient manner. To speak with a care manager, call **1-800-279-1878** (TTY **711**).

We will follow DMAS guidelines or nationally recognized guidelines for any alternative care proposed. Alternative care must be preauthorized by us before services are rendered. The support and education provided under Care Management will be made to meet your special health care needs.

Our Care Management program is designed to help make sure you understand your condition and treatment plan. Our staff is made up of registered nurses or social workers who have received training in the care management process. Care Managers have a variety of daily activities as they interact with everyone involved in your life. They coordinate care in the following ways:

- Work one-on-one with you to create a plan based on your goals
- Review your plan to help make sure you do not have gaps in care
- Consult with your doctors
- Help you make specialist and primary care doctors appointments
- Verify that the right medicines and treatments are in place
- Help make sure you receive preventive care
- Work to ensure you and your family have the support you need
- Ask questions to make sure your home is safe
- Provide patient and family education about programs and services available in the community and through your doctor
- Make sure you have support for any mental health needs
- Help you when your child is moving from pediatric to adult care
- Work with you to get the right care for your child's special needs (including foster care, adoptive care, and early intervention)
- Help you transition to other care when your benefits end, if necessary

We have programs to address your specific needs such as maternity care for high-risk pregnancy and neonatal care for your infant. We also have programs to assist you if you have had or need a transplant. We can also assist with transitioning you from a facility back to your home or place of residence. These programs help you take good care of you and your family.

If you feel you need care management services or if you have any questions about care management, call Member Services at **1-800-279-1878** (TTY **711**). If you are in a program, but don't want to be, call the same phone number to get out of the program. Tell our Member Services staff you want to speak to a care manager.

Your Care Manager serves as your single point of contact and will assess, arrange, and monitor all care services provided by other care providers. Your Care Manager will work closely with you to manage your

care. If you would like to change your Care Manager, please call Member Services at **1-800-279-1878** (TTY **711**).

Your Care Manager can also:

- Answer questions about your health care.
- Assist with appointment scheduling.
- Answer questions about getting any of the services you need.
- Help with arranging transportation to your appointments when necessary. If you need a ride to receive a Medicaid covered service and cannot get there, non-emergency transportation is covered. Just call **1-800-279-1878** (TTY **711**) or call your Care Manager for assistance.
- Answer questions you may have about your daily health care and living needs including these services:
    - Nursing care
    - Physical therapy
    - Occupational therapy
    - Speech therapy
    - Home health care
    - Behavioral health services
    - Services to treat addiction
    - Other services that you need

CALL	**1-800-279-1878**. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY: **711**. This call is free. 24 hours a day, 7 days a week This number is for people who have hearing or speaking problems. You must have special equipment to call this number.
FAX	**1-866-207-8901**
WRITE	Aetna Better Health of Virginia 9881 Mayland Drive Richmond, VA 23233
EMAIL	Please visit the contact page on our website at **AetnaBetterHealth.com/Virginia/Contact-Us** to send us a secure message. You may send email directly to **vamedicaidmemberservices@aetna.com**
WEBSITE	**AetnaBetterHealth.com/Virginia**

Medical Advice Line Available 24 Hours a Day, 7 Days a Week

You can reach a nurse or behavioral health professional 24 hours a day, 7 days a week to answer your questions toll-free at **1-800-279-1878** (TTY **711**).

We encourage our members to work with their PCP and care manager (for members in care management) for their health care needs. However, if you have a medical question and you are not sure what to do, call our 24-Hour Nurse Help Line. Our nurse helpline can help answer specific questions or give you advice on what to do when you need health care, such as calling your PCP, making an appointment, or going immediately to the emergency room.

CALL	**1-800-279-1878**. This call is free. 24 hours a day, 7 days a week.

	We have free interpreter services for people who do not speak English.
TTY	TTY: **711**. This call is free. 24 hours a day, 7 days a week This number is for people who have hearing or speaking problems. You must have special equipment to call this number.

Behavioral Health Crisis Line

Contact Aetna Better Health if you do not know how to get services during a crisis. We will help find a crisis provider for you. Call **1-800-279-1878** (TTY **711**). If your symptoms include thoughts about harming yourself or someone else, you should:

- Get help right away by calling **911**.
- Go to the closest hospital for emergency care.

CALL	**1-800-279-1878**. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY: **711**. This call is free. 24 hours a day, 7 days a week This number is for people who have hearing or speaking problems. You must have special equipment to call this number.

Other Important Contact Numbers

DMAS Dental Benefits Administrator	For questions or to find a dentist in your area, call the DMAS Dental Benefits Administrator at **1-888-912-3456**. Information is also available on the DMAS website at **https://www.dmas.virginia.gov/for-members/benefits-and-services/dental** or the DentaQuest website at **www.dentaquestgov.com**.
Aetna Better Health Transportation	**1-800-734-0430**
DMAS Transportation Contractor for transportation to and from DD Waiver Services	**1-866-386-8331** TTY **1-866-288-3133** Or dial 711 to reach a relay operator
Magellan of Virginia; DMAS Behavioral Health Services Administrator	Toll free: **1-800-424-4046** TDD **1-800-424-4048** Or dial **711** to reach a relay operator. **www.magellanofvirginia.com**
Department of Health and Human Services' Office for Civil Rights	**1-800-368-1019** or visit the website at **www.hhs.gov/ocr**

2. How Managed Care Works

The program is a mandatory managed care program for members of Virginia Medicaid (**12VAC30-120-370**). The Department of Medical Assistance Services (DMAS) contracts with managed care organizations (MCOs) to provide most Medicaid covered services across the state. Aetna Better Health is approved by DMAS to provide person-centered care coordination and health care services. Through this person-centered program, our goal is to help you improve your quality of care and quality of life.

What Makes You Eligible to be a Member?

When you apply for Medical Assistance, you are screened for all possible programs based on your age, income, and other information. To be eligible for a Medical Assistance Program, you must meet the financial and non-financial eligibility conditions for that program. Please visit the Virginia Department of Social Services' (VDSS) Medicaid Assistant Program page for eligibility details and/or VDSS Medicaid Forms and Applications page for application and other Medicaid form details.

You are eligible for when you have full Medicaid benefits, and meet one of the following categories:

- Children under age 21
- Foster Care and Adoption Assistance Child under age 26
- Pregnant women including two months post delivery
- Parent Caretakers

Medicaid eligible persons who do not meet certain exclusion criteria must participate in the program. Enrollment is not a guarantee of continuing eligibility for services and benefits under the Virginia Medical Assistance Services Program. For more information about exclusionary criteria and participation, please refer to **12VAC30-120-370** at **https://law.lis.virginia.gov/admincode/title12/agency30/chapter120/section370**.

What Makes You NOT Eligible to be a Member?

You would not be able to participate if any of the following apply to you:

- You lose Medicaid eligibility
- You do not meet one of the eligible categories above
- You meet exclusionary criteria listed in 12VAC30-120-370
- You are hospitalized at the time of enrollment
- You are enrolled in a Home and Community Based (HCBS) waiver
- You are admitted to a free-standing psychiatric hospital
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21)
- You meet the criteria for another Virginia Medicaid program
- Hospice
- Virginia Birth-Related Neurological Injury Compensation Act

Third Party Liability

Comprehensive Health Coverage

- Members enrolled in Medicaid, determined by DMAS as having comprehensive health coverage, other than Medicare, will be eligible for enrollment in Medallion 4.0, as long as no other exclusion applies.
- Members who obtain other comprehensive health coverage after enrollment in Medallion 4.0 remain enrolled in the program.
- Members who obtain Medicare after Medallion 4.0 enrollment will be disenrolled and subsequently enrolled into the Commonwealth Coordinated Care Plus (CCC Plus) program.
- Aetna Better Health is responsible for coordinating all benefits with other insurance carriers (as applicable) and following Medicaid "payer of last resort" rules.
- Aetna Better Health covers the member's deductibles and coinsurance up to the maximum allowable reimbursement amount that would have been paid in the absence of other primary insurance coverage.
- When the TPL payor is a commercial MCO/HMO organization, the MCO is responsible for the full member copayment amount.

Aetna Better Health ensures that members are NOT held accountable for payments and copayments for any Medicaid covered service, unless copayments are required regardless of other insurance payments.

For children with commercial insurance coverage, providers must bill the commercial insurance first for covered early intervention services except for:

1. Those services federally required to be provided at public expense as is the case for:
    a. assessment/EI evaluation
    b. development or review of the Individual Family Service Plan (IFSP), and
    c. targeted case management/service coordination
2. Developmental services
3. Any covered early intervention services where the family has declined access to their private health/medical insurance

Enrollment

Enrollment in the program is required for eligible individuals. DMAS and the Managed Care Helpline manage the enrollment for the program. To participate, you must be eligible for Medicaid. The program allows for a process which speeds up member access to care coordination, disease management, 24-hour nurse call lines, and access to specialty care. This is especially important for members with chronic care needs, pregnant women, and foster care children who quickly need access to care.

Health Plan Assignment

You received a notice from DMAS that included your initial health plan assignment. With that notice, DMAS included a comparison chart of health plans in your area. The assignment notice provided you with instructions on how to make your health plan selection.

You may have chosen us to be your health plan. If not, DMAS may have assigned you to our health plan based upon your history with us as your managed care plan. For instance, you may have been enrolled with us before through Medicaid. You may also have been assigned to us if certain providers you see are in our network.

Changing Your Health Plan

By mobile app. Download the free Virginia Managed Care app on your Android or iPhone to compare health plans, find a provider, or change your health plan to Aetna Better Health of Virginia. Search for "Virginia Managed Care" on Google Play or the App Store.

Online. Visit **virginiamanagedcare.com**

By phone. Call the Managed Care Helpline at **1-800-643-2273** (TTY: **1-800-817-6608),** Monday through Friday, 8:30 a.m. to 6:00 p.m. Interpreter services are free.

Assistance through the Managed Care Helpline can help you choose the health plan that is best for you. For assistance, call the Managed Care Helpline at **1-800-643-2273** or visit the website at **virginiamanagedcare.com**. The Managed Care Helpline is available Monday through Friday (except on state holidays) from 8:30 am to 6 pm. Operators can help you understand your health plan choices and/or answer questions about which doctors and other providers participate with each health plan, among many helpful items. The helpline services are free and are not connected to any health plan.

You can change your health plan during the **first 90 days** of your enrollment for any reason. You can also change your health plan once a year during open enrollment for any reason. You will get a letter from DMAS during open enrollment with more information. You may also ask to change your health plan for "good cause" at any time. The Helpline handles good cause requests and can answer any questions you have. Contact the Helpline at **1-800-643-2273** or visit the website at **virginiamanagedcare.com**.

Automatic Re-Enrollment

If your enrollment ends with us and you regain eligibility for the program within 60 days or less, you will automatically be re-enrolled with Aetna Better Health. You will be sent a re-enrollment letter from the Department of Medical Assistance Services.

What Are the Advantages of Choosing Aetna Better Health?

Some of the advantages include:

- Access to Aetna Better Health's Care Managers. Aetna Better Health's Care Managers work with you and with your providers to make sure you get the care you need.
- The ability to take control over your care with help from Aetna Better Health's Care Team and Care Managers.
- A Care Team and Care Managers who work with you to come up with a care plan specifically designed to meet your health needs.
- An on-call nurse or other licensed staff is available 24 hours a day, 7 days a week to answer your questions. We are here to help you. You can reach us by calling **1-800-279-1878** (TTY: **711**) at any time.

Why is Aetna Better Health a great choice? We help you get the care you need when you need it. Need a ride to the doctor? We have you covered with on-demand transportation. Have an Aetna Better Health question? Call Member Services at **1-800-279-1878** (TTY: **711**) 24 hours a day, 7 days a week. The call is free. Have a question about your benefits or care? Our nurses and Member Services reps are here.

Local presence, national strength

Aetna Better Health is committed to improving the health and lives of members 24 hours a day, 7 days a week. Just call us when you need help. Aetna Better Health is accredited with the National Committee for Quality Assurance (NCQA). NCQA evaluates how well a health plan manages all parts of its delivery system in order to improve health care for its members. Aetna Better Health is owned by Aetna, which provides services for over 3 million Medicaid members across the country.

Enhancing service, quality and accessibility with value-added benefits

In addition to our standard benefits, such as doctor and hospital coverage, immunizations, and preventive exams, we also provide enhanced benefits and services, which include:

- Adult vision
- Adult hearing
- Asthma prevention
- Better breathing
- Diabetes care for life
- Home-delivered meals
- Weight management
- No-cost cell phones
- Expanded Member Services call center hours 24 hours a day, 7 days a week
- Non-traditional medicine
- General Educational Development (GED) Incentives
- Swimming lessons
- Ted E. Bear, M.D., Wellness Club for children
- Youth sports physicals
- Over-The-Counter Health Solutions Period Stipend: A monthly stipend of $20 for members with periods to spend on their choice of period products through CVS Pharmacy®. Learn more at **CVS.com/Otchs/ABHVA**

What is a Health Risk Assessment?

Within the first few weeks after you enroll with Aetna Better Health, a Care Manager will reach out to you to ask you some questions about your needs and choices. They will talk with you about any medical, behavioral, physical, and social service needs that you may have. This meeting may be in-person or by phone and is known as a health risk assessment (HRA). An HRA is a very complete assessment of your medical, psychosocial, cognitive, and functional status. The HRA is generally completed by a Care Manager **within the first 30 to 60 calendar days** of your enrollment with Aetna Better Health depending upon the type of services that you require. This health risk assessment will enable your Care Manager to help you get the care that you need.

Transition of Care Period

If Aetna Better Health is new for you, you can keep previously authorized and/or scheduled doctor's appointments and prescriptions for the first 180 days. If your provider is not currently in Aetna Better Health's network, then you may be asked to select a new provider that is in Aetna Better Health's provider network. If your doctor leaves Aetna Better Health's network, we will notify you within 15 days so that you have time to select another provider.

What If I Have Other Coverage?

Medicaid is the payer of last resort. This means that if you have another insurance, are in a car accident, or if you are injured at work, your other insurance or Workers Compensation has to pay first.

We have the right and responsibility to collect for covered Medicaid services when Medicaid is not the first payer. Let Member Services know if you have other insurance so that we can best coordinate your benefits. Aetna Better Health's Care Member Services or Care Managers will also work with you and your other health plan to coordinate your services.

3. How to Get Regular Care and Services

"Regular care" means regular exams, routine check-ups, shots, or other treatments to keep you well, getting medical advice when you need it, and referring you to a hospital or specialist when needed. Be sure to call your PCP whenever you have a medical question or concern. If you call after hours or on weekends, leave a message with where or how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how the health plan works.

Your care must be medically necessary. The services you get must be needed:

- To prevent, or diagnose and correct what could cause more suffering, or
- To deal with a danger to your life, or
- To deal with a problem that could cause illness, or
- To deal with something that could limit your normal activities.

How to Get Care from A Primary Care Provider (PCP)

A PCP is a doctor selected by you who meets state requirements and is trained to give you basic medical care. You will usually see your PCP for most of your routine health care needs. Your PCP will work with you to coordinate most of the services you get as a Member of our plan. Coordinating your services or supplies includes checking or consulting with other plan providers about your care. If you need to see a doctor other than your PCP you may need a referral (authorization) from your PCP. You may also need to get approval in advance from your PCP before receiving certain types of covered services or supplies. In some cases, your PCP will need to get authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Contact Member Services with any questions about referrals or prior authorizations.

Special Note About Care from Tribal Providers

Tribal providers in Virginia who serve Medicaid members are not paid by us. DMAS pays for these services. Tribal Virginia Medicaid members have an expanded free choice of providers. Tribal members have the right to get services from Tribal providers. This ensures they have access to health care services in a setting that is culturally relevant.

Virginia has two Tribes. These are the Mattaponi and the Nansemond. These tribes support primary care and health care services to Tribal Medicaid members. The Tribal providers listed below have been added to our provider directory.

- Aylett Family Wellness (Upper Mattaponi Indian Tribe)
- Fishing Point Healthcare (Nansemond Indian Tribe)

If you are a Tribal member and receive a prescription or referral from a Tribal provider, it will be honored the same way as our network providers.

Provider Directory

Find a provider near you. Visit **AetnaBetterHealth.com/Virginia** and select **"Find a Provider"** to access our online provider search tool. You can also download a PDF version of our full directory by visiting **AetnaBetterHealth.com/Virginia/Members/Provider-Directory**.

The provider directory includes a list of of all the doctors, specialty physicians, hospitals, clinics, pharmacies, laboratories, affiliations, accommodations for persons with physical disabilities, behavioral health providers, provider addresses, phone numbers, web site URLs, and new patient acceptance (open or closed panels) who are contracted with Aetna Better Health. Upon request we can also provide you with a paper copy of the provider directory. You can also call Aetna Better Health Member Services at the number on the bottom of this page for assistance.

Choosing Your PCP

If you do not have a PCP, we can help you find a highly-qualified PCP in your community. For help locating a provider, you can use our online provider search tool at **AetnaBetterHealth.com/Virginia**.

You may want to find a doctor who:

- Knows you and understands your health condition
- Is taking new patients
- Can speak your language
- Has the accommodations that you require.

If you have a disabling condition or chronic illness, you can ask us if your specialist can be your PCP. We also contract with Federally Qualified Health Centers (FQHC). FQHCs provide primary and specialty care. Another clinic can also act as your PCP if the clinic is a network provider.

Women can choose an OB/GYN for women's health issues. These include routine check-ups, follow-up care if there is a problem, and regular care during a pregnancy. Women do not need a PCP referral to see an OB/GYN provider in our network.

If you do not select a PCP by the 25th of the month before the effective date of your coverage, Aetna Better Health will auto-enroll you with a PCP. Aetna Better Health will notify you in writing of the assigned PCP. You will need to call the Member Services number at the bottom of the page to select a new PCP.

If Your Current PCP Is Not in Aetna Better Health's Network

You can continue to see your current PCP for up to **180 days** even if your PCP is not in the Aetna Better Health network. You can request to have your provider added to our network. We will work with your provider to help them enroll in Aetna Better Health. If your provider does not join Aetna Better Health's network, your Care Manager can help you find a PCP in Aetna Better Health's network within the first 180 days of your enrollment.

At the end of the **180-day period**, if you do not choose a PCP in the Aetna Better Health network, we will choose a provider for you, or your provider will need to request prior authorization in advance of any services you receive.

How to Get Care from Other Network Providers

Our provider network includes access to care 24 hours a day, 7 days per week and includes hospitals, doctors, specialists, urgent care facilities, behavioral health providers, home and community-based service providers, early intervention providers, rehabilitative therapy providers, addiction and recovery treatment services providers, home health providers, durable medical equipment providers, and other types of providers. Aetna Better Health provides you with a choice of providers and they are located so that you do not have to travel very far to see them. There may be special circumstances where longer travel time is required; however, that should be only on rare occasions.

Changing Your PCP

You may call or visit Aetna Better Health's Member Services to change your PCP at any time to another PCP in our network. Please understand that it is possible your PCP will leave Aetna Better Health network. We will tell you within 15 days of the provider's intent to leave our network. We are happy to help you find a new PCP. The web address for our Member Services program is **AetnaBetterHealth.com/Virginia**.

You can change your PCP on our secure member web portal at **AetnaBetterHealth.com/Virginia**. Or you can call Member Services at **1-800-279-1878** (TTY: **711**). You need to do this before you visit your new doctor.

If we receive your request on or before the 15th of the month, the change will be made to the first day of that month. If your request is received after the 15th of the month, you will need to wait until the first day of the next month to use your new PCP.

Getting an Appointment with Your PCP

Your PCP will take care of most of your health care needs. Call your PCP to make an appointment. If you need care before your first appointment, call your PCP's office to ask for an earlier appointment. If you need help making an appointment, call Member Services at the number below.

Appointment Standards

You should be able to get an appointment with your PCP within the same amount of time as any other patient seen by that PCP. Expect the following times to see a provider:

- For an emergency – immediately
- For urgent care office visits with symptoms – within 24 hours of request
- For routine primary care visits – within 30 calendar days of request

If you are pregnant, you should be able to make an appointment to see an OB/GYN as follows:

- First trimester (first 3 months) – within seven (7) calendar days of request
- Second trimester (3 to 6 months) – within seven (7) calendar days of request
- Third trimester (6 to 9 months) – within three (3) business of request
- High-Risk pregnancy – within three (3) business days of request or immediately if an emergency exists

You should be able to make an appointment for behavioral healthcare as follows:

- For non-life-threatening emergency – within 6 hours of request

- For urgent care – within 48 hours of request
- For initial visit for routine care - within 10 business days

If you are unable to receive an appointment within the times listed above, call Member Services at the number below and they will help you schedule the appointment.

Travel Time and Distance Standards

Aetna Better Health will provide you with the services you need within the travel time and distance standards described in the table below. These standards apply for services that you travel to receive from network providers. If you live in an urban area, you should not have to travel more than 30 miles or 45 minutes to receive services. If you live in a rural area, you should not have to travel more than 60 miles or 75 minutes to receive services.

Member Travel Time & Distance Standards		
Standard	**Distance**	**Time**
Urban PCP Specialists*	 15 Miles 30 Miles	 30 Minutes 45 Minutes
Rural PCP Specialists*	 30 Miles 60 Miles	 45 Minutes 75 Minutes

*Unless specialist is an OB/GYN in which case travel time should be no more than 45 minutes for any pregnant member.

Accessibility

Aetna Better Health wants to make sure that all providers and services are as accessible (including physical and geographic access) to individuals with disabilities as they are to individuals without disabilities. If you have difficulty getting an appointment to a provider or accessing services because of a disability, contact Member Services at the telephone number below for assistance.

Telehealth Visits

We cover telehealth. Telehealth is the use of audio or video conferencing technology with your health care provider. Telehealth covers medical and behavioral health benefits that do not require an in-person visit. Due to the COVID-19 pandemic, the use of telehealth has increased, which allows members to still see their provider but in the safety of their home.

Talk to your provider about scheduling a telehealth visit. If you need assistance scheduling an appointment, our Member Services team is here to help. Call **1-800-279-1878** (TTY **711**).

We can also assist you and your provider with telehealth interpreter services via 3-way video. All languages, including American Sign Language are available.

What If a Provider Leaves Aetna Better Health's Network?

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

- Even though our network of providers may change during the year, we must give you uninterrupted
- access to qualified providers.
- When possible, we will give you at least 30 days' notice so that you have time to select a new provider.
- We will help you select a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to ask, and we will work with you to ensure, that the medically necessary treatment you are getting is not interrupted.
- If you believe we have not replaced your previous provider with a qualified provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out one of your providers is leaving our plan, please contact your Case Manager so we can assist you in finding a new provider and managing your care. You may also call Member Services at the number below.

What Types of People and Places Are Network Providers?

Aetna Better Health's network providers include:

- Doctors, nurses, and other health care professionals.
- Clinics, hospitals, and urgent care centers.
- Providers for children with special health care needs.
- Behavioral health and substance abuse practitioners, therapists, and counselors.

What Are Network Pharmacies?

Network pharmacies are pharmacies (drug stores) that have agreed to fill prescriptions for our members. You can use the Provider and Pharmacy Directory to find the network pharmacy you want to use.

Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to help you pay for them. Call Member Services at the number at the bottom of the page for more information. Both Member Services and Aetna Better Health's website can give you the most up-to-date information about changes in our network pharmacies and providers.

Services You Can Get Without A Referral or Prior Authorization

You are not required to get a referral from your PCP or OB/GYN before you see another Aetna Better Health network provider. However, you should talk to your PCP to let them know you are going to the other provider. This helps your PCP coordinate your care. Some services may need to be preauthorized. See Section 11 of this handbook for a list of the services that need to be approved before they can be covered.

4. How to Get Specialty Care and Services

What are Specialists?

If you need care that your PCP cannot provide, your PCP may refer you to a specialist. Most of the specialists are in Aetna Better Health network. A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

If you need to see a specialist for ongoing care, your PCP may be able to refer you for a specified number of visits or length of time (known as a standing referral). If you have a standing referral, you will not need a new referral each time you need care. If you have a disabling condition or chronic illnesses, you can ask us if your specialist can be your PCP.

How Do I Access a Network Specialist?

To find a participating provider or specialist, go to our website at **AetnaBetterHealth.com/Virginia**. Your specialist can be your PCP in some cases. You can narrow results down to a particular specialty if needed. If you need help finding a provider or specialist near you, call Member Services at **1-800-279-1878** (TTY: **711**).

We do not require you to get a referral from your PCP before you see another Aetna Better Health in-network provider. You still should call your PCP or care manager to let him/her know you are going to the other provider. This helps your PCP coordinate your care.

Some services from your specialist may need to be preauthorized. See Section 11 of this handbook for a list of the services that need to be approved before they can be covered.

How to Get Care from Out-Of-Network Providers

If we do not have a specialist in the Aetna Better Health network to provide the care you need, we will get you the care you need from a specialist outside of the Aetna Better Health network. Some services may need to be preauthorized.

We will also get you care outside of the Aetna Better Health network in any of the following circumstances:

- When Aetna Better Health has approved a doctor out of its established network
- When emergency and family planning services are rendered to you by an out of network provider or facility
- When you receive emergency treatment by providers not in the network
- When the needed medical services are not available in Aetna Better Health's network
- When Aetna Better Health cannot provide the needed specialist within the distance standard of more than 30 miles in urban areas or more than 60 miles in rural areas
- When an Aetna Better Health in-network provider is not able to provide the services you need due to moral or religious objections
- Within the first 180 calendar days of your enrollment, where your provider is not part of Aetna Better Health's network, but he has treated you in the past, and
- If you are in a nursing home when you enroll with Aetna Better Health, and the nursing home is not in the Aetna Better Health network

If your PCP or Aetna Better Health refer you to a provider outside of our network, you are not responsible for any of the costs, except for your patient pay toward long term service and supports. See Section 14 of this handbook for information about what a patient pay is and how to know if you have one.

See Section 11 of this handbook for a list of the services that need to be approved before they can be covered.

How To Get Care From Out of State Providers

Aetna Better Health is not responsible for services you obtain outside Virginia except under the following circumstances:

- Necessary emergency or post-stabilization services
- Where it is a general practice for those living in your locality to use medical resources in another state
- The required services are medically necessary and not available in-network and within the Commonwealth

5. How to Get Emergency Care and Services

What is an Emergency?

An emergency is a sudden or unexpected illness, severe pain, accident, or injury that could cause serious injury or death if it is not treated immediately. An emergency is always a covered service.

What to Do in an Emergency?

If you are having an emergency, call 911 immediately! You do not need to call Aetna Better Health first. Go to the closest hospital. Calling 911 will help you get to a hospital. You can use any hospital for emergency care, even if you are in another city or state. If you are helping someone else, please remain calm.

Tell the hospital that you are an Aetna Better Health member. Ask them to call Aetna Better Health at the number on the back of your ID Card.

What is a Medical Emergency?

This is when a person thinks he or she must act quickly to prevent serious health problems. It includes symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you believe that it could cause:

- Serious risk to your life or health; or
- Serious harm to bodily functions; or
- Serious dysfunction of any bodily organ or part; or
- In the case of a pregnant woman in active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer you to another hospital before delivery.
  - The transfer may pose a threat to your health or safety or to that of your unborn child.

What is a Behavioral Health Emergency?

A behavioral health emergency is when a person thinks about or fears they might hurt themselves or someone else.

Examples of Non-Emergencies

Examples of non-emergencies include colds, sore throat, upset stomach, minor cuts and bruises, or sprained muscles. If you are not sure, call your PCP or the Aetna Better Health medical advice line at **1-800-279-1878** (TTY: **711**) 24 hours a day, 7 days a week.

If You Have an Emergency When You Are Away from Home

You or a family member may have a medical or a behavioral health emergency away from home or while traveling. If this happens, go to the closest hospital emergency room. You can use any hospital for emergency care. Show them your Aetna Better Health member ID card. Tell them you are enrolled in Aetna Better Health's program.

What is Covered If You Have an Emergency?

Aetna Better Health covers appropriate emergency care whenever you need it, anywhere in the United States or its territories. If you need an ambulance to get to the emergency room, our plan covers that. If you have an emergency, we will talk with the doctors who give you emergency care. Those doctors will tell us when your medical emergency is complete.

Notifying Aetna Better Health About Your Emergency

Call Aetna Better Health at **1-800-279-1878** (TTY: **711**) to notify us about the emergency within 48 hours or as soon as you can. You will not have to pay for emergency services if there is a delay in telling us about your emergency visit. Telling us allows us to follow up on your emergency care. Your Care Manager will assist you in getting the correct services in place before you are discharged to ensure that you get the best care possible. Please call Aetna Better Health's Member Services at **1-800-279-1878** (TTY: **711**). This number is also listed on the back of your member ID card.

After an Emergency

Aetna Better Health will provide necessary follow-up care, including out of network providers, until your physician says that your condition is stable enough for you to transfer to an in-network provider, or for you to be discharged. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible after your physician says you are stable. You may also need follow-up care to be sure you continue to get better. Your follow-up care will be covered by our plan.

If You Are Hospitalized

If you are hospitalized, a family member or a friend should contact Aetna Better Health as soon as possible. By keeping Aetna Better Health informed, your Care Manager can work with the hospital team to organize the right care and services for you before you are discharged. Your Care Manager will also keep

your medical team including your home care services providers informed of your hospital treatment and plans.

What If It Wasn't a Medical Emergency After All?

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

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

- You go to a network provider
- The additional care you get is considered "urgently needed care" and you follow the rules for getting urgently needed care. (See Urgently Needed Care in section 6 of this handbook.)

6. How to Get Urgently Needed Care

What is Urgently Needed Care?

Urgently needed care is care you get for a sudden illness, injury, or condition that isn't an emergency but should be treated right away. For example, you might have an existing condition that worsens, and you need to have it treated right away. Other examples of urgently needed care include sprains, strains, skin rashes, infection, fever, flu, etc. In most situations, we will cover urgently needed care only if you get this care from a network provider.

You can find a list of urgent care centers we work with in our Provider and Pharmacy Directory on our website at **AetnaBetterHealth.com/Virginia**.

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

7. How to Get Prescription Drugs

This section explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or drug store.

Rules for Aetna Better Health's Outpatient Drug Coverage

Aetna Better Health will usually cover your drugs as long as you follow the rules in this section.

1. You must have a doctor or other provider write your prescription. This person often is your primary care provider (PCP). It could also be another provider if your primary care provider has referred you for care. Prescriptions for controlled substances must be written by an in-network doctor or provider.
2. You generally must use a network pharmacy to fill your prescription.
3. Your prescribed drug must be on Aetna Better Health's List of Covered Drugs. If it is not on the Drug List, we may be able to cover it by giving you an authorization.
4. Your drug must be used for a medically accepted indication. This means that the use of the drug is approved by the Food and Drug Administration or supported by certain reference books.

Getting Your Prescriptions Filled

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

To find a network pharmacy, you can look in the Provider and Pharmacy Directory on our website at **AetnaBetterHealth.com/Virginia** or contact Member Services at the number at the bottom of the page.

To fill your prescription, show your Member ID Card at your network pharmacy. The network pharmacy will bill Aetna Better Health for the cost of your covered prescription drug. If you do not have your member ID Card with you when you fill your prescription, ask the pharmacy to call Aetna Better Health to get the necessary information.

If you need help getting a prescription filled, you can contact Member Services at the number at the bottom of the page.

List of Covered Drugs

Aetna Better Health has a List of Covered Drugs that are selected by Aetna Better Health with the help of a team of doctors and pharmacists. The Aetna Better Health List of Covered Drugs also includes all of the drugs on the DMAS Preferred Drug List (PDL). The List of Covered Drugs can be found at **AetnaBetterHealth.com/Virginia**. The List of Covered Drugs tells you which drugs are covered by Aetna Better Health. It also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get.

You can call Member Services to find out if your drugs are on the List of Covered Drugs or view this list on our website at **AetnaBetterHealth.com/Virginia**. We can also mail you a paper copy of the List of Covered Drugs. The List of Covered Drugs may change during the year. To get the most up-to-date List of Covered Drugs, visit **AetnaBetterHealth.com/Virginia** or call **1-800-279-1878** (TTY: **711**).

We will generally cover a drug on Aetna Better Health's List of Covered Drugs as long as you follow the rules explained in this section. You can also get drugs that are not on the list when medically necessary. Your physician may have to obtain a service authorization from us in order for you to receive some drugs.

Limits for Coverage of Some Drugs

Some prescription drugs have special rules about how and when we cover them. In general, our rules encourage you to get a drug that works for your medical condition and that is safe and effective, as well as cost effective.

If there is a special rule for a drug you are prescribed, it usually means that you or your provider will have to take extra steps for us to cover the drug. For example, your provider may need to request a service authorization for you to receive the drug. We may or may not agree to approve the request without taking extra steps. Refer to Service Authorization and Benefit Determination and Service Authorizations and Transition of Care in section 11 of this handbook.

If Aetna Better Health is new for you, you can keep getting your authorized drugs for the duration of the authorization or for 180 days after you first enroll, whichever is sooner. Refer to Transition of Care Period in section 11 of this handbook.

If we deny or limit coverage for a drug, and you disagree with our decision, you have the right to appeal our decision. Refer to Your Right to Appeal in Section 12 of this handbook. If you have any concerns, contact your Care Coordinator. Your Care Coordinator will work with you and your PCP to make sure that you receive the drugs that work best for you.

Getting Approval in Advance

For some drugs, you or your doctor must get a service authorization approval from Aetna Better Health before you fill your prescription. If you don't get approval, Aetna Better Health may not cover the drug.

Trying a Different Drug First

We may require that you first try one (usually less-expensive) drug before we will cover another (usually more-expensive) drug for the same medical condition. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, then we will cover Drug B. This is called step therapy.

Quantity Limits

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

To find out if any of the rules above apply to a drug your physician has prescribed, check the List of Covered Drugs. For the most up-to-date information, call Member Services or visit our website at **AetnaBetterHealth.com/Virginia**.

Emergency Supply

There may be instances where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit a service authorization request for the prescribed medication.

Noncovered Drugs

There are some types of drugs that are not covered by Medicaid or Medicare by law. These drugs include:

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction, such as Viagra®, Cialis®, Levitra®, and Caverject®, unless such agents are used to treat a condition other than sexual or erectile dysfunction, for which the agents have been approved by the FDA
- Drugs used for treatment of anorexia, weight loss, or weight gain
- All DESI (Drug Efficacy Study Implementation) drugs as defined by the FDA to be less than effective, including prescriptions that include a DESI drug

- Drugs that have been recalled
- Experimental drugs or non-FDA-approved drugs
- Any prescription drugs marketed by a manufacturer who does not participate in the Virginia Medicaid Drug Rebate program

Changing Pharmacies

If you need to change pharmacies and need a refill of a prescription, you can ask your pharmacy to transfer the prescription to the new network pharmacy. If you need help changing your network pharmacy, you can contact Member Services at the number at the bottom of the page or your Care Manager.

If the pharmacy you use leaves Aetna Better Health's network, you will have to find a new network pharmacy. To find a new network pharmacy, you can look in the Provider and Pharmacy Directory, visit our website, or contact Member Services at the number at the bottom of the page or your Care Manager. Member Services can tell you if there is a network pharmacy nearby.

What if You Need a Specialized Pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include pharmacies that supply drugs for home infusion therapy. Specialty drugs are used for treatment of complex diseases and when prescribed the medications required special handling or clinical care support prior to dispensing. Only a limited number of pharmacies are contracted by each MCO to provide these drugs. These medications will be shipped directly to the member's home or the prescriber office and cannot be picked up at all retail outlets. Also, these drugs usually require a service authorization prior to dispensing. Be sure to check with the formulary of your plan regarding coverage of these specialty drugs and allow time for shipment deliveries.

Contact Member Services at the number at the bottom of the page for information about benefits. Or call your Care Manager if you need help with your drugs.

Can You Use Mail-Order Services to Get Your Prescriptions?

For certain kinds of drugs, you can use the plan pharmacies. Generally, the drugs available through mail order are drugs that you take on a regular basis for a chronic or long-term medical condition. The drugs available through our mail order service are marked as mail-order drugs in our Drug List. Our mail-order service allows you to order up to a 90-day supply.

To get order forms and information about filling your prescriptions by mail, call Member Services or your Care Manager at **1-800-279-1878** (TTY: **711**) 24 hours a day, 7 days a week. You may request a mail order form, or you can register online with CVS Caremark at www.caremark.com.

Can You Get a Long-Term Supply of Drugs?

If a drug is listed as a maintenance drug on our drug list, you can get a long-term supply of that drug. The Provider and Pharmacy Directory tell you which network pharmacies give you a long-term supply of maintenance drugs. You can also call member services at the phone number listed on the bottom of the page. For certain kinds of drugs, you can use mail-order services to get a long-term supply of maintenance drugs. See the section above to learn about mail-order services.

Can You Use a Pharmacy that is not in Aetna Better Health's Network?

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

We will pay for prescriptions filled at an out-of-network pharmacy if you:

- Get a prescription in connection with emergency care.
- Get a prescription in connection with urgently needed care when network pharmacies are not available.
- If you are unable to get a covered prescription drug in a timely manner within our service area because there is no network pharmacy with 24-hour service within a reasonable driving distance.
- Are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (these prescription drugs include orphan drugs or other specialty pharmaceuticals).
- Traveling outside your service area (within the United States) and run out of your medication, if you lose your medication, or if you become ill and cannot get to a network pharmacy.
- Have not received your prescription drug during a state or federal disaster declaration or other public health emergency declaration in which you are evacuated or otherwise displaced from your service area or place of residence. If you needed to purchase a drug at an out of network pharmacy due to a federal disaster, you may send us a request to pay you back.

If any of the above cases apply to you, please call member services at **1-800-279-1878** (TTY: **711**) to see if there is a network pharmacy near you.

Utilization Management

Utilization Management affirmative statement about incentives

We understand members want to feel confident that they are receiving the health care and services that are best for them. We have policies that our staff and practitioners and providers follow to ensure you receive the right healthcare and services in the right place. Our UM staff uses clinical review criteria, practice guidelines, and written policies to make these decisions. Utilization decisions are based on the following reasons:

- Services requested are medically needed (also called medically necessary)
- Services requested are covered
- We do not use incentives to encourage barriers to care and/or service, or to reward inappropriate
- restrictions of care. This is called an affirmative statement.
- We want to let you know that:
- Utilization management decisions are based only on appropriateness of care and services and whether they are covered
- We do not reward or pay our network of providers or employees to deny reviews
- No financial incentives are offered to encourage underutilization

We want to ensure each member receives the right care, at the right time, and in the right place. If you need help understanding this information, call Member Services at **1-800-279-1878** (TTY: **711**).

What is the Patient Utilization Management and Safety (PUMS) Program?

Some members who require additional monitoring may be enrolled in the Patient Utilization Management and Safety (PUMS) program. The PUMS program is required by DMAS and helps make sure your drugs and health services work together in a way that won't harm your health. As part of this program, we may check the Prescription Monitoring Program (PMP) tool that the Virginia Department of Health Professions maintains to review your drugs. This tool uses an electronic system to monitor the dispensing of controlled substance prescription drugs.

If you are chosen for PUMS, you may be restricted to or locked into only using one pharmacy or only going to one provider to get certain types of medicines. We will send you a letter to let you know how PUMS works. The inclusion period is for 12 months. At the end of the lock in period, we'll check in with you to see if you should continue the program. If you are placed in PUMS and don't think you should be in the program, you can appeal. You must appeal to us within 60 days of when you get the letter saying that you have been put into PUMS. You can also request a State Fair Hearing. Refer to Appeals, State Fair Hearings, and Complaints in section 12 of this handbook.

If you're in the PUMS program, you can get prescriptions after hours if your selected pharmacy doesn't have 24-hour access. You'll also be able to pick a PCP, pharmacy, or other provider where you want to be locked in. If you don't select providers for lock in within 15 days, we'll choose them for you.

Members who are enrolled in PUMS will receive a letter from Aetna Better Health that provides additional information on PUMS including all of the following information:

- A brief explanation of the PUMS program
- A statement explaining the reason for placement in the PUMS program
- Information on how to appeal to Aetna Better Health if placed in the PUMS program
- Information regarding how to request a State Fair Hearing after first exhausting the Aetna Better
- Health's appeals process
- Information on any special rules to follow for obtaining services, including for emergency or after-hours services
- Information on how to choose a PUMS provider
- Contact Member Services at the number below or your Care Manager if you have any questions on PUMS

8. Benefits

General Coverage Rules

To receive coverage for services you must meet the following general coverage requirements:

1. Your services (including medical care, services, supplies, equipment, and drugs) must be medically necessary. Medically necessary generally means you need the services to prevent, diagnose, or treat a medical condition or prevent a condition from getting worse.
2. In most cases, you must get your care from a network provider. A network provider is a provider who works with Aetna Better Health. In most cases, Aetna Better Health will not pay for care you get from an out-of-network provider unless the service is authorized by Aetna Better Health.

Section 3 has information about these services. Section 4 has more information about using network and out-of-network providers.

3. Some of your benefits are covered only if your doctor or other network provider gets approval from us first. This is called service authorization. Section 11 includes more information about service authorizations.
4. Aetna Better Health providers will file most claims for you. You may have to file claims if you get care outside of the Aetna Better Health network. You can get the claim form by calling Member Services at the number below. Send your claims to:
   Aetna Better Health of Virginia
   P.O. Box 63518
   Phoenix, AZ 85082-3518
5. If Aetna Better Health is new for you, you can keep seeing the doctors you go to now for the first **180 days**. You can also keep getting your authorized services for the duration of the authorization or for **180 days** after you first enroll, whichever is sooner. Also see Transition of Care Period in Section 11.

Benefits Covered Through Aetna Better Health

Aetna Better Health covers the following services when they are medically necessary:

- Regular medical care, including office visits with your PCP, specialists, exams, etc. (See section 3 of this handbook for more information about PCP services)
- Preventive care, including regular check-ups, well baby/child care (See section 3 of this handbook for more information about PCP services).
- Addiction, recovery, and treatment services (ARTS), including inpatient, outpatient, community based, medication assisted treatment, peer services, and case management. Services may require authorization. Additional information about ARTS services is provided later in this section of the handbook.
- Behavioral health services, including inpatient and outpatient psychotherapy individual, family, and group are covered
- Clinic services.
- Colorectal cancer screening.
- Court ordered services.
- Durable medical equipment and supplies (DME).
- Early and periodic screening diagnostic and treatment services (EPSDT) for children under age 21. Additional information about EPSDT services is provided later in this section of the handbook.
- Early intervention services designed to meet the developmental needs of children and families and to enhance the development of children from birth to the day before the third birthday. Additional information about early intervention services is provided later in this section of the handbook.
- Electroconvulsive therapy (ECT).
- Emergency custody orders (ECO).
- Emergency services including emergency transportation services (ambulance, etc.).
- Emergency and post stabilization services. Additional information about emergency and post stabilization services is provided in sections 5 and 6 of this handbook.
- End stage renal disease services.
- Eye examinations.

- Family planning services, including services, devices, drugs (including long-acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including through providers who are in/out of Aetna Better Health's network. Aetna Better Health does not require you to obtain service authorization or PCP referrals on family planning services.
- Gender dysphoria treatment services.
- Glucose test strips.
- Hearing (audiology) services.
- Home health services.
- Hospital care – inpatient/outpatient.
- Human Immunodeficiency Virus (HIV) testing and treatment counseling.
- Immunizations.
- Inpatient psychiatric hospital services.
- Laboratory, Radiology and Anesthesia Services.
- Lead testing and investigations.
- Mammograms.
- Maternity care- includes pregnancy care, doctors/certified nurse-midwife services. Additional
- information about maternity care is provided in section 6 of this handbook.
- Mental health services, including outpatient psychotherapy services, community-based, crisis and inpatient services. Community and facility-based services include:
    - Mental Health Case Management
    - Therapeutic Day Treatment (TDT) for Children
    - Mental Health Skill-building Services (MHSS)
    - Intensive In-Home
    - Psychosocial Rehabilitation
    - Applied Behavior Analysis
    - Mental Health Peer Recovery Supports Services
    - Mental Health Partial Hospitalization Program
    - Mental Health Intensive Outpatient
    - Assertive Community Treatment
    - Multisystemic Therapy (MST)
    - Functional Family Therapy (FFT)
    - Mobile Crisis
    - Community Stabilization
    - 23-Hour Observation
    - Residential Crisis Stabilization
- Nurse Midwife Services through a Certified Nurse Midwife provider.
- Organ transplants.
- Orthotics, including braces, splints, and supports - for children under 21, or adults through an intensive rehabilitation program.
- Outpatient hospital services.
- Pap smears.
- Physician's services or provider services, including doctor's office visits.
- Physical, occupational, and speech therapies.

- Podiatry services (foot care).
- Prenatal and maternal services.
- Prescription drugs. See section 7 of this handbook for more information on pharmacy services.
- Private duty nursing services (through EPSDT) Under Age 21.
- Prostate specific antigen (PSA) and digital rectal exams.
- Prosthetic devices including arms, legs and their supportive attachments, breasts, and eye prostheses).
- Psychiatric or psychological services.
- Radiology services.
- Reconstructive breast surgery.
- Renal (kidney) dialysis services.
- Rehabilitation services – inpatient and outpatient (including physical therapy, occupational therapy, speech pathology and audiology services).
- Second opinion services from a qualified health care provider within the network or we will arrange for you to obtain one at no cost outside the network. The doctor providing the second opinion must not be in the same practice as the first doctor. Out of network referrals may be approved when no participating provider is accessible or when no participating provider can meet your individual needs.
- Surgery services when medically necessary and approved by Aetna Better Health.
- Telemedicine services.
- Temporary detention orders (TDO).
- Tobacco Cessation Services, education, and pharmacotherapy for all members.
- Transportation services, including emergency and non-emergency (air travel, ground ambulance, stretcher vans, wheelchair vans, public bus, volunteer/ registered drivers, taxi cabs. Aetna Better Health will also provide transportation to/from most carved-out services. Additional information about transportation services is provided later in this section of the handbook.
- Vision services.
- Well Visits – Call your PCP and set up time for a checkup.
  - As soon as you receive you're ID Card, even if you are not sick. It is important for your PCP to get to know you better and help with future health problems before they happen, or at least find them sooner.
  - Your PCP will look for any problems you might have because of your age, weight, and habits. Your PCP will also help you find ways to be healthier.
  - Children should also see their PCP for checkups, shots, and screenings as soon as possible. For checkups, shots, and screening, try to call your PCP two or three weeks ahead to ask for an appointment.
- Abortion services only in instances when there is or would be a substantial danger to life of the mother.

Extra Benefits for Aetna Better Health Members

As a member of Aetna Better Health, you have access to services that are not generally covered through Medicaid fee-for-service. These services are known as "enhanced benefits." We provide the following enhanced benefits:

Adult vision	• Eye exam and $100 for glasses or contacts per year Eye exam and $250 for glasses or contacts per year
Adult hearing	• Exam and one hearing aid per year, plus unlimited visits for hearing aid fittings (Limited to $500 annually) Hearing exam and $1,500 for hearing aids plus 60 batteries per year. Unlimited visits for hearing aid fittings included
Transportation	• Free rides (30 round trips or 60 one-way trips each year) to grocery store, farmers market, food bank, food pantry, place of worship, library, gym, or exercise class, DSS, DMV, WIC, Social Security Office, and more
Healthy moms and kids	• Baby Matters maternity incentive program with $50 gift card and 300 free diapers, plus virtual baby showers and portable cribs for attendees • Ted E. Bear M.D. Wellness Club • Free youth swim lessons • Free youth sports physicals
Phone and online tools	• Free smartphone with free unlimited minutes and texts, plus 10 GB of data monthly • 24/7 Member Services • 24 Hour Nurse Line
Wellness program	• Asthma program with second inhaler or nebulizer plus bed and carpet cleaning • Diabetes Care for Life program • Weight management • Wellness rewards card
Other benefits	• Meals delivered to your home after discharge (2 meals each day for 7 days) • GED certificate incentive

For more details about your benefits, refer to your member handbook. You may view the handbook on our website at AetnaBetterHealth.com/Virginia. You can call us at **1-800-279-1878** (TTY: **711**) to ask us to mail you a paper copy, at no cost to you. We will send you a paper copy within five business days. You can request the handbook, also at no cost to you, in a language other than English, or in other formats such as audio, large print or Braille.

The covered benefit information in this brochure is a brief summary. It's not meant to be a complete description of all benefits available to you. Limitations and restrictions may apply. Certain co-pays may apply for FAMIS members.

Wellness rewards

You can earn gift cards for each healthy step you complete. It really does pay to check on your health.

Screenings

- $15: Mammogram screening
- $15: Cervical cancer screening

Pregnancy and birth care

- $50: Earn rewards for going to your pre- and postnatal visits

Ted E. Bear M.D. Wellness Club

Earn rewards for getting important childhood care such as wellness exam, shots (as needed), weight and nutrition counseling, and growth and development checks. Be sure to have your provider complete the incentive form at your visit.

- Ages 0-4: $10
- Ages 5-10: $15
- Ages 11-13: $20
- Ages 14-17: $25

Age-appropriate prizes are also available once you enroll in our Ted E. Bear M.D. Wellness Club:

- Ages 0-4: Ted E. Bear, Portion plates, Sippy cups, Onesies
- Ages 5-10: Coloring book, Crayons/ Coloring pencils, Drawstring bags, Jump rope
- Ages 11-13: Key chain/Key light, Water bottle, Ear buds, 3 in 1 Charging cable
- Ages 14-17: Infinite Phone ring, 3 in 1 Charging cable, Folding umbrella, USB flash drive, Exercise band

Limit two per member.

If you have any questions about these benefits, please call our Member Services Department at the number on the bottom of this page.

What IS Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)?

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a federal law (42 CFR § 441.50 et seq), which requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. These benefits include:

- Services for nursing care
- Customized treatments specific to developmental issues
- Accessing carve-out services
- When medically necessary, inpatient behavioral therapy for substance abuse treatment services
- Clinical trials under EPSDT, only when no acceptable effective standard is available (evaluated on a case-by-case basis)

EPSDT promotes the early and universal assessment of children's healthcare needs through periodic screenings, and diagnostic and treatment services for vision, dental and hearing. EPSDT screenings are conducted by physicians or certified nurse practitioners and can occur during the following:

- Screening/well child check-ups (EPSDT/Periodic screenings) – Checkup that occur at regular intervals
- Sick visits (EPSDT/Inter-periodic Screenings) – unscheduled check-up or problem focused assessment that can happen at any time because of child's illness or a change in condition

We also cover any and all services identified as necessary to correct or improve any identified defects or conditions. Coverage is available under EPSDT for services even if the service is not available under the State's Medicaid Plan to the rest of the Medicaid population. All treatment services require service authorization (before the service is rendered by the provider).

How to Access EPSDT Service Coverage

Aetna Better Health provides most of the Medicaid EPSDT covered services. However, some EPSDT services, like pediatric dental care, are not covered by Aetna Better Health. For any EPSDT services not covered by Aetna Better Health, you can get these through the Medicaid fee-for-service program. Additional information is provided in section 11 of this handbook.

How to Access Early Intervention (EI) Service Coverage

If you have a baby under the age of 3, and you believe that he or she is not learning or developing like other babies and toddlers, your child may qualify for early intervention services. Early intervention services include services that are designated to meet the developmental needs of an infant or toddler with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development. The services include speech therapy, physical therapy, and occupational therapy. The first step is meeting with the local Infant and Toddler Connection program in your community to see if your child is eligible. Children from birth to age three are eligible if he/she has:

1. A 25% developmental delay in one or more areas of development
2. Atypical development
3. A diagnosed physical or mental condition that has a high probability of resulting in a developmental delay

For more information, call your care manager. If your child is enrolled in Aetna Better Health, we provide coverage for early intervention services, including assistance with transportation and appointment scheduling.

Your Care Manager will work closely with you and the Infant and Toddler Connection program to help you access these services and any other services that your child may need. Information is also available at **www.infantva.org** or by calling **1-800-234-1448**.

Foster Care and Adoption Assistance

Aetna Better Health can provide individuals who are in foster care or are receiving adoption assistance with provider referrals, transition planning (for you about to leave the foster care program) and care coordination. Aetna Better Health has a care management team that specializes in these services and in working with local Departments of Social Services to help navigate medical and/or behavioral health care and other resources. For more information about these resources, call Member Services and ask to speak to a member of our Care Management Foster Care Team.

How to Access Maternal and Child Health Services with your Medicaid or FAMIS MOMS health care coverage

Getting medical care early in your pregnancy is very important. Aetna Better Health covers prenatal and maternal services to help you have a healthy pregnancy and a healthy baby.

Aetna Better Health has programs for pregnant women that include:

- Prenatal and post-partum services
- Pregnancy-related and infant programs.
- Services to treat any medical condition that may complicate pregnancy.
- Lactation consultation and breast pumps.
- Smoking cessation
- Postpartum depression screening.

Aetna Better Health's Maternity Program

Baby Matters is Aetna Better Health of Virginia's maternity program and is geared toward pregnant women and children up to age 2. The program is designed to empower women throughout their pregnancy by providing appropriate health services and information to improve and impact the quality of your healthcare needs. Our Baby Matters program provides member education to improve pregnancy outcomes. We also help manage high-risk pregnancy. We work together with your doctor to decide through risk screening if you need extra services. Covered services include:

- Patient education classes
- Nutrition assessment and counseling by a registered dietitian
- Homemaker services if your doctor ordered bed rest
- Coordination of community resources for classes such as childbirth and parenting
- Follow-up monitoring to confirm you are receiving the care you need
- Guidance and support through the pregnancy
- Blood glucose meters
- Testing for HIV
- Coordination to obtain residential or day treatment for substance abuse and transportation to receive those services

Enrollment for Newborns

Babies born to mothers enrolled in Aetna Better Health will automatically be enrolled into Aetna Better Health. The baby will be covered for the birth month plus 2 additional months, even if you do not stay enrolled with our plan.

Once you have your baby, you will need to enroll your baby as quickly as possible for Medicaid. Medicaid eligibility rules ensures continuous enrollment for your baby up to 12 months following birth. It is very important that you call your local Department of Social Services (DSS) to report the birth of your child and get a Medicaid/FAMIS Plus ID card for your baby.

You can do this by:

- Calling the Cover Virginia Call Center at **833-5CALLVA** to report the birth of your child over the phone, or
- Contacting your local Department of Social Services to report the birth of your child.

You will be asked to provide your information and your infant's:

- Name
- Date of Birth
- Race
- Sex
- The infant's mother's name and Medicaid ID number

If your baby does not have a Medicaid/FAMIS Plus ID number by the end of the third month following birth, your baby will lose coverage.

How to Access Family Planning Services

Family planning include services, devices, drugs (including long-acting reversible contraception) and supplies for the delay or prevention of pregnancy. You are free to choose your method for family planning including providers who are in/out of the Aetna Better Health network. Aetna Better Health does not require you to obtain a referral before choosing a family planning provider.

Aetna Better Health does not cover services to treat infertility or to promote fertility.

How to Access Behavioral Health Services

Many individuals struggle with mental health conditions such as depression, anxiety, or other mental health issues as well as using substances at some time in their lives. Behavioral health services offer a wide range of treatment options for individuals with a mental health or substance use disorder.

These behavioral health services aim to help individuals live in the community and maintain the most independent and satisfying lifestyle possible. Services range from outpatient counseling to hospital care, including day treatment and crisis services. These services can be provided in your home or in the community, for a short or long timeframe, and all are performed by qualified individuals and organizations.

Contact your Care Manager if you are having trouble coping with thoughts and feelings. Your Care Manager will help you make an appointment to speak with a behavioral healthcare professional.

Some Behavioral Health services are covered for you through Magellan, the DMAS Behavioral Health Services Administrator (BHSA). Aetna Better Health's Member Services can help coordinate the services you need, including those that are provided through the BHSA.

Some behavioral health services require preauthorization including:

- Outpatient services in a psychiatrist or licensed clinical psychologist's office, certified hospital departments, and in the community mental health clinics approved and/or operated by the Virginia Department of Behavioral Health and Developmental Services. Plans must follow Mental Health Parity and Addiction Equity Act (MHPAEA) requirements.
- Medically necessary outpatient individual, family and group mental health and substance abuse treatment services.
- Inpatient behavioral health hospital services, including inpatient stays for the medical conditions that relate to substance abuse (like acute gastritis, seizures, pancreatitis, and cirrhosis) need to be preauthorized by us.
- Psychological tests that are related to an apparent or diagnosed psychiatric illness and are part of your doctor's treatment plan.
- Children who have special needs for medically necessary assessment and treatment services, including children who have been victims of child abuse and neglect, if:
  - The services are delivered by a doctor or provider whose specialty is in the diagnosis and treatment of child abuse and neglect
  - The services are provided by a doctor or provider who has similar expertise and who meets these standards as verified by DMAS
- Services required by a Temporary Detention Order (TDO) are covered for members up to 96 hours
- All care given in a freestanding psychiatric hospital is covered for members up to the age of 21 and over the age of 64. When a child is admitted as a result of an EPSDT screening, a certification of the need for care must be completed as required by federal and state law.

Your new (and improved) mental health benefits

Your mental health is important. Just as important is being able to get the care you need – when you need it, where you need it. That's why we're excited to tell you about your new (and improved) mental health benefits.

Services you can get starting July 1, 2021

Service	For adults	For youth
Assertive Community Treatment	X	
Mental Health Partial Hospitalization Program	X	X
Mental Health Intensive Outpatient Program	X	X

Services you can get starting December 1, 2021

Service	For adults	For youth
Multisystemic Therapy		X

Functional Family Therapy		X
Mobile Crisis	X	X
Community Stabilization	X	X
23-Hour Observation	X	X
Residential Crisis Stabilization	X	X

Behavioral Therapy is now Applied Behavior Analysis (ABA)

On December 1, 2021, Behavioral Therapy will transition to Applied Behavior Analysis (ABA). **If your child is currently receiving behavioral therapy, your services and provider will not change. There is no action needed on your part.**

What is ABA and how can it help my child?

ABA supports your child's behavioral health needs by:

- Helping build important social skills,
- Improving communication, and
- Learning other new skills that can be used in everyday life (at home and school).

Important: Avoiding duplicate services

ABA cannot be combined with the following services: intensive in-home, mental health skills building, Family Functional Therapy (FFT), partial hospitalization program, or assertive community treatment. Doing so would mean a duplication of services. However, a 14-calendar day authorization can be approved for your child if being admitted or discharged from FFT.

Additional information about your new mental health benefits

Assertive Community Treatment (ACT)

ACT takes a person-centered approach to your care – and it's done in the community where you live. ACT helps adults manage severe mental illness during recovery. Trained staff will work with you to create a plan for day-to-day life and build important life skills. They will help you manage your medicine. ACT services also help you coordinate your next health care visits. That way you get the follow-up care you need when you need it.

Mental Health Partial Hospitalization Program (MH-PHP)

MH-PHP services are offered at least five days per week and four hours each day. It is a structured program done in a safe environment. It does not require an overnight stay. Health care staff will work with you on how to handle a crisis and be safe. They will work with you on your symptoms to help prevent a future setback. They use a variety of approaches in caring for you.

Mental Health Intensive Outpatient Program (MH-IOP)

MH-IOP takes place at least three days a week. It is a structured program in an outpatient setting. It includes therapy and help with building life skills. Treatment for substance use, care coordination, and

behavior change may also be part of the program. MH-IOP is more intense than traditional outpatient services. This can help support members, so they stay out of the hospital.

Multisystemic Therapy (MST)

MST works with the family, school, and community to aid at-risk youth. Its aim is to support those who need help with behavior, mood, or substance use. The service helps youth stay in the home and in school. It helps keep them out of trouble, the hospital, or other facilities. Positive behavior is modeled. Parents and guardians are empowered, as are youth, in this program.

Functional Family Therapy (FFT)

FFT helps at-risk youth. Trained staff work with the family. This is done to address the behavioral or emotional needs of their child. The focus is on strengthening family connections and creating positive behaviors. Its aim is to keep children in the home and school and out of the hospital or justice system. A community partner may refer a child they see as at-risk. The program is short-term.

Mobile Crisis

A mobile crisis team comes to you during a crisis. They will help you work through the crisis and make sure you are safe. They assist with trauma and can connect you to helpful resources where you live. This can help you stay out of the hospital.

Community Stabilization

These services take place in the community. They only last a short time and are meant to stabilize someone after a mental health crisis.

23-Hour Observation

This is a walk-in program where you can go in to be evaluated when you notice a big change in how you feel. It's meant to help you before a crisis takes place. You can access this service 24 hours a day, 7 days a week. It takes place in a clinic type setting where you can stay up to 23 hours.

Residential Crisis Stabilization

Trained staff will help you when you are experiencing a mental health or substance use crisis. The service takes place in your community at a residential crisis unit. It is meant to support you during this time and keep you out of the hospital. This service is offered 24 hours a day, 7 days a week for a short time.

Please call Member Services at **1-800-279-1878** (TTY: **711**) for further information or to obtain preauthorization.

How to Access Addiction and Recovery Treatment Services (ARTS)

Addiction is a medical illness, just like diabetes, that many people struggle with. Aetna Better Health offers a variety of addiction services that help people who are struggling with substance abuse, such as drugs and alcohol.

If you need treatment for addiction, we provide services that can help you, no matter how bad the problem may seem. These services include settings in inpatient, outpatient, residential, and community-based treatment. Medication assisted treatment options are also available if you are dealing with prescription or non-prescription drug use. Other options that are helpful include peer services (someone who has

experienced similar issues and in recovery), as well as care management services. Talk to your PCP or call your Care Manager to determine the best option for you and how to get help in addiction and recovery treatment services. To find an ARTS provider, you can look in the Provider and Pharmacy Directory, visit our website, call your Care Manager, or contact Member Services at one of the numbers below.

In order to learn more on how to obtain ARTS services, please call Member Services at **1-800-279-1878** (TTY: **711**). Your provider will need to submit the ARTS Service Authorization Review Form for the following services that require prior authorization by Aetna Better Health:

- Intensive Outpatient Services
- Partial Hospitalization Services
- Clinically Managed Low Intensity Residential Services
- Clinically Managed Population Specific High Intensity Residential Services
- Clinical Managed High Intensity Residential Services
- Medically Monitored Intensive Inpatient Services
- Medically Managed Intensive Inpatient Services

How to Access Non-Emergency Transportation Services

Transportation Services Covered by Aetna Better Health

Non-emergency transportation services are covered by Aetna Better Health for covered services, carved out services, and enhanced benefits. Aetna Better Health offers non-emergency transportation services for covered benefits such as vision, dental, behavioral, and medical health visits. These transportation services may be provided if you need to see a physician or go to a health care facility and have no other means of getting there.

Transportation is covered if your pharmacy does not offer delivery, will not mail the prescription, or cannot be filled at the medical facility. Normally, prescriptions should be filed initially on the return trip from the medical appointment. Transportation is not covered for picking up prescriptions and refills at a pharmacy if drugs can be delivered or mailed.

In the case of an emergency, call **911**. Refer to How to Get Care for Emergencies in Chapter 5 of this handbook.

For urgent or non-emergency medical appointments, call the transportation reservation line at **1-800-734-0430**. Call Member Services at **1-800-279-1878** (TTY: **711**) if you have any problems getting transportation to your appointments. You must call three business days before your appointment, or we may not be able to guarantee a ride.

9. Services Not Covered

The following services are not covered by Medicaid or Aetna Better Health. If you receive any of the following non-covered services, you will be responsible for the cost of these services.

- Acupuncture
- Administrative expenses, such as completion of forms and copying records
- Artificial insemination, in-vitro fertilization, or other services to promote fertility
- Assisted suicide
- Certain drugs not proven effective

- Certain experimental surgical and diagnostic procedures
- Chiropractic services
- Christian science nurses
- Cosmetic treatment or surgery
- Daycare, including sitter services for the elderly (except in some home- and community-based service waivers)
- Drugs prescribed to treat hair loss or to bleach skin
- Elective abortions
- Erectile dysfunction drugs
- Experimental or Investigational Procedures
- Eyeglasses repair for members aged 21 or older. (Eyeglasses or contacts are covered as an Aetna Better Health enhanced benefit)
- Medical care other than emergency services, urgent services, or family planning services, received from providers outside of the network unless authorized by Aetna Better Health
- Services rendered while incarcerated
- Weight loss clinic programs unless authorized
- Care received outside of the United States and its territories

If You Receive Non-Covered Services

If you receive non-covered services, Aetna Better Health we will only cover your services when you are enrolled with our plan and:

- Services are medically necessary.
- Services are listed as Benefits Covered Through Aetna Better Health in section 8 of this handbook.
- You receive services by following plan rules.

If you receive services that are not covered by our plan or covered through DMAS, you will be responsible for the full cost of the services received. You have the right to ask us if you are not sure and want to know if we will pay for any medical service or care. You can call Member Services or your Care Manager to find out more about services and how to obtain them. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision. Section 12 provides instructions for how to appeal Aetna Better Health's coverage decisions. You may also call Member Services to learn more about your appeal rights or to obtain assistance in filing an appeal.

10. Services Covered Through Medicaid Fee-For-Service

DMAS will provide you with coverage for any of the services listed below. These services are known as "carved-out services." You stay in Aetna Better Health when receiving these services. Your provider bills fee-for-service Medicaid (or its contractor) for these services.

Carved out services

- Dental Services are provided through the DMAS Dental Benefits Administrator.
  - DMAS has contracted with a DMAS Dental Benefits Administrator to coordinate the delivery of all Medicaid dental services. The dental program provides coverage for the following populations and services:

- For children under the age 21: diagnostic, preventive, restorative/surgical procedures, as well as orthodontia services.
- For pregnant women: x-rays and examinations, cleanings, fillings, root canals, gum related treatment, crowns, partials, dentures, tooth extractions, other oral surgeries, and other appropriate general services. Orthodontic treatment is not included. Dental coverage ends on the last day of the month following the 60th day after the baby is born.
- For adults aged 21 and over, dental coverage includes cleanings, x-rays, exams, fillings, dentures, root canals, gum-related treatment, oral surgery, and more.

If you have any questions about your dental coverage through the DMAS Dental Benefits Administrator, you can reach DentaQuest Member Services at **1-888-912-3456**, Monday through Friday, 8 a.m. – 6 p.m. EST. The TTY number is **1-800-466-7566**. Additional program information is available at: **https://www.dmas.virginia.gov/for-members/benefits-and-services/dental/**.

Aetna Better Health provides coverage for non-emergency transportation for any dental services covered through the DMAS Dental Benefits Administrator, as described above. Contact Aetna Better Health Member Services at the number below if you need assistance.

Aetna Better Health provides coverage for oral services such as hospitalizations, surgeries or services billed by a medical doctor not a dentist.

- School health services including certain medical, mental health, hearing, or rehabilitation therapy services that are arranged by your child's school. The law requires schools to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While schools are financially responsible for educational services, in the case of a Medicaid-eligible student, part of the costs of the services identified in the student's IEP may be covered by Medicaid. When covered by Medicaid, school health services are paid by DMAS. Contact your child's school administrator if you have questions about school health services.

Services That Will End Your Enrollment

If you receive any of the services below, your enrollment with Aetna Better Health will close and you will be served by the Medicaid Fee-For-Service program so long as you remain eligible for Medicaid.

- You are receiving care in an Intermediate Care Facility for Individuals with Intellectual Disabilities.
- You are receiving care in a Psychiatric Residential Treatment Level C Facility (children under 21).
- You are receiving care in a nursing facility.
- You are receiving care in a long-term care facility.
- You begin or are receiving hospice care.

11. Service Authorization Procedure

Service Authorizations Explained

There are some treatments, services, and drugs that require approval before you receive them or in order to be able to continue receiving them. This is called a service authorization. Your doctor makes requests for service authorizations.

A service authorization helps to determine if certain services or procedures are medically needed and covered by the plan. Decisions are based on what is right for each member and on the type of care and services that are needed.

We look at standards of care based on:

- Medical policies.
- National clinical guidelines.
- Medicaid guidelines.
- Your health benefits.

Service authorizations are not required for early intervention services, emergency care, family planning services (including long-acting reversible contraceptives), preventive services, and basic prenatal care. The following treatments and services must be authorized before you get them:

- Durable Medical Equipment (DME)
- Genetic testing
- Home based services, including personal care
- imaging (scans)
- Injectables
- Inpatient services
- Neuropsychological testing
- Orthotics/Prosthetics
- Outpatient surgery
- Psychological testing
- Services from providers not in your network
- Sleep studies
- Therapies
- Nuclear Radiology
- Transplant consultations, evaluations, and testing/transplant procedures

Aetna Better Health does not reward employees, consultants, or providers to:

- Deny care or services that you need
- Support decisions that approve less than what you need
- Say you don't have coverage

Call Member Services at the number below to find out more about how to request approval for these treatments and services.

Service Authorizations and Transition of Care

If you are new to Aetna Better Health, we will honor any service authorization approvals made by the Department of Medical Assistance Services or issued by another plan for up to **180 days** (or until the authorization ends if that is sooner than 180 days).

How to Submit a Service Authorization Request

Some services may need to be approved as "medically necessary" by Aetna Better Health before your provider can arrange for you to get these services. This process is called "prior authorization". Your

provider will work with Aetna Better Health Utilization Management team to request and secure prior authorization for any of these services. Your provider needs to call us for approval at least 3 working days before the scheduled care. We may ask to see written notes showing that your care was medically needed before it is preauthorized.

Prior Authorization Process:

1. Your health care provider must contact Aetna Better Health with information that can support your covered service and medical necessity for service.
2. An Aetna Better Health licensed clinician will review the services requested. We will decide if your request can be approved based on Aetna Better Health clinical guidelines. If our clinician cannot approve it, an Aetna Better Health doctor will review it. Our doctor may attempt to contact your requesting provider to discuss the request.
3. If your authorization is approved, we will notify your provider that it's approved and send you written notice of our decision.
4. If a denial, reduction, suspension, or termination of services happens, we will send you a written notice. Your health care provider will also be notified of the decision.
5. If you do not agree with our decision, you have the right to file an appeal and ask us to look at your case again. (See Your Right to Appeal in Section 12 of this handbook)
6. At any time, you and your provider may ask for a copy of the clinical criteria that was used to make a denial decision for medical services.

What Happens After Submitting a Service Authorization Request?

Aetna Better Health has a review team to be sure you receive medically necessary services. Doctors and nurses are on the review team. Their job is to be sure the treatment or service you asked for is medically needed and right for you. They do this by checking your treatment plan against medically acceptable standards. The standards we use to determine what is medically necessary are not allowed to be more restrictive than those that are used by DMAS.

Any decision to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination (decision). These decisions will be made by a qualified health care professional. If we decide that the requested service is not medically necessary, the decision will be made by a medical or behavioral health professional, who may be a doctor or other health care professional who typically provides the care you requested. You can request the specific medical standards, called clinical review criteria, used to make the decision for actions related to medical necessity.

After we get your request, we will review it under a standard or expedited (fast) review process. You or your doctor can ask for an expedited review if you believe that a delay will cause serious harm to your health. If your request for an expedited review is denied, we will tell you and your case will be handled under the standard review process.

Timeframes for Service Authorization Review

In all cases, we will review your request as quickly as your medical condition requires us to do so but no later than mentioned below.

Physical and Behavioral Health Services	Service Authorization Review Timeframes
Inpatient Hospital Services (Standard or Expedited Review Process)	No later than seventy-two (72) hours after receipt of the request for service. We may extend the seventy-two (72) hour turnaround time frame by up to fourteen (14) calendar days if the member requests an extension or we'll justify to DMAS a need for additional information and how the extension is in the member's interest.
Outpatient Services (Standard Review Process)	Within fourteen (14) calendar days following receipt of the request for service, with a possible extension of up to fourteen (14) additional calendar days if the member or the provider requests extension
Outpatient Services (Expedited Review Process)	Within 72 hours from receipt of your request or, as quickly as your condition requires

Pharmacy Services	Service Authorization Review Timeframes
Pharmacy services	We must provide decisions by telephone or other telecommunication device within 24 hours.
There may be an instance where your medication requires a service authorization, and your prescribing physician cannot readily provide authorization information to us, for example over the weekend or on a holiday. If your pharmacist believes that your health would be compromised without the benefit of the drug, we may authorize a 72-hour emergency supply of the prescribed medication. This process provides you with a short-term supply of the medications you need and gives time for your physician to submit an authorization request for the prescribed medication.	

If we need more information to make either a standard or expedited decision about your service request, we will:

- Write and tell you and your provider what information is needed. If your request is in an expedited review, we will call you or your provider right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 days from the day we asked for more information.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give Aetna Better Health to help decide your case. This can be done by calling Aetna Better Health's Member Services at **1-800-279-1878** (TTY: **711**).

You or someone you trust can file a complaint with Aetna Better Health if you don't agree with our decision to take more time to review your request. You or someone you trust can also file a complaint about the

way Aetna Better Health handled your service authorization request to the State through the Managed Care Helpline at **1-800-643-2273**. Also see Your Right to File a Complaint, in section 12 of this handbook.

Benefit Determination

We will notify you with our decision by the date our time for review has expired. But if for some reason you do not hear from us by that date, it is the same as if we denied your service authorization request. If you disagree with our decision, you have the right to file an appeal with us. Also see Your Right to Appeal, in section 12 in this handbook.

We will tell you and your provider in writing if your request is denied. A denial includes when the request is approved for an amount that is less than the amount requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain what options for appeals you have if you do not agree with our decision. Also see Your Right to Appeal, in section 12 of this Handbook.

Continuation of Care

In most cases, if we make a benefit determination to reduce, suspend, or end a service we have already approved and that you are now getting, we must tell you at least 10 days before we make any changes to the service.

Post Payment Review

If we are checking on care or services that you received in the past, we perform a provider post payment review. If we deny payment to a provider for a service, we will send a notice to you and your provider the day the payment is denied. You will not have to pay for any care you received that was covered by Aetna Better Health even if we later deny payment to the provider.

12. Appeals, State Fair Hearings, and Complaints (Grievances)

Your Right to Appeal

You have the right to appeal any adverse benefit determination (decision) by Aetna Better Health that you disagree with that relates to coverage, payment of services, or medical necessity.
For example, you can appeal if Aetna Better Health denies:

- A request for a health care service, supply, item, or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that Aetna Better Health denied.

You can also appeal if Aetna Better Health stops providing or paying for all or a part of a service or drug you receive that you think you still need.

Authorized Representative

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform Aetna Better Health of the name of your authorized representative. You can do this by calling our Member Services Department at one of the phone numbers

below. We will provide you with a form that you can fill out and sign stating who your representative will be.

Adverse Benefit Determination

There are some treatments and services that you need to get approval for before you receive them or in order to be able to continue receiving them. Asking for approval of a treatment or service is called a service authorization request. This process is described earlier in this handbook. Any decision we make to deny a service authorization request or to approve it for an amount that is less than requested is called an adverse benefit determination. Refer to Service Authorization and Benefit Determinations in section 11 of this handbook.

How to Submit Your Appeal

If you are not satisfied with a decision we made about your service authorization request, you have 60 calendar days after the date on the adverse benefit determination to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at one of the numbers below if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied, we will tell you and your appeal will be reviewed under the standard process.

Send your Appeal request to:

Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Phone: **1-800-279-1878** (TTY: **711**)
Fax: **866-669-2459**

If you send your standard appeal by phone, it must be followed up in writing. Expedited appeals submitted by phone do not require you to submit a written request.

Continuation of Benefits

In some cases, you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied, or care is changing or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial **you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this section.**

What Happens After We Get Your Appeal

Within three (3) business days, we will send you a letter to let you know we have received and are working on your appeal.

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to decide on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing to:

Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Fax: **866-669-2459**

You can also call Member Services at one of the numbers below if you are not sure what information to give us.

Timeframes for Appeals

Standard Appeals

If we have all the information we need, we will tell you our decision within thirty (30) days of when we receive your appeal request. We will send you a written notice of our decision within two (2) calendar days from the date we make our decision.

Expedited Appeals

If we have all the information we need, expedited appeal decisions will be made within **72 hours** of receipt of your appeal and we will send a written notice and attempt to provide oral notice within this timeframe. If there is a need for additional documentation or if a delay in rendering a decision is in your interest the timeframe for an expedited appeal decision, the timeframe may be increased up to an additional 14 days.

If We Need More Information

If we can't make the decision within the needed timeframes because we need more information we will:

- Write you and tell you what information is needed. If your request is in an expedited review, we will call you right away and send a written notice later.
- Tell you why the delay is in your best interest.
- Make a decision no later than 14 additional days from the timeframes described above.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give Aetna Better Health to help decide your case. This can be done by calling or writing to:

Aetna Better Health of Virginia
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

You or someone you trust can file a complaint with Aetna Better Health if you do not agree with our decision to take more time to review your appeal. You or someone you trust can also file a complaint about the way Aetna Better Health handled your appeal to the State through the Help Line at **1-800-643-2273**.

State Fair Hearing Process for Medallion Members

If you disagree with our decision on your appeal request, you can appeal directly to DMAS. This process is known as a State Fair Hearing. You may also submit a request for a State Fair Hearing if we deny payment for covered services or if we do not respond to an appeal request for services within the times described in this handbook. The State requires that you first exhaust (complete) Aetna Better Health appeals process before you can file an appeal request through the State Fair Hearing process. If we do not respond to your appeal request timely DMAS will count this as an exhausted appeal.

Standard of Expedited Review Requests

For, appeals that will be heard by DMAS you will have an answer generally **within 90 days** from the date you filed your appeal with Aetna Better Health. The 90-day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. If you want your State Fair Hearing to be handled quickly, you must write "EXPEDITED REQUEST" on your appeal request. You must also ask your doctor to send a letter to DMAS that explains why you need an expedited appeal. DMAS will tell you if you qualify for an expedited appeal **within 72 hours** of receiving the letter from your doctor.

Authorized Representative

You can give someone like your PCP, provider, friend, or family member written permission to help you with your State Fair Hearing request. This person is known as your authorized representative.

Where to Send the State Fair Hearing Request

There are a few ways to ask for an appeal with DMAS. Your deadline to ask for an appeal with DMAS is 120 calendar days from when we issue our final MCO internal appeal decision.

1. **Electronically**. Online at www.dmas.virginia.gov/#/appealsresources or email to appeals@dmas.virginia.gov
2. **By fax**. Fax your appeal request to DMAS at (804) 452-5454
3. **By mail or in person**. Send or bring your appeal request to Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219
4. **By phone**. Call DMAS at (804) 371-8488 (TTY: 1-800-828-1120)

To help you, an appeal request form is available from DMAS at **www.dmas.virginia.gov/#/appealsresources**. You can also write your own letter. Include a full copy of our final denial letter when you file your appeal with DMAS. Also include any documents you would like DMAS to review during your appeal. All information submitted during the initial request **and** during the DMAS appeal process will be considered to determine if the individual meets the criteria for approval of the requested eligibility/service(s).

After You File Your State Fair Hearing Appeal

DMAS will notify you of the date, time, and location of the scheduled hearing. Most hearings can be done by telephone.

State Fair Hearing Timeframes

Expedited Appeal

If you qualify for an expedited appeal, DMAS will give you an answer to your appeal within 72 hours of receiving the letter from your doctor. If DMAS decides right away that you win your appeal, they will send you their decision within 72 hours of receiving the letter from your doctor. If DMAS does not decide right away, you will have an opportunity to participate in a hearing to present your position. Hearings for expedited decisions are usually held within one or two days of DMAS receiving the letter from your doctor. DMAS still has to give you an answer within 72 hours of receiving your doctor's letter.

Standard Appeal

If your request is not an expedited appeal, or if DMAS decides that you do not qualify for an expedited appeal, DMAS will give you an answer within 90 days from the date you filed your appeal with Aetna Better Health. The 90-day timeframe does not include the number of days between our decision on your appeal and the date you sent your State fair hearing request to DMAS. You will have an opportunity to participate in a hearing to present your position before a decision is made.

Continuation of Benefits

In some cases, you may be able to continue receiving services that were denied by us while you wait for your State Fair Hearing appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied, or care is changing
- By the date the change in services is scheduled to occur.

Your services will continue until you withdraw the appeal, the original authorization period for your service ends, or the State Fair Hearing Officer issues a decision that is not in your favor. You may, however, have to repay Aetna Better Health for any services you receive during the continued coverage period if Aetna Better Health's adverse benefit determination is upheld, and the services were provided solely because of the requirements described in this Section.

If the State Fair Hearing Reverses the Denial

If services were not continued while the State Fair Hearing was pending

If the State Fair Hearing decision is to reverse the denial, Aetna Better Health must authorize or provide the services under appeal as quickly as your condition requires and no later than 72 hours from the date Aetna Better Health receives notice from the State reversing the denial.

If services were provided while the State Fair Hearing was pending
If the State Fair hearing decision is to reverse the denial and services were provided while the appeal is pending, Aetna Better Health must pay for those services, in accordance with State policy and regulations.

If You Disagree with the State Fair Hearing Decision
The State Fair Hearing decision is the final administrative decision rendered by the Department of Medical Assistance Services. If you disagree with the Hearing Officer's decision you may appeal it to your local circuit court.

External Review for FAMIS Members

If you are not happy with our appeal decision and your appeal is about our decision to deny, reduce, change, or terminate payment for your health care services, you can request an external review. Your appeal will be reviewed by an External Review Organization (ERO) which is an independent organization DMAS uses to review appeals. The ERO's decision in these matters shall be final and we shall comply with this decision. If you wish to file an appeal with the ERO, the appeal must be filed within 30 calendar days of the date you received notice of the appeal decision from us. You can only request an external review if it relates to a denial of a service, a reduction in service, termination of a previously preauthorized service, or failure to provide service timely. You must exhaust Aetna Better Health of Virginia's appeals process before requesting an external review.

Your request for an external review should be in writing and sent to:

FAMIS External Review c/o KePro
2810 N. Parham Road Suite #305
Henrico, VA 23294
Phone: **804-622-8900**
KePro Website: **www.DMAS.Kepro.com**

Your Benefits During the Appeal, State Fair Hearing, or External Review Process

While your appeal, State Fair Hearing, or External Review is in process, your Aetna Better Health benefits will continue if:

- You or your doctor files the appeal within 10 days of the date on the notice to deny, reduce, change, or end payment for your health care services or before the effective date of the notice.
- Your appeal is about our decision to terminate, suspend or reduce a course of treatment that was already preauthorized.
- The services were ordered by an authorized provider.
- The time frame covered by the preauthorization has not passed.
- You request that your benefits be extended.

To request a continuation of benefits, call Aetna Better Health Member Services at **1-800-279-1878** (TTY: **711**). While the appeal is pending, your benefits will continue until:

- You withdraw the appeal
- The time frame of the preauthorization has been met
- The service limit of the preauthorization has been met

If the final result of your appeal is to uphold the original decision, your benefits will not continue past 10 days after we mail the results. If you request to continue your benefits pending a State Fair Hearing or External Review decision, your benefits will continue until a State Fair Hearing officer or External Review upholds our original decision.

If the final result of your appeal is to uphold the original decision to deny, reduce, change or end payment for your services, we may take back the money that was paid for the services while the appeal was in process.

Your Right to File a Complaint

Aetna Better Health will try its best to deal with your concerns as quickly as possible to your satisfaction. Depending on what type of concern you have, it may be handled as a complaint or as an appeal.

What Kinds of Problems Should be Complaints

The complaint process is used for concerns related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the Aetna Better Health's complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy or shared information about you that is confidential or private.

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Aetna Better Health staff treated you poorly.
- Aetna Better Health is not responding to your questions.
- You are not happy with the assistance you are getting from your Care Manager.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care.

Complaints about communication access

- Your doctor or provider does not provide you with a qualified interpreter for the deaf or hard of hearing or an interpreter for another language during your appointment.

Complaints about waiting times

- You are having trouble getting an appointment or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other Aetna Better Health staff.

Complaints about cleanliness

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

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.
- You asked for help in understanding information and did not receive it.

There Are Different Types of Complaints

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by Aetna Better Health. An external complaint is filed with and reviewed by an organization that is not affiliated with Aetna Better Health.

Internal Complaints

To make an internal complaint, call Member Services at the number below. You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing. You can file a complaint in writing, by mailing or faxing it to us at:

Aetna Better Health of Virginia Attn: Appeals
9881 Mayland Drive
Richmond, VA 23233
Fax: **866-669-2459**
Phone: **1-800-279-1878**

So that we can best help you, include details on who or what the complaint is about and any information about your complaint. Aetna Better Health will review your complaint and request any additional information. You can call Member Services at the number below if you need help filing a complaint or if you need assistance in another language or format.

We will notify you of the outcome of your complaint within a reasonable time, but no later than 30 calendar days after we receive your complaint.

If your complaint is related to your request for an expedited appeal, we will respond within 24 hours after the receipt of the complaint.

External Complaints

You Can File a Complaint with the Managed Care Helpline

You can make a complaint about Aetna Better Health to the Managed Care Helpline at **1-800-643-2273** (TTY: **1-800-817-6608**) Monday – Friday, 8:30 a.m. – 6 p.m.

You Can File a Complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit **http://www.hhs.gov/ocr** for more information. Complaints can be sent to:

Office of Civil Rights- Region III

Department of Health and Human Services
150 S Independence Mall West Suite 372
Public Ledger Building
Philadelphia, PA 19106
1-800-368-1019 (TDD: 1-800-537-7697)
Fax: 215-861-4431

13. Member Rights

Your Rights

It is the policy of Aetna Better Health to treat you with respect. We also care about keeping a high level of confidentiality with respect for your dignity and privacy. As a member you have certain rights. You have the right to:

- Be informed of Aetna Better Health and all covered services
- Receive information about Aetna Better Health, our services, doctors, other providers, and member rights and responsibilities
- Be treated with respect, dignity, and the right to privacy
- Choose your personal Aetna Better Health doctor/primary care provider (PCP)
- Change your Aetna Better Health primary care provider (PCP)
- Be treated regardless of race, gender, religion, disability, ethnicity, national origin, or source of payment
- Expect all information about your health to be confidential and to have your privacy protected
- Not have your medical records shown to others without your approval, unless allowed by law
- Receive information from your doctor about treatment options or other types of care available to you, appropriate to your condition, and explained in a way you can understand
- Receive services from out of network doctors/providers
- Receive a second opinion on a medical procedure from an in-plan doctor/provider. If an Aetna Better Health provider is not available, we will help you get a second opinion from a non-participating provider at no cost to you
- Participate with your doctor/provider in making decisions about your health care
- Tell the doctor/provider that you do not want treatment and be told what may happen if you do not have the treatment. You can continue to get Medicaid and medical care without any repercussions even if you say no to treatment
- Make an official complaint or grievance about Aetna Better Health or file an appeal if you are not happy with the answer to your question, complaint/grievance, or care given
- Appeal a medical decision made by Aetna Better Health directly to the Department of Medical Assistance Services (DMAS)
- Know the cost to you if you choose to get a service that Aetna Better Health does not cover
- Be told in writing by Aetna Better Health when any of your health care services requested by your PCP are reduced, suspended, terminated, or denied. You must follow the instructions in your notification letter
- Have you and/or your child's doctor/provider tell you about treatment choices you may have, no matter what the cost or benefit coverage

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Find out what is in your medical records and request that they be corrected or amended
- Request a copy of your medical records
- Exercise your rights and to know that you will not have any retaliation against you by Aetna Better Health, any of our doctors/providers or state agencies
- Access to health care services and medical advice twenty-four (24) hours a day, seven (7) days a week, including urgent and emergency services
- Get family planning services from any participating Medicaid provider without prior authorization
- Get information in different formats (i.e., large print, Braille, etc.), at no cost to you, if needed and in an easy form that takes into consideration the special needs of those who may have problems seeing or reading
- Get interpretation services if you do not speak English or have a hearing impairment to help you get the medical services you need
- Make recommendations or suggestions regarding Aetna Better Health's member rights and responsibilities
- Develop Advance Directives or a Living Will, which tell how to have medical decisions made for you if you are not able to make them for yourself
- Ask for a description of all types of payment arrangements that we use to pay providers for health care services
- Change your health plan once a year for any reason during open enrollment or change your MCO after open enrollment for an approved reason. Reference section 2 of this handbook or call the Managed Care Helpline at **1-800-643-2273** (TTY: **1-800-817-6608**) or visit the website at **www.virginiamanagedcare.com** for more information.
- Make recommendations regarding our member rights and responsibility policy, for example by joining our Member Advisory Committee (as described later in this section of the handbook.)
- Get treatment that is nondiscriminatory based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information, or source of payment.
- Receive information and treatment that is considerate of your cultural or ethnic background.
- Get free interpreter services if you speak another language or are hearing impaired.
- Receive information about advance directives and to formulate or nullify advance directives.
- Obtain emergency care without prior approval from Aetna Better Health or your PCP regardless of whether the emergency care facility is in the Aetna Better Health network.

Your Right to be Safe

Everyone has the right to live a safe life. Aetna Better Health strives to ensure our members remain safe. We do this by working with you to help you stay out of the hospital and provide education on how to stay healthy. We have programs that monitor services and care that you receive to help make sure you stay safe. We also monitor our network to ensure you receive the best quality of care possible.

Your Right to Confidentiality

Aetna Better Health will only release information if it is specifically permitted by state and federal law or if it is required for use by programs that review medical records to monitor quality of care or to combat fraud or abuse.

Aetna Better Health staff will ask questions to confirm your identity before we discuss or provide any information regarding your health information.

We understand the importance of keeping your personal and health information secure and private. Both Aetna Better Health and your doctors make sure that all your member records are kept safe and private. We limit access to your personal information to those who need it. We maintain safeguards to protect it. For example, we protect access to our buildings and computer systems. Our Privacy Office also assures the training of our staff on our privacy and security policies. If needed, we may use and share your personal information for "treatment," "payment," and "health care operations." We limit the amount of information that we share about you as required by law. For example, HIV/AIDS, substance abuse and genetic information may be further protected by law. Our privacy policies will always reflect the most protective laws that apply.

Your Right to Privacy

We are required by law to provide you with the Notice of Privacy Practices. This notice is included in your member packet and our member newsletter. This notice informs you of your rights about the privacy of your personal information and how we may use and share your personal information.

Changes to this notice will apply to the information that we already have about you as well as any information that we may receive or create in the future. You may request a copy at any time by calling Member Services at **1-800-279-1878** (TTY: **711**) or by going to our website at aetnabetterhealth.com/virginia.

In your doctor's office, your medical record will be labeled with your identification and stored in a safe location in the office where other people cannot see your information. If your medical information is on a computer, there is a special password needed to see that information.

Your medical record cannot be sent to anyone else without your written permission, unless required by law. When you ask your doctor's office to transfer records, they will give you a release form to sign. It is your doctor's office responsibility to do this service for you. If you have a problem getting your records or having them sent to another doctor, please contact our Members Services at **1-800-279-1878** (TTY: **711**).

Our Member Services department will help you get your records within 10 working days of the record request. We will assist you:

- To provide quick transfer of records to other in or out of network providers for the medical management of your health
- When you change primary care provider, to assure that your medical records or copies of medical records are made available to your new primary care provider.
- If you would like a copy of your medical or personal records, you may send us a written request. You may also call Member Services at **1-800-279-1878** (TTY: **711**) and ask for a form that you or your representative can fill out and send back to us. You have a right to review your requested medical records and ask they be changed or corrected.

How to Join the Member Advisory Committee

Aetna Better Health would like you to help us improve our health plan. We invite you to join our Member Advisory Committee. On the committee, you can let us know how we can better serve you. Going to these meetings will give you and your caregiver or family member the chance to help plan meetings and meet

other members in the community. These educational meetings are held once every three months. If you would like to attend or would like more information, please contact Aetna Better Health Member Services at the number below. You may also email **VAOutreach@aetna.com**. Please title your email: Interested in MAC – Medallion 4.0.

We Follow Non-Discrimination Policies

You cannot be treated differently because of your race, color, national origin, disability, age, religion, gender, marital status, pregnancy, childbirth, sexual orientation, or medical conditions.

If you think that you have not been treated fairly for any of these reasons, call the Department of Health and Human Services, Office for Civil Rights at **1-800-368-1019**. TTY users should call **1-800-537-7697**. You can also visit **www.hhs.gov/ocr** for more information.

Aetna Better Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

14. Member Responsibilities

Your Responsibilities

As a member, you also have some responsibilities. These include:

- Reading the member handbook. It tells you about Aetna Better Health services and how to file a complaint or grievance
- Schedule wellness check-ups. Members under twenty-one (21) years of age need to follow the Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule
- Get care as soon as you know you are pregnant. Keep all prenatal appointments
- Carrying with you and showing your Aetna Better Health identification (ID) card to each doctor before getting health services
- Protecting your member ID card and not sharing it with others
- Getting medical care from providers in our network
- Knowing the name of your assigned PCP
- Telling the doctor that you and/or your child are/is a member of Aetna Better Health at the time that you speak with the doctor's office
- Keeping doctor's appointments or calling to cancel them at least twenty-four (24) hours ahead of time
- Using the emergency room (ER) for true emergencies only
- Learning the difference between emergencies and when you need urgent care
- Treating the doctors/providers, staff and people providing services to you with respect
- Giving all information about your health to Aetna Better Health and your doctor in order to provide care
- Telling the doctor if you do not understand what they tell you about your health so that you and your doctor can make health plans together
- Following what you and your doctor agree to do including making follow up appointments, taking medicines and following your doctor's care instructions
- Telling Aetna Better Health and DMAS when your address changes

- Telling Aetna Better Health about changes in your family that might affect your eligibility or enrollment such as family size, employment, and moving out of the state of Virginia
- Telling Aetna Better Health if you have other health insurance, including Medicare
- Giving your doctor a copy of your Living Will and/or Advance Directive
- Learning about prescription drugs and reasons for taking them
- Reading the member handbook. It tells you about Aetna Better Health services and how to file a complaint or grievance
- Following what you and your doctor agree to do including making follow up appointments, taking medicines and following your doctor's care instructions
- Telling Aetna Better Health about changes in your family that might affect your eligibility or enrollment such as family size, employment, and moving out of the state of Virginia.
- Letting Aetna Better Health know how we can work better for you Tell us if you have problems with any health care staff. Call Member Services at one of the numbers below:
    - If the size of your family changes.
    - If you have any liability claims, such as claims from an automobile accident.
    - If you are admitted to a nursing facility or hospital.
    - If you get care in an out-of-area or out-of-network hospital or emergency room.
    - If your caregiver or anyone responsible for you changes.
    - If you are part of a clinical research study.

Advance Directives

You have the right to say what you want to happen if you are unable to make health care decisions for yourself and your care. There may be a time when you are unable to make health care decisions for yourself. Before that happens to you, you can:

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

The legal document that you can use to give your directions is called an advance directive. An advance directive goes into effect only if you are unable to make health care decisions for yourself. Any person aged 18 or over can complete an advance directive. There are different types of advance directives and different names for them. Examples are a living will, a durable power of attorney for health care, and advance care directive for health care decisions.

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

Where to Get the Advance Directives Form

You can get the Virginia Advance Directives form at **www.vdh.virginia.gov/OLC/documents/2011/pdfs/2011-VA-AMD-Simple.pdf**.

You can also get the form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicaid, such as Hospice and Home Care, may also have advance directive forms. You can also contact Member Services at **1-800-279-1878** (TTY: **711**) to ask for the forms.

Completing the Advance Directives Form

Fill it out and sign the form. The form is a legal document. You may want to consider having a lawyer help you prepare it. There may be free legal resources available to assist you.

Share the Information with People You Want to Know About It

Give copies to people who need to know about it. You should give a copy of your Living Will, Advance Care Directive, or Power of Attorney form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.

If you are going to be hospitalized and you have signed an advance directive, take a copy of it to the hospital. The hospital will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

We Can Help You Get or Understand Advance Directives Documents

Your Care Manager can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself.

Remember, it is your choice to fill out an advance directive or not. You can revoke or change your advance care directive or power of attorney if your wishes about your health care decisions or authorized representative change.

Other Resources

You may also find information about advance directives in Virginia at **www.virginiaadvancedirectives.org.**

You can store your advance directive at the Virginia Department of Health Advance Healthcare Directive Registry: **www.connectvirginia.org/adr**.

If Your Advance Directives Are Not Followed

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the following organizations.

For complaints about doctors and other providers, contact the Enforcement Division at the Virginia Department of Health Professions:

CALL	Virginia Department of Health Professions: Toll-free phone: **1-800-533-1560** Local phone: **804-367-4691**
WRITE	Virginia Department of Health Professions Enforcement Division 9960 Mayland Drive, Suite 300 Henrico, Virginia 23233 1463
FAX	**804-527-4424**
EMAIL	**enfcomplaints@dhp.virginia.gov**
WEBSITE	**www.dhp.virginia.gov/Enforcement/complaints.htm**

For complaints about nursing facilities, inpatient and outpatient hospitals, abortion facilities, home care organizations, hospice programs, dialysis facilities, clinical laboratories, and health plans (also known as managed care organizations), contact the Office of Licensure and Certification at the Virginia Department of Health:

CALL	Virginia Department of Health Professions: Toll-free phone: **1-800-955-1819** Local phone: **804-367-2106**
WRITE	Virginia Department of Health Office of Licensure and Certification 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233 1463
FAX	**804-527-4503**
EMAIL	**OLC-Complaints@vdh.virginia.gov**
WEBSITE	**www.vdh.state.va.us/olc/complaint/**

15. Fraud, Waste, and Abuse

What is Fraud, Waste, and Abuse

Fraud is an intentional deception or misrepresentation. It is made by a person with the knowledge that the deception could result in some unauthorized benefit to them or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Waste includes overutilization, underutilization, or misuse of resources. Waste typically is not an intentional act, but it does result in spending that should not have occurred. As a result, waste should be reported so that improper payments can be identified and corrected.

Abuse includes practices that are inconsistent with sound fiscal, business, or medical practice, and result in unnecessary cost to the Medicaid program, payment for services that are not medically necessary, or fail to meet professionally recognized health care standards.

Common types of health care fraud, waste, and abuse include:

- Medical identity theft
- Billing for unnecessary items or services
- Billing for items or services not provided
- Billing a code for a more expensive service or procedure than was performed (known as up-coding)
- Charging for services separately that are generally grouped into one rate (Unbundling)
- Items or services not covered
- When one doctor receives a form of payment in return for referring a patient to another doctor. These payments are called “kickbacks”

How Do I Report Fraud, Waste, or Abuse?

You should report instances of fraud and abuse to Aetna Better Health of Virginia Fraud and Abuse Help Line at:

- Phone**: 1-844-317-5825** (TTY: **711**)
- Email: **reportfraudabuseVA@aetna.com**

If you would prefer to refer your fraud, waste, or abuse concerns directly to the State, you can report to the contacts listed below.

Department of Medical Assistance Services Fraud Hotline

- Recipient Fraud: **1-800-371-0824** or **804-786-1066**
- Provider Fraud: **1-800-371-0824** or **804-786-2071**

Virginia Medicaid Fraud Control Unit (Office of the Attorney General)

- Email: **MFCU_mail@oag.state.va.us**
- Fax: **804-786-3509**
- Mail: Office of the Attorney General Medicaid Fraud Control Unit
  202 North Ninth Street, Richmond, VA 23219

Virginia Office of the State Inspector General

- Fraud, Waste, and Abuse Hotline Phone: **1-800-723-1615**
- Fax: **804-371-0165**
- Email: **covhotline@osig.virginia.gov**
- Mail: State FWA Hotline
  101 N. 14th Street
  The James Monroe Building 7th Floor Richmond, VA 23219

16. Important information for FAMIS members

What is FAMIS?

FAMIS stands for Family Access to Medical Insurance Security and is Virginia's health insurance program for children. It makes health care affordable for children of eligible families.

How do I know if I am a FAMIS member?

If you are a FAMIS member, your member ID card will include the FAMIS icon in the righthand corner. You will receive a schedule of benefits in your welcome packet. This is a two-sided document that shows you what services are covered and what you will pay as a member for that service.

Are there any costs?

There are no enrollment costs or monthly premiums for FAMIS members. However, some services do require a copayment. Your schedule of benefits explains what you must pay for certain benefits and services, and if they have yearly or lifetime limits.

The most you or your family members will pay in copayments each year is called the out-of- pocket maximum. The out-of-pocket maximum is also stated in the schedule of benefits. You must keep track of the copayments paid during the year. Send all your copayment receipts to Cover Virginia. Cover Virginia

can be reached at **833-5CALLVA**. They will verify that you have reached the yearly copayment maximum and notify us. We will then send you a notice telling you that you will not need to make copayments for the remainder of the year.

Income guidelines
Qualifying for FAMIS depends on family size and household income. If your income changes, contact Cover Virginia at **833-5CALLVA** to report this change. It may affect your eligibility.

Renewal and change of address
FAMIS and FAMIS Plus must be renewed at least every 12 months. It is very important that you report any change in your address to Cover Virginia immediately. If we do not have a correct address, we will not be able to notify you when it is time to renew coverage and your child will be cancelled from the program.

Additional information
For additional information about FAMIS, including a copy of the FAMIS handbook, as well as income guidelines, please call Cover Virginia at **833-5CALLVA** or visit **www.coverva.org**.

FAMIS is a program of the Commonwealth, administered by the Department of Medical Assistance Services in partnership with Aetna Better Health of Virginia.

17. Medicaid Expansion – New health insurance coverage for adults

Welcome to Aetna Better Health of Virginia. If you're one of the many new Virginians enrolled in our health plan as part of Medicaid Expansion, we have some important information for you. Let's get started.

What Makes You Eligible to be a Medicaid Expansion Member

You are eligible for Medicaid Expansion if you are 19 years of age to 64 years of age and you meet all of the following categories:

- You are not already eligible for Medicare coverage,
- You are not already eligible for Medicaid coverage through a mandatory coverage group (you are pregnant or disabled, for example)
- Your income does not exceed 138% of the Federal Poverty Level (FPL)

Medicaid eligibility is determined by your local Department of Social Services (DSS) or the Cover Virginia Central Processing Unit. Contact your local DSS eligibility worker or call Cover Virginia at **833-5CALLVA (TDD: 1-888-221-1590)** with any Medicaid eligibility questions. The call is free. For more information, you can visit Cover Virginia's website at **http://www.coverva.org**.

Enrollment for a Medicaid Expansion Member

You can change your health plan during the first 90 days of your Medallion program enrollment for any reason. You can also change your health plan during your annual open enrollment period for any reason. You may contact the Managed Care Helpline at
1-800-643-2273 (TTY: 1-800-817-6608) or visit **www.virginiamanagedcare.com** to find out the open

enrollment period for your region. You will get a letter from DMAS during the open enrollment period with more information.

Medicaid Expansion Benefits and Services

As a Medicaid Expansion member, you have a variety of health care benefits and services available to you. You will receive most of your services through Aetna Better Health.

If you are an eligible Medicaid Expansion member, in addition to the standard Medicaid services available to all Medicaid members, you will also receive the following four health benefits:

- Annual adult wellness exams
- Nutritional counseling if you are diagnosed with obesity or chronic medical diseases
- Recommended adult vaccines or immunizations

Aetna Better Health will also encourage you to take an active role in your health. This may mean taking part in disease management programs, getting a flu shot, quitting smoking or using tobacco/nicotine products, or accessing services that are not typically covered by traditional medical practices like gym memberships or vision services.

If you frequently visit the emergency room, we will reach out to you to help you address your needs. There may be opportunities to address your needs outside of the emergency room, like in physician offices and clinics.

Aetna Better Health may also discuss several opportunities with you to help you take advantage of job training, education, and job placement assistance to help you find the work situation that is right for you.

What is a Health Screening?

Within four months after you enroll with us, an Aetna Better Health representative will contact you or your authorized representative via telephone or in person to ask some questions about your health needs and social circumstances. These questions will make up what is called the “Health Screening.” The representative will ask about any medical conditions you currently have or have had in the past, your ability to do everyday things, and your living conditions. Your answers will help Aetna Better Health understand your needs and identify whether you have medically complex needs.

If you meet the medically complex criteria, you will transfer from the Medicaid Managed Care Medallion 4.0 program to the CCC Plus program. If it is determined you do not have medically complex needs, you will remain in the Medallion 4.0 program. Also, if we are unable to contact you, or you refuse to participate in the entire health screening, you will remain enrolled in the Medallion program. You will stay with Aetna Better Health no matter which program you are in. If you prefer to change health plans, you can change within the first 90 days of enrolling into the Medallion 4.0 program:

- Online: **www.virginiamanagedcare.com**
- By mobile app: To download the app for Android or iPhone, search for "Virginia Medallion" on Google Play or the App Store
- By phone: **1-800-643-2273** (TTY: **1-800-817-6608**)

If you do not meet medically complex criteria and do not agree, you have a right to submit a complaint or grievance to us. See the *Your Right to File a Complaint (Grievance)* section for details.

Please contact Aetna Better Health if you need accommodations to participate in the health screening. If you have questions about the health screening, please contact Member Services at **1-800-279-1878 (TTY: 711)**. This call is free.

18. Other Important Resources

Department of Medical Assistance Services (DMAS)
www.dmas.virginia.gov

Cover Virginia
833-5CALLVA
www.coverva.org

Department of Social Services
www.dss.virginia.gov

Reporting Abuse, Neglect, and Exploitation
Child Protective Services (CPS)
Virginia: **1-800-552-7096**
Out-of-State: **804-786-8536**
Adult Protective Services (APS) 24 Hour Hotline: **1-888-832-3858**

Virginia 2-1-1
Dial **2-1-1** on your phone
www.211virginia.org
2-1-1 Virginia is a free service that can help you find the local resources you need

Virginia Division for the Aging
www.vda.virginia.gov/aaalist.asp
Includes a list of area agencies on aging by location

Foster My Future – Virginia's Foster Care Portal for Young Adults
www.dss.virginia.gov/fmf

The Virginia Department for the Deaf and Hard of Hearing (VDDHH)
The Technology Assistance Program (TAP) provides telecommunication equipment to qualified applicants whose disabilities prevent them from using a standard telephone. VDDHH outreach specialists can also provide information and referral for assistive technology devices.
804-662-9502 (Voice / TTY)
1-800-552-7917 (Voice / TTY)
804-662-9718 (Fax)
1602 Rolling Hills Drive, Suite 203
Richmond, VA 23229-5012

www.vddhh.org

Other community resources
You can also find additional community resources on our website. Visit **AetnaBetterHealth.com/Virginia**. Select "Health & Wellness" from the navigation, then "Community Resources." These community resources include, but are not limited to: food, housing, and utility assistance; child care resources; senior services; disability services; mental health services; and job training and employment resources.

19. Key Words and Definitions Used in this Handbook

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program. Abuse includes reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

Adverse benefit determination: Any decision to deny a service authorization request or to approve it for an amount that is less than requested.

Aetna Better Health: The Medicaid program offered by us.

Appeal: A way for you to challenge an adverse benefit determination (such as a denial or reduction of benefits) made by Aetna Better Health if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal.

Balance billing: A situation when a provider (such as a doctor or hospital) bills a person more than Aetna Better Health's cost-sharing amount for services. We do not allow providers to "balance bill" you. Call Member Services if you get any bills that you do not understand.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are made and sold by other drug companies.

Care Manager: One main person from Aetna Better Health who works with you and with your care providers to make sure you get the care you need.

Care Management: A person-centered individualized process that assists you in gaining access to needed services. The Care Manager will work with you, your family members, if appropriate, your providers and anyone else involved in your care to help you get the services and supports that you need.

Care plan: A plan for what health and support services you will get and how you will get them.

Care team: A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team will also help you make a care plan.

Helpline: An Enrollment Broker that DMAS contracts with to perform choice counseling and enrollment activities.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare and Medicaid programs.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of your care, our network providers, or our network pharmacies. The formal name for "making a complaint" is "filing a grievance."

Cosmetic services and surgery: Services and surgery that are mainly to improve your looks. Cosmetic services and surgery do not help your body work better or keep you from getting sick.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we will pay for your health services.

Covered drugs: The term we use to mean all of the prescription drugs covered by Aetna Better Health.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services covered by Aetna Better Health.

Department of Social Services (DSS): The agency which decides whether a person is eligible for Medicaid/FAMIS Plus.

Durable Medical Equipment (DME): Certain items your doctor orders for you to use at home. Examples are walkers, wheelchairs, or hospital beds.

Emergency medical condition: An emergency means your life could be threatened or you could be hurt permanently (disabled) if you don't get care quickly. If you are pregnant, it could mean harm to the health of you or your unborn baby.

Emergency medical transportation: Your condition is such that you are unable to go to the hospital by any other means but by calling 911 for an ambulance.

Emergency room care: A hospital room staffed and equipped for the treatment of people that require immediate medical care and/or services.

Early Periodic Screening and Diagnostic Testing (EPSDT): The child health component of Medicaid. that provides comprehensive and preventive health care services for children under age 21, who are enrolled in Medicaid. EPSDT is important to ensure children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.

Excluded services: Services that are not covered under the Medicaid benefit.

Fair hearing: See State Fair Hearing. The process where you appeal to the State on a decision made by us that you believe is wrong.

Family planning care: Family planning care helps you to plan your family size. It gives you information on birth control methods.

Fee-for-service: The general term used to describe Medicaid services covered by the Department of Medical Assistance Services (DMAS).

Generic drug: A prescription drug that is approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It is usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care.

Health insurance: Type of insurance coverage that pays for health, medical and surgical expenses incurred by you.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has Care Managers to help you manage all your providers and services. They all work together to provide the care you need.

Health risk assessment: A review of a patient's medical history and current condition. It is used to figure out the patient's health and how it might change in the future.

Helpline: An Enrollment Broker that DMAS contracts with to perform choice counseling and enrollment activities.

Hospitalization: The act of placing a person in a hospital as a patient.

Hospital outpatient care: Care or treatment that does not require an overnight stay in a hospital.

List of Covered Drugs (Drug List): A list of prescription drugs covered by Aetna Better Health. Aetna Better Health chooses the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary."

Medically necessary: This describes the needed services to prevent, diagnose, or treat your medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice or as necessary under current Virginia Medicaid coverage rules.

Medicaid (or Medical Assistance): A health care program created by the federal government but administered by the state, that helps people with limited incomes and resources pay for medical care and services.

Member: Any person who gets services from DMAS and who has Aetna Better Health coverage.

Member Services: A department within Aetna Better Health responsible for answering your questions about your membership, benefits, grievances, and appeals.

Model of Care: A way of providing high-quality care. The model of care includes care coordination and a team of qualified providers working together with you to improve your health and quality of life.

Network: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports. They are licensed or certified by Medicaid and by the state to provide health care services. We call them "network providers" when they agree to work with the Aetna Better Health and accept our payment and not charge our members an extra amount. While you are a member of Aetna Better Health, you must use network providers to get covered services. Network providers are also called "plan providers."

Network pharmacy: A pharmacy (drug store) that has agreed to fill prescriptions for Aetna Better Health members. We call them "network pharmacies" because they have agreed to work with Aetna Better Health. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Non-participating provider or out-of-network provider: A provider or facility that is not employed, owned, or operated by Aetna Better Health and is not under contract to provide covered services to members of Aetna Better Health.

Participating provider: Providers, hospitals, home health agencies, clinics, and other places that provide your health care services, medical equipment, and long-term services and supports that are contracted with Aetna Better Health. Participating providers are also "in-network providers" or "plan providers."

Physician services: Care provided to you by an individual licensed under state law to practice medicine, surgery, or behavioral health.

Post-stabilization care: Medically needed care a member gets after an emergency has been stabilized.

Prescription drug coverage: Prescription drugs or medications covered (paid) by your Aetna Better Health. Some over-the -counter medications are covered.

Prescription drugs: A drug or medication that, by law, can be obtained only by means of a physician's prescription.

Primary care physician (PCP): Your primary care physician is the doctor who takes care of all of your health needs. They are responsible to provide, arrange, and coordinate all aspects of your health care. Often, they are the first person you should contact if you need health care. Your PCP is typically a family practitioner, internist, or pediatrician. Having a PCP helps make sure the right medical care is available when you need it.

Prosthetics and Orthotics: These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function.

Provider: A person who is authorized to provide your health care or services. Many kinds of providers participate with Aetna Better Health, including doctors, nurses, behavioral health providers and specialists.

Rehabilitation services and devices: Treatment you get to help you recover from an illness,

accident, injury, or major operation.

Service area: A geographic area where a Aetna Better Health is allowed to operate. It is also generally the area where you can get covered services.

Service authorization: Approval needed before you can get certain services or drugs. Some network medical services are covered only if your doctor or other network provider gets an authorization from Aetna Better Health.

Specialist: A doctor who provides health care for a specific disease, disability, or part of the body.

Urgently needed care: Care you get for a non-life threatening sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable, or you cannot get to them.

Waste: The rendering of unnecessary, redundant, or inappropriate services, medical errors, and incorrect claims submissions. Waste generally is not considered a criminally negligent action but rather the misuse of resources.

Aetna Better Health of Virginia Member Services

CALL	**1-800-279-1878**. This call is free. 24 hours a day, 7 days a week. We have free interpreter services for people who do not speak English.
TTY	TTY: **711**. This call is free. 24 hours a day, 7 days a week This number is for people who have hearing or speaking problems.
FAX	**1-866-207-8901**
WRITE	Aetna Better Health of Virginia 9881 Mayland Drive Richmond, VA 23233
EMAIL	Please visit the contact page on our website at **AetnaBetterHealth.com/Virginia/Contact-Us** to send us a secure message. You may send email directly to **vamedicaidmemberservices@aetna.com**
WEBSITE	**AetnaBetterHealth.com/Virginia**

Aetna Better Health® of Virginia
9881 Mayland Drive
Richmond, VA 23233

Notes:

AetnaBetterHealth.com/Virginia