2025-2026
Member Handbook

Aetna Better Health® of West Virginia
Mountain Health Promise

AetnaBetterHealth.com/WestVirginia

866772-WV-EN (rev 8/25)

aetna®

Aetna Better Health® of West Virginia

Helpful Information

Aetna Better Health® of West Virginia
Member Services
1-888-348-2922 (TTY: 711)

Website
AetnaBetterHealth.com/WestVirginia

Hours of operation
24 hours a day, 7 days a week

Liberty Dental
800-267-6610 (TTY: 711)

Non-Emergent transportation – Modivcare
1-844-549-8353

Prescription Drugs – Gainwell Technologies
1-888-483-0797

HELP IN YOUR LANGUAGE

If you do not speak English, you can call us at **1-888-348-2922 (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.
Spanish: Si usted no habla inglés, llámenos al **1-888-348-2922** y **711**. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

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WELCOME

Welcome to the Mountain Health Promise program! We are glad that you have enrolled with us. This handbook gives you the information you need to know about your health care plan. The words "you" and "your" in this handbook are intended to mean the member of Aetna Better Health of West Virginia. This could be an adult, a parent, a guardian, or a dependent child.

Please read this handbook to understand the way your plan works. This handbook will help you get the most from Aetna Better Health. It will answer many of the questions that come up about the benefits and services offered by Aetna Better Health.

You can also ask us any questions you may have by calling us at **1-888-348-2922**. If you are speech or hearing impaired, please dial **TTY: 711**. If you would like a printed copy of this handbook, please call us and one will be mailed to you within five (5) business days of your request.

ABOUT OUR PLAN

Aetna Better Health has a contract with the West Virginia Department of Human Services (DoHS), formerly called Department of Health and Human Resources (DHHR).

We are able to select a group of health care practitioners and providers to form a provider network. Provider networks are usually made up of doctors and specialists, hospitals, and other health care facilities. Our practitioners and providers help to meet the health care needs of children in the Mountain Health Promise Program. The Provider Directory lists all of our network providers you can use to get services across the state. It can be found online at our website, **AetnaBetterHealth.com/WestVirginia**.

It is important to us that you receive quality health care and customer service. Your satisfaction matters to us. The Quality Management (QM) program ensures our services meet high standards of quality and safety. We want to make sure you have:

- The right kind of care
- Easy access to quality medical and behavioral health care
- Help with any chronic conditions or illnesses
- Support when it is needed most
- High satisfaction with your doctors and with us

For more information about our Quality Management program visit our website at **AetnaBetterHealth.com/WestVirginia**. If you have a problem, please call Member Services at **1-888-348-2922**.

CONTACT US

Member Services Department
Hours : We're here for you 24 hours a day, 7 days a week
Address: 500 Virginia Street East, Suite 400, Charleston, WV 25301
Toll-free: **1-888-348-2922 (TTY: 711)**
Online: **AetnaBetterHealth.com/WestVirginia**

You can call Member Services toll-free anytime you have a question about your health plan or a health problem. It will speed up the process if you have your member identification (ID) number with you when you call. Your member ID number can be found on your member ID card. You can also visit our website, **AetnaBetterHealth.com/WestVirginia**, for other information.

If you do not understand or speak English, we can help. Please call us toll-free at **1-888-348-2922 (TTY: 711)**. We can answer questions about your benefits in your language. We have free interpreter services. We can help you find a health care practitioner who can communicate with you in any language. We can also provide free interpreter services for medical visits .

If you have a disability, we can help. Aetna Better Health offers auxiliary aids and services so that you can communicate effectively with us and your practitioner or provider. We provide free sign language interpreter services and a TTY phone number: **1-888-348-2922 (TTY: 711)**.

We can offer this handbook and all written materials in many formats, such as large print or through other auxiliary aids and services, at no cost to you. Please call us toll-free at **1-888-348-2922** to ask for materials in another format.

For other important phone numbers, please see the Important Contact Information in the back of this handbook.

You can call or visit our website to:

- Ask questions about Medicaid services and benefits.
- Change your primary care provider (PCP) or get help choosing a provider.
- File a complaint or appeal.
- Replace a lost member ID card.
- Get help with finding a specialist.
- Let us know if you're pregnant.
- Let us know if you give birth to a new baby.
- Ask about any change that might affect your benefits.
- Let us know about any changes to personal information.
- Request interpreter services or get help for people with disabilities.
- Find community resources and educational materials.
- Access online versions of the Member Handbook and Provider Directory that you can search.

MEMBER WEB PORTAL

Aetna Better Health has a secure online tool, the Member Web Portal. The portal is your go-to resource to manage your plan – and your health. You can access your personal health information and other benefit information such as:

- Authorization status.
- Temporary member ID card.
- The name and phone number of your PCP.
- Cost sharing information.
- Claim status.

You can also:

- Change your PCP.
- Request a new member ID card.
- Get personalized health information and learn tips and tools to manage your health.
- Learn about programs to help you stay on track with health goals.
- Get in touch with a nurse.

For more information, and to access the Member Web Portal, visit our website at **AetnaBetterHealth.com/WestVirginia/member-portal.html.** Click on *Log In* then select *register* to set up your account. You just need your member ID card and a current email address to create an account. You can also call us to sign up over the phone.

FAMILYCARE CENTRAL

FamilyCare Central is Aetna Better Health of West Virginia's website that supports Mountain Health Promise members. It is a new tool that supports our adoption families by:

- Supporting care coordination.
- Making key information available to your child's Care Team.

Your child's Care Team includes:

- Members
- Care Managers

In FamilyCare Central you can:

- See your child's health record and member profile
- View your child's ID card
- Find care coordination and planning tools for your child
- Contact your child's care coordinator
- See notifications for your child

Scan the QR Code to get started with FamilyCare Central

The FamilyCare Central website works on a computer, tablet, or a cell phone. It works wherever you need it. It helps you to get the most out of their health benefits and services. It supports your child's path to better health!

CONFIDENTIALITY

We respect your rights to privacy. We will never give out your medical information or social security number without your written permission, unless required by law. To learn more about rights to privacy, please call Member Services at **1-888-348-2922** (TTY: **711**) or visit our website at **AetnaBetterHealth.com/WestVirginia**. You can find our notice of privacy practices in the back of this handbook.

DISCRIMINATION

Benefits must comply with the 1964 Civil Rights Act. Discriminatory administration of benefits because of sex, race, color, religion, national origin, ancestry, age, political affiliation or physical, developmental, or mental challenges is not allowed. If you have questions, complaints, or want to talk about whether you have a disability according to the Americans with Disabilities Act (ADA), you can contact the State ADA Coordinator at:

WV Department of Administration
Building 1, Room E-119
1900 Kanawha Blvd. East
Charleston, WV 25305

304-558-4331

DEFINITIONS

Appeal: A way for you to request the review of Aetna Better Health's decision if you think we made a mistake. For example, you might not agree with a decision that denies a benefit or payment.

Authorized Representative: Any person or entity acting on behalf of a member and with the member's written consent. Some authorized representatives may have the legal right to act on your behalf.

Auxiliary Aids: Devices or services that enable effective communication. Auxiliary aids include but are not limited to qualified interpreters, transcription services and assistive listening devices.

Case Manager: A nurse or other healthcare professional who assists with supporting you or your child's medical care or services and locating community resources. The Case Manger works with you and your care team to create an individualized wellness/Care plan.

Children with Severe Emotional Disorders Waiver (CSEDW): A program that offers intensive mental and behavioral health services in the homes and communities for children with a mental, behavioral, or emotional disorder that severely limits the child's daily activities with family, in school, or in the community.

Complaint: An expression of dissatisfaction, either in writing or orally, about any aspect of service delivery provided or paid for by Aetna Better Health, including complaints about our practitioners or providers. In this handbook "grievance" and "complaint" mean the same thing.

Co-payment or Co-pay: A fixed amount you pay each time you get a covered service or supply.

Durable Medical Equipment (DME): Certain items your practitioner or provider can order for you to use if you have an illness or injury, such as a walker or a wheelchair.

Emergency Medical Condition: An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

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

Emergency Room (ER) Care: Emergency services you receive in an ER.

Emergency Services: Services you receive to evaluate or treat an emergency medical condition.

Excluded Services: Health care services that Aetna Better Health does not pay for or cover.

Fee-For-Service: A fee-for-service benefit is covered by the West Virginia Medicaid program and not by Aetna Better Health.

Federal Poverty Level (FPL): A measure of income issued every year by the Department of Health and Human Services to determine your eligibility for certain programs and benefits.

Gender Affirmation Surgery: Surgeries that change the physical appearance and function of a person's sex traits to align with their gender identity.

Gender Dysphoria: A distressed state arising from conflict between a person's gender identity and the sex a person has or was identified of having at birth.

Grievance: A complaint you make, either in writing or verbally to Aetna Better Health. In this handbook "grievance" and "complaint" mean the same thing.

Habilitation Services and Devices: Services or items that help you keep, learn, or improve skills and functioning for daily living. They can be used in inpatient and / or outpatient settings.

Health Insurance: A contract that requires Aetna Better Health to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home such as nurse visits or physical therapy.

Home and Community-Based Services: Health care and support services provided to members who need assistance with everyday living and activities, in order to keep them living in a home and community setting.

Hospice Services: Services to provide comfort and support for members and their families in the last stages of terminal illness. A terminal illness means the provider believes the member has six months or less to live if the illness runs its natural course.

Hospitalization: Admission to a hospital for treatment that usually requires an overnight stay

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

Medically Necessary: Health care services or supplies needed to get and stay healthy. The services or supplies must be for diagnosing, evaluating, treating or preventing an injury, illness, condition, or disease, based on evidence- based clinical standards of care. Determination of medical necessity is based on specific criteria.

Minor: Persons under the age of eighteen (18) years.

Network: A group of providers who has contracted with Aetna Better Health to give care to members.

Non-participating Practitioner / Provider: A doctor, hospital, facility, or other health care professional who has not signed a contract to provide services to Aetna Better Health members.

Physician Services: Health care services that a licensed medical physician provides or coordinates.

Plan: An entity that provides, offers, or arranges coverage of certain health care services needed by plan members. You are a member of our health plan, Aetna Better Health.

Prior Authorization: Approval from Aetna Better Health that may be required before you get certain services or treatments in order for them to be covered.

Participating Practitioner / Provider: A doctor, hospital, facility, or other licensed health care professional who has signed a contract agreeing to provide services to Aetna Better Health members. They are listed in the Provider Directory.

Practitioner: A licensed or certified professional who provides medical or behavioral health care services, such as a doctor, nurse practitioner, or psychologist. In this handbook, the word "doctor" may be used to mean any type of practitioner.

Prescription Drugs: Drugs and medication that, by law, require a prescription.

Prescription Drug Coverage: Health insurance that helps pay for prescription drugs. Aetna Better Health does not provide prescription drug coverage, but the State of West Virginia does.

Primary Care Practitioner/ Primary Care Provider (PCP): A physician, nurse practitioner, physician assistant, or other participating practitioner you have chosen to be your personal doctor. Your PCP works with you to provide and coordinate your health care, such as giving you checkups and shots, sending you to specialists if needed, or admitting you to the hospital.

Provider: An institution or organization that provides services, such as a hospital, residential treatment center, home health agency or rehabilitation facility.

Rehabilitation Services and Devices: Health care services and items that help you recover from an illness, accident, injury, or surgery.

Severe Emotional Disorder (SED): A mental, behavioral, or emotional disorder that is determined by a licensed psychologist to severely limit a child's daily activities with family, in school, or in the community.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home.

Specialist: A doctor who focuses on a specific kind of health care such as a surgeon or a cardiologist (heart doctor).

Socially Necessary Services (SNS): Services provided to improve relationships and social functioning. Socially necessary services are interventions designed to maintain or establish safety, permanency and well-being for targeted populations.

Care Advocate Team (CAT): A system of care team is a network of community and plan-based services and supports organized to meet the individuals and families involved with multiple service agencies, like child welfare, mental health, schools, justice and health care systems.

Telehealth: Sometimes called telemedicine, uses video calling and other technologies to help you see your provider without an in-person office visit.

Urgent Care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away.

YOUR RIGHTS

As a member of Aetna Better Health, you have rights around your health care. You have the right to:

- Be told about your rights and responsibilities.
- Get information about Aetna Better Health, our services, our practitioners and providers, and your rights.
- Be treated with respect and dignity and have your privacy protected.
- Get interpretation services if you do not speak English or have a hearing impairment.
- Not be discriminated against by Aetna Better Health.
- Access all services that Aetna Better Health must provide.
- Choose a practitioner or provider in our network.
- Take part in decisions about your health care.
- Accept or refuse medical or surgical treatment and choose a different provider.
- A second opinion at no cost (including out of network, if an in-network provider is not available).
- Learn about other treatment options and different courses of care no matter how much they cost and/or if Aetna Better Health will pay for it.
- Access your health information through technology platforms like Aetna Better Health's member portal and mobile app; and receive information on how to access them.
- Access the Provider Directory through Aetna Better Health's website, member portal, mobile app, or other Aetna Better Health technology platforms.
- Be aware of the information available on Aetna Better Health's website and other technology platforms.
- Ask for and get your medical records.
- Ask that your medical records be amended or corrected, if needed.
- Be sure your medical records are kept private.
- Tell us how we can improve our policies and procedures, including the member rights and responsibilities policy.
- Be free from abuse, neglect, financial exploitation, or any form of restraint or seclusion used as a means of force, discipline, convenience, or retaliation.
- Get covered services, no matter what your cultural or ethnic background is or how well you understand English.
- Get covered services regardless of any physical or mental disability, or if you are homeless.
- Get accessible services and receive reasonable disability accommodations.
- Refer yourself to in-network and out-of-network family planning providers.
- Get necessary services from an out-of-network provider if the services are not available within our network, for as long as our provider network is unable to provide them.
- Access certified nurse midwife services and certified pediatric or family nurse practitioner services.
- Get emergency post-stabilization services.
- Get emergency health care services at any hospital or other setting.

- Receive information about advance directives.
- Have your parent or a representative make treatment decisions when you can't.
- Submit a complaint or appeal about Aetna Better Health or the care it provides.
- A quick response to problems raised around complaints, grievances, appeals, authorization, coverage, and payment of services.
- Ask for a state fair hearing after a decision has been made about your appeal.
- Request and get a copy of this Member Handbook.
- Obtain advocacy on your behalf.
- Disenroll from your health plan.

YOUR RESPONSIBILITIES

As a member of Aetna Better Health, you have the responsibility to:

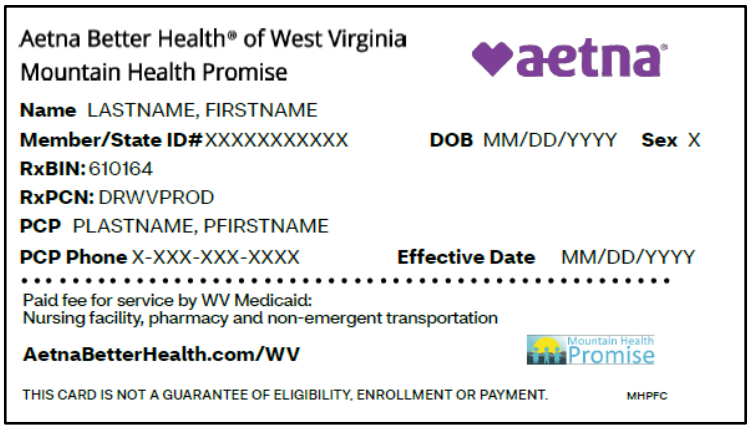
- Read through and follow the instructions in your Member Handbook.
- Work with your PCP to manage and improve your health.
- Ask your PCP any questions you may have.
- Call your PCP any time you need health care.
- Give all information about your health to Aetna Better Health and your doctor.
- Tell your doctor if you do not understand your health problems.
- Work together with your doctor to make plans about your care.
- Show your ID card to each doctor before getting health services.
- Protect your member ID card. Do not lose or share it with others.
- Only use the emergency room (ER) for true emergencies.
- Keep your appointments.
- If you must cancel an appointment, call your PCP as soon as you can to let them know.
- Follow plans and instructions for care that you and your practitioner agree to.
- Follow your practitioner's recommendations about appointments and medications.
- Go back to your PCP or ask for a second opinion if you do not get better.
- Call Member Services at **1-888-348-2922 (TTY: 711)** whenever anything is unclear to you or if you have questions.
- Contact DoHS Change Report Center at **1-877-716-1212** to report changes in family size, employment, address and/or phone number.
- Treat doctors, staff, and people providing services to you with respect.
- Tell Aetna Better Health if you have other health insurance, including Medicare.

MEMBER ID CARD

After you join Aetna Better Health, we will send you your member ID card in the mail. If multiple people have joined Aetna Better Health, each person will receive their own card. If you have not received your member ID card after five (5) business days, please call Member Services at **1-888-348-2922 (TTY: 711).**

It is important to always keep your member ID card with you. You will need it any time you get care. Your card is proof that you are a member of Aetna Better Health.

Your member ID card should look like this:


Aetna Better Health® of West Virginia
Mountain Health Promise

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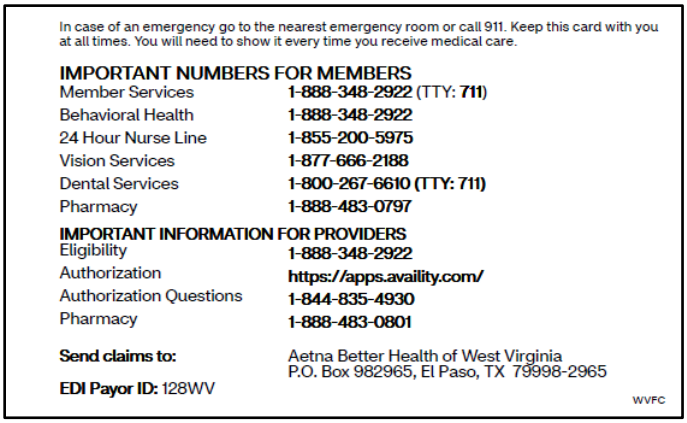
Name LASTNAME, FIRSTNAME
Member/State ID# XXXXXXXXXXX **DOB** MM/DD/YYYY **Sex** X
RxBIN: 610164
RxPCN: DRWVPROD
PCP PLASTNAME, PFIRSTNAME
PCP Phone X-XXX-XXX-XXXX **Effective Date** MM/DD/YYYY

Paid fee for service by WV Medicaid:
Nursing facility, pharmacy and non-emergent transportation

AetnaBetterHealth.com/WV

Mountain Health Promise

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


In case of an emergency go to the nearest emergency room or call 911. Keep this card with you at all times. You will need to show it every time you receive medical care.

IMPORTANT NUMBERS FOR MEMBERS

Member Services	**1-888-348-2922** (TTY: **711**)
Behavioral Health	**1-888-348-2922**
24 Hour Nurse Line	**1-855-200-5975**
Vision Services	**1-877-666-2188**
Dental Services	**1-800-267-6610 (TTY: 711)**
Pharmacy	**1-888-483-0797**

IMPORTANT INFORMATION FOR PROVIDERS

Eligibility	**1-888-348-2922**
Authorization	**https://apps.availity.com/**
Authorization Questions	**1-844-835-4930**
Pharmacy	**1-888-483-0801**

Send claims to: Aetna Better Health of West Virginia
P.O. Box 982965, El Paso, TX 79998-2965

EDI Payor ID: 128WV

WVFC

You will find useful information on your card like your Medicaid ID number, PCP's name and office phone number, the start date of your health coverage, and other important phone numbers. Having your card out when you call Member Services can help us serve you faster.

Please call Member Services immediately at **1-888-348-2922 (TTY: 711)** if:

- You lose your card
- Your card is stolen
- You have not received your card(s)
- Any of the information on the card(s) is wrong
- You move

Please call your county DoHS office immediately at **1-877-716-1212** if you move to another state or to another county.

PROVIDER DIRECTORY

The online Provider Directory is a list of all doctors, hospitals, dental and specialty care practitioners and other providers who work with Aetna Better Health. It is available on our website at **AetnaBetterHealth.com/WestVirginia**. Click on *Find doctors and medicines*.

The Provider Directory includes the following information about each provider:

- Name, address and phone number
- Professional qualifications
- Specialty

If you would like information about a practitioner's education, such as medical school and residency, cultural competency, or board certification, call us. For a printed copy of the Provider Directory please call **1-888-348-2922 (TTY: 711**). We will mail you a paper-based Provider Directory within five business days of your request.

CHOOSING YOUR CHILD'S PRIMARY CARE PROVIDER (PCP)

A Primary Care Provider (PCP) is a specific clinician responsible for coordinating your health care needs. Each member of Aetna Better Health chooses a PCP from the Provider Directory. Member Services can help you select a PCP to best fit your needs. If you do not pick a PCP from the Provider Directory, we will choose one for you.

Your PCP's name and office phone number will be listed on your member ID card. If you would like to change your PCP, just give us a call.

If you have a chronic illness, then you may be able to select a specialist as your PCP. Please call Member Services at **1-888-348-2922 (TTY: 711)** for more information.

HOW TO SCHEDULE AN APPOINTMENT

You will visit your PCP for all routine health care needs. You should try to schedule an appointment within 30 calendar days of joining Aetna Better Health. You can schedule your appointments by calling the PCP's office phone number which is on your member ID card. You can call 24 hours a day, seven days a week. If you need help scheduling an appointment, please give us a call.

On the day of your visit, remember to take your Aetna Better Health member ID card. Please show up on time or call to cancel an appointment if you cannot make it. We work with our provider offices to make sure you are seen as close to your appointment time as possible.

Aetna Better Health will ensure hours of operation are convenient and do not discriminate against members. We also have requirements about how long it should take to get certain kinds of care. See the Access and Availability Guide section in this handbook for more information.

CHANGING YOUR PCP

You can change your PCP for any reason at any time. Let us know right away by calling Member Services at **1-888-348-2922 (TTY: 711).** You can also request a PCP change in your online member portal at **AetnaBetterHealth.com/WestVirginia/members/portal**. You must choose a PCP who will see new patients.

When you change your PCP, we will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history. It is important to have your medical records sent to the new PCP.

Sometimes PCPs leave our network. If we find out your PCP is leaving, we will let you know by mail within 15 calendar days. We will try to give you 30 calendar days' notice before your PCP leaves. We can assign you a new PCP or you can pick a new one yourself. If we need to assign you a new PCP for another reason, we will let you know. Unless you need a highly specialized service, we will usually give you a choice of at least two practitioners.

WHERE TO GET MEDICAL CARE

Please read below to understand what type of care you may need in different situations.

ROUTINE CARE

You should see their PCP for all routine health care visits. Routine visits are when a delay in medical care would not cause a serious problem with your health. Some reasons to get a routine health care visit include checkups, screenings, physicals, and care for diabetes and asthma. You can call your PCP if you need.

- Well-care Visits – A well care visit is when you see your PCP for a preventive visit. These visits are not for treating conditions or diseases, so you should schedule a well care visit even if you do not feel sick. During the appointment, the PCP will review your medical history and health. The PCP may suggest ways to improve your health, too. You can learn more about well-care visits under the section titled “More Information about Your Health Plan”.
- Health Management – Visits to manage your health, such as diabetes, asthma, or high blood pressure. These visits are to treat your diseases or help you get better.
- After Hours Care – You can reach your PCP even if it is after normal business hours. Just leave a message with your name and phone number. Your PCP or another PCP on call for your PCP will call you back.

We cover medically necessary care given by licensed Aetna Better Health of West Virginia practitioners. You may receive care in the practitioner’s office, a clinic, a health center, or other places needed to treat an illness, injury or disease. You can get care from practitioners and providers listed in the Aetna Better Health of West Virginia Provider Directory.

URGENT CARE

You can visit an urgent care center when you have an injury or illness that needs care right away but is not an emergency. Some examples of when to get urgent care are:

- A sprained ankle
- A bad splinter
- Flu symptoms
- Ear or sinus pain
- A cut that needs stitches

You can schedule an urgent care appointment by calling your PCP. You should explain the medical problem so that your PCP can make your appointment or help you decide what to do.

You can also get urgent care if you are traveling and are too far from your PCP's office. If you think you might need urgent care when you are away from your home or after hours, you can also call the 24-Hour Nurse Line at **1-855-200-5975 (TTY: 711)**. They can help you decide what kind of care you need.

EMERGENCY CARE

You should get emergency care when you have a very serious and sudden medical problem. An emergency would make someone think they need to be treated right away.

Some examples of an emergency are:

- Severe bleeding that does not stop
- Severe chest pain
- Seizures
- Rape
- A major psychiatric event
- Attempted suicide
- Incidents of self-harm

You should not go to the emergency room (ER) for things like:

- Minor fevers and colds
- Minor cuts and bruises
- Sprained muscles

If you believe you have a medical emergency, call 911 immediately or go to the nearest ER. When you get there, show your member ID card. You do not need approval from your PCP or Aetna Better Health. If you are traveling and away from home when you have a medical emergency, go to the nearest ER. You have the right to go to the nearest hospital, even if it is not in our network. If you're not sure what to do, call your PCP or Aetna Better Health at **1-888-348-2922 (TTY: 711)**.

Remember to use the ER only if you have an emergency. You are always covered for emergencies.

If you need to stay in the hospital after an emergency, please make sure Aetna Better Health is called within 24 hours. If you are told that you need other medical care to treat the problem that caused the emergency, the provider must call Aetna Better Health. If you are able, call your PCP to let them know that you have a medical emergency. You will need to schedule follow-up services (called post-stabilization) with your PCP.

For more information about emergency transportation and care after an emergency, please see the Mountain Health Promise Covered Benefits table in the *Your Benefits* section below.

HOSPITAL CARE

Inpatient Hospital Care

If it is not an emergency, we must prior authorize your hospital stay before you go to the hospital. You must go to a hospital that is an Aetna Better Health of West Virginia provider. You will be under the care of your PCP or other practitioner designated by the PCP.

We help manage all hospital stays. We look at the care you get while in the hospital. The care is covered as long as there is a medical need for the care. If all or part of the hospital stay is not medically needed, you provider will be told that coverage will end, and you will not be responsible for payment.

Outpatient Hospital Care

Outpatient hospital care is care in a hospital that does not require an overnight stay. It may include tests to find sickness or care to help you heal. If you get an x-ray or have physical therapy in a hospital, that is outpatient hospital care.

You need to tell your PCP when you receive outpatient hospital care.

CARE AWAY FROM HOME

Aetna Better Health's service area is the entire State of West Virginia. If you are traveling or out of the service area, you are only covered for emergency services. Routine care out of the service area or out of the country isn't covered by Medicaid. If you are out of the service area and you need health care services, call your PCP. He or she will tell you what to do. (You can also call us to check if you are out of the service area.)

If you are not in West Virginia and you think your life is in danger, go to the closest ER. Show your Aetna Better Health ID card and any other insurance ID cards you have to the ER staff. If you get services in the ER and are admitted to the hospital, have staff call us at the number on the back of your ID card.

YOUR BENEFITS

You can get many services through Aetna Better Health and others through Medicaid fee-for-service. For most benefits, you will need to go through your PCP. There are some services that do not require a referral, including behavioral health services. This means that you do not need approval from your PCP. Look in our Provider Directory for the list of providers/practitioners who offer these services. You can schedule the appointment yourself. If you have any questions, we can help. Just call us at **1-888-348-2922 (TTY: 711)**.

COVERED SERVICES

Mountain Health Promise includes medical, behavioral health, dental and vision services. Your covered services must be medically necessary. You should get these services from providers/practitioners in the Aetna Better Health network. Your PCP will provide covered services or refer you to another practitioner or provider to do so.

You can get the services listed in the Mountain Health Promise Covered Benefits table by using your Aetna Better Health member ID card.

Telehealth lets your provider care for you without an in-person office visit. Telehealth is done online with internet access on your computer, tablet, or smartphone.

- Telehealth visits are covered, just like in-person visits.
- Medicaid will only pay for telehealth for covered benefits.
- Ask your provider if they do phone or video visits.

Some limitations may apply to telehealth.

Mountain Health Promise Covered Benefits
Medical • PCP and Specialist Office Visits in the Aetna Better Health provider network • Clinic Services – Outpatient clinics including general clinics, birthing centers, and health department clinics. • Federally Qualified Health Centers/Rural Health Clinics – Includes physician, physician assistant, nurse practitioner, and nurse midwife services. • Laboratory and X-ray Services – Includes lab services related to substance used disorder (SUD) treatment. Services must be ordered by a physician, and certain procedures have service limits. • Physician Services – Inpatient or outpatient medical or surgical services provided by a doctor or dentist. Certain services may require prior authorization or have service limits. Services may be delivered through telehealth. • Vaccinations are included for children, and as approved for adults.

Mountain Health Promise Covered Benefits

Behavioral Health

- Behavioral Health Rehabilitation/Psychiatric Residential Treatment Facility – Includes services for children with mental illness and substance use disorder. Limits on frequency and amount of services.
- Drug Screening – laboratory service to screen for presence of one (1) or more drugs of use, if ordered by treating practitioner and deemed medically necessary. Some limits apply.
- Inpatient Hospital – includes behavioral health and substance use disorder hospital stays.
- Inpatient Psychiatric – includes treatment through an individual plan of care including post-discharge plans for aftercare. Service is expected to improve the condition or prevent relapse so the service will no longer be needed.
    - Under age 21 - Includes services at a psychiatric hospital or psychiatric unit of a hospital. Certification that community outpatient behavioral health services did not meet the member's treatment needs is required. Pre-admission and continued stay authorization is required.
    - Age 21-64 – Includes services at an Institution for Mental Diseases (IMD). Limitations apply.
- Outpatient Services – Includes services for individuals with mental illness and substance use disorder. Limits on frequency and amount of services. Assertive Community Treatment (ACT) is covered for members ages 18-21 years. Only ACT providers certified by Bureau for Medical Services (BMS) or the Bureau for Behavioral Health may provide ACT services.
- Psychological Services – Evaluation and treatment, including individual, family, and group therapies. Services may be delivered using telehealth. Some evaluation and testing procedures have frequency restrictions.
- Substance Use Disorder (SUD) Services - Targeted care management, physician-supervised medication, and counseling services to treat members with SUD. Some exclusions apply. Opioid Treatment Program services will be provided through fee-for-service.

Emergency

- Emergency Transportation – Transportation to secure medical care and treatment on a scheduled or emergency basis. Includes emergency ambulance and air ambulance. Out of state requires prior authorization. To call for Emergency Transportation, dial 911.
- Post-stabilization Services – Includes care after an emergency health condition is under control. Care provided in a hospital or other setting.

Home Health Care Services – Includes services given at member's residence. This does not include a hospital nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or state institutions. Some suppliers have service limits.

Mountain Health Promise Covered Benefits
Hospice – Includes nursing care, physician services, medical social services, short-term inpatient care, durable medical equipment, drugs, biologicals, home health aide, and homemaker. Requires physician certification.
Hospital • Inpatient – Includes all inpatient services (including bariatric surgery, corneal transplants and long-term acute care). Corneal transplant services must be in a center approved by Medicare and Medicaid. Adults in institutions for mental diseases and some behavioral health inpatient stays are not included. • Outpatient – Includes preventive, diagnostic, therapeutic, all emergency services, and rehabilitative medical services.
Maternity • Maternity Care – Includes prenatal, inpatient hospital stays during delivery, and post-partum care. • Right From The Start – Includes enhanced prenatal care and care coordination for pregnant members through 12 months after giving birth and their newborn infants less than one year of age. No prior authorization required.
Nursing Services • Nurse Practitioner Services – Some procedures have service limits. • Private Duty Nursing – Includes 24-hour nursing care if medically necessary. Prior approval is required.
Preventive Care and Disease Management • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) – Based on the periodicity schedule. Includes health care services for any medical or psychological condition discovered during screening (for members under age 21). • Family Planning – Includes all family planning providers and services. No referral needed for out-of-network providers. Sterilization is not covered for members under age twenty-one (21), for member in institutions, or for those who are mentally incompetent., Hysterectomies and pregnancy terminations are not considered family planning services. Treatment for infertility is not covered. • Tobacco Cessation – Includes therapy, counseling and WV Tobacco Quitline services. Guidance and risk-reduction counseling covered for children during routine well visits. • Sexually Transmitted Disease Services – Includes screening, diagnosis, and treatment from your PCP, a specialist in our network, or an out-of-network family planning practitioner.

Mountain Health Promise Covered Benefits

Other Services

- Ambulatory Surgical Center Services – Includes services, equipment and use of the facility for surgical procedures.
- Children with Special Health Care Needs Services – Includes coordination of services and limited medical services, equipment and supplies.
- Children's Residential Services – Services provided by Children's Residential Facility
- Durable Medical Equipment (DME) – Devices and medical equipment prescribed by a physician to ameliorate disease, illness or injury. Customized special equipment considered. May have services limits or require prior authorization
- Emergency Shelter Services – Services provided by an emergency shelter provider.
- Gender Affirming Surgery for Gender Dysphoria– Procedure that aligns an individual's biological sex with their gender identity. Adults must be 21 or older prior to being considered for the procedure. Requires prior authorization.
- Orthotic and Prosthetic Devices – May have service limits or require prior authorization. Customized special equipment is considered.
- Podiatry – Includes treatment of acute conditions. Includes some surgeries, reduction of fractures and other injuries, and orthotics. Routine foot care is not covered.

Rehabilitation Services

- Chiropractor Services – Includes radiological exams and manipulation to correct subluxation. Certain procedures have service limits.
- Inpatient Rehabilitation – Includes inpatient rehabilitation services and general medical outpatient services that meet the certification requirements.
- Occupational Therapy – 20 visits per calendar year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Physical Therapy – 20 visits per calendar year for habilitative and rehabilitative services (combined for physical and occupational therapy).
- Speech Therapy – Habilitative and rehabilitative services including hearing aid evaluations, hearing aids and supplies, batteries, and repairs. Some procedures have service limits or require prior authorization.

Specialty Rehabilitation Services

- Pulmonary Rehabilitation – Includes procedures to increase strength of respiratory muscle and functions.
- Cardiac Rehabilitation - Includes supervised exercise sessions with electrocardiograph monitoring.

Mountain Health Promise Covered Benefits
Dental • Children (under age 21) – Includes preventive, emergency, non-emergency, diagnostic, surgical, restorative treatment, and orthodontic services. • Adults (21 and over) – Includes preventative, diagnostic, and restorative services and emergency procedures to treat fractures, reduce pain, or eliminate infection. Non-emergency dental services are limited to $2,000 per member per two benefit years.[1] Cosmetic services are not covered.
Tubal Ligation - Family planning service for individuals of childbearing age to permanently prevent pregnancy. Service requires informed consent.
Vision – Includes eye exams, lenses, frames, and needed repairs for children (under age 21). Includes medical treatment and one pair of glasses after cataract surgery for adults and contact lenses for adults and children with certain conditions. Does not cover prescription sunglasses or designer frames. Vision coverage has some limits. Please check with VSP before getting vision services.

BENEFITS COVERED UNDER MEDICAID FEE-FOR-SERVICE

The following services fall under fee-for-service Medicaid.

Benefits Under Fee-for-Service Medicaid
Abortion – Includes drugs or devices to prevent implantation of the fertilized ovum and procedures for termination of ectopic pregnancy. Physician certification required. All Federal and State laws regarding this benefit apply.
Early Intervention Services – Includes services and supports provided through the West Virginia Birth to Three program for children under age three (3) who have a delay in their development, or may be at risk of having a delay, and for their families.
ICF/IID Intermediate Care Facility – Includes physician and nursing services, dental, vision, hearing, lab, dietary, recreational, social services, psychological, habilitation, and active treatment for members with intellectual/developmental disabilities. Requires physician or psychologist certification. Limits apply.
Nursing Facility Services – Includes nursing, social services, and therapies.
Organ Transplant Services – Generally safe, effective, medically necessary transplants covered, when no alternative is available. Cannot be used for investigational/research nature or for end-stage diseases. Must be used to manage disease.
Personal Care Services – Includes personal hygiene, dressing, feeding, nutrition, environmental support, and health-related functions. Room and board services require physician certification. May not exceed 60 hours per month without prior authorization.

[1] The benefit year begins on July 1st each year.

Benefits Under Fee-for-Service Medicaid
Prescription Drugs – Includes medications dispensed on an ambulatory basis by a pharmacy, family planning supplies, diabetic supplies, vitamins for children (to age 21), and prenatal vitamins. Hemophilia blood factor, Hepatitis-C, weight gain, cosmetic, hair growth, fertility, less than effective and experimental drugs are not covered. Drugs dispensed by a physician at no cost are not covered.
School-based Services – Services provided by a physical therapist, speech therapist, occupational therapist, nursing care agency, or audiologist in a school-based setting. Limited to individuals under age twenty-one (21)
Substance Use Disorder Services – Physician-supervised opioid agonist medication and counseling services provided to those with severe opioid use disorder.
Transportation (non-emergency) – Includes multi-passenger van services and common carriers (public railways, buses, cabs, airlines, ambulance as appropriate, and private vehicle transportation). Prior authorization is required. To get transportation, call Modivcare at **1-844-549-8353**.

VALUE-ADDED SERVICES

In addition to your benefits, Aetna Better Health offers value-added services. Eligible members can complete the healthy behaviors in the table below to receive a reward. We offer these services to encourage health education and to promote good health habits. Co-payments will not be charged, and members do not have the right to an appeal or a state fair hearing for value-added services. Please note that value-added services sometimes change. Call Member Services at **1-888-348-2922 (TTY: 711)** for details.

Value-Added Services and Rewards	
Good Health Practices	**Reward**
Yearly well care visit for ages 12-21	$25 reward
Complete recommended HPV shots before age 13	$50 reward
Complete lead screening test by age 2	$25 reward
Complete behavioral health follow-up visit after emergency room visit for mental health issue or self-harm (ages 6 and older).	$50 reward for follow-up within **7** days $25 reward for follow-up within **30** days
Complete follow-up visit after diagnosis of substance use disorder (for members 13 and older)	$50 reward for follow-up within **7** days $25 reward for follow-up within **30** days
Annual flu shot	$50 reward for members who have had **two flu shots before age 2** $25 West Virginia State Park gift card (adults 18 and older)
Cervical cancer screening/pap test (ages 21-64)	$50 reward
Healthy Activities	**Reward**
Ted E. Bear, MD Cub Club (age 13 and under)	Participation gifts
Keep Kids Safe	Medication Lock Box
Essential Needs Duffle Bags (new enrollees only)	Duffle bag with essential hygiene and personal care supplies
Health related summer camps for children	Camp scholarships
Legal Services, Clinics and Education	Access to dedicated attorney and paralegal
Complete ATV rider safety and training course	$25 reward
Complete a walking program (adults 18 and older)	$25 reward
Enrollment with Complex Care Management	Birthday in a Box
Asthma	**Reward**
Enroll in Asthma Care Program	One-on-one asthma education and a peak flow meter to help with breathing exercises

Value-Added Services and Rewards	
Diabetes	**Reward**
Enroll in diabetes support program and complete A1C testing (Available in certain counties)	$25 reward
Complete yearly diabetic eye exam (age 18 and older)	$50 reward
Pregnancy	**Reward**
Attend 6 prenatal appointments	Cribette
Attend 1 post-partum appointment within **7-84** days of having your baby	$50 reward
Enroll in Moms and Babies Program (for pregnant women with substance use disorder)	Cribette or Baby Wrap Carrier upon delivery
Complete the Moms and Babies Program	Educational Toy on baby's first birthday
Support for all ages	**Reward**
Diaper Club (birth to 2½ years of age)	Up to $45 of diapers/month
Caring Closets (newly displaced members age 13+)	$100 clothing voucher (two per year)
Connections for Life Program (ages 13-17, restrictions apply)	Tablet
Connections for Life Program (ages 18+, restrictions apply)	Laptop
Afterschool Program	$100 toward cost of 4-H activities.
High School Graduation prep courses	High School Equivalency Diploma

COMMUNITY SERVICES

Good health and well-being is about more than just having good medical care. Community services are programs and services that improve the health of people, families, and communities. There are many services in West Virginia that can help meet your needs. Whether you need help with a housing problem or childcare or getting healthy food or help with a substance use problem our Care Management team can help. Call us at **1-888-348-2922 (TTY: 711)** or visit our website for a list of resources. Go to **AetnaBetterHealth.com/WestVirginia** and click on M*embers* then *Resources and services*.

WV 211

WV 211 is a free resource that can connect you with services you need. Do you need help with paying your bills or finding food or housing? Visit **www.wv211.org**. You just need to provide your ZIP code to get started.

Our Member Services and Care Management teams can also help you with finding resources to help you and your family. Just call us at **1-888-348-2922 (TTY: 711)**

You can also call, text or chat for help. Just dial **211** or text your zip code to **898-211**. The service is available 24 hours a day, 7 days a week. A trained specialist will help you. The 211 service is free and confidential.

WEST VIRGINIA FAMILY RESOURCE NETWORKS

Family Resource Networks (FRNs) are local community organizations that partner with community members and organizations to help improve access to services and resources. FRNs also develop community resource guides to help connect community members to available programs and services. Visit **wvfrn.org** and click on *Counties* to contact your local FRN and find services that can help you and your family.

WEST VIRGINIA WOMEN, INFANTS, AND CHILDREN (WIC)

WIC provides nutritional services to improve the health of women, infants and children in West Virginia by providing quality nutrition and breastfeeding counseling and education; as well as health monitoring and nutritious foods.

The West Virginia WIC program may help you and your family get healthy foods and have better nutrition. To reach the office of the West Virginia WIC program call **304-558-0030** or go to their website at **ons.wvdhhr.org**.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS (CSHCN)

The CSHCN program provides specialized medical care for children who have certain chronic, disabling medical conditions and who meet eligibility requirements.

Children who have a diagnosis covered by CSHCN and receive West Virginia Medicaid may be eligible to receive care management and/or limited services from the program. For more information, call **1-800-642-9704.**

WORKFORCE WEST VIRGINIA

WorkForce WV offers tools to help with job searches, unemployment, and training. The education and training opportunities provide residents work skills needed by businesses. Visit their website at **http://workforcewv.org**. If you don't have a job due to a health issue, please contact us for assistance at **1-888-348-2922 (TTY: 711)**.

WORKING FOR SUCCESS PROGRAM

Job Corps is a tuition-free training and education program for eligible people ages 16-24. Job Corps helps young people complete their high school education, train for meaningful careers, and obtain employment. Job Corps also offers tuition-free housing, meals, basic health care, a living allowance, and career transition assistance. For more information reach out to a Case Manager at **1-888-348-2922**.

MORE INFORMATION ABOUT YOUR HEALTH PLAN

Please read below for more details about your benefits and services. If you have any questions, please call Member Services at **1-888-348-2922 (TTY: 711)**.

WELL-CHILD VISITS

The Early and Periodic Screening, Diagnostics and Treatment (EPSDT) Program is a child preventive health component of Medicaid. HealthCheck is the name for West Virginia's EPSDT Program. The HealthCheck Program promotes regular preventive medical care and the diagnosis and treatment of any health problem found during a screening.

Well-child visits are important to make sure children are healthy and stay healthy. HealthCheck covers all medically necessary and preventive health care services for members up to age 21. Covered screening services are medical, mental health, vision, hearing, and dental. Both sick and well care services are provided by your child's PCP at no cost.

HealthCheck Screening Schedule for Well-child visits	
Stage	**Ages for Well-child visits**
Infancy	Birth, 3-5 days old, by 1 month, 2 months, 4 months, 6 months and 9 months
Early Childhood	12 months, 15 months, 18 months, 24 months, 30 months, 3 years and 4 years
Middle Childhood and Adolescence	Every year from age 5 to age 21

Some screenings that children can get include:

- Physical exams
- Laboratory tests
- Vision testing
- Immunizations
- Hearing test
- Dental services
- Behavioral health screenings
- Health education
- Health and development history

Immunizations are important to keep you healthy. See Appendix A in this handbook for the recommended immunization schedule. Checkups and screenings are needed to detect health problems. Your PCP can diagnose and treat any health issues early, before they become more serious. Call your PCP or Member Services to schedule a well-child visit. New Aetna Better Health members should have a well-child visit within 30 calendar days of enrollment. Transportation and scheduling help is also available at no cost upon request.

Aetna Better Health has trained professionals on staff to help you move from child to adult care. We can help you to get the right care for your child's special needs. Please call **1-888-348-2922 (TTY: 711)** and ask to speak to a Care Management team member.

POPULATION HEALTH MANAGEMENT

Aetna Better Health has many programs to help members get healthy and stay as healthy as possible. These programs help you take good care of yourself. We will automatically put you into the program if you are eligible. Call us if you do not want to be part of a program. For questions about these programs, call us at **1-888-348-2922 (TTY: 711)**.

Program	Who Is Eligible
Healthy Pregnancies, Healthy Babies	Pregnant members and their babies up to 12 months after giving birth
Healthy Adults and Children	All members
Flu Vaccination Program	All members over 6 months of age
Living with Diabetes	Members with Diabetes
Moms and Babies	Pregnant women who have substance use disorder (drug addiction) and their babies
Readmission Avoidance	Members who are in the hospital or have recently been discharged
Opioid Management	Members who use certain drugs
Chronic Condition Management	Members with at least one chronic condition: Asthma, Diabetes, Heart Failure, COPD (Lung Disease), Coronary Artery Disease (CAD), Depression
Managing Diabetes and Heart Disease	Members with both Diabetes and Heart Disease
Emergency Room (ER) Utilization Management	Members who frequently use the ER
Integrated Care Management (ICM)	Members who need help managing their care
Children's Specialty Program	Assists and supports members in the child and family welfare system

CARE COORDINATION

All members are eligible for care coordination services. We have a team of nurses and care coordinators who can help coordinate your health care services. We can help with:

- Coordination between settings of care
- Coordinating services you receive from other organizations
- Coordinating services you receive in fee-for-service Medicaid
- Coordinating services you receive from community and social support providers

If you would like help with care coordination, call us at **1-888-348-2922 (TTY: 711)** and ask to speak to a Case Manager.

INTEGRATED CARE MANAGEMENT

Our Integrated Care Management (ICM) Program can help you understand your condition and treatment plan. We have nurses, social workers, and support staff who work with many health care practitioners, agencies and organizations to get you the services and the care that you need. We will help you get the best care in the most efficient manner. Our Case Managers help coordinate care in the following ways:

- Work one-on-one with you and your care team to create a plan based on your goals
- Review your plan to help make sure you do not have gaps in care
- Coordinate care with your doctors and care team
- Help you make specialist and primary care doctor appointments
- Verify that the right medicines and treatments are in place
- Help make sure you receive preventive care
- Work to ensure you have the support you need
- Discuss home safety and other safety concerns
- Help identify barriers and needs
- Provide patient and family education about programs and services available in the community and through your doctor.
- Make sure you have support for any behavioral health needs.
- Help you transition to other care when benefits end, if necessary

We want to help you get the care and services you need. As a member of Mountain Health Promise, you are automatically enrolled in Care Management.

To reach your Case Manager, call us toll-free at **1-888-348-2922 (TTY: 711)** Monday - Friday from 8:30 AM to 5 PM and ask for Care Management. After normal business hours, you may leave a message. We'll call you the next business day.

UTILIZATION MANAGEMENT

We want to ensure that our members are getting the services or benefits they need to get or to stay healthy. This is called "utilization management" (UM). Our UM program helps make sure you get the right services at the right place. UM staff use clinical criteria, guidelines and written policies to make UM decisions. We call this Prior Authorization. They check that requested services are:

- Needed to get or keep you healthy
- Covered by Aetna Better Health of West Virginia

You or your practitioner or provider can get a copy of the guidelines we use to approve or deny services. You can call us toll-free at **1-888-348-2922** Monday - Friday from 8:30 AM to 5 PM. with questions about our UM program. Member Services may transfer your call to the UM department for a staff member to help you. After normal business hours, you may leave a message. We'll call you the next business day. If someone from our UM team calls you, they will give you their name and title and say they are calling from Aetna Better Health.

We're here to help you with any UM issues:

- For help if you have vision and/or hearing problems, call us at **1-888-348-2922 (TTY:711)**.
- For help with language or translation services, call Member Services at **1-888-348-2922.**

We understand members want to feel confident they are receiving the health care and services that are best for them. We have policies our practitioners and providers follow to ensure you receive the right health care. 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 (UM) decisions are made by looking at your benefits and choosing the most appropriate care and service.
- We don't reward doctors or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services you get.

We want to make sure that each member receives the right health care. If you need help understanding this information, call us at **1-888-348-2922 (TTY: 711)**.

MEDICATIONS

Your prescription medicine is covered under fee-for-service Medicaid. If you have questions about prescription medicine that you pick up at a pharmacy, please contact Gainwell Technologies at **1-888-483-0797**.

If medically necessary, Aetna Better Health covers:

- Medicine you get in a hospital or other inpatient facility.
- Medicine you get at the doctor's office or at home, when given by a health care professional.

We want to be sure you get the right medication for your condition. If your doctor wants you to have a medication that requires approval, they will work with us the same way they do for medical care that requires approval. If you have questions about these kinds of medicines, talk to your doctor or give us a call at **1-888-348-2922** .

FAMILY PLANNING SERVICES

Aetna Better Health covers care to help you if you plan to have a family, want to know how to avoid getting pregnant, or want to know how to protect yourself against sexually transmitted infections (STIs). This includes coverage for contraceptives, testing and treatment for STIs, and screenings for issues before they plan to become pregnant.

You don't need to get an okay from your PCP to get family planning care. You may go to any licensed family planning clinic or provider. The provider doesn't have to be part of our network. If you choose to see a family planning provider who is not part of our network, let your PCP know about the family planning visit. The family planning provider and PCP will work together to make sure you get the right care.

Family planning records are kept private. Medical records may be shared with other doctors who

take care of you, public health officials, or government agencies.

PREGNANCY AND MATERNITY SERVICES

Aetna Better Health provides coverage for prenatal care, inpatient hospital stays during delivery, and post-partum care. Our Healthy Pregnancies/Healthy Babies program can offer you support throughout pregnancy and after delivery. Call **1-888-348-2922** and ask to speak to Care Management for more information on the program.

Pregnant members and their newborn infants are eligible for Medicaid coverage for up to one year after delivery. You must report your baby's birth. As soon as your baby is born be sure to:

- Call your county DoHS office at **1-877-716-1212**, AND
- Call us at **1-888-348-2922 (TTY: 711)**

The West Virginia WIC program may help you and your family get healthy foods and have better nutrition. To reach the office of the West Virginia WIC program call **304-558-0030** or go to their website at **ons.wvdhhr.org**.

SOCIALLY NECESSARY SERVICES (SNS)

Socially Necessary Services are provided to improve relationships and social functioning. These services help children stay safe and get along well at home and in school. Socially necessary services are interventions to help maintain or establish safety, permanency and well-being for members.

Aetna Better Health coordinates access to these services through an Administrative Service Organization arrangement or contract with Acentra Health, formerly Kepro. The State is responsible for paying for approved SNS services.

For more information on SNS call the Social Necessity Line at **304-380-0616** or toll free at **1-800-461-9371.** The SNS fax line is **1-866-473-2354**.

DENTAL SERVICES

Dental care is important to your overall health. Aetna Better Health uses a dental benefit manager, Liberty Dental, to provide dental services to Mountain Health Promise members. All dental services are provided by a licensed dentist or dental specialist in an office, clinic, hospital, or other setting.

Members under 21 years of age should visit their dentist for a checkup once every six months. Checkups begin at six months after an infant's first tooth erupts or by twelve months of age.

Children and adolescents can get orthodontic services for the entire length of treatment and other services to fix dental problems. Members under age 21 can also access the Fluoride Varnish Program, offered by practitioners certified from the WVU School of Dentistry. For more information about the fluoride varnish application, ask your practitioner. Children are covered for

non-emergency and emergency dental services. If you need to speak with Liberty regarding your child's dental benefit, please call **1-888-983-4693.**

For adults 21 years and older, diagnostic, preventive, restorative and emergency dental services are covered . Non-emergency dental services are limited to $2,000 per member per two-year budget period. (other limitations apply)[2]. Dental services may be provided by a dentist, orthodontist, or oral surgeon.

Some examples of a dental emergency include:

- Severe pain
- Hemorrhage
- Traumatic injury to the teeth and surrounding tissue
- Unusual swelling of the face or gums

If you need to speak with Liberty Dental regarding the dental benefit, please call **1-800-267-6610 (TTY: 711)**

BEHAVIORAL HEALTH SERVICES

Aetna Better Health provides inpatient and outpatient services to members. This benefit includes mental health services, substance use disorder (SUD) services (alcohol and drugs), care management, rehabilitation and clinic services, and psychiatric residential treatment services.

You do not need a referral for behavioral health services. Your PCP or Member Services can help you get these services from behavioral health practitioners/providers. You can call us at **1-888-348-2922 (TTY:711)**. Let your PCP know if you visit a behavioral health specialist, so they can support your care.

If there is a mental health or substance use emergency, please call 911 right away.

Call the Suicide and Prevention Lifeline at **988** if you or another person are having thoughts about harming yourself, mental health or substance use crisis, or any other kind of emotional distress.

Help for mental health and substance use problems is also available 24/7 across the state through the **HELP4WV** helpline. The Children's Mobile Crisis Response Team can help de-escalate a crisis by phone or in person. If you need help call **844-HELP4WV (844-435-7498**). You can learn more about the program at **www.help4wv.com**. For additional resources visit **kidsthrive.wv.gov**.

COURT ORDERED SERVICES

Medically necessary court ordered treatment services are covered by Aetna Better Health as long as the service is a covered benefit. If the service is not covered by Aetna Better Health, it may be by the State fee-for-service program or the Bureau for Social Services (BSS).

[2] The benefit year begins on July 1st every year.

DRUG FREE MOMS AND BABIES PROGRAM

The Drug Free Moms and Babies (DFMB) program supports healthy outcomes for pregnant and postpartum women and babies in Medicaid by providing prevention, early intervention, addiction treatment, and recovery support. Covered benefits through this program include:

- Care coordination with Aetna Better Health case managers, DFMB care coordinators, DFMB community health workers, and DFMB providers.
- Early intervention through provider outreach and education.
- Recovery support services.
- Addiction treatment.
- Assistance with health-related social needs of members.
- Long-term follow-up with recovery coach to help women stay in the path of recovery and access to needed resources.
- Services are limited to the duration of the member's pregnancy and one year postpartum.

SECOND MEDICAL OPINIONS

You may need a second opinion for an illness, surgery and/or confirming a treatment of care your practitioner has told you that you need. Contact your practitioner or Member Services for help to get a second opinion. If an appropriate provider or practitioner for the second opinion is not available within the Aetna Better Health network, we will arrange for you to get the second opinion outside the network. There is no cost to you for the second opinion.

SERVICES NOT COVERED

Some services are not available through Aetna Better Health or Medicaid. If you choose to get these services, you may have to pay the entire cost of the service. Aetna Better Health is not responsible for paying for these services:

- All non-medically necessary services
- Sterilization of a mentally incompetent or institutionalized individual
- Except in an emergency, inpatient hospital tests that are not ordered by the attending physician or other licensed practitioner, acting within the scope of practice, who is responsible for the diagnosis or treatment of a particular patient's condition
- Some organ transplants
- Treatment for infertility and the reversal of sterilization
- All cosmetic services, except in the case of accidents or birth defects
- Christian science nurses and sanitariums
- Duplicate services
- Service codes determined by BMS as not covered
- Health services or supplies from nonparticipating practitioners, except in an emergency, for family planning or when otherwise approved by Aetna Better Health
- Health Services prohibited by law or regulation
- Services that require a prior authorization but did not get a prior authorization.

This is not a complete list of the services that are not covered by Aetna Better Health or Medicaid. If a service is not covered, not authorized, or is provided by an out-of-network provider, you may have to pay. If you have a question about whether a service is covered, please call us at **1-888-348-2922 (TTY: 711).**

NEW TECHNOLOGY FOR MEDICAL PROCEDURES

We are always looking at new medical procedures and methods. We want to be sure members get safe, high-quality care. We have a team of doctors who review new health care technologies. They decide if new technologies should become covered services. (We don't cover things that are investigational or still under research.)

To decide if a new technology will become a covered service, we will:

- Study the purpose of it
- Review medical literature
- Look at the impact and benefits
- Develop rules on how and when to use the technology

GETTING YOUR CHILD'S BENEFITS

REFERRALS & SPECIALTY CARE

Sometimes you may need care from a specialist. Specialists treat certain diseases and special types of conditions, including behavioral health or substance use concerns. Your PCP can recommend a specialist or behavioral health care provider to you. You don't need a formal referral from your PCP as long as the specialist is in our provider network.

Female members have direct access to an Aetna Better Health women's health specialist for routine and preventive care. Women's health specialists include, but are not limited to, obstetricians, gynecologists and certified nurse midwives. Routine or preventive care include covered services such as breast exams, mammograms, pap tests and prenatal care. You do not need an okay from your PCP or permission from us. You must go to an Aetna Better Health practitioner in order for your service to be covered, except for emergency services or family planning services. You can use any family planning provider for family planning services.

Let your PCP know if you visit a specialist, so they can support your care.

If you need help finding a specialist, please call us at **1-888-348-2922 (TTY: 711)** or visit **AetnaBetterHealth.com/WestVirginia**. Click on Find doctors and medicines.

SERVICE AUTHORIZATIONS

If you need to see a practitioner/provider who is not in our network, your PCP must ask Aetna Better Health for approval. Asking for an out-of-network referral is called a service authorization request. It is important to remember that your PCP must ask us for approval before you see an out-of-network practitioner/provider. You or your PCP can call Member Services at **1-888-348-2922 (TTY: 711)**. If you are approved to see a practitioner or provider who is outside of our network, your visits will be covered. If we do not approve a service authorization we will send you a written notice. You can appeal the decision.

PRIOR AUTHORIZATIONS

Sometimes you may need certain services or treatments that require approval. Before you get this type of care, your practitioner or provider must ask our Prior Authorization team. If we do not approve a prior authorization we will send you a written notice. You can appeal the decision.

We give prior authorizations to Aetna Better Health practitioners or providers when you need health care, drugs or supplies that are medically needed. Your practitioner or provider needs to call us at least two (2) working days before the scheduled care. However, earlier notification helps the review process. We may ask to see written notes showing that the care is medically needed before it is prior authorized.

Our Prior Authorization team is available from 8:30 AM - 5 PM (ET) Monday through Friday. If you have questions, call us at **1-888-348-2922 (TTY: 711)**. After normal business hours, you may leave a message, and someone will return your call the next business day.

Prior authorization is required before you receive the services listed below:

- Home health care
- Physical or Occupational Therapy (after initial 20 combined visits)
- Chiropractic care (after initial 20 visits)
- Speech Therapy
- Durable medical equipment (DME)
- Sleep apnea studies)
- Genetic testing
- Pain management services
- Computerized Tomography (CT scan)
- Magnetic Resonance Imaging (MRI)
- Magnetic Resonance Angiogram (MRA)
- Positive Emission Tomography (PET Scan)
- Inpatient hospital care
- Outpatient surgery
- Intensive outpatient behavioral health services
- Partial hospitalization
- Psychiatric residential treatment facility care
- Services from a non-participating provider (except emergency services and family planning)

This list is not intended to be all inclusive. If you have any questions, call Member Services at **1-888-348-2922 (TTY: 711).**

OUT-OF-NETWORK SERVICES

If our network is unable to provide certain covered services, you may get out-of-network services.

You can go to a practitioner or provider outside the Aetna Better Health network only if:

(1) the care is needed; and
(2) there are no Aetna Better Health practitioners or providers who can give you the care you need.

We will help you get out-of-network services if the care is needed. We have the right to say where the out-of-network services can be given. The care must be preauthorized before your visit. Your PCP or the practitioner that wants to give you the care should ask for this prior authorization.

If we have approved care outside our network, the cost will be no greater than it would be if you received the services within our network. We will coordinate payment for the care. You can continue to get the approved care outside our network as long as there are no Aetna Better Health providers that can provide the needed care. Services will be provided in an adequate and timely manner. If you have questions, call Member Services at **1-888-348-2922 (TTY: 711)**.

COST SHARING

Cost sharing, or a co-payment, is the money that would be paid at the time of service. Mountain Health Promise members do not have co-pays or cost-sharing.

If you get a bill for a covered health care service, call us at **1-888-348-2922 (TTY: 711)**.

ACCESS AND AVAILABILITY GUIDE

Aetna Better Health offers services in every county of West Virginia. The table below lists how long it should take for you to be seen by a practitioner in different situations.

Type of Visit:	When You Should be Seen:
Routine Care	Within 21 calendar days
Urgent Care	Within 48 hours
Initial Prenatal Care	Within 14 days of known pregnancy
Emergency Care – medical or behavioral health	Immediately or referred to ER
Specialty Care – new patient/initial visit	Within 90 calendar days
Specialty Care – follow-up visit	Within 30 calendar days
Initial Behavioral Health visit	Within 10 business days
Urgent Behavioral Health visit	Within 48 hours
Care for a non-life-threatening behavioral health emergency	Within 6 hours
Follow-up care with a Behavioral Health practitioner (routine)	Within 60 calendar days

The following table shows what your travel time should be for your appointments.

Traveling to Your:	Should Take No Longer Than:	Should be no further than
PCP	30 minutes	20 miles
OB/GYN	30 minutes	25 miles
Specialist You See Often	30 minutes	20 miles
Hospital	45 minutes (urban) 90 minutes (rural)	30 miles (urban) 60 miles (rural)
Dentist	30 Minutes	25 Miles
Dental Specialist	60 Minutes	45 Miles
Behavioral Health Provider, Clinic, or Facility	60 Minutes	45 Miles
SUD Provider, Clinic, or Facility	60 Minutes	45 Miles

LETTING US KNOW WHEN YOU'RE UNHAPPY

When you have a problem, try speaking with Member Services or your PCP to resolve it. If you are still unhappy or do not agree with a decision we have made about your health care, you can file a complaint or an appeal. A complaint may also be called a "grievance". You can also request a state fair hearing once you have gone through the process for complaints and appeals. You have a right to receive oral or written information about our complaint and appeal process.

COMPLAINTS/GRIEVANCES

As a member of Aetna Better Health, you have the right to file a complaint at any time. You can file a complaint (also called a grievance) if you are unhappy with something about Aetna Better Health or one of our practitioners or providers. You can also file a complaint if you disagree with our decision about your appeal. To file an informal complaint, call us at **1-888-348-2922** to let us know that you are unhappy with Aetna Better Health or your health care services. You can also call your Case Manager to help you.

You can also take steps to file a formal (written) complaint or allow someone like your PCP to do so on your behalf. If someone files a complaint on your behalf, we will need your okay in writing.

To file a written complaint, you will need to send us a letter that has:

- The member's name
- Provider/practitioner name if your complaint is about a service
- Date of service, if your complaint is about a service
- Your mailing address
- The reason you are filing the complaint and what you want Aetna Better Health to do
- Any information or additional documents that could support your case

Please mail it to our secure mailing address at:

Aetna Better Health of West Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181

Our special mail service makes sure your letters get where they need to go and are handled quickly. We will acknowledge receipt of your complaint in writing within 3 calendar days from when we receive it. We will get our response to you within 90 calendar days from the date your complaint is received. If it is in your interest, you can ask for a delay in our decision for up to 14 calendar days. If we need to delay our decision for another reason, we will give you written notice within 2 calendar days.

If you need help with a complaint, you can call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can assist you in completing forms. We also offer interpreter services or assistance for your vision or hearing preferences such as auxiliary aids, and other services.

APPEALS

As a member of Aetna Better Health, you have the right to appeal a decision, including a non-coverage decision. You can file an appeal for many reasons, such as if you do not agree with our decision about your service authorization, prior authorization request, or a bill you received. Our decision to reduce, suspend, or stop services will be sent to you in a Notice of Action letter.

You will have 60 calendar days from the date of the Notice of Action to file an appeal with Aetna Better Health. Appeals can be filed verbally or in writing. If you would like your benefits to continue while the appeal is pending, you or your practitioner/provider must file a request within 13 calendar days of the date on the Notice of Action letter. If our appeal decision is not in your favor, you may have to pay for services you received while the appeal was pending.

You can file an appeal by calling Member Services at **1-888-348-2922 (TTY: 711)** or you can do so in writing. If you choose to write to us, you will need to include your address. You can have someone else file an appeal on your behalf, such as your PCP, a lawyer or a family member. We just need your okay in writing.

To file a written appeal, you will need to send us a letter that has:

- Your name
- The provider's name
- The date of service
- Your mailing address
- The reason why we should change our decision
- A copy of any information that you think supports your appeal, such as written comments, additional documents, records or information related to your appeal

Please mail it to our secure mailing address at:

Aetna Better Health of West Virginia
P.O. Box 81139
5801 Postal Road
Cleveland, OH 44181

Our special mail service makes sure your letters get where they need to go and are handled quickly. Aetna Better Health will respond to your appeal within 30 calendar days from the day your appeal is received. If it is in your interest, you can ask for a delay in our decision for up to 14 days. If we need to delay our decision for another reason, we will give you written notice within two days. For appeals that need to be resolved more quickly, we will give you our decision within 72 hours after receiving your appeal. You may have to pay the cost of services, depending on the outcome.

If you need help with an appeal, you can call Member Services toll-free at **1-888-348-2922 (TTY: 711)**. We can assist you in completing forms. We also offer interpreter services or assistance for your vision or hearing preferences such as auxiliary aids and other services.

FAIR HEARINGS

You have the right to request a state fair hearing if we denied your appeal about covered benefits or services including EPSDT. The state fair hearing process is different from the Aetna Better Health complaint and appeal process. You can only request a state fair hearing after you have received notice that Aetna Better Health is upholding the decision to reduce, suspend, or stop your benefits for a Mountain Health Promise covered service. You must request the state fair hearing no later than 120 calendar days from the date of our decision notice. It is our job to mail you the form and give you the information you need.

Once you get the form, please mail it back to:

The West Virginia Department of Health and Human
Resources One Davis Square
Suite 100 East
Charleston, WV 25301-3708

If you would like your benefits to continue while the hearing is going on, you or your practitioner or provider must file a request within 13 calendar days of the date on the Notice of Action letter. You may have to pay the cost of services, depending on the outcome. Parties to the state fair hearing can include the State, Aetna Better Health, your representative, or the representative of a deceased member. The State will hear your case and decide within 90 calendar days of the date of your request for a state fair hearing.

Please call Member Services at **1-888-348-2922 (TTY: 711)**. if you have questions about requesting a state fair hearing. You can also call the Department of Human Services at **304-558-0684**.

REPORTING FRAUD

If you suspect fraud, waste, or abuse by an Aetna Better Health member, practitioner, or provider, please report it to our Special Investigative Unit (SIU). You do not need to give us your name or information when you call or fill out the form. To report fraud, waste, or abuse, please call **1-888-348-2922**.

You may also complete the Fraud, Waste, and Abuse Reporting form on our website at **AetnaBetterHealth.com/WestVirginia/fraud** or by mailing it to us at:

Aetna Better Health
500 Virginia Street East, Suite 400
Charleston, WV 25301

Some examples of fraud, waste or abuse include, but are not limited to:

- Receiving money or gifts in return for your member ID number.
- Billing for a non-covered service as a covered service.
- Requesting cash payments from members instead of billing health insurance company.
- Using another person's Medicaid card.

OUR POLICIES

MEDICAL RECORDS

You have the right to ask for your medical records and get them within 30 calendar days from when you ask for them. You can also ask to have your medical records amended or corrected. Aetna Better Health will take action on your request to have medical records corrected no later than sixty (60) calendar days from when you ask us. Your medical records will always be kept private.

YOUR RIGHT TO INFORMATION ABOUT YOUR HEALTH PLAN

You may request the following information at any time:

- A description of how physicians are paid, including any incentives
- How many complaints and appeals we receive and how we resolve them
- Information on the structure and operation of Aetna Better Health
- A copy of the Aetna Better Health community report

To request this information, call us at **1-888-348-2922 (TTY: 711)**.

ACCREDITATION REPORT

Aetna Better Health is accredited by the National Committee for Quality Assurance (NCQA). You can request a summary of our accreditation report by calling us at **1-888-348-2922 (TTY: 711)**.

ADVANCE DIRECTIVES

Under Federal and State law, members age 18 and older have the right to make decisions about their medical care, including an advance directive. An advance directive is a legal document with your wishes regarding medical treatment. It allows you to plan in ahead and make decisions about your health. An advance directive is a way to let your doctors know what kind of treatment you do or do not want if there comes a time when you are too sick to make your decisions known. You can also allow someone you trust to make treatment decisions for you. Many people choose a relative or someone they know well.

You should speak with your doctor about making an advance directive. You do not have to fill one out, but you may want to. If you decide to let someone you trust make treatment decisions for you, be sure to speak with that person. Making an advance directive requires filling out forms and stating your wishes in writing. You will need to sign and date your advance directive and have two witnesses sign it. You should keep a copy of your advance directive and be sure your doctor also has a copy. The advance directive will become part of your medical records. Remember, you can change your advance directive at any time.

Your doctor can help you complete an advance directive or answer any questions you may have. For a copy of an advance directive form, call us at **1-888-348-2922 (TTY: 711)**.

THIRD PARTY LIABILITY

If you have insurance other than Medicaid, please call and let us know. Please also let us know if another insurance company has been involved with your:

- Worker's compensation claim
- Personal injury
- Medical malpractice lawsuit
- Car accident

You must use any other health insurance you have first before using Medicaid.

BALANCE BILLING

Your provider must accept assignment of benefits and cannot bill you for any charges above the fee allowance or for any discount amount applied to a provider's charge to determine payment. This is known as the "prohibition of balance billing" and applies to any MHP provider.

RECOMMENDING CHANGES IN POLICIES OR SERVICES

If you have recommendations or ideas, please tell us about them. You can help us make changes to improve our policies and services.

We also invite you to join our Member Advisory Committee (MAC). The MAC meets to review plan facts, share ideas, and talk about changes or new programs. You can also earn rewards for participating. To join the MAC or tell us about your ideas call us at **1-888-349-2922 (TTY: 711)**.

CHANGES TO YOUR HEALTH PLAN

If there are any changes to your benefits or other information in this handbook, we will let you know at least 30 calendar days before the effective date of the change, and no later than the actual effective date. Please let us know if you have any questions about program changes.

REPORTING ABUSE AND NEGLECT

If you need to report abuse and neglect of a child or adult, please call the DoHS Centralized Intake for Abuse and Neglect hotline at **1-800-352-6513**. The hotline is operated 24 hours a day, 7 days a week. If it is an emergency situation, call **911**.

FEDERAL AND STATE LAWS

Aetna Better Health complies with all applicable federal and state laws, including:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act
- Section 1557 of the Patient Protection and Affordable Care Act

TREATMENT OF MINORS

Aetna Better Health follows the guidance of West Virginia Code §§ 16-4-10 "Minors" and 16-29-1 "Copies of Health care Records to be Furnished to Patients." Anyone over 16 years old who has been deemed emancipated in a court of law, or who is over 16 and legally married, will be treated, and have all the privileges, rights and duties of an adult.

Oral interpreters are provided to minors on an as needed basis including emergencies.

ENDING YOUR MEMBERSHIP

If you are an adoptive parent and you do not want your child to be a member of Aetna Better Health, you have the right to disenroll them at any time. The enrollment broker can help you. Just call **1-800-486-0797**.

Sometimes members are disenrolled from the health plan involuntarily. This can happen if:

- You are no longer eligible for Medicaid managed care
- You move out of West Virginia
- You are placed in a nursing facility, State institution, or intermediate care facility for individuals with intellectual/developmental disabilities for more than 30 calendar days
- You were incorrectly enrolled in Aetna Better Health

If this happens, your services may stop suddenly.

Member Services [**1-888-349-2922**] and the DoHS Customer Service Line [**877-716-1212**] can answer any questions you may have about disenrollment.

If you move out of the county or out of state, call the DoHS Customer Service Line at **1-877-716-1212**.

CHILDREN WITH SERIOUS EMOTIONAL DISORDER WAIVER (CSEDW)

PROGRAM OVERVIEW

In addition to providing services under the Mountain Health Promise program, Aetna Better Health is also the Managed Care Organization (MCO) for children and youth participating in the Children with Serious Emotional Disorder Waiver (CSEDW) program. This program offers intensive mental and behavioral health services in the homes and communities of the children receiving services.

The CSEDW is a Medicaid Home and Community Based Services (HCBS) waiver program authorized under §1915(c) of the Social Security Act. This waiver provides services (in addition to services available through the Medicaid State Plan) for children and youth ages three until their 21st birthday who are enrolled in the CSEDW program. The CSEDW allows for intensive behavioral health services to be provided in the home to offer supports to the child and their family. By offering services in your home and community, West Virginia hopes to see fewer children and youth placed in residential treatment and psychiatric rehabilitation treatment facilities. Additionally, for children and youth coming home from placement, this waiver will allow for services and supports to continue in the child's home and community.

Children and youth who are enrolled in the CSEDW program must enroll with Aetna Better Health as the Managed Care Organization. Individuals who are not willing to enroll with Aetna are not eligible to enroll in the CSEDW program.

ELIGIBILITY PROCESS FOR THE CSEDW PROGRAM

For your child to be found eligible for the CSEDW program, they must:

- Be an eligible West Virginia Medicaid member or apply for a Special Medical card once approved for a CSED Waiver. Medicaid eligibility is independent of medical eligibility for the CSEDW and is not impacted by enrollment in the CSEDW
- Choose to receive services in the home and community over receiving services in an institutional setting
- Choose to enroll with Aetna Better Health
- Meet CSEDW medical eligibility
- Be at least three years of age and not yet 21
- Be a resident of West Virginia, even if presently living out of state in a Psychiatric Residential Treatment Facility (PRTF), and
- Be able to provide proof of residency upon application to the waiver

Enrollment in the CSEDW program is dependent upon the availability of a funded CSEDW slot.

Initial medical eligibility is determined through review of an Independent Evaluation (IE) report completed by an Evaluator, who is a member of the Independent Evaluator Network (IEN). The report will include background information, a mental status examination, a measure of adaptive behavior, a measure of achievement and any other documentation deemed appropriate.

If a slot is not available, you will receive a letter telling you that your child has been placed on a Managed Enrollment List (MEL) in the chronological order in which your child was determined eligible. When a slot becomes available, you will receive a letter telling you that your child may proceed with the enrollment process for the CSEDW program.

In the event that your child is assigned to an MCO other than Aetna Better Health while your child is on the managed enrollment list, your child is required to transfer to Aetna Better Health when a funded slot becomes available.

Each child approved for the program is assigned an anchor date. The anchor date is the first day of the following month that your child was originally found to be eligible for the CSEDW program. You will receive a letter informing you of your child's anchor date.

For each year your child is on the program, they will receive a reassessment to make sure they remain eligible. The reassessment will happen up to 90 calendar days prior to your child's anchor date.

For complete 'Eligibility and Enrollment' information please refer to Chapter 502: Children with Serious Emotional Disorder Waiver (CSEDW), which can be found here: **dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx**

SLOT ALLOCATION AND SELECTION PROCESS

Once a funded slot becomes available, you will receive a welcome packet which includes a Freedom of Choice form where you must indicate your choice to receive services in the home and community as opposed to services in an institution. You will also choose your child's Wraparound Facilitation Agency and other Therapy Service Provider Agency on this form. You have a short amount of time to return the completed Freedom of Choice form, so please send this form in as soon as possible. For more information on Wraparound facilitation, see the benefits table below.

Once the Freedom of Choice form is received by Aetna, a referral will be sent to the agencies you chose. There may be times when an agency you picked is unable to provide services, so it's a good idea to contact the agency before choosing them on the form.

Some reasons why the Wraparound Facilitation Agency or other Therapy Service Provider Agency may not be able to provide services include:

- The referral appears to have been received in error
- The agency is at maximum service capacity and unable to accept referrals at this time
- The agency is unable to meet your child's medical and/or behavioral needs

CHILD AND FAMILY TEAM AND CSEDW SERVICE DESCRIPTIONS

When your child's Wraparound Facilitation Agency accepts your child's referral, they will contact you to initiate services and to schedule a seven-day Plan of Care meeting. The Wraparound Facilitator will review the services available to your child at that time and you will have an opportunity to choose which services your child will receive. This seven-day meeting will help your child's Wraparound Facilitator understand your child's needs and will help them start to develop your child's Plan of Care (POC). The POC will include how the team can best serve your child's needs.

Your child's POC development will begin within seven (7) days of the Wraparound Facilitation provider accepting the referral and must be completed within thirty (30) days of the Wraparound Facilitation provider accepting the referral. Following this thirty (30) day meeting, you and your Child and Family Team will review your child's POC monthly to make sure treatment is on track and treatments are helping.

You are allowed to choose services from providers that are not a member of our network. In that case, we will assist you in making that request happen. The provider must meet the same qualifications as our in-network providers. If your child needs a specialized service that is not available through our network, we will arrange for the service to be provided outside the network when a qualified provider is available.

Children with Serious Emotional Disorder Waiver (CSEDW) Benefits
Wraparound Facilitation: The Wraparound Facilitator is responsible for working with you and your family in a partnership of shared decision-making regarding the development of your child's POC and implementation of the plan throughout your child's enrollment on the CSEDW program. Your child's Wraparound Facilitator will work with other supports and resources that may be available to your family to make sure you are getting the services your child needs. Your child's Wraparound Facilitator will also work with your child's other CSED Waiver service providers to make sure services and treatment goals are working and being delivered as your child's team have said they need to be delivered. Your Wraparound Facilitator will lead your child's team through initial plan development, while providing wraparound Facilitation to help your child to be successful. This will also include developing a plan for when your child discharges from the CSEDW program. To prevent conflict of interest, your Wraparound Facilitation agency cannot provide any other CSEDW services to your child. So, you will need to choose another provider or providers for the other services you choose to receive.
Independent Living/Skills Building: Available to individuals who are aged 15-20. This service focuses on helping your child to be successful in the community, through improved socialization, the building of positive social behavior, and learning how to handle common life demands.
Job Development: Available to individuals who are aged 15-20 and is used to provide your child with learning and work experiences prior to getting paid employment. Activities under this service include volunteer work and activities related to employment where your child can develop general non-job specific strengths and skills that contribute to your child obtaining paid employment.
Individual Supported Employment: Available to individuals who are aged 18-20 and is used to help your child to obtain and maintain a job in competitive or customized employment, or self-employment in an integrated work setting paying at or above West Virginia's minimum wage. The outcome of this service is sustained paid employment in the general workforce in a job that helps your child to meet personal and career goals.
Specialized Therapy: Activity therapies such as music, dance, art or play therapies that are not for recreation, but related to the care and treatment of your child's needs. This service will help your child get the skills necessary to cope with their serious emotional disorder while building on your child's problem-solving skills and coping mechanisms. It will also assist with the development of symptom and behavior management.
Assistive Equipment: This service is available if your child needs equipment to help with their serious emotional disorder.

Children with Serious Emotional Disorder Waiver (CSEDW) Benefits
Community Transition: Available to individuals aged 18-20 who are leaving residential placement and entering an independent living setting like an apartment or home where they will be directly responsible for their own living expenses. The money from this service can be used to set-up security deposits for a lease, utility services, moving expenses and essential household furnishings.
Family Therapy: Includes counseling and support services for your child and your family. This service is provided by a mental health professional and includes trauma-informed individual and family therapy in the family home or in the provider office.
In-Home Family Support: This service allows your child and family to practice and use the coping strategies the in-home family therapist has recommended. The support person will also help your child and your family to apply the skills and interventions that will allow your child to function successfully.
Peer-Parent Support: Designed to offer support to the parent/legal representative of a child with a serious emotional disorder. This service helps to empower the parent/legal representative to enhance community living skills, while developing natural supports. The Peer-parent Support Worker is a mentor who has experience in raising or working with a child with serious emotional disorder. They can provide support and guidance to other parent/legal representatives by providing guidance about available community services and programs.
In-Home Respite Care: A service providing temporary care relief to a child's regular caregiver including kinship foster placements. This service is provided in the home. This service is not an option for members living in a traditional foster care, facility, or independent living setting.
Out-of-Home Respite Care: A service providing temporary care relief to the child's regular caregiver. This service is provided in the community.
Non-Medical Transportation: Transportation to and from services your child is receiving in local and public community locations.

YOUR CHILD'S RIGHTS WHILE PARTICIPATING IN THE CSEDW PROGRAM

You and your child have the following rights while participating in the CSEDW program:

- Choice between Home and Community Based Services (HCBS) instead of receiving care in an institutional setting.
- Choice of which providers you want to provide services to your child.
- The right to address dissatisfaction with services through the CSEDW provider's grievance process.
- The right to access the state fair hearing process consistent with state and federal law.
- The right to be free from abuse, neglect and exploitation including financial exploitation.
- The right to be notified and attend any and all of your child's Plan of Care (POC) meetings, including Significant Life Event meetings.
- The right to choose who you wish to attend your child's POC meetings, in addition to those attendees who are required to attend by regulation.
- The right to obtain advocacy if you choose to do so.
- The right to file a complaint regarding the results of your child's annual reassessment for eligibility.
- The right to have all assessments, evaluations, treatments and Plans of Care explained in a way that your child can understand, even if your child has a legal representative making final decisions in regard to their care.
- The right to make decisions regarding your child's services.
- Receive reasonable accommodations afforded to your child under the Americans with Disabilities Act (ADA).

YOUR CHILD'S RESPONSIBILITIES WHILE PARTICIPATING IN THE CSEDW PROGRAM

You and your child have the following responsibilities while participating in the CSEDW program:

- To be present during POC meetings. The individual must be present and stay for the entire meeting if they are their own legal representative.
- To understand this is an optional program and that not all needs may be able to be met through the services available within this program.
- To participate and give correct information in the annual assessments for determination of medical eligibility.
- To participate in treatment as outlined on the POC.
- To comply with all CSEDW policies including monthly home visits by the Wraparound Facilitator.
- To implement portions of the POC for which they have accepted responsibility.
- To maintain a safe home environment for all service providers.
- To notify your Wraparound Facilitator immediately if the child's living arrangements change, their needs change, they are hospitalized or if there is a need for a Significant Life Event meeting.

Non-compliance with these responsibilities may jeopardize the child's continuation of CSEDW services and may result in discharge from the program.

ADDITIONAL INFORMATION ABOUT APPEALS, GRIEVANCES, COMPLAINTS AND FAIR HEARINGS FOR THE CSEDW PROGRAM

This information is in addition to the information regarding appeals, grievances, complaints, and the state fair hearing process outlined in a previous section of this handbook.

An individual receiving services has the right to get oral and written information from their providers about complaints and grievance policies. If you or your child are dissatisfied with a provider or the quality of their services, you will need to follow that agency's complaint and grievance process. If you are unable to resolve the issue with the agency, you may file a provider complaint directly with the DoHS Secretary's office.

Aetna Better Health defines a complaint as an expression of dissatisfaction made about the MCO decision or services received from the MCO when an informal grievance is filed; some complaints may be subject to appeal. Complaints are handled as outlined in the complaint section above and reported at least quarterly or more often if needed. Grievance is defined as an expression of dissatisfaction, either in writing (formal) or orally (informal), regarding any aspect of service delivery provided or paid for by the MCO, other than those MCO actions that are subject to appeal. The term grievance also refers to the overall system that includes grievances and appeals handled at the MCO level and access to the state fair hearing process.

The MCO will complete an investigation for all grievances received and report the results to the Bureau for Medical Services as the agency who oversees the CSEDW program and to the individual receiving services or their parent/legal representative.

OVERVIEW OF THE CSEDW INCIDENT REPORTING GUIDELINES

There may be times while your child is receiving CSEDW services when you or someone involved with your child's care will need to report an incident to protect the safety of your child or others. These situations are called critical and non-critical incidents.

Critical incidents are very serious and indicate a potential for harm or risk to your child's safety. In the event of a critical incident a report is filed and submitted to CSED team and to the Bureau of Medical Services. The team is required to ensure that there is resolution of the incident and is also responsible for tracking and identifying trends.

Although non-critical incidents are not harmful to your child, they will also be reported. Reporting an incident helps answer why the incident happened, what is needed to keep it from happening again. It also allows the team to see and find any trends.

Remember. both critical and non-critical incidents need to be reported. In the tables below, you will find the information and examples of critical and non-critical incidents.

CRITICAL INCIDENTS

Critical Incident Types and Definitions	
Critical Incident Type	**Description**

Suspected Abuse	Examples include, but are not limited to:
	• **Physical Abuse:** Injury or punishment to a child that results in physical pain or injury.
	  ○ Hitting, smacking, slapping, punching, pinching, scratching, biting, kicking
	  ○ Physical restraint or holding the child down causing injury
	• **Sexual Abuse:** Having a child participate in sexual activity that he or she does not fully understand, is unable to agree to, is not prepared for, or is illegal
	  ○ Unwanted touching
	  ○ Fondling
	  ○ Sexual threats
	  ○ Sexually inappropriate remarks or jokes
	  ○ Any other sexual activity when the child is not able to understand, cannot agree to, is threatened, or physically forced to engage in sexual activity
	• **Mental Abuse:** Verbal, written or gestured communications that could cause shame, make them feel bad about themselves, cause embarrassment, or cause emotional distress resulting in damaged psychological growth and development.
	  ○ Constant rejection, ignoring
	  ○ Belittle, dominate, and criticize

Critical Incident Types and Definitions	
Critical Incident Type	**Description**
	○ Yelling or swearing ○ Name calling, insults, mocking ○ Threats, intimidation ○ Isolating ○ Humiliating
Suspected Neglect	Neglected child means a child: A) Whose physical or mental health is harmed or threatened by a refusal, failure, or inability of the child's parent, guardian, or caretaker to give the child necessary food, clothing, shelter, supervision, medical care, or education, when that refusal, failure, or inability is not due primarily to a lack of financial means on the part of the parent, guardian, or caretaker. B) Who is currently without necessary food, clothing, shelter, medical care, education, or supervision because of the disappearance or absence of the child's parent or caretaker. Examples include, but are not limited to: • Neglect: The caretaker does not provide for the child's basic needs or does not seek help with providing the child's basic needs like: ○ Food ○ Shelter ○ Housing conditions ○ Clothing ○ Medical services ○ Supervision
Missing Person	When the responsible caregiver and/or provider cannot locate the child, there is reason to believe the child may be lost or in danger, or the child left their home without permission, and they cannot be located.
Serious Medication or Dietary Error	Errors involving medication prescribed by a doctor or medication management by CSEDW providers, or a life-threatening reaction to a medication or food that requires medical attention in an ER, urgent care center, or hospital. • Regardless of whether medication is taken by the child by themselves or if they get help from staff, examples of medication errors include, but are not limited to: ○ Given at a time other than scheduled ○ Not by the prescribed route ○ Wrong medication was given ○ Incorrect dosage is taken ○ Medication not given

Critical Incident Types and Definitions	
Critical Incident Type	**Description**
Homicidal Action Plan	Your child is planning to kill someone and has a detailed plan to kill someone else, or they are violent toward someone with the potential to result in injury or death. If there is an imminent threat, 911 must be activated.
Suicidal Action Plan	Your child is planning to kill themselves, is violent or participates in self-harming behavior that results in injury. If there is an imminent threat, 911 must be activated.

Unnatural or Unexpected Death	The end of life due to unnatural or unexpected causes. The cause of death is not due to a terminal diagnosis or diagnosed disease process where the expected outcome is death.
	• Examples include, but are not limited to:
	  ○ Death from suicide, homicide, medical complications, medical errors, an undiagnosed condition, criminal activity, or an accident
	  ○ Death that is suspicious due to possible abuse or neglect

Event Involving Police/Emergency Personnel Intervention	An incident in which the police or emergency personnel are required to intervene.
	• Examples include, but are not limited to:
	  ○ Crisis intervention involving law enforcement
	  ○ Your child and/or provider is arrested for, charged with, or convicted of a crime
	  ○ Unplanned fire or emergency evacuation
	  ○ Your child files police report and/or is the victim of a crime

Other	Incidents or conditions not included above that are serious in nature and are an immediate risk to the health, safety, or welfare of your child or others.

REPORTABLE EVENTS

Reportable Event Types and Definitions	
Reportable Event Type	**Description**

Minor Injury or Risk of injury	Injuries needing medical attention. Minor injuries do not create a risk of potential death, disability, or effect quality of life. Minor injuries that only require an ice pack or ibuprofen are not reportable, but your CSEDW Wraparound Facilitator should still be told.
	
	Risk of injury would include behaviors that happen over and over again, that are new to your child and have not yet resulted in problems but are reviewed by the Child and Family Team.
	• Examples include, but are not limited to:
	  ○ Falls that need medical attention
	  ○ Sunburn requiring medical treatment or need for a doctor's appointment
	  ○ Patterns of self-harming behavior such as cutting themselves, picking at wounds or banging their head

Suspected Financial Exploitation	Illegal or improper use of a child's money. This includes cashing a child's checks without permission or misusing or stealing a child's money or belongings.
	• Other examples include, but are not limited to:
	  ○ Tricking your child into giving away money
	  ○ Stealing money or items
	  ○ Forging signatures on checks
	  ○ Using your child's money without permission
	  ○ Denying your child access to his/her own home or money
	  ○ Forcing your child to sign contracts or other legal documents

Unplanned Hospital Admission or Emergency Room (ER) or Emergency Department (ED) Visit	Admission to a medical hospital when it's not related to a planned surgery or the natural course of a serious illness. This may include use of an ER or ED that results in admission to a medical hospital.
	• Examples include, but are not limited to:
	  ○ Use of an urgent care center or other clinic for emergency medical treatment or treatment of a serious medical condition (e.g., stroke, broken bone, lacerations that require stitches, heart attack, etc.)
	  ○ Use of an ER or ED

Reportable Event Types and Definitions	
Reportable Event Type	**Description**

Natural or Expected Death	The end of life due to natural or expected causes. The cause of death is due to a terminal diagnosis or diagnosed disease process where the expected outcome is death.
	• Examples include, but are not limited to:
	  ○ Death due to an acute or long-standing disease process
	  ○ Death from a motor vehicle accident
	  ○ An increased chance of death due to diabetes, cancer, advanced heart disease, acquired immune deficiency syndrome (AIDS), serious infection, etc.
	  ○ Death of your child who has been receiving hospice care or treatment for end-stage disease

Medication Refusal or Medication Error Not Requiring Medical Attention	Your child refuses to take prescribed medications or misses a medication dose that does not create a health risk or issue. Medication refusal is considered a non-critical incident; however, if medication refusal results in a need for medical attention in an ER, urgent care center, or hospital admission, this must be reported as a critical incident. If your child does not follow their care plan and they are not making progress in the CSED program, waiver services can be discontinued. While refusing to take medication by itself would not necessarily mean the child is not making progress, it may indicate they are not willing to participate in overall treatment.
Sexually Transmitted Diseases (STDs)	If your child is diagnosed with an STD and there is suspected abuse, this must be reported under the critical incident type "suspected abuse." Also, if your child is under the age of consent the diagnosis should also be reported as potential abuse and investigated by law enforcement.

Now that you understand what critical incidents and reportable events are, it is important for you to know that both of these types of events are reportable and may be investigated. All agencies providing CSEDW services or supports to your child must have policies they follow to report and investigate critical incidents and reportable events when necessary.

In addition to reporting, all CSEDW providers and Aetna staff assisting with your child's services and supports are mandated reporters. This means that if suspected abuse, neglect or exploitation occurs with your child, it must be reported to the Centralized Intake Unit within the Adult and Child Protective Services unit which is under the Bureau of Social Services (BSS). It must also be reported to Aetna Better Health.

If you witness abuse, neglect, exploitation, or any type of critical incident regarding your child, please report it to the Centralized Intake Unit as soon as possible by calling **1-800-352-6513**. Additional information is available at the DoHS website: **https://dhhr.wv.gov/bcf/Services/Pages/Centralized-Intake-for-Abuse-and-Neglect.aspx.**

If a situation is life threatening, call local law enforcement or 911 before you report the situation to the Centralized Intake Unit and Aetna Better Health.

Any critical incident or reportable incident will also need to be reported to Aetna Better Heath as soon as possible by calling **959-299-6206**. When reporting to the Centralized Intake Unit or to Aetna Better Health, you will need to report as much detail as possible regarding the incident including: the date of the incident, the location, parties involved and specific information about what happened.

If an incident is reported on behalf of your child by a provider agency or Aetna Better Health staff, the Aetna Better Health staff assigned to your case will notify you about what happened and will also notify the agencies assigned to provide CSEDW services to your child so this can be addressed by your Child and Family Team.

Remember, the most important thing is the health and safety of your child, so if you are questioning whether or not to report an issue, please report it so that everyone involved in your child's care can be made aware of what happened.

All information about who to contact with questions about the CSEDW program can be found at the following website: **dhhr.wv.gov/bms/Programs/WaiverPrograms/CSEDW/Pages/SED.aspx**

IMPORTANT CONTACT INFORMATION

This table provides information about services that members can call for support. For information about other services you may need, you can call us at **1-888-348-2922**.

Entity	Description	Phone Number	Address	Hours
Emergency	If you have a medical or behavioral health emergency, dial **911** right away.	**911**		24/7
Suicide & Crisis Lifeline	If you are having thoughts about self-harm or a mental health or substance use crisis dial **988** right away.	Dial **988**		24/7
Aetna Behavioral Health Crisis Line	If you are having thoughts about self-harm or a mental health or substance use crisis call our Behavioral Health Crisis Line.	**1-888-348-2922,** press option 1	500 Virginia Street East, Suite 400 Charleston, WV 25301	24/7
Aetna 24-Hour Nurse Line	If you have a medical question, our 24-hour nurse line can help you decide what kind of treatment you need.	**1-855-200-5975**		24/7
Aetna Better Health Member Services	Available to answer questions about your health care needs and services to help you.	**1-888-348-2922**	500 Virginia Street East, Suite 400 Charleston, WV 25301	24/7
Aetna Better Health Care Management and Behavioral Health	Get in touch with a Case Manager to help you with ongoing medical or behavioral health needs.	**1-888-348-2922**	500 Virginia Street East, Suite 400 Charleston, WV 25301	8am – 5 pm, M-F
Aetna Better Health Complaints/ Grievances/ Appeals	Available to assist in filing a complaint or appeal, including help in completing forms, offering auxiliary aid or interpreters, and other services.	**1-888-348-2922**	Aetna Better Health of West Virginia Box 81139 5801 Postal Road Cleveland, OH 44181	8am –5 pm, M-F
Aetna Better Health Fraud, Waste, and Abuse	The Special Investigation Unit investigates cases of suspected fraud, waste, or abuse by an Aetna Better Health member or provider.	**1-888-348-2922**	500 Virginia Street East, Suite 400 Charleston, WV 25301	8am – 5 pm, M-F
Aetna Better Health Medical Management	Available to assist with Utilization management or prior authorization questions.	**1-888-348-2922**	500 Virginia Street East; Suite 400 Charleston, WV 25301	8:30 am –5 pm, M-F

BMS - West Virginia Bureau for Medical Services	The state agency that administers the Medicaid program.	**304-558-1700**	Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301	8am – 5 pm, M-F
County Department of Human Services (DoHS)	The DoHS office in your county of residence can help you apply for various benefits.	**1-877-716-1212**	Find your county office online at dhhr.wv.gov/pages/field-offices.aspx	8:30 am– 5:00 pm, M-F
Children with Serious Emotional Disorder (CSED) Waiver – Acentra Health	Acentra Health processes CSED waiver requests. Acentra Health was formerly Kepro.	**1-844-304-7107**	wvcsedw@kepro.com	
Dental - Liberty Dental	Call Liberty Dental to answer questions related to dental benefits and to connect you to a dental service provider.	**1-800-267-6610 (TTY: 711)**	Call for information	8 am – 5 pm, M-F
Prescription Drugs - Gainwell Technologies	Gainwell can answer questions related to prescription drug benefits for Medicaid members.	**1-888-483-0797,** press option 1		8 am – 7 pm, M-F
Socially Necessary Services (SNS) Program – Acentra Health	Acentra Health processes SNS service requests. Acentra Health was formerly Kepro.	**1-800-461-9371**	wv_bh_sns@kepro.com	
State Fair Hearing	Available to answer questions about requesting a state fair hearing.	**304-558-1700**	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301	8am – 5 pm, M-F
Transportation (non-emergent) – Modivcare	Provides non-emergency transportation services.	**1-844-549-8353**	602 Virginia Street East Charleston, WV 25301	24/7
Vision - VSP	Call VSP to answer questions related to vision benefits and connect you to a vision service provider.	**1-877-666-2188**	Call for information	9 am – 8 pm, Mon-Sat
WV 211 (get help with food, housing, utility bills, etc.)	Call or go online to find resources such as food or housing in your area	Dial **211**	Online at **www.wv211.org**	24/7
WV Tobacco Quitline	The WV Tobacco Quitline can help you take steps to stop using tobacco.	**1-800-QUIT-NOW** (1-800-784-8669)	Call for information	24/7

APPENDIX A: IMMUNIZATION CHARTS

Immunizations are important to keep your child healthy. The tables on the following pages provide the CDC recommended immunization schedules for children up to age eighteen (18). Please visit https://www.cdc.gov/vaccines/hcp/imz-schedules/child-adolescent-age.html for detailed notes and recommendations on this immunization schedule. Compliant versions of these immunization schedules can also be found at this link.

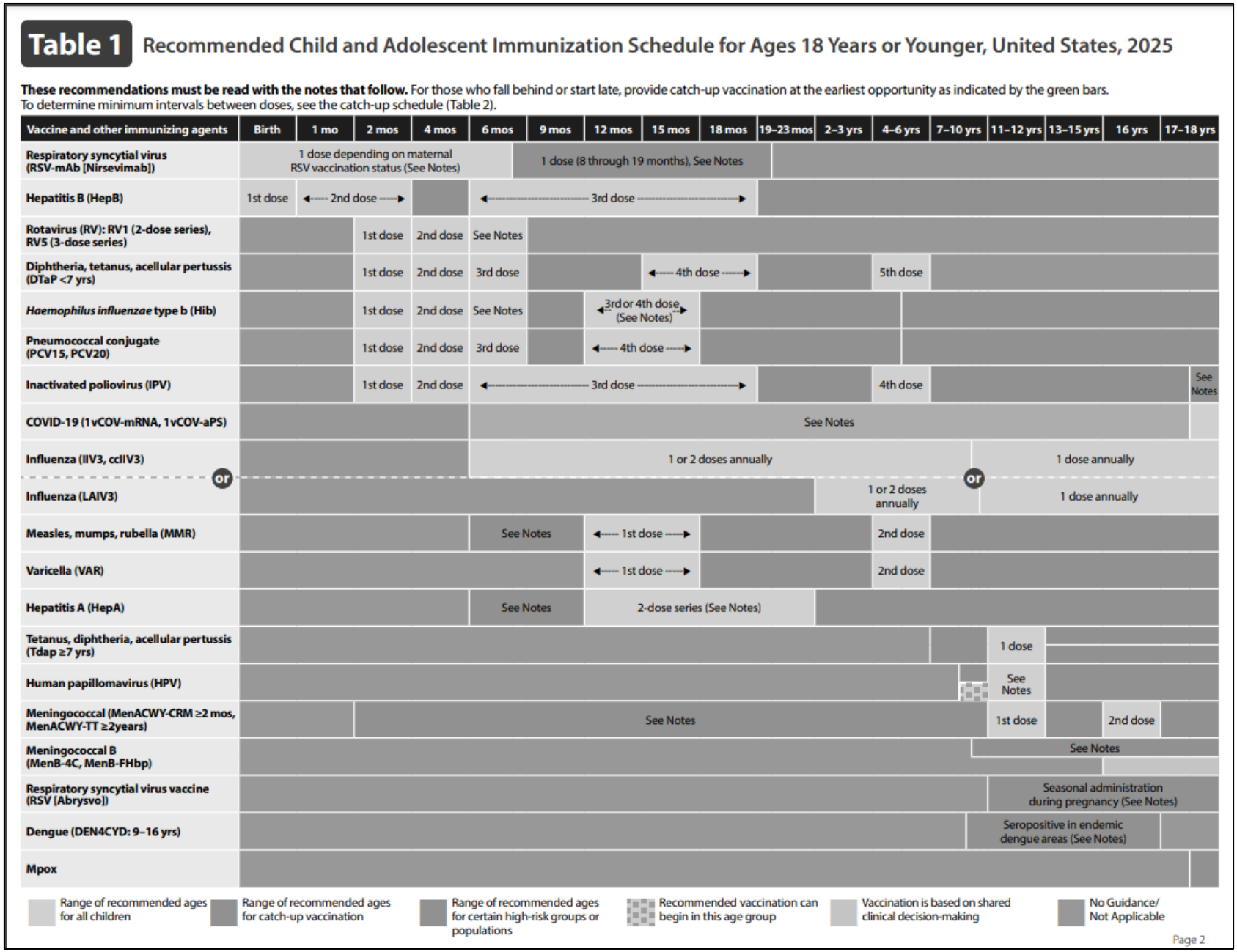


Table 1 Recommended Child and Adolescent Immunization Schedule for Ages 18 Years or Younger, United States, 2025

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars.
To determine minimum intervals between doses, see the catch-up schedule (Table 2).

Vaccine and other immunizing agents	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos	18 mos	19–23 mos	2–3 yrs	4–6 yrs	7–10 yrs	11–12 yrs	13–15 yrs	16 yrs	17–18 yrs
Respiratory syncytial virus (RSV-mAb [Nirsevimab])	1 dose depending on maternal RSV vaccination status (See Notes)					1 dose (8 through 19 months), See Notes											
Hepatitis B (HepB)	1st dose	◄---- 2nd dose ----►			◄---------- 3rd dose ----------►												
Rotavirus (RV): RV1 (2-dose series), RV5 (3-dose series)			1st dose	2nd dose	See Notes												
Diphtheria, tetanus, acellular pertussis (DTaP <7 yrs)			1st dose	2nd dose	3rd dose			◄---- 4th dose ----►				5th dose					
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See Notes		◄-- 3rd or 4th dose (See Notes) --►										
Pneumococcal conjugate (PCV15, PCV20)			1st dose	2nd dose	3rd dose		◄---- 4th dose ----►										
Inactivated poliovirus (IPV)			1st dose	2nd dose	◄---------- 3rd dose ----------►							4th dose					See Notes
COVID-19 (1vCOV-mRNA, 1vCOV-aPS)					See Notes												
Influenza (IIV3, ccIIV3)					1 or 2 doses annually									1 dose annually			
or													or				
Influenza (LAIV3)											1 or 2 doses annually			1 dose annually			
Measles, mumps, rubella (MMR)					See Notes		◄---- 1st dose ----►					2nd dose					
Varicella (VAR)							◄---- 1st dose ----►					2nd dose					
Hepatitis A (HepA)					See Notes		2-dose series (See Notes)										
Tetanus, diphtheria, acellular pertussis (Tdap ≥7 yrs)														1 dose			
Human papillomavirus (HPV)														See Notes			
Meningococcal (MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See Notes											1st dose		2nd dose	
Meningococcal B (MenB-4C, MenB-FHbp)														See Notes			
Respiratory syncytial virus vaccine (RSV [Abrysvo])														Seasonal administration during pregnancy (See Notes)			
Dengue (DEN4CYD: 9–16 yrs)														Seropositive in endemic dengue areas (See Notes)			
Mpox																	

Range of recommended ages for all children
Range of recommended ages for catch-up vaccination
Range of recommended ages for certain high-risk groups or populations
Recommended vaccination can begin in this age group
Vaccination is based on shared clinical decision-making
No Guidance/ Not Applicable

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Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 Month Behind, United States, 2025

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the Notes that follow.**

Children age 4 months through 6 years					
Vaccine	**Minimum Age for Dose 1**	**Minimum Interval Between Doses**			
		Dose 1 to Dose 2	**Dose 2 to Dose 3**	**Dose 3 to Dose 4**	**Dose 4 to Dose 5**
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose** minimum age for the final dose is 24 weeks		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** maximum age for final dose is 8 months, 0 days		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months** A fifth dose is not necessary if the fourth dose was administered at age 4 years or older ***and*** at least 6 months after dose 3
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix), Vaxelis or unknown **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; **OR** if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; **OR** if both doses were PedvaxHIB and were administered before the 1st birthday	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older **4 weeks** if first dose was administered before the 1st birthday **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older **4 weeks** if current age is younger than 12 months ***and*** previous dose was administered at <7 months old **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); **OR** if current age is 12 months or older ***and*** at least 1 dose was administered before age 12 months	**8 weeks (as final dose)** This dose is only necessary for children age 12 through 59 months regardless of risk, or age 60 through 71 months with any risk, who received 3 doses before age 12 months.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years **6 months (as final dose)** if current age is 4 years or older	**6 months (minimum age 4 years for final dose)**	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday	**6 months** if first dose of DTaP/DT was administered before the 1st birthday	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older ***and*** at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years **OR** if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older			
Dengue	9 years	**6 months**	6 months		

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2025

Always use this table in conjunction with Table 1 and the Notes that follow. Medical conditions are often not mutually exclusive. If multiple conditions are present, refer to guidance in all relevant columns. See Notes for medical conditions not listed.

Vaccine and other immunizing agents	Pregnancy	Immunocompromised (excluding HIV infection)	HIV infection CD4 percentage and count[a]		CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Heart disease or chronic lung disease	Kidney failure, End-stage renal disease or on dialysis	Chronic liver disease	Diabetes
			<15% or <200/mm³	≥15% and ≥200/mm³						
RSV-mAb (nirsevimab)		2nd RSV season		1 dose depending on maternal RSV vaccination status (See Notes)			2nd RSV season for chronic lung disease (See Notes)	1 dose depending on maternal RSV vaccination status (See Notes)		
Hepatitis B										
Rotavirus		SCID[b]								
DTaP/Tdap	DTaP Tdap: 1 dose each pregnancy									
Hib		HSCT: 3 doses	See Notes			See Notes				
Pneumococcal										
IPV										
COVID-19		See Notes		See Notes						
Influenza inactivated		Solid organ transplant: 18yrs (See Notes)								
LAIV3							Asthma, wheezing: 2–4 years[c]			
MMR	*									
VAR	*									
Hepatitis A										
HPV	*	3-dose series (See Notes)								
MenACWY										
MenB										
RSV (Abrysvo)	Seasonal administration (See Notes)									
Dengue										
Mpox	See Notes									

Recommended for all age-eligible children who lack documentation of a complete vaccination series

Not recommended for all children, but recommended for some children based on increased risk for or severe outcomes from disease

Vaccination is based on shared clinical decision-making

Recommended for all age-eligible children, and additional doses may be necessary based on medical condition or other indications. See Notes.

Precaution: Might be indicated if benefit of protection outweighs risk of adverse reaction

Contraindicated or not recommended
*Vaccinate after pregnancy, if indicated

No Guidance/ Not Applicable

a. For additional information regarding HIV laboratory parameters and use of live vaccines, see the General Best Practice Guidelines for Immunization, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote J) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

b. Severe Combined Immunodeficiency

c. LAIV3 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

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Aetna Better Health®
Notice of Privacy Practices

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

This notice took effect on September 1, 2025..

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

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

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

How we use and share your health information

Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care, this could be doctors or drug stores.

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

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

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

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

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

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

Sharing with other businesses

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

Other reasons we might share your health information

We also may share your health information for these reasons:

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

Once health information is shared for any of the reasons above it may potentially be reshared or used for purposes not in this document.

Some state and federal laws may require additional limits on how we use and disclose sensitive health information like mental health or communicable diseases. We will follow the most strict law that applies to your health information.

Reasons that we will need your written okay

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

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

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

What are your rights?

You have the right to look at your health information.

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

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

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

You have the right to get a list of people or groups that we have shared your health information with.

You have the right to ask for a private way to be in touch with you.

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

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

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

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

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

Call us at the toll-free number on your member ID card to:

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

You also have the right to send us a complaint. If you think your privacy rights were violated, write to us at PrivacyAetna@AETNA.com or:

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

You also can file a complaint with the Department of Health and Human Services, Office for Civil Rights. Call us to get the address.

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

Protecting your information

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

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

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

Will we change this notice?

By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. We will mail you the notice if a material change is made. You can get a copy of the most recent notice on our web site at **https://www.aetnabetterhealth.com/privacy-center.html.**

Aetna Better Health® of West Virginia

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, health status or need for health care services.

Aetna:

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

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

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

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

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

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

This notice is available at the Aetna Better Health website: **AetnaBetterHealth.com/WestVirginia**.

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

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

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

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

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104** (ATS : **711**).

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

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104**)للصم والبكم: **711**(.

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

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

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

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

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

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**).

NEPALI: ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि गन:शुल्क रूपमा भाषा सहायता सेवाहरू उपलब्ध छन्। तपाईंको आइडी कार्डको पछाडि रहेको नम्बर वा **1-800-385-4104** (TTY: **711**) मा फोन गर्नुहोस्।

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104**)TTY: **711**(تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

URDU: توجہ دیں: اگر آپ اردو زبان بولتے ہیں، تو زبان سے متعلق مدد کی خدمات آپ کے لئے مفت دستیاب ہیں ۔ اپنے شناختی کارڈ کے پیچھے موجود نمبر پر یا **1-800-385-4104**)TTY: **711**(پر رابطہ کریں۔

Aetna Better Health of West Virginia
500 Virginia Street East, Suite 400
Charleston, WV 25301

Member Services
1-888-348-2922 (TTY: **711**)

AetnaBetterHealth.com/WestVirginia

86.07.339.1-WV

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