AETNA BETTER HEALTH® OF ILLINOIS

Managed Long Term Service and Support (MLTSS)
Member Handbook

Your benefits

www.aetnabetterhealth.com/illinois

IL 16 06 04

Helpful information

Aetna Better Health
Member Services
1-855-849-3201
Representatives available 24 hours a day,
7 days a week

Address
Aetna Better Health
333 West Wacker Drive, Suite 2100
Mail Stop F646
Chicago, IL 60606

Services for the Hearing Impaired
Illinois Relay 711

Enrollment and Application Services
Illinois Client Enrollment Services
1-877-912-8880
1-866-565-8576 (TTY)

Transportation Services
Medical Transportation Management, Inc.
1-888-513-1612

Dental Services
DentaQuest
1-800-416-9185

Behavioral Health Services
1-855-849-3201

Vision Services
March Vision
1-888-493-4070

Pharmacy Services
Call Member Services
1-855-849-3201

Prescriptions by Mail
CVS
1-855-271-6603
1-800-863-5488 (TTY)
Monday through Friday
8 a.m.- 8 p.m. EST

Language Interpretation Services
Including Sign Language Interpretation
and CART Reporting
Call Aetna Better Health Member Services
1-855-849-3201
Representatives available 24 hours a day,
7 days a week

Grievance and Appeals
Aetna Better Health
Attn: Appeals and Grievance Manager
333 West Wacker Drive, Suite 2100
Mail Stop F646
Chicago, IL 60606
1-855-849-3201
Illinois Relay 711

To make a request for a fair hearing:
Illinois Department of Healthcare
and Family Services
Bureau of Administrative Hearings
69 W. Washington Street
4th Floor
Chicago, IL 60602
1-855-418-4421

Fraud and Abuse Hotline
1-877-436-8154

Reporting Abuse, Neglect and Exploitation
Adult Protective Services (APS)
1-866-800-1409
1-888-206-1327 (TTY)

Personal information

My member ID number

My primary care provider (PCP)

My provider's phone number

www.aetnabetterhealth.com/illinois

AETNA BETTER HEALTH® OF ILLINOIS

MEMBER HANDBOOK

Managed Long Term Support and Services (MLTSS)

Welcome to Aetna Better Health - Managed Long Term Support and Services (MLTSS). The program is for adults and older adults with disabilities, ages 21 and over, who are eligible for Medicare and Medicaid. You'll receive your Medicaid waiver services through Aetna Better Health, along with a few extra benefits but you have opted to use another health plan for your Medicare benefits which include services such as preventive care, specialty care, emergency care and inpatient care.

Members enrolled with Aetna Better Health must live in one of the following counties:

- Cook
- Kane
- DuPage
- Will
- Kankakee

This member handbook also has your Certificate of Coverage (below), which is required by state law. The effective date of this Certificate of Coverage is the same as the date shown on the front of your Aetna Better Health identification card.

How to use your member handbook and Certificate of Coverage

Please read this entire member handbook very carefully. Much of the information in different sections of this handbook is related. Reading just a few of the items or pages may not help you fully understand what you may want to know.

This Certificate of Coverage may be subject to amendment, modification, or termination by mutual agreement between Aetna Better Health, an Illinois corporation ("health plan") and the Illinois Department of Healthcare and Family Services ("department") without your consent. You will be notified of any such changes as soon as possible after they're made.

By choosing or accepting health care coverage under Aetna Better Health, an Illinois corporation, members agree to all the terms and conditions in this Certificate of Coverage.

CERTIFICATE OF COVERAGE

This certificate is issued by Aetna Better Health, an Illinois corporation, operating as a health maintenance organization (HMO). In consideration of the member's enrollment, Aetna Better Health shall provide and/or arrange for covered health care services to the member in accordance with the provisions of this Certificate of Coverage.

IN WITNESS WHEREOF, Aetna Better Health of Illinois has caused this Certificate of Coverage to be executed by its duly authorized officer on the date indicated below, under which certificate coverage will begin on the effective date indicated on the member's Aetna Better Health identification card.

EFFECTIVE DATE: Aetna Better Health Inc., an Illinois Corporation

By: _____
(Title)

TABLE OF CONTENTS

HELPFUL PHONE NUMBERS

Topic	Contact Information
Other communication methods Please call Member Services if you want information in other formats. We have audio CD-ROM, large print and Braille.	**1-855-849-3201**
Behavioral health crisis 24 hours a day, 7 days a week	**1-855-849-3201**
Behavioral health services For questions about benefits or help finding a behavioral health provider, call Member Services.	**1-855-849-3201**
Complaints, grievances or appeals If you have a complaint, grievance or appeal, call Member Services.	**1-855-849-3201**
Claims For questions about claims or bills, call Provider Services.	**1-855-849-3201**
Emergency If you have a medical condition that could cause serious health problems or even death if not treated immediately.	Call **911** or go immediately to the emergency room.
Enrollment and disenrollment Call the Illinois Client Enrollment Services if you have questions about eligibility or enrollment.	**1-877-912-8880** TTY **1-866-565-8576**
Hearing impaired (TDD/TTY)	Illinois Relay **711**
Interpreter services Language interpretation services, including sign language, are available free of charge. Call Member Services for help.	**1-855-849-3201** or **1-866-340-7229**
Transportation Medical Transportation Management (MTM) For non-emergency transportation.	**1-855-849-3201** or **1-888-513-1612**

WELCOME TO AETNA BETTER HEALTH® OF ILLINOIS

Managed Long Term Support and Services (MLTSS)

Thank you for choosing Aetna Better Health as your health plan.

If you have questions, call our Member Services Department at **1-855-849-3201**. Member Services can answer questions about your health benefits. We're here to help you, 24 hours a day, 7 days a week.

Member information

Your health is important to us. Read this handbook. It has good information about your health care services such as:

- How our Member Services Department can help you
- Why it's important to have a primary care provider (PCP) as your medical home
- Which services Aetna Better Health pays for
- Which services Aetna Better Health doesn't pay for
- How to get care and services
- Your rights and responsibilities
- How to make appointments with health care providers
- How to file a grievance or an appeal
- How to plan for your care if you can't tell providers what you want

Member services department

If you have questions, you can call Member Services at **1-855-849-3201**. We're here 24 hours a day, 7 days a week. We can answer your questions and give you information. Below is a list of some of the things we can help you with:

- Your rights and responsibilities
- Finding a health care provider for your needs
- Making an appointment with your PCP
- Coordinate with your other health plan if you want to change your PCP
- How to get care from other providers
- Your health care services
- Filing a grievance or appeal
- Making an address, telephone or email address change
- Getting a free interpreter (language services, including sign language)
- Getting information in a language other than English
- Getting information in other ways, like audio CDs, large print or Braille
- Getting a ride to your provider appointments
- Getting behavioral health care
- Coordinating with your other health plan for your dental and vision care, along with getting your medications
- Getting medical supplies
- Where to get help for domestic violence or elder abuse

Please call us at **1-855-849-3201** for help.

Language services

If you speak another language and need interpreter services call **1-855-849-3201**. We'll get you an interpreter in your language. We can also help if you need sign language interpretation. You can also use this service at your health care provider's office. This service is available at no cost to you.

You can get this member handbook in another language, call Member Services at **1-855-849-3201**.

Other ways to get information

If you're deaf or hard of hearing, please call the Illinois Relay at **711**. Illinois Relay can help in many ways:

- TTY users
- TTY users (Spanish)
- Voice users
- VCO (Voice Carry Over)
- Speech to speech
- ASCII (American Standard Code for Information Interchange)
- Telebraille

If you have a hard time seeing or hearing, or you don't read English, you can get information in the following ways:

- Audio CD
- Large print
- Braille

Website
Our website is: **www.aetnabetterhealth.com/illinois**. It has information to help you get health care.

- Find a health care provider in your area
- Send us questions through email
- Get information about your benefits
- Get health information
- Get a copy of the member handbook

Enrollment

Open enrollment
During open enrollment you can choose any health plan that you wish. One health plan that will coordinate both your Medicare and Medicaid benefits or you can choose to have one health plan coordinate your Medicare benefit and another your Medicaid benefit. Our care coordinator can help you coordinate your Medicare and Medicaid benefits.

If you're new to Aetna Better Health, you have 90 calendar days from when you first sign up with us to try our health plan. You can change health plans for any reason. You can change monthly or annually, whatever you choose.

You can change health plans at a certain time every year. Each year, at the end of your enrollment year, you'll get a letter from the Illinois Client Enrollment Services. The letter will say that you can change plans if you want to. The letter will give you the dates that you can do this. You'll have 60 calendar days to make a change. This 60 day period is called "open enrollment." You don't have to change health plans, but you can if you want to. If you choose to change plans during open enrollment, you'll be a member in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay with Aetna Better Health, you'll be locked in that plan for the next 12 months.

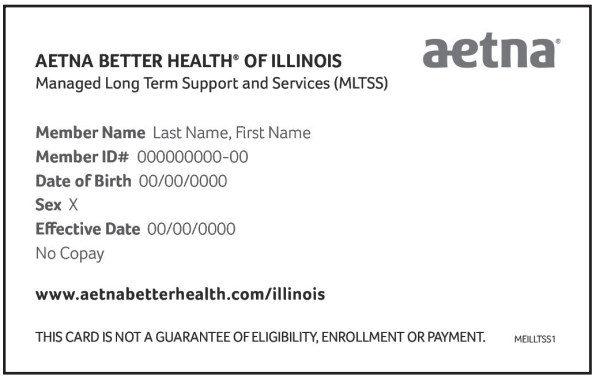
ID card
You'll get an ID card when you join. You need this ID card to get health care. Keep your ID card in a safe place. Show it whenever you need health care services.

Please call us at **1-855-849-3201** if:

- You don't have an ID card
- You lose your ID card

We'll send you a new ID card.

You're the only one who can use your ID card. Don't give, loan or sell your ID card to anyone. Don't give the information on the ID card to anyone. If you give your card to someone, you could have problems getting health benefits.


AETNA BETTER HEALTH® OF ILLINOIS
Managed Long Term Support and Services (MLTSS)

aetna

Member Name Last Name, First Name
Member ID# 000000000-00
Date of Birth 00/00/0000
Sex X
Effective Date 00/00/0000
No Copay

www.aetnabetterhealth.com/illinois

THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEILLTSS1


IMPORTANT INFORMATION FOR MEMBERS

Member Services	1-855-849-3201 (24 hours/7 days a week)
Hearing Impaired	Illinois Relay 711
Behavioral Health Services	1-855-849-3201
Transportation Services	1-888-513-1612

IMPORTANT INFORMATION FOR PROVIDERS
To verify member eligibility please call **1-855-849-3201**.

Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call **1-855-849-3201**.

Send Medical Claims To
Aetna Better Health
PO Box 66545
Phoenix, AZ 85082-6545

Aetna Better Health
Payer ID 26337
Provider Claims Questions
1-855-849-3201

ILLTSS1

Privacy notice

Your welcome packet has a Notice of Privacy Practices. It says how we use your personal information. It tells how you can get copies of your health records. It shows how to make changes in your records. Your health care information is private. We'll only give it out if the law allows or if you let us give it out. For another copy for our Notice of Privacy Practices, please call Member Services at **1-855-849-3201** or go to **www.aetnabetterhealth.com/illinois**.

Member rights and responsibilities

You have rights and responsibilities as a member. You can use all of your member rights without being treated differently. You can use all of your member rights without losing any health care services.

You have the right to information about your treatment or treatment options. You have a right to get this information in a language you understand. This information includes the following things:

- Names of health care providers and care managers
- Copies of medical records as allowed by law
- A description of our services or covered benefits
- A description of your rights and responsibilities as a member, including the right to refuse treatment
- How we provide for after-hours and emergency health care services
- How we pay providers and manage costs
- How you can use services
- Member survey
- Grievance results
- How much a service will cost you if it's not covered
- How to get services
- What type of authorization may be needed for services
- A description of how we evaluate new technology for inclusion as a covered benefit
- What treatment choices or types of care are available to you, and the benefits or drawbacks of each choice
- Informing you about your right to make advance directives
- Health care benefit or network changes

You also have a right to respect, fairness and dignity. This includes the following rights:

- To get covered services without concern about payer source, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, ability to pay, or ability to speak English
- Quality medical services that support your beliefs, medical condition and background
- Interpreter services if you don't speak English or you have impaired hearing
- Written information in other formats (e.g., audio CD-ROM, large print, Braille)
- To be free from any form of restraint or seclusion

You have a right to make decisions about your health care. You can also have a representative, such as a family member or friend make decisions on your behalf. This includes the following rights:

- To choose a participating primary care provider (PCP) to help with planning and coordinating care
- To see a women's health care provider (WCHP) without a referral
- Timely access to providers and care from a specialist when it's needed
- To know about all treatment options, no matter what they cost or whether they're covered
- To be told about any risks in your care
- To be told in advance if a proposed care or treatment is part of a research experiment and the right to refuse experimental treatments
- To change your PCP
- To request specific, condition-related information from a PCP
- To request information about procedures and who will perform them
- To decide who should be in attendance at treatments and examinations
- To choose to have a female in the room for breast and pelvic exams

- To refuse a treatment, including leaving the hospital, even though a provider advises against it, and to request an explanation of consequences. Eligibility or medical care doesn't depend on your agreement to follow a treatment plan
- To stop taking medications
- To receive written notification when health care services are reduced, suspended, terminated or denied. Notification has instructions on how to file a grievance or request a fair hearing from the Illinois Department of Health and Family Services (DHFS).

You have a right to seek emergency care and specialty services. This includes the following rights:

- Getting emergency services without prior approval in an emergency
- Getting services from a specialist with a recommendation from your PCP
- Refusing care from a specialist you were referred to and request another recommendation
- Getting a second opinion

You have a right to confidentiality and privacy. This includes the following rights:

- Private and confidential health care information
- Information only given out as allowed by law
- Getting a copy of your medical records
- Asking for changes to your records
- Asking how your health care information has been given out
- Talking to providers and care managers privately

You have a right to report your concerns. This includes the following rights:

- Filing a complaint or grievance against Aetna Better Health or our providers
- Asking for a state fair hearing
- Asking for changes to policies and services
- Getting a detailed explanation if you're denied care that you think you should receive

You have the following responsibilities:

- Knowing the name of your PCP and/or care manager
- Knowing your coverage and the rules you must follow to get care
- Telling us about any changes in eligibility, or any other information that may affect your membership, health care needs or access to benefits
- Respecting those who are providing services to you
- Sharing any concerns, questions or problems with us
- Providing all health information needed by providers
- Asking questions if you don't understand a treatment plan or health condition
- Following instructions and guidelines agreed upon with providers
- Protecting your ID card and showing it when you get health care
- Telling us about other insurance you have and about other benefits you may be eligible for
- Scheduling appointments during office hours, when you can
- Arriving at appointments on time
- Telling your providers when you have to cancel an appointment
- Following your providers' instructions
- Providing consent to managed care plans, health care providers and their designees for the purpose of providing patient care management, outcomes improvement and research

Getting care

Aetna Better Health members must use in-network, contracted providers to obtain health care services.

Copays

Aetna Better Health members don't pay copays for any standard Medicaid services or additional services offered by us, such as transportation for services covered under our plan.

Providers may not bill Aetna Better Health members for any services or copayments. If you do receive a bill from a provider, call Member Services at **1-855-849-3201**. A Member Services representative will help you.

Provider directory
Our provider directory is online at **www.aetnabetterhealth.com/illinois**. If you want help finding a provider for any of your covered services, call Member Services at **1-855-849-3201**. They'll be glad to help you.

Your medical home
A medical home is the place where your primary care provider (PCP) is located. Aetna Better Health will contract with that Provider or will find an in network provider for you. Aetna Better Health Member Services representatives and case managers will help you coordinate your waiver services through your PCP/ medical home.

Your provider's office
When you see your provider, ask him or her and the office staff, the questions listed below. By knowing the answers, you'll be better prepared for getting health care services.

- What are your office hours?
- Do you see patients on weekends or at night?
- What kinds of special help do you offer for people with disabilities?
- (If you're hearing impaired) Do you have sign language interpreters? **Note**: if your provider's office doesn't have sign language interpreters, Aetna Better Health can provide you with a sign language interpreter at no cost to you. Call us at **1-855-849-3201** at least three days before your appointment and ask to arrange for a sign language interpreter at your provider office visit.
- Will you talk about problems with me over the phone?
- Who should I contact after hours if I have an urgent situation?
- How long do I have to wait for an appointment?

Waiver Services

A waiver is a program that provides services that allow individuals to remain in their own home or live in a community setting. Every member who receives waiver services will be assigned to a Care Coordinator who can assist them.

Our Care coordinators can help you with different needs. They can put you in touch with community services that you may find helpful:

- Understanding your waiver benefits
- Setting up health care appointments
- Setting up rides to appointments
- Making sure you can get needed health care services
- Helping you understand paperwork from your provider
- Support groups, if needed
- Becoming Active in your community

For more information call Member Services at **1-855-849-3201**.

Services for members with visual impairments
Our care coordinators can help you with different needs. They can put you in touch with community services that you may find helpful:

- Making sure you can get member information on audio CD, in large print or in Braille
- Setting up health care appointments
- Rides to health care appointments
- Making sure you can get needed health care services
- Helping you understand paperwork from your provider
- Support group, if needed

For more information call Member Services at **1-855-849-3201**.

Transportation services
If you need a ride to your health care visits, please call Member Services at **1-855-849-3201**. If you need a family member or personal care attendant to ride with you, they can at no cost to you.

If you have a medical emergency, dial 911. Use of emergency transportation must be for emergencies only and will be paid for by your health plan covering your Medicare benefits.

You need to set up a ride at least three days before your visit.

Prior authorization

Some services must be approved before you can get them. This is called "prior authorization." If your provider thinks you need a service, they'll ask us for prior authorization. Our medical staff makes decisions about the care and services you need. These decisions are based on three things:

- Your medical needs
- National clinical guidelines
- Information from your provider

If you're new to Aetna Better Health, we'll honor prior authorizations of services from Medicaid or another health plan for 90 calendar days after you join.

Call Member Services at **1-855-849-3201** if you have questions about this.

Prior authorization steps

- Your provider contacts us by phone, fax or online to ask for prior authorization. They tell us about the service and why you need it.
- Our medical staff looks at the information to decide if the service can be approved. They may talk more with your provider.
- If the service is approved, we tell your provider.
- If the service isn't approved, we send a letter to you and your provider. This is called a "Notice of Action letter." It explains the decision.
- You and your provider can get a copy of the medical reasons used to make a denial decision.
- If you disagree with the decision, you can file an appeal or ask for a State Fair Hearing. See "Grievance and Appeals" on page 15 to learn more.

We don't reward a provider for denying, limiting or delaying coverage of health care services. We don't give money to staff that make medical necessity decisions to get them to turn down services.

You don't pay for medically necessary covered services. You may have to pay when we don't cover the service provided. Your provider should tell you that a service isn't covered before you get it.

What's medical necessity?
When your provider asks for prior authorization, they must tell us why the service is medically necessary.

A service is medically necessary if it meets the descriptions below:

- It's appropriate
- It's considered by other health professionals to be good medical practice
- It meets Aetna Better Health guidelines, policies and procedures
- It's used to diagnose or treat a covered illness or injury
- It's used to prevent an illness
- It's used to help you get well or stay well

This definition also applies to supplies.

Covered services

Services covered by Aetna Better Health are listed below. Some limitations and prior authorization requirements may apply. If you have questions about covered services, call Member Services at **1-855-849-3201**.

Type of care	Covered services	Coverage and benefit limitations
Behavioral Health	**Mental health services including but not limited to:** • Mental health assessment and/or psychological evaluation • Medication management • Community mental health center services, including community support • Therapy/counseling **Alcohol and substance abuse treatment, including but not limited to:** • Outpatient treatment • Intensive outpatient treatment • Residential treatment • Detoxification • Psychiatric evaluation	Covered benefit.
Transportation	To health care provider visits, including behavioral health visits	Covered benefit. To schedule a ride Monday - Saturday from 8 a.m. - 6 p.m. Central time. Please set up a ride at least three days before your appointment.
Nursing home	Nursing facility coverage	Covered benefit. Provides custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and using the bathroom, as well as meals, laundry, and other housekeeping needs.

Value added benefits

Value added services covered by Aetna Better Health are listed below. Some limitations and prior authorization requirements may apply. All services must be medically necessary.* If you have questions about covered services, call Member Services at **1-855-849-3201**.

Extra covered services – Aetna Better Health of Illinois	Description of coverage: MLTSS
Cell phone benefit	Cell phone benefit is covered for free calls to our Member Services, 350 free minutes per month, unlimited text messaging, free health-related texts and texts from the health plan. Benefit for members who qualify for the federal free cell phone program.
Health education	Wide array of health and education tools and programs that are available to you at no additional cost
Meal benefit (expanded benefit)	Prior authorization is required. Ten home-delivered nutritional meals after in-patient hospitalization or nursing home stay
Nursing hotline	Access to a registered nurse 24 hours a day, 7 days a week, 365 days a year
Over-the-counter drugs	$10 per month through mail order catalog service; no carry-overs
Respite care (expanded benefit)	16 hours per month of in-home care
Smoking cessation (expanded benefit)	Medically necessary cessation counseling sessions (up to 50 per year), nicotine patches, gum, and lozenges, as well as certain pharmacy medications without needing prior authorization
Transportation (expanded benefit)	To plan-approved locations
Weight management (adult) – (expanded benefit)	Includes health coaching

Below are the waiver services that we cover:

Agency	Waiver program	Services
Illinois Department on Aging (IDoA)	Elderly waiver also known as the aging waiver community care program	• Adult day service • Adult day service transportation • Homemaker • Personal emergency response system
Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with disabilities waiver also known as the disabilities waiver	• Adaptive equipment • Adult day service • Adult day service transportation • Environmental • Accessibility adaptations • Home delivered meals • Home health aide • Homemaker • Nursing-skilled, intermittent • Personal assistant • Personal emergency response system • Physical, occupational, and speech therapy • Respite • Nursing -skilled
The Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with brain injury waiver also known as the brain injury waiver or TBI waiver	• Adaptive equipment • Adult day service • Adult day service transportation • Behavioral services • Day habilitation • Environmental accessibility adaptations • Home delivered meals • Home health aide • Homemaker • Nursing-skilled • Nursing -skilled, intermittent • Personal assistant • Personal emergency response system • Physical, occupational, and speech therapy • Prevocational services • Respite • Supported employment

Agency	Waiver program	Services
Division of Rehabilitation Services within DHS (DHS-DRS)	Persons with HIV or AIDS waiver also known as the AIDS waiver	• Adaptive equipment • Adult day service • Adult day service transportation • Environmental accessibility adaptations • Home delivered meals • Home health aide • Homemaker • Nursing-skilled • Nursing-skilled, intermittent • Personal assistant • Personal emergency response system • Physical, occupational, and speech therapy • Respite
Illinois Department of Healthcare and Family Services (HFS)	Supportive living facilities waiver also known as the SLF or SLP waiver	Also known as assisted living service

Out-of-area coverage

Aetna Better Health covers members who live in the following counties:

Cook, Kane, DuPage, Will and Kankakee

If you plan to take a trip away from home, please call your care manager or Member Services at **1-855-849-3201** so we can help you stay healthy while you're away.

Aetna Better Health doesn't cover services outside of the United States.

Sometimes the care you need isn't close to where you live. In these cases, we may approve health care services in another county. Aetna Better Health will only pay for these services if we approve them first.

Health tips

Below is a list of some useful health tips:

- See your PCP for regular checkups
- Always go to your PCP visits. If you can't keep your appointment, call to cancel it and make another one
- Follow the directions your PCP gives you
- If you take prescription medicine every day, get refills at least five days before you run out
- Never share your medicine with anyone else
- Eat right, get enough sleep and exercise
- Brush your teeth at least two times a day
- Always wear your seat belt when you're in a car

Health guidelines for adults

Adults need regular checkups to stay healthy. Here are some important tests and checkups. These services won't be covered by Aetna Better Health, but your other Medicare health plan will. It's very important to take care of yourself.

Health Exams	
Age 19-25 26-39 40-49 50-65 65 and older	**How often** Every 5 years Every 5 years Every 3 years Every 1-2 years Every 1-2 years
Mammogram	Every year for women starting at age 40.
Pap tests (cervical cancer screening)	Every one to three years for women starting at age 19 or when sexually active. Frequency may decrease when there's no history of abnormal pap tests and three or more tests are normal.
Prostate exams	For men starting at age 40. Frequency to be determined by the PCP based on individual circumstances.
Diabetes screening	Test at age 45 for adults with no symptoms and then every three years.
Shots (immunizations) Check with your provider to see if you need any of these shots.	• TD (tetanus and diphtheria) • Pneumococcal (pneumonia) • Influenza (flu) • Hepatitis A and B • MMR (measles, mumps and rubella) • Varicella (chicken pox) • Meningococcal (meningitis)

Complaints, grievances and appeals

We want you to be happy with services you get from us and our providers. If you aren't happy, you can file a grievance or appeal.

Grievances

A grievance is a complaint about any matter other than a denied, reduced or terminated service or item.

Aetna Better Health takes member grievances very seriously. We want to know what's wrong so we can make our services better. If you have a grievance about a provider or the quality of care or services you have received, you should let us know right away. We have special procedures in place to help you file grievances. We'll do our best to answer your questions or help to resolve your concern. Filing a grievance won't affect your health care services or your benefits coverage.

These are examples of when you might want to file a grievance:

- Your provider or an Aetna Better Health staff member didn't respect your rights
- You had trouble getting an appointment with your provider in an appropriate amount of time
- You were unhappy with the quality of care or treatment you received
- Your provider or an Aetna Better Health staff member was rude to you
- Your provider or an Aetna Better Health staff member was insensitive to your cultural needs or other special needs you may have

You can file your grievance on the phone by calling Member Services at **1-855-849-3201**. You can also file your grievance in writing via mail or fax at:

Aetna Better Health
Attn: Grievance and appeals dept.
333 W. Wacker Drive, Mail Stop F646
Chicago, IL 60606
Fax: 1-855-545-5196

In the grievance letter, give us as much information as you can. For example, include the date the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your member ID number. You can ask us to help you file your grievance by calling member services at **1-855-849-3201**.

If you don't speak English, we can provide an interpreter at no cost to you. Please include this request when you file your grievance. If you are hearing impaired, call the Illinois Relay at **711**.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be "your representative." If you decide to have someone represent you or act for you, inform Aetna Better Health of Illinois in writing the name of your representative and his or her contact information.

We will try to resolve your grievance right away. If we cannot, we may contact you for more information.

Appeals
You may not agree with a decision or an action made by Aetna Better Health of Illinois about your services or an item you requested. An appeal is a way for you to ask for a review of our actions. You may appeal within **sixty (60) calendar days** of the date on our Notice of Action form. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than **ten (10) calendar days** from the date on our Notice of Action form. The list below includes examples of when you might want to file an appeal:

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

If we decide that a requested service or item can't be approved, or if a service is reduced or stopped, you will get a "Notice of Action" letter from us. This letter will tell you the following:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it and when you may have to pay for the services

Here are two ways to file an appeal.

1) Call Member Services at **1-855-849-3201**. If you file an appeal over the phone, you must follow it with a written signed appeal request.
2) Mail or fax your written appeal request to:

Aetna Better Health
Attn: Grievance and appeals dept
333 W. Wacker Drive, Mail Stop F646
Chicago, IL 60606
Fax: 1-855-545-5196

If you do not speak English, we can provide an interpreter at no cost to you. Please include this request when you file your appeal. If you are hearing impaired, call the Illinois Relay at **711**.

Can someone help you with the appeal process?
You have several options for assistance. You may:

- Ask someone you know to assist in representing you. This could be your Primary Care Physician or a family member, for example.
- Choose to be represented by a legal professional.

- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at **1-800-641-3929** (Voice) or **1-888-460-5111** (TTY).

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at: **www.aetnabetterhealth.com/illinois**.

Appeal Process
We will send you an acknowledgement letter within three business days saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing.

A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce or stop the medical service.

Aetna Better Health of Illinois will send our decision in writing to you within 15 business days of the date we received your appeal request. Aetna Better Health of Illinois may request an extension up to 14 more calendar days to make a decision on your case if we need to get more information before we make a decision. You can also ask us for an extension, if you need more time to obtain additional documents to support your appeal.

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

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

Things to keep in mind during the appeal process:

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

Can someone help you with the appeal process?
You have several options for assistance. You may:

Ask someone you know to assist in representing you. This could be your Primary Care Physician or a family member, for example.

- Choose to be represented by a legal professional.
- If you are in the Disabilities Waiver, Traumatic Brain Injury Waiver, or HIV/AIDS Waiver, you may also contact CAP (Client Assistance Program) to request their assistance at **1-800-641-3929** (Voice) or **1-888-460-5111** (TTY).
- To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information or, 2) fill out the Authorized Representative Appeals form. You may find this form on our website at: **www.aetnabetterhealth.com/illinois**.

How can you expedite your appeal?
If you or your provider believes our standard timeframe of 15 business days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Action letter, information about your case and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 24 hours to inform you of our decision and will also send you and your authorized representative the Decision Notice.

How can you withdraw an Appeal?
You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request.

Aetna Better Health of Illinois will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Aetna Better Health of Illinois at **1-855-849-3201**.

What happens next?
After you receive the Aetna Better Health of Illinois appeal Decision Notice in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing Appeal and/or asking for an External Review of your appeal within **30 calendar days** of the date on the Decision Notice. You can choose to ask for both a State Fair Hearing Appeal and an External Review or you may choose to ask for only one of them.

State Fair Hearing
If you choose, you may ask for a State Fair Hearing Appeal within **30 calendar days** of the date on the Decision Notice, but you must ask for a State Fair Hearing Appeal within **10 calendar days** of the date on the Decision Notice if you want to continue your services. If you do not win this appeal, you may be responsible for paying for these services provided to you during the appeal process.

At the State Fair Hearing, just like during the Aetna Better Health of Illinois Appeals process, you may ask someone to represent you, such as a lawyer or have a relative or friend speak for you. To appoint someone to represent you, send us a letter informing us that you want someone else to represent you and include in the letter his or her contact information.

You can ask for a State Fair Hearing in one of the following ways:

- Your local Family Community Resource Center can give you an appeal form to request a State Fair Hearing and will help you fill it out, if you wish.
- If you want to file a State Fair Hearing Appeal related to your medical services or items, or Elderly Waiver Community Care Program (CCP) services, send your request in writing to:

  Illinois Department of Healthcare and Family Services
  Bureau of Administrative Hearings
  69 W. Washington Street,
  4th Floor Chicago, IL 60602
  Fax: (312) 793-2005
  Email: HFS.FairHearings@illinois.gov
  Or you may call **1-855-418-4421**, TTY: **1-800-526-5812**

- If you want to file a State Fair Hearing Appeal related to mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service, send your request in writing to:

  Illinois Department of Human Services
  Bureau of Hearings
  69 W. Washington Street, 4th Floor
  Chicago, IL 60602
  Fax: (312) 793-8573
  Email: DHS.HSPAppeals@illinois.gov
  Or you may call **1-800-435-0774**, TTY: **1-877-734-7429**.

State Fair Hearing Process
The hearing will be conducted by an Impartial Hearing Officer authorized to conduct State Fair Hearings. You will receive a letter from the appropriate Hearings office informing you of the date, time and place of the hearing. This letter will also provide information about the hearing. It is important that you read this letter carefully.

At least three business days before the hearing, you will receive information from Aetna Better Health of Illinois. This will include all evidence we will present at the hearing. This will also be sent to the Impartial Hearing Officer. You must provide all the evidence you will present at the hearing to Aetna Better Health and the Impartial Hearing Officer at least three business days before the hearing. This includes a list of any witnesses who will appear on your behalf, as well as all documents you will use to support your appeal.

You will need to notify the appropriate Hearings Office of any accommodation you may need. Your hearing may be conducted over the phone. Please be sure to provide the best phone number to reach you during business hours in your request for a State Fair Hearing. The hearing may be recorded.

Continuance or postponement
You may request a continuance during the hearing, or a postponement prior to the hearing, which may be granted if good cause exists. If the Impartial Hearing Officer agrees, you and all parties to the appeal will be notified in writing of a new date, time and place. The time limit for the appeal process to be completed will be extended by the length of the continuation or postponement.

Failure to Appear at the Hearing
Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date and place on the notice and you have not requested postponement in writing. If your hearing is conducted via telephone, your appeal will be dismissed if you do not answer your telephone at the scheduled appeal time. A Dismissal Notice will be sent to all parties to the appeal.

Your hearing may be rescheduled, if you let us know within **10 calendar days** from the date you received the Dismissal Notice, if the reason for your failure to appear was:

- A death in the family
- Personal injury or illness which reasonably would prohibit your appearance
- A sudden and unexpected emergency

If the appeal hearing is rescheduled, the Hearings Office will send you or your authorized representative a letter rescheduling the hearing with copies to all parties to the appeal.

If we deny your request to reset your hearing, you will receive a letter in the mail informing you of our denial.

The State Fair Hearing Decision
A Final Administrative Decision will be sent to you and all interested parties in writing by the appropriate Hearings Office. This Final Administrative Decision is reviewable only through the Circuit Courts of the State of Illinois. The time the Circuit Court will allow for filing of such review may be as short as 35 days from the date of this letter. If you have questions, please call the Hearing Office.

External Review (for medical services only)
Within **30 calendar days** after the date on the Aetna Better Health of Illinois appeal Decision Notice, you may choose to ask for a review by someone outside Aetna Better Health of Illinois. This is called an external review. The outside reviewer must meet the following requirements:

- Board certified provider with the same or like specialty as your treating provider
- Currently practicing
- Have no financial interest in the decision
- Not know you and won't know your identity during the review

External Review is not available for appeals related to services received through the Elderly Waiver; Persons with Disabilities Waiver; Traumatic Brain Injury Waiver; HIV/Aids Waiver; or the Home Services Program.

Your letter must ask for an external review of that action and should be sent to:

Aetna Better Health of Illinois
Attn: Grievance and appeals dept.
333 W. Wacker Dr.Chicago IL, 60606
1-855-849-3201

What happens next?

- We will review your request to see if it meets the qualifications for external review. We have five business days to do this. We will send you a letter letting you know if your request meets these requirements. If your request meets the requirements, the letter will have the name of the external reviewer.
- You have five business days from the letter we send you to send any additional information about your request to the external reviewer.

The external reviewer will send you and/or your representative and Aetna Better Health of Illinois a letter with their decision within five calendar days of receiving all the information they need to complete their review.

Expedited external review
If the normal time frame for an external review could jeopardize your life or your health, you or your representative can ask for an expedited external review. You can do this over the phone or in writing. To ask for an **expedited external review** over the phone, call Member Services at **1-855-849-3201**. To ask in writing, send us a letter at the address below. You can only ask one time for an external review about a specific action. Your letter must ask for an external review of that action.

Aetna Better Health
Attn: Grievance and Appeals Dept
333 W. Wacker Drive, Mail Stop F646
Chicago, IL 60606

What happens next?
Once we receive the phone call or letter asking for an expedited external review, we will immediately review your request to see if it qualifies for an expedited external review. If it does, we will contact you or your representative to give you the name of the reviewer. We will also send the necessary information to the external reviewer so they can begin their review. As quickly as your health condition requires, but no more than two business days after receiving all information needed, the external reviewer will make a decision about your request. They will let you and/or your representative and Aetna Better Health of Illinois. Know what their decision is verbally. They will also follow up with a letter to you and/or your representative and Aetna Better Health of Illinois. With the decision within 48 hours.

The Medicare Beneficiary Ombudsman also shares information with the Secretary of Health and Human Services, Congress, and other organizations about what does and doesn't work well to improve the quality of the services and care you get through Medicare.

If you've contacted **1-800-MEDICARE** about a Medicare-related inquiry or complaint but still need help, ask the Medicare representative to send your inquiry or complaint to the Medicare Ombudsman's Office. The Medicare Ombudsman's Office helps make sure that your inquiry or complaint is resolved.

Fraud and abuse

You must report any member or provider fraud, waste or abuse. The Department of Healthcare and Family Services' Office of the Inspector General (OIG) audits and investigates fraud and abuse. The OIG is responsible for the following:

- Investigating providers suspected of overbilling or defrauding the Illinois Department of Healthcare and Family Services Medical Program
- Recovering overpayments
- Issuing administrative sanctions
- Referring cases of suspected fraud for criminal investigation

You can make a report over the phone. Call the:

Welfare and Medical Fraud Hotline
Monday - Friday (except state holidays)
8:30 a.m. - 5 p.m.
1-844-453-7283

Here are examples of member fraud:

- Lending, selling or giving your Aetna Better Health MLTSS ID card to someone else
- Changing the information on your ID card by any means other than calling Member Services to get a new ID card
- Changing information on a prescription

Here are examples of provider fraud:

- Billing for services that weren't given
- Ordering services that aren't medically necessary
- Referring members to an emergency room or other services when it's not medically necessary

You don't have to give your name when you call. If you do give your name, the person you're reporting won't be told that you called.

Advance directives

A time may come when you're too sick to talk to your provider, family or friends. You may not be able to tell anyone what kind of health care you want. It's important to plan for this kind of situation.

Even if you're not sick or injured now, you should think about what kind of care you would want if you couldn't speak for yourself. This is where advance directives can help. Advance directives are legal documents that tell your providers and family what you want for end-of-life care.

There are several kinds of advance directives.

Living will
A living will is a legal document that tells others your wishes for care that could keep you alive if you were in danger of dying. This care might include life support systems, such as:

- Breathing machines
- Tube feeding
- Resuscitation if your breathing or heartbeat stops
- Dialysis if your kidneys stop working

Health care power of attorney
A health care power of attorney is a document in which you choose a person to make health care decisions for you if you can't make them for yourself. You must give this person permission in writing to make your health care decisions for you.

Mental health treatment preference declaration
A mental health treatment preference declaration lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you want to be admitted to a mental health facility for up to 17 days of treatment.

Do not resuscitate (DNR) orders
You can also ask your PCP to help you make a Don't Resuscitate, or DNR, order. A DNR order is an order for medical treatment that says cardiopulmonary resuscitation, or CPR, won't be used if your heart and/or breathing stops. If this is something you want, talk to your PCP about helping you with a DNR order.

Please note: you don't have to make an advance directive to receive medical care. You can still get health care if you don't have advance directives. This includes being admitted to a hospital or other facility. But most hospitals strongly encourage you to have them.

More details on the types of advance directives in Illinois are in your welcome packet.

Other information

- If you don't have an advance directive, talk to your PCP. Or call Member Services at **1-855-849-3201** for information.
- An advance directive is part of your medical record.
- Give all of your providers a copy of your advance directives.
- An advance directive doesn't require a lawyer. You may still want to talk to one to get the best advice for you.
- You may change or cancel an advance directive. Any changes should be written, signed and dated.
- If you have filled out an advance directive in another state, you must still fill out advance directives forms for the state of Illinois.
- Keep a card in your purse or wallet that says that you have an advance directive and where it's located.
- If you have a car, keep a copy of your advance directives in your car.

If you have complaints about non-compliance with advance directive laws and regulations, call the State's complaint hotline at **1-844-453-7283**.

We'll update you of any changes to the advance directive laws as soon as possible from the change date.

Changing health plans

If you're new to Aetna Better Health, you have 90 calendar days from when you first sign up with us to try the health plan. During the first 90 calendar days, you can change health plans for any reason. Within those 90 days, you can change monthly or annually.

You can change health plans at a certain time every year. Each year, at the end of your enrollment year, you'll get a letter from the Illinois Client Enrollment Services. The letter will say that you can change plans if you want to. The letter will give you the dates that you can do this. You'll have 60 calendar days to make a change. This 60 day period is called "open enrollment." You don't have to change health plans, but you can if you want to. If you choose to change plans during open enrollment, you'll be a member in the new plan at the end of your current enrollment year. Whether you pick a new plan or stay with Aetna Better Health, you'll be locked in that plan for the next 12 months.

When you change health plan, make sure your primary care provider/medical home participates in that health plan so that you don't have to find another doctor to take care of you. After you sign up with a new health plan, you'll receive a new ID card and information on that health plan in the mail.

Disenrollment

This is a required program of members receiving waiver services or that reside in a nursing home.

Illinois Client Enrollment Services is only one agency that can enroll you or disenroll you. Call the Illinois Client Enrollment Services with questions at **1-877-912-8880** or TTY **1-866-565-8576**.

Key health care terms

The list below includes definitions for health care terms.

Term	Definitions
Advance directive	A document that tells your health care provider and family how you wish to be cared for. It's used when you're too ill to make health care decisions for yourself.
Appeal	A request that you, your provider or representative can make when you don't agree with Aetna Better Health Opt Out Option's decision to deny, reduce and/or end a covered benefit or service.
Covered benefits	Health care services that are covered by Aetna Better Health Opt Out Option.
Durable medical equipment	Items such as wheelchairs and oxygen tanks.
emergency	A life-threatening or serious medical condition that must be treated right away.
Grievances	When you let us know you aren't satisfied with a provider, Aetna Better Health or a benefit. You can do this in writing or tell us verbally. Someone you appoint can file a grievance for you.
Identification card	A card that shows you're an Aetna Better Health member.
Managed care plan	A health plan like Aetna Better Health that works with health care providers to keep you well.
Medically necessary services	A service, supply or medicine that: • Is appropriate • Is considered by other health professionals to be good medical practice • Meets Aetna Better Health guidelines, policies and procedures • Is used to diagnose or treat a covered illness or injury • Is used to prevent an illness or used to help you get well or stay well
Member	A person who has chosen Aetna Better Health in the Illinois Integrated Care Program.
Prescription medicine	A drug for which your provider writes an order so you can get it filled at a pharmacy.
Primary care provider (PCP)	Your personal provider. He or she manages all your health care needs.
Prior authorization	When Aetna Better Health needs to approve health care services or medicines requested by your provider before you can get them.
Provider	Doctors, nurse practitioners, dentists, hospitals, pharmacies and laboratories that work with Aetna Better Health to provide you with health care services.
Specialist	A doctor who practices in a specific field of medicine.
Treatment	The care you get from providers and facilities.
Women's health care provider (WHCP)	A doctor, nurse practitioner or other provider who specializes in obstetrics, gynecology, or family practice selected by a female member to see as needed and without a referral.

Common questions

Q. What should I do if I don't get or lose my Member ID card?

A. Call Member Services at **1-855-849-3201** to get a new ID card.

Q. How do I know which services are covered? Not covered?

A. Please view the Covered Services section in this member handbook. You can also ask your provider. You can call Member Services for help at **1-855-849-3201**. You can also check our website at **www.aetnabetterhealth.com/illinois**.

Q. What should I do if I get a bill?

A. If you get a bill, call your provider's office. Give their staff your information. If you keep getting a bill, call Member Services for help at **1-855-849-3201**.

Q. I need help getting to my appointments. What can I do?

A. If you'ren't able to find a ride, please call Ride Right/Medical Transportation Management (MTM) at **1-888-513-1612** for help. You must call at least three days in advance to set up your ride.

Q. What's an emergency?

A. An emergency is when you have a serious medical problem. This means you're in danger of lasting harm or dying. If you have an emergency, go to the nearest hospital or call 911.

Q. Do you have urgent care?

A. Yes. If you have an urgent care need, call your PCP. At night or on weekends or holidays, your PCP's answering service will take your call. Your PCP will call you back and tell you what to do.

Q. How do I get services that aren't covered by Aetna Better Health, but are covered under my Medicaid benefits?

A. Call Member Services at **1-855-849-3201** and our staff will tell you how to get these services.