AETNA BETTER HEALTH®

Description of coverage

The Managed Care Reform and Patient Rights Act of 1999 established rights for members in health care plans. These rights cover the following:

- What emergency room visits will be paid for by your health care plan.
- How specialists (both in and out of network) can be accessed.
- How to file complaints and appeal health care plan decisions
- How to obtain information about your health care plan, including general information about its financial arrangements with providers.

You are encouraged to review and familiarize yourself with these subjects and the other benefit information in the attached Description of Coverage Worksheet. Since the Description of Coverage is not a legal document, for full benefit information, please refer to your contract or certificate, or contact your health care plan at the toll-free number on the next page. In the event of any inconsistency between your Description of Coverage and contract or certificate, the terms of the contract or certificate will control.

For general assistance and information, please contact the Illinois Department of Healthcare and Family Services at **1-800-226-0768**. (Please be aware that the Illinois Department of Healthcare and Family Services will not be able to provide specific plan information. For this type of information you should contact your health care plan directly.)

Description of Coverage Worksheet

Service Area

Members must live in the following counties to be able to enroll with Aetna Better Health:

- Suburban Cook (areas with ZIP codes that do not begin with “606”)
- DuPage
- Kane
- Kankakee
- Lake
- Will
- Additional counties as approved by the Illinois Department of Healthcare and Family Services

Exclusions and Limitations

Some services are excluded from this plan. The following are some excluded services. For more information call Member Services at **1-866-212-2851**.

- Experimental procedures
- Cosmetic procedures or surgeries
- Infertility testing and treatment
- Consultation requested by a third party or agency
- Acupuncture

Pre-certification and Utilization Review

For non-emergency care, the member’s Primary Care Provider (PCP) must participate in and concur with inpatient hospital stays by pre-approving elective admissions, outpatient surgery and specialty services. In addition to the PCP’s pre-approval of elective admissions, hospital admissions require the authorization of the Health Plan’s Medical Director or designated Utilization Management (UM) department representative. The PCP or specialist must make the necessary arrangements for hospitalization, outpatient procedures or other services if medically necessary as defined in the certificate of coverage.

Emergency Care

In an emergency, a member immediately should seek medical care by calling **9-1-1** or going to the nearest hospital emergency department. Medically necessary emergency services are covered regardless of whether or not the emergency services are provided by a participating provider. Medically necessary post-stabilization medical services provided by a non-participating provider are covered if either pre-approved by the Health Plan or if the Health Plan does not deny approval for such post-stabilization medical services within one hour of the non-participating provider’s good faith attempt to obtain approval for such services from the Health Plan.

Primary Care Provider (PCP) Selection

Members must choose a Primary Care Provider (PCP) from the provider directory available at the time of enrollment. The member’s PCP is the member’s medical home responsible for providing and coordinating care, making recommendations for specialty care and other services. Members may change this PCP by calling Member Services at **1-866-212-2851**.

Out-of-Area Coverage
Out-of-area coverage is available only for emergency care. Once the condition has stabilized, the member must return to the service area as soon as medically appropriate to receive continuing and/or follow up covered services.

Access to Specialty Care
A PCP may recommend a participating specialist provider for a member for medically necessary covered services. A member may see a participating specialist provider for medically necessary covered services if the specialist obtains approval from the health plan first. In some situations, a participating specialist may request a standing authorization.

If the health plan determines a request for authorization from a specialist is appropriate for medically necessary services and a qualified specialist who is a participating provider does not exist, the Health Plan may approve an authorization to a specialist who is not a participating provider, however, the specialist must be an Illinois Medical Assistance Program Provider.

Female members may see, in addition to a PCP, a family practitioner, obstetrician/gynecologist, or Woman's Health Care Provider (WHCP) without a referral for all covered services. At the request of any WHCP the Health Plan shall follow Health Plan utilization and quality assurance procedures and protocols in evaluating the WHCP as a PCP.

Members do not need a prior approval to access some covered services if the provider participates in the health plan's network. This includes Emergency Services, Behavioral Health, Vision and Dental. Additionally, members may obtain family planning serves from out of network providers.

Financial Responsibility
There are no co-payments, deductibles or premiums payable by the member for covered, eligible care.

Continuity of Care
Subject to certain conditions, a new member, who either requires an ongoing course of treatment or who is in her second or third trimester of pregnancy, may request to continue to see their existing Provider even if this provider is not contracted with Aetna Better Health until ninety (90) days after the effective date of coverage, in the case of an ongoing course of treatment, and including post-partum care directly related to delivery in the case of pregnancy.

Subject to certain conditions, if an existing member's participating provider leaves the Health Plan's network and the existing member is either receiving an ongoing course of treatment from the participating provider, or the existing member is in her second or third trimester of pregnancy and is receiving care from the participating provider, the existing member may request to continue to see that provider for ninety (90) days from the date the Health Plan notifies member that the provider is leaving the Health Plan's network.

In either case, in order for services rendered to a member by a provider to be covered by the Health Plan, the provider must agree to the health plan's Quality Improvement and Utilization Plan policies and

procedures, and payment. If services requested are denied and the member would like to appeal, the member must make their request within thirty (30) days of being notified of the denial. The Health Plan will respond in writing fifteen (15) days of receiving all required information with approval or the specific reason for denial of the request.

Grievance and Appeal Process

All grievances and appeals must first be submitted to the Health Plan for resolution, but may later by appealed to the Illinois Department of Human Services. For administrative issues, members may submit grievances in writing or by calling Member Services. A resolution to the grievance will be mailed to the member, unless it is handled orally and informally. If the member is not satisfied with the resolution, he or she can appeal the grievance decision. The member will be notified of the appeal decision. Information on this process will be included in the communication to the member.

For clinical issues, members may appeal decisions, which will be evaluated by a Health Plan committee that includes a clinical peer who was not involved in the original decision. In all appeals, the member and provider will be notified orally and in writing within a time period to be determined by the nature of the appeal, e.g. Expedited or Non-Expedited. Information at each step of this process will be included in any communication to the member.

Members may call **1-866-212-2851** to receive more information concerning the appeal process and request assistance with filing a grievance or appeal.

A member not satisfied with the Health Plan's resolution of any appeal may request a fair hearing by the Illinois Department of Healthcare and Family Services at the following location:

Illinois Department of Healthcare and Family Services
Bureau of Administrative Hearings
401 S Clinton Street, 6th Floor
Chicago, IL 60607
1-800-435-0774 (TTY: **1-877-734-7429**)

IMPORTANT: In the event of any inconsistency between your Description of Coverage and certificate of coverage, the terms of the contract or certificate will control.

Plan Name: **Aetna Better Health Inc., an Illinois Corporation**
Address: **One South Wacker Drive**
Mail Stop F646
Chicago, IL 60606

Toll-Free Telephone Number: **1-866-212-2851.**

Description of Coverage

*Some limitations apply. Please see your Certificate of Coverage or call Member Services for additional information.

Basics	Your Doctor	Selection of PCP should occur at the time of enrollment. Changes may be made by calling Member Services.		
	Annual Deductible	None		
	Out-of-Pocket	None		
	Lifetime Maximums	None		
	Pre-existing Condition Limitations	None		
		Description of Coverage	**Health plan Covers**	**You Pay**
In the Hospital	Number of Days of Inpatient Care	All	100%	0%
	Room & Board	All	100%	0%
	Surgeon's Fee	All	100%	0%
	Doctor Visits	All	100%	0%
	Medications		100%	0%
	Other Miscellaneous Charges	Medically necessary and eligible services including laboratory, radiology and supplies provided by the hospital.	100%	0%
Emergency Care	Emergency Services	Medical condition manifesting itself by acute symptoms of sufficient severity (including but not limited to, severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.	100%	0%
	Emergency Post-	Services provided to a member that	100%	0%

	Stabilization Services	are furnished in a licensed hospital by a provider that is qualified to furnish such services, and determined to be medically necessary and directly related to the emergency medical condition following stabilization.		
In the Doctor's Office	Doctor Office Visits	Primary Care and Specialist	100%	0%
	Routine Physical Exams	Covered	100%	0%
	Diagnostic Tests & X-rays	Covered	100%	0%
	Immunizations	Covered	100%	0%
	Allergy Treatment & Testing	Covered	100%	0%
Medical Services	Outpatient Surgery	Covered	100%	0%
	Maternity Care -Hospital Care -Physician Care	 Covered Covered	 100% 100%	 0% 0%
	Infertility Services	Not Covered		
	Mental Health -Outpatient -Inpatient	 Covered Covered	 100% 100%	 0% 0%
	Substance Abuse -Outpatient -Inpatient	 Covered Covered	 100% 100%	 0% 0%
	Outpatient Rehabilitation Services	Covered	100%	0%
	Hospice	Covered	100%	0%
	Home Health Care	Covered	100%	0%
	Pharmacy and Prescription Drugs	Covered • 90-day supply of prescription drugs mailed to your home. • Expanded coverage of OTC medications for all members.	100%	0%
	Skilled Nursing	Covered	100%	0%
	Durable Medical Equipment	Covered with Prior Authorization	100%	0%
	Chiropractic	Covered; limits apply	100%	0%
Other Services	Dental Services	Covered • Dental cleaning two times a year for adults • "Practice visits" if needed	100%	0%

		• Mobile dental services for members in intermediate care facilities and nursing homes		
	Vision Care	Covered; limits apply	100%	0%
	Medical Transportation	Covered • Includes rides to provider visits • Includes rides to pharmacy if immediately following a provider visit • Includes transportation for a personal attendant or caregiver	100%	0%

www.aetnabetterhealth.com/illinois