Healthy happens together

2020 Member Handbook

Learn about your health care benefits

aetna™

AetnaBetterHealth.com/Michigan

Aetna Better Health® of Michigan

86.07.324.1-MI

Important phone numbers

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

24-Hour Nurse Line
1-866-711-6664 (TTY **711**)

Emergency
911

Vision (VSP)
1-800-877-7195

Non-Emergency Transportation – Member Services
1-866-316-3784 (TTY **711**), follow prompts for transportation

Dental (DentaQuest)
1-866-316-3784

Behavioral Health Services
1-866-827-8704

Healthy Michigan Plan Beneficiary Helpline
1-800-642-3195

Aetna Better Health of Michigan

Welcome and thank you for choosing Aetna Better Health of Michigan as your health plan. We have a strong network of doctors, hospitals and other health care providers. They offer a wide range of services to meet your health care needs.

It's important that you understand how our plan works. This Member Handbook has information you need to know about your Medicaid benefits.

Please take the time to read it carefully. You can also download a copy from our website **AetnaBetterHealth.com/Michigan**.

Our Member Services department is always ready to answer your questions. Just call **1-866-316-3784**, TTY **711**, Monday – Friday, 8 AM to 5 PM.

We look forward to serving you.

Sincerely,

Beverly Allen
Executive Director

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Section 1: Important information about your Medicaid and MIChild coverage

About your coverage

This handbook contains the facts you need to know about your Medicaid and MIChild benefits. MIChild members have the same services as Medicaid as of January 1, 2016.

Cost for MIChild:

- Most families will pay $10 per family per month for MIChild coverage. There are no co-pays for MIChild or Medicaid Aetna Better Health of Michigan members.

If you need to contact someone about your Aetna Better Health of Michigan coverage, please contact:

Aetna Better Health of Michigan, Member Services
1333 Gratiot Avenue, Suite 400
Detroit, Ml 48207
1-866-316-3784, TTY **711**

If you have a medical question, call our 24-Hour Nurse Hotline **1-866-711-6664**, TTY **711**. Get answers to your medical questions 24/7. They'll help answer questions about your symptoms. They will also tell you what you need to do.

Please make sure you read and understand the complaints/grievance and appeals procedures in this handbook. Please read it before taking any other action. Contact information for complaints/grievances and appeals:

Aetna Better Health of Michigan, Attn: Appeals Coordinator
1333 Gratiot Avenue, Suite 400
Detroit, Ml 48207
1-866-316-3784, TTY **711**

Does your child have other insurance?

If your dependent has more than one type of insurance coverage, please let us know. We may manage benefits so your child can get the highest payment on claims.

Your child may be eligible for coordination of benefits if:

- He or she has health care or prescription drug coverage through some other type of insurance, such as
  - automobile insurance.
  - home owner's insurance.
  - workers' compensation.
- He or she is covered by Medicare.
- He or she is covered by coverage through their other parent's health care plan.
- Your spouse is employed and has coverage through his or her employer.

Call Member Services at **1-866-316-3784**, TTY **711** , so that we can work together to make sure your child has full coverage.

Members reaching adulthood

Members reaching adulthood can receive assistance with finding an adult primary care provider. Call Member Services at **1-866-316-3784**, TTY **711**.

Members changing their health insurance coverage

Members who are changing from Fee-for-Service (FFS) Medicaid or from another health insurance plan to Aetna Better Health of Michigan can continue to receive services covered under their previous plan, in certain circumstances. Members may be able to keep their current providers during this time. For more information, contact Member Services at **1-866-316-3784**, TTY **711**.

Communication/translation services

We want to make sure you understand your benefits. Members Services can help if you:

- Have problems hearing
  - Call, TTY **711**.
  - Aetna Better Health of Michigan can arrange for interpreters for situations requiring communication between hearing and deaf persons.
  - If you need a sign language interpreter, we can arrange this service.
- Have vision problems
  - You can request this Handbook in another format including Braille or on tape.
- Have problems reading
  - You can request another format or an interpreter.
- Do not speak English
  - You can request materials translated in another language.

Interpreter services

If you do not speak or understand English, call **1-866-316-3784** to ask for help. We will get you an interpreter when needed. All Interpreter services are free.

Other languages spoken at provider offices

If you speak a language other than English, please check our provider directory for a provider who speaks your language. If you need a free provider directory, we can mail you one. Just call Member Services at **1-866-316-3784**, TTY **711**. You can also go to **AetnaBetterHealth.com/Michigan** for a provider list. For the most up-to-date information, just visit our website and select "Find a Provider."

Non-emergency transportation

If you need a ride to your appointment, Aetna Better Health may help you. Aetna Better Health will cover transportation to and from visits to your doctor, behavioral health provider, pharmacy and other medically necessary appointments. You can also get paid for your gas to get to and from these visits.

Just call Member Services at **1-866-316-3784**, Monday to Friday, 8 AM to 5 PM, and follow the prompts for transportation to schedule transportation.

If possible, call at least three working days (not including Saturdays, Sundays, and holidays) before your scheduled appointment. If you have an urgent appointment and need transportation, we will work to get you a ride the same day if at all possible.

When you call for transportation or gas reimbursement, please have ready:

- Your name, address and telephone number.
- Your Aetna Better Health ID number.
- Address and telephone number of where you are going.
- Type of appointment, provider's name, date and time of appointment.

To learn more about transportation or to cancel your ride, call Member Services at **1-866-316-3784**, Monday to Friday, 8 AM to 5 PM, and follow the prompts for transportation.

If you need a ride to the hospital for emergency medical services, dial **911**.

Benefits available from the state of Michigan (not covered by Aetna Better Health)

The state of Michigan covers some services that Aetna Better Health of Michigan does not. You can contact your MDHHS worker or the Beneficiary Helpline at 1-800-642-3195 to learn how to get these benefits and services:

- Dental services except for pregnant women and postpartum women. Pregnant and postpartum women are eligible for dental coverage through Aetna Better Health.
- Custodial care in a nursing facility.
- Home- and community-based waiver program services.
  - Inpatient hospital psychiatric services.
  - Outpatient partial hospitalization psychiatric care.
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility), after the 45 days covered by Aetna Better Health.
- Pharmacy
- Services provided by a school district and billed through the intermediate school district.
- Therapy services (speech, language, physical, occupational), provided to persons with developmental disabilities which are billed through community mental health services program providers or intermediate school districts.

- Mental health services for members meeting the guidelines under Medicaid policy for serious mental illness or severe emotional disturbance.
- Personal care of home help services.
- Substance use disorder services through accredited provider including:
  - Screenings and assessments.
  - Detoxification.
  - Intensive outpatient counseling and other outpatient services.
  - Methadone treatment.
- Traumatic brain injury program services.
- Transportation to services not covered by the health plan.

Children Special Health Care Services (CSHCS)

CSHCS is a state of Michigan program that serves children, and some adults, with special health care needs. CSHCS covers more than 2,700 medical diagnoses.

Aetna Better Health of Michigan members who have CSHCS get additional benefits.

- Help from your local Health Department with:
  - Community resources, schools, community mental health, respite care, financial support, childcare, Early On and the Women, Infants and Children (WIC) program.
  - Transitioning to adulthood services.
- Help from the Family Center for Child and Youth with Special Health Care Needs
  - Call the CSHCS toll-free Family Phone Line at **1-800-359-3722**, Monday – Friday from 8 AM to 5 PM.
  - Parent-to-parent support network.
  - Parent/professional training programs.
- Financial help to go to conferences about CSHCS medical conditions and "Relatively Speaking," a conference for siblings of children with special needs.
- Help from Children's Special Needs Fund (CSN). The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS. To see if you qualify for help from the CSN Fund, call **517-241-7420**. Examples of help include:
  - Wheelchair ramps.
  - Van lifts and tie downs.
  - Therapeutic tricycles.
  - Air conditioners.
  - Adaptive recreational equipment.
  - Electrical surge upgrades for eligible equipment.

- Services that are not covered by Aetna Better Health and are only covered by CSHCS include:
  - Orthodontia services provided for certain diagnosis*.
  - Respite services*.
  - Certain over-the-counter medications.
  - Hemophilia drugs.
  - Certain orphan drugs.

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

CSHCS member transitioning to adulthood

Aetna Better Health of Michigan can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services.

Start planning for your move to adult services early around 12 years old

- Planning allows for better control of your condition
- You will know how to obtain health care and other services
- As you get older you will want your independence which is part of being an adult

You will be seeing new doctors and will need to tell them about your health

- Learn to ask for what you need
- Learn to have an active role in your health
- Understand your condition

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

You must give doctors and insurance companies approval to speak to your parents

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

Finding a new doctor

- Ask your current doctor who they would like you to see
- Your health plan has a list of providers for you to choose from
- You can change your doctor anytime you like if you are not happy

Section 2: Rights and responsibilities

Your rights and responsibilities

As a member of Aetna Better Health of Michigan, You have the right to:

- Get information about your health, PCP, our providers and Aetna Better Health services and members' rights and responsibilities.
- Request information on the Plan's structure, operations and services.
- Be treated with respect and dignity.
- Be certain that your personal information is kept private and confidential (See Notice of Privacy Practices).
- Seek advice and help.
- Discuss all treatment options for your condition, regardless of cost or benefit coverage.
- Voice grievances, complaints, appeals and offer advice about Aetna Better Health and/or the services we provide.
- Make recommendations about our members' rights and responsibilities policy.
- Choose a primary care provider (PCP) as your personal medical provider.
- Work with doctors in making decisions about your health.
- Know about a diagnosis, treatment and prognosis.
- Get prompt and proper treatment for physical and emotional problems.
- Receive discharge planning.
- Receive guidance and suggestions for more medical care if health care coverage is ended.
- Access your medical records according to state and federal law.
- Get information about how your PCP is paid. If you need more information, call Member Services at **1-866-316-3784**.
- Request an emergency PCP transfer if your health or safety are threatened.
- Receive culturally and language appropriate services.
- Request and get a copy of your medical records and request for records to be amended or corrected.
- Participate in decisions regarding your health care in a manner that you can understand, including the right to refuse treatment and express your desires about treatment options.
- Be free to exercise your rights without adversely affecting the way Aetna Better Health and its Providers or the state treats you.
- Be free from any form of restraint or isolation used as a means of force, punishment, convenience or retaliation.

- Be provided health care services consistent with the contract and state and federal rules and laws.
- Be free from other discrimination forbidden by state and federal rules and laws.

Any Native American enrolled in Aetna Better Health and eligible to receive services from an in-network Indian Health Coverage Program (IHCP) provider can choose that IHCP as his or her primary care provider. Our staff and participating providers will obey all requirements about enrollee rights.

As a member of Aetna Better Health of Michigan, you also have responsibilities. These responsibilities include:

- Giving information to the Plan, its Practitioners and Providers needed for our staff to take care of you.
- Following the care plans and instructions given to you by your doctors.
- Understanding your health condition and sharing in the decisions for your health care.
- Treating Aetna Better Health staff and doctors with respect and dignity.
- Keeping all appointments and calling to cancel them when you cannot make them.
- Understanding what medicine to take.
- Giving us feedback about your health rights and responsibilities.
- Letting us know of any changes in your name, address or telephone number.

Members have a responsibility to follow the Aetna Better Health rules. Failure to follow our rules could result in disenrollment from the Plan.

Reporting fraud, waste and abuse

You have a right and responsibility to report suspected fraud, waste and abuse. Fraud involves getting benefits or services that were not approved. Waste is spending that can be eliminated without reducing the quality of care. Abuse is doing things that result in unneeded costs.

Provider fraud may include billing for services, procedures or supplies that were not provided. Waste may include inefficient claims processing and health care administration. Abuse may include providing treatment or services that are not needed to treat an illness.

An example of member fraud would be using changed or forged prescriptions. An example of member abuse would be frequent requests for early prescription refills. An example of member waste would be unneeded emergency room (ER) visits.

If you suspect a provider, member or someone else of fraud or abuse, you can report it without giving your name. You should call our Fraud and Abuse Hotline at **1-866-806-7020**. You may also write to us at Aetna Better Health of Michigan 1333 Gratiot Avenue, Suite 400, Detroit, MI 48207.

Penalties

Criminal Health Care Fraud

Persons who knowingly make false claims may be subject to:

- Criminal fines up to $250,000
- Prison for up to 20 years
- Being suspended from Michigan Medicaid

If the violations resulted in death, the individual may go to prison for years or for life. For more information, refer to 18 U.S.C. Section 1347.

Anti Kickback Statue

The Anti-Kickback Statue bans knowingly and willingly asking for, getting, offering, or making payments (including any kickback, bribe, or rebate,) for referrals for services that are paid, in whole or in part, under a federal health care program (including the Medicare Program). For more information, refer to 42 U.S.C. Section 1320a-7b(b).

Member rights about treatment

When you are seriously ill, how can you make sure your medical care wishes are followed?

- Does your doctor know what you would want?
- Does your family know what your wishes are?
- What kind of medical care would you want if you were very sick or dying?

Members who are 18 years and older have rights under Michigan law about their desired medical care. The Patient Self Determination Act protects members' rights about desired medical care.

So what does this mean? It lets all people who are 18 years and older make decisions about their own medical care. This includes the right to accept or refuse medical or surgical treatment. You must put your desires in writing in advance.

Advance directives (Michigan's durable power of attorney for health care)

An advance directive is a written advance care planning document. This document explains how medical decisions should be made for a patient who cannot make decisions. This document also explains how medical decisions should be made for someone who cannot express his or her wishes about health care.

The Durable Power of Attorney for Health Care (DPAHC) is the form of advance directive recognized by the Michigan Department of Health and Human Services (1998, Public Act 386).

This lets a patient choose another person to make decisions about their care, custody and medical treatment if they cannot make these decisions for themselves. This way, a person's desire to accept or refuse medical treatment is honored when they cannot make that choice themselves.

According to Michigan Law:

Anyone age 18 or older, and of sound mind, may have a DPAHC. The DPAHC will go into effect in case something happens and they cannot make decisions for themselves.

This act allows a person to choose someone as their patient advocate to make medical treatment decisions for them.

- You may change the person you appoint as your advocate at any time.
- You may write on the form the types of treatment you do and do not want.
  - If a member writes on the form that they want their patient advocate to order doctors to withhold or withdraw life-sustaining treatment in certain situations, the doctors must honor their wishes.
- You should keep a copy of your DPAHC with you at all times.

If you need additional information, please call Member Services at **1-866-316-3784**, TTY **711**.

For complaints about how Aetna Better Health of Michigan allows your wishes, write or call:
Bureau of Professions Licensing, Grievance & Allegation Division
P.O. Box 30670
Lansing, MI 48909
517-241-0199 or e-mail at **bhpinfo@michigan.gov** or **BPLHelp@michigan.gov**

The BHP Grievance & Allegation website is **michigan.gov/healthlicense** or **michigan.gov/bpl.**

How your doctor is paid

You can request information about how Aetna Better Health of Michigan pays its doctors. If you would like to know more, just call Member Services at **1-866-316-3784**, TTY **711**. You have a right to learn how we pay our doctors and what that means to you.

You can also get the following information about our providers:

- License information.
- Qualifications and Education.
- What services need authorization.

Aetna Better Health does not prevent our providers from:

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

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

Aetna Better Health and its providers cannot refuse care on the basis of:

- pre-existing health conditions.
- color.
- creed.
- age.
- national origin.
- handicap.
- sexual preference.
- cost of medical treatment.

How does Aetna Better Health make sure providers are qualified

Aetna Better Health makes sure when you receive care, it's from a qualified doctor. Our doctors meet education and experience standards. We require our network of doctors to give you high quality health care services. You can get more facts about your doctor's education or clinical qualifications by calling Member Services at **1-866-316-3784**, TTY **711**.

Beneficiary Monitoring Program (BMP)

The Beneficiary Monitoring Program is a program that reviews the use of Medicaid services. The program looks at certain types of Medicaid services to assess appropriate use. They also look to see if the services are needed for your medical condition. The program also provides education on the correct way to use Medicaid services.

After reviewing your medical condition, Aetna Better Health may place you in the BMP if you are:

- Visiting the ER too much.
- Going to too many different doctors.
- Filling too many prescriptions.

You may also be placed in the BMP for committing fraud and/or abuse.

If you have any questions about the BMP, call us at **1-866-316-3784**, TTY **711**.

Section 3: Enrollment and eligibility

Enrollment

Michigan's Medicaid Enrollment Broker, Ml ENROLLS **1-888-367-6557** is available to help you with enrollment in a health plan. Once you become our member, we will help you to sign up with an in-network provider, if you did not already choose one when you enrolled in our plan through Ml ENROLLS.

Ml ENROLLS is also there to help you if there are problems with your enrollment in a health plan.

Causes for disenrollment

You can be disenrolled from the plan. Here are some reasons why you can be disenrolled:

- Moving out of our service area.
- Abusive, threatening and/or violent behavior towards doctors and their staff or Aetna Better Health of Michigan staff.
- Letting someone use your Aetna Better Health member ID card to get services.

You may also ask to leave a health plan:

- For any reason in the first 90 days of being a health plan member or after the state sends you a notice of enrollment.
- During annual open enrollment.
- If you and your PCP believe that you are not receiving the care you need.

Change in family size

Call your local Department of Human Services office if your family size changes for any reason. You can call Michigan Enrolls at **1-888-ENROLLS** (**1-888-367-6557**) to have a new family member enrolled into Aetna Better Health of Michigan.

Change of address or other status changes

It's important for us to get in touch with you. If you change your address or telephone number, just call Member Services at **1-866-316-3784**, TTY **711** to let us know of these changes. You'll also need to call your local Department of Human Services office if you move. If you move outside the Aetna Better Health of Michigan service area, you may be disenrolled. You also need to tell Aetna Better Health and your MDHHS caseworker about other changes such as if your name changes.

Member ID card

When you become a member of Aetna Better Health of Michigan, you'll get a member ID card. An ID card is needed to get most services. You should carry this card with you at all times. If you lose your ID card, call Member Services at **1-866-316-3784**, TTY **711**. Member Services will send you another card. Your card will look like this:


Aetna Better Health® of Michigan

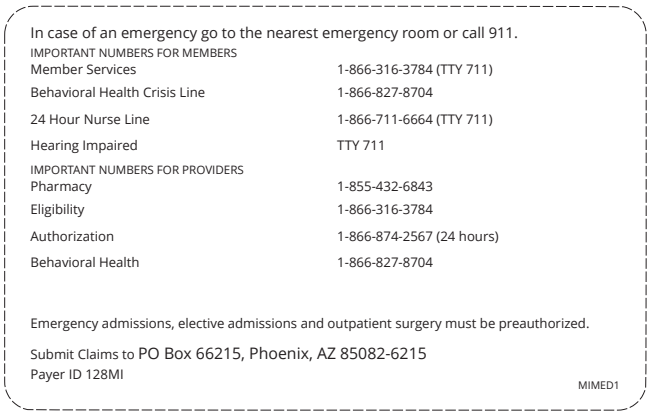
aetna™

Name
Member ID/State Medicaid ID#
PCP
PCP Phone

Copay: $0
RxBIN: 610591 RxPCN: ADV RxGROUP: RX8826

CVS caremark™

aetnabetterhealth.com/michigan
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.
MEMIMED1


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

IMPORTANT NUMBERS FOR MEMBERS

Member Services	1-866-316-3784 (TTY 711)
Behavioral Health Crisis Line	1-866-827-8704
24 Hour Nurse Line	1-866-711-6664 (TTY 711)
Hearing Impaired	TTY 711

IMPORTANT NUMBERS FOR PROVIDERS

Pharmacy	1-855-432-6843
Eligibility	1-866-316-3784
Authorization	1-866-874-2567 (24 hours)
Behavioral Health	1-866-827-8704

Emergency admissions, elective admissions and outpatient surgery must be preauthorized.

Submit Claims to PO Box 66215, Phoenix, AZ 85082-6215
Payer ID 128MI
MIMED1

Your member ID card includes:

- Your name.
- Your member ID number.
- Your primary care provider (PCP) name or health center.
- Your PCP's phone number.

Every Aetna Better Health member has their own ID card. Only the person on the card may use it for service. You may be asked to show a picture ID when using the ID card. This is to make sure no one else is using your ID Card.

A new card will be sent to you if you:

- Change or correct the spelling of your name.
- Call because your card is lost or stolen.
- Change your PCP or health center.

Section 4: Getting help

Member Services

Aetna Better Health of Michigan has a toll-free line for Member Services **1-866-316-3784**, TTY **711**. The Member Service staff will help you:

- Select or change your PCP or doctor.
- Understand how to use the plan and how it works.
- Change your address or phone number.

- Get an ID card.
- Get information on how to access or get community support and services.
- Get an address or phone number for a PCP or specialist doctor.
- Get claims or billing information including submissions when needed.
- Get benefit or coverage information.
- File a grievance or appeal.
- Quality Improvement Program (QIC) information available on request.

You can reach Member Services at **1-866-316-3784**, TTY **711**, Monday – Friday, 8 AM to 5 PM. You can also visit us online at **AetnaBetterHealth.com/Michigan**.

If you do not speak English, we have someone to help you. We have oral interpretation services. We have a Spanish-speaking Member Service representative to help you. All other languages are assisted by the use of our language line. If you are hearing impaired please use the, TTY **711** line. There is no cost to use the interpretation services or language line.

Website information

You can get up-to-date information about your Aetna Better Health plan on our website at **AetnaBetterHealth.com/Michigan**. You can visit our website to get information about the services we provide. This includes our provider network, frequently asked questions, contact phone numbers and email addresses.

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

Smartphone program

You may be eligible for a smartphone at NO COST.

Now you can stay connected with those who care about you. Call your doctor, your family and your friends.

You may be eligible for a new phone and/or a data package (Lifeline service):

- Android smartphone
- Voice minutes
- Data packages
- Unlimited text messaging
- Unlimited calls to Aetna Better Health

To learn more or see if you're eligible, call us at **1-866-316-3784**.

Member web portal and health management tools

MyActiveHealth is an easy way to take charge of your health, so you can live a healthy life. As a member of Aetna Better Health, you'll get MyActiveHealth at no cost to you. To access the site, just sign into your secure member portal at **AetnaBetterHealth.com/Michigan/members/portal**. Once signed in, you can:

- Complete health surveys and keep track of health records.
- Get help for health goals like quitting smoking and weight management.
- Sign up for digital health coaching program.
- Find information on healthy lifestyle program.
- View health and wellness videos and podcast.

Aetna Better Health of Michigan member web portal offers members help with the use of an online tool to get and ask for services. You can ask questions, make changes or get information about your health benefits. You can:

- View medical and pharmacy claims.
- See if you are active with Aetna Better Health (eligibility).
- See your benefits.
- View authorizations and referrals.
- Print, view, and request ID cards.
- Ask benefit questions.
- Change your PCP.
- Update your address and phone number.
- Notify us of other insurance.
- Request member materials.
- View service requests.

Care Management program

Aetna Better Health of Michigan offers a care management program to help members with mental and physical health needs. This is a voluntary program that allows you to talk with a care coordinator about your health care. The care coordinator can help you learn more about your health needs. The care coordinator can also teach you how to better manage your care. If you need help, call Member Services at **1-866-316-3784**.

The care coordinator services include but are not limited to:

- Education and support about Medicaid benefits.
- Outreach to members with health conditions to connect them with providers and agencies that provide treatment and help.

Complex Care Management program

If you have a complex health issue such as HIV, sickle cell anemia or heart disease our Complex Care Management Program can help you. Our care coordinators will work with you and your doctors to make sure you get the needed medical care. If you would like more information, call Member Services at **1-866-316-3784**, TTY **711**.

Disease Management program

Our care coordinators are available to help members learn how to manage certain chronic conditions. These include asthma, diabetes, heart diseases, and high-risk pregnancy. Members may ask to enroll or the Plan may enroll you. You may be enrolled by the plan based on information provided by your doctor or hospital. If you are placed in this program and you do not want to be in the program, call Member Services at **1-866-316-3784**, TTY **711**.

Pregnancy program

Prenatal care and postpartum care is important for a healthy baby and mom. Aetna Better Health of Michigan offers this program to help pregnant members have a healthy pregnancy and baby. It's important for you to visit your OB/GYN doctor as soon as you know that you are pregnant.

Your doctor may have you come in for six or more visits during your pregnancy. Try to ensure that you make all of your visits. Our outreach staff can help you make prenatal and postpartum appointments. If you are high risk you may want to talk to our High Risk OB care coordinator. If you would like to learn more, call our Outreach Department at **1-855-737-0770,** TTY **711**.

Your pregnancy

If you are pregnant, early and regular checkups can help protect you and your baby's health.

Aetna Better Health of Michigan wants to make sure that you and your baby get the services you need.

These services include:

- Routine pregnancy medical checkups.
- Information about your hospital choices.
- Information about pregnancy, labor and delivery.
- HIV counseling and testing.
- Help in applying for programs such as the Women, Infants and Children (WIC) program, low- or no-cost health insurance for your family and children, and referrals for MIHP services.
- Services after delivery.
- Health care for your baby.
- Family planning services.

Member Outreach can help make sure you and your baby receive the important health care you need while you are pregnant. If you are pregnant, call us at **1-855-737-0770**, TTY **711**.

Dental services for pregnant women

Members who are or become pregnant are able to access dental services during their pregnancy and postpartum period directly through their Medicaid health plan. Pregnant members will be able to see dentists that are contracted as part of the Aetna Better Health of Michigan network. Members may also receive transportation to and from scheduled dental appointments.

To receive dental services the member must:

- Notify Aetna Better Health of the pregnancy and due date by calling Member Services at **1-866-316-3784** TTY **711**.

Members should also notify their caseworker of their pregnancy and due date.

Lead screening program

Children are at risk if they come in contact with lead. Lead can be found in older homes. It has been found in the paint, soil, clay products, pipes and solder. All children should be tested for lead exposure at age 1 and on or before the child's second birthday. All children should be tested by the age of 2. Children should also get a lead screening at least one time between the ages of 3 and 6.

Those children who are at risk or who are high risk will need to be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Our program provides the lead level testing. It also tracks your child's levels and will make sure they have follow-up care from their primary care provider (PCP).

Tobacco cessation

Aetna Better Health of Michigan wants to help you stop smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor or nurse can help you. You can also help yourself.

To get more information and to find out about incentives to quit smoking, just call Member Outreach at **1-855-737-0770,** TTY**711**.

Aetna Better Health will cover the following to help you quit smoking:

- Group and individual counseling and coaching.
- Prescription inhalers or nasal sprays used to stop smoking.
- Non-nicotine drugs.
- Over-the-counter items to help stop smoking.
  - Patches.
  - Gums.
  - Lozenges.

Here are other resources to help you quit:

- Go to **smokefree.gov**.
- Call the Michigan Tobacco Quitline at **1-800-QUITNOW** (**1-800-784-8669**) and talk to someone on how to quit.
- Go to **cancer.org** and enter "Tobacco and Cancer" for more resources on quitting.

Authorization and utilization questions

If you have specific questions about an authorization, you can call Member Services at **1-866-316-3784**, TTY **711**. They can help answer your questions. They can also get a care coordinator who can help answer your questions. Our care coordinators are available during normal business hours.

Satisfaction survey

Aetna Better Health of Michigan surveys members at least once a year. You may get a survey to fill out or you may get a call asking you to take a survey. These surveys help us to understand how we can better serve you. We hope you will help. For more information on our surveys, call Member Services **1-866-316-3784**, TTY **711**.

If you are not satisfied with your services for any reason, please contact Member Services to let us know how we can improve.

Daily steps to health

Don't smoke

- If you do smoke, talk to your doctor about quitting.
- If you are pregnant and smoke, quitting now will help you and your baby. Your doctor or nurse can help you. You can also help yourself.
- Learn about our Health Yes Tobacco No Program. Just call Aetna Better Health of Michigan at **1-855-737-0770**.
- Find tips on how to quit at **smokefree.gov**.
- To talk to someone about how to quit, call the Michigan Tobacco Quitline: **1-800-QUITNOW** (**1-800-784-8669**).
- Find more resources at **cancer.org** – search for "tobacco and cancer."

Stay active. Check with your provider before starting any physical activity

- Walking briskly, mowing the lawn, dancing, swimming and bicycling are all examples of moderate physical activity.
- If you are not already physically active, start small and work up to 30 minutes or more of moderate physical activity most days of the week.

Eat a healthy diet

- Eat fruits, vegetables, whole grains and fat-free or low-fat milk and milk products.
- Include lean meats, poultry, fish, beans, eggs, and nuts.
- Eat foods low in saturated fats, trans fats, cholesterol, salt (sodium) and added sugars.

Stay at a healthy weight

- Balance calories from foods and beverages with calories you burn off by your activities.
- To prevent gradual weight gain over time, make small decreases in food and beverage calories and increase physical activity.

Drink alcohol in moderation

- If you drink alcohol, have no more than one drink a day.
  - A standard drink is one 12-ounce bottle of beer or wine cooler, one 5-ounce glass of wine, or 1.5 ounces of 80 proof distilled spirits.
- If you are pregnant, avoid alcohol.

Section 5: Using your benefits

Choosing and changing your primary care provider (PCP)

Your PCP is the health care provider who takes care of all your health needs. When possible, they're the first person you should contact if you need health care. You'll need to choose a PCP as soon as you join our plan.

Your PCP will see you for well care checkups and medical problems. Your PCP is your medical home. Having a medical home helps make sure the right medical care is available when you need it. Get to know your PCP. If you have a new PCP, call and make an appointment, even if you are not sick. Your PCP will learn about your overall health. This will help him or her prevent future sickness.

You'll find a list of PCPs in our Provider Directory. You can ask Member Services for a list or search for providers on our website at **AetnaBetterHealth.com/Michigan**. Just select "Find a Provider" at the top of any page. You can choose one of the following provider types as your PCP:

- General practice doctor.
- Family practice doctor.
- Internal medicine doctor.
- OB/GYN doctor.
- Nurse practitioner.

If you have a chronic health condition like diabetes or end-stage renal disease (ESRD), you may need a specialist to take care of you as your PCP. Member Services can help you with this decision. Just call **1-866-316-3784**, TTY **711**.

You may also get services from a federal qualified health center (FQHC), a rural health center (RHC) or at a tribal health center (THC) for primary care. These centers can be in or out of our network.

You may also get services from child and adolescent health centers (CAHCPs) and local health departments without prior authorization from the plan. See your Certificate of Coverage for more details regarding these services.

When you select Aetna Better Health of Michigan, you must have an in-network PCP. You may choose your PCP. If you do not, one is chosen for you. Your PCP will manage your health care needs. You may change your PCP at any time for any reason. You can also do this online through the member web portal. Most changes will take effect on the first of the next month.

Your PCP will help you get the health care services you needs. When you need care:

- Call and make an appointment as soon possible.
- Take your Aetna Better Health ID card with you to the appointment.
- Please be on time.

If you cannot keep your appointment, call and cancel it as soon as possible.

Seeing a specialist

If you need to see a specialist your primary care provider (PCP) will arrange for these services for you. Your PCP is the best person to help you locate the right specialist for your needs. If you need to see an OB/GYN, you can choose one from our provider list and go on your own. You will not need a referral or approval to see:

- an OB/GYN.
- certified nurse midwife.
- certified nurse practitioner.
- certified family nurse practitioner.
- certified pediatric nurse practitioner.
- a pediatrician.

You can get regular OB/GYN care without seeing your PCP first. If you need to see a doctor that is not in our network, Aetna Better Health of Michigan must approve it first. Your PCP will work with the Plan to make sure you get this care.

Other medical services, equipment and supplies may require an authorization by Aetna Better Health. If you have questions on what services require authorization, you can call Member Services at **1-866-316-3784**, TTY **711**.

Tell your PCP when you are receiving care from any other doctors. You may get a list of our specialists from Member Services at **1-866-316-3784**, TTY **711**. You can also find them on our website at **AetnaBetterHealth.com/Michigan**.

Behavioral health services[1, 2]

Aetna Better Health of Michigan covers outpatient visits for behavioral health services. For more information, call Member Services at **1-866-316-3784**, TTY **711**. If you are having serious behavioral health symptoms, you can get help with behavioral health services at **1-866-827-8704**. You may be referred to the community mental health program in your county.

Substance use disorder services

Here are some signs of someone who has a substance use disorder:

- Continues to use drugs/alcohol regardless of existing health problems that are affected or caused by drug/alcohol use.
- Person is:
  - irritable.
  - angry.
  - hostile.
  - having fatigue.
  - agitated.
  - anxious.
  - depressed.
  - psychosis (seeing or hearing things that others don't see or hear)
  - lacking coordination.
  - having difficulty concentrating.
- Schedules the day around using drugs/alcohol.
- Continues to use drugs/alcohol even though they may lose their job or fail school.
- Person is arrested, doing things that you would normally not do, such as stealing to obtain drugs/alcohol.

[1]Aetna Better Health of Michigan members can receive treatment for substance use disorders through their local community mental health services program at no cost. If you need help finding a provider, just call Member Services at **1-866-316-3784**, TTY **711**.

[2]Services provided include: screening and assessment, counseling and other outpatient services, detoxification, methadone treatment

Getting the care you need

It's important to be prepared and to understand where to go and when to go for medical care before you need care. This helps you get the right care at the right time and at the right place. Use the information below to help guide you to the right place of care for your medical needs. Remember to go to the emergency room only for true emergencies. Be sure to know the difference between a medical emergency and a situation where you should see your primary care provider (PCP) or an urgent care clinic.

Primary care – your PCP

If you have a cough, sore throat, rash or other medical concern, call to schedule an office visit. Your PCP should provide most of your care, including regular checkups, care for medical problems and follow-up care.

24-Hour Nurse Line

The best place to start when you have a question about your health is our free 24-Hour Nurse Line at **1-866-711-6664**, TTY **711**. You'll speak to a registered nurse who will give you expert advice and quick answers. They'll help you decide what to do next. They may have you see your doctor. They may have you go to the emergency room. They may help you treat the problem at home.

Our 24-hour Nurse Line is open for our members 24/7. Our nurses speak English and Spanish. Interpreters are available for other languages.

After hours care or urgent care

For non-emergency care after normal business hours, you should call your PCP. Your PCP will provide instructions for getting the care you need. If you cannot reach the PCP, our 24-Nurse Hour Nurse line can help you. Urgent care clinics are places you can go when you cannot see your PCP. They treat conditions that need immediate attention. These conditions are not life threatening. You should not use urgent care clinics for routine care. You should schedule routine care with your PCP.

Emergency care

Aetna Better Health of Michigan will cover all emergency services without prior approval when a person believes they have an emergency.

You should get emergency care when you have severe pain or a serious illness or injury that will cause death or disability if not treated at once. Examples are:

- Chest pains or heart attack.
- Poisoning.
- Choking or breathing problems.
- Broken bones.
- A lot of bleeding or bleeding that will not stop.
- Call **911** or go to the nearest hospital emergency department for care.

Your PCP must arrange all follow-up care.

Always bring your Aetna Better Health ID card with you when going to the hospital. Never go to the emergency department for routine care.

Care 'out of state' or 'out of the area'?

If you are out of town and have a medical emergency or need urgent care, go to the nearest urgent care center or emergency department for care. The hospital or urgent care center may call Aetna Better Health of Michigan for authorization to treat you. Remember to make an appointment with your PCP after all emergency or urgent care visits.

Hospital services

All hospital services, except emergency care, must be approved or arranged by your PCP or Aetna Better Health. There may be some exceptions. Call Member Services if you have questions about a hospital stay or visit.

Getting a second opinion

You may want a second opinion about an illness or surgery to confirm the treatment or care your doctor says you need. If you need help getting a second opinion, talk to your doctor. You can also get help through Member Services. Just call **1-866-316-3784**, TTY **711**. There is no additional cost to you for the second opinion from an Aetna Better Health of Michigan provider. Second opinions from an out-of-network provider will require preauthorization from Aetna Better Health.

Section 6: Covered services

Aetna Better Health of Michigan covers the following services. We will cover these services if they are medically needed.

Medically needed services include:

- The tests you need to find out if you are ill or injured.
- The medical care to treat you if you are ill or injured.
- The preventive care to help you avoid becoming ill or injured.

Medically needed services must:

- Be appropriate.
- Meet your basic health care needs.
- Be given to you in an appropriate and cost-effective way.
- Be the services that medical research and science guidelines recommend.
- Be used to treat your health condition.
- Not be experimental.

Covered services

- Continuous glucose monitors for some individuals with Type 1 diabetes*
- Dental services are covered for pregnant and postpartum women.
- Immunizations (shots)*.
- Inpatient and outpatient hospital services (including consultations).
- Intermittent or short-term restorative or rehabilitative services (in nursing facility), up to the first 45 days per year.
- Maternity and newborn care.
- Maternal infant health program.
- Mental/behavioral health care (outpatient).
- Oral surgery.
- Orthognathic surgery.
- Out-of-state services authorized by the Plan.
- Outpatient prescription drugs.
- Over-the-counter drugs and supplies.
- Pain management services.
- Parenting and birthing classes.
- Pharmacy services.
- Podiatry services.
- Prosthetics and orthotics/support devices.
- Radiology examinations and laboratory procedures.
- Reconstructive surgery.
- Short-term rehabilitative therapy.
- Skilled nursing facility.
- Temporomandibular joint syndrome (TMJS).
- Therapeutic services (speech, physical, occupational).
- Tobacco cessation including pharmaceutical and behavioral support.
- Transplant services.
- Transportation for medically needed covered services.
- Treatment for sexually transmitted diseases (STD)*.
- Vision services.
- Weight loss services.

**No prior authorization required.*

To learn more about your benefits and limits, just call Member Services at **1-866-316-3784**, TTY **711**.

You'll find a more detailed description of some of your benefits below. Review your Certificate of Coverage for more details on benefits, limits and exclusions.

Extra Aetna Better Health of Michigan benefits

Disease Management program: a program to help members learn how to manage certain chronic conditions such as:

- Asthma.
- Chronic renal failure.
- COPD.
- High-risk pregnancy.
- Diabetes.
- Hypertension (high blood pressure).
- Congestive heart failure.
- Sickle cell disease
- Coronary artery disease
- Preventive health education and reminder mailings.
- Member Advisory Committee (MAC): This committee allows Aetna Better Health to hear from members about how we can better serve you. For more information, call Member Services at **1-866-316-3784** (TTY **711**).
- Unlimited calls to Aetna Better Health with free cell phone. Call Member Services for details.

Transportation services

If you need a ride to the hospital for emergency medical services, dial **911**.

Ambulance services are covered when required for a trip to or from the hospital, a skilled nursing facility or member's home.

Non-emergency transportation services also are available to members. For more information, call Member Services at **1-866-316-3784** (TTY **711**).

Pregnant women can also receive transportation to dental appointments.

Medical equipment

When you need a wheelchair, walker, crutches or a brace, see your PCP. The doctor will arrange for you to get this equipment from an Aetna Better Health of Michigan provider. The doctor may also give you a prescription for the equipment. You can take this prescription to an Aetna Better Health medical equipment provider. If you need help with this, please call Member Services at **1-866-316-3784**, TTY **711**.

Vision services

Eye care services are provided through our eye doctors. If you need glasses or an eye exam, just call **1-866-316-3784**, TTY **711**. You can also call a provider from our list of vision providers. For medical eye problems, talk to your PCP.

Hospice services

Hospice services are covered for any member who has six months or less to live. Hospice gives support to you and your family. If you would like more facts on hospice, please call **1-866-316-3784**, TTY **711**.

Prescription services

Your Aetna Better Health of Michigan benefits include coverage for prescriptions. Aetna Better Health works with CVS, our pharmacy benefit manager. They help manage your prescription drug coverage. You can fill your prescriptions at over 35,000 pharmacies nationwide.

Aetna Better Health uses a closed formulary, which means that only drugs listed on the formulary are covered (except with prior approval in special circumstances). For updates to our formulary please visit our website at **AetnaBetterHealth.com/Michigan**. If you would like more information on the formulary or drugs that require our prior approval, Member Services can help. Just call **1-866-316-3784**, TTY **711**. If you need a prescription filled, present your Aetna Better Health ID card with the prescription at any participating pharmacy.

You will need to use your MI HEALTH card for certain drugs covered by the state. For example, anti-psychotic and HIV/AIDS drugs are covered by the state.

Hearing services

The diagnosis or treatment of diseases or conditions of the ears is covered when authorized by the PCP. Audiometric examination and hearing aid evaluation testing are covered when performed by a provider in our network. Coverage includes purchase of hearing aids, as well as repairs, maintenance and replacement batteries for hearing aids.

Orthotic and/or prosthetic services

When you need orthotic and/or prosthetic services your PCP or specialist can arrange for you to get this service from an Aetna Better Health of Michigan provider. The doctor may also give you a prescription for the orthotic or prosthetic services. You can take this prescription to an Aetna Better Health provider. If you need help with this, please call Member Services at **1-866-316-3784**, TTY **711**, or speak with our care coordinator. Member Services will help you get to the right person.

Health education

We want to help our members stay healthy. It's important that you and your child see your primary care provider (PCP) for regular checkups. It is also important to eat right and exercise regularly. If you are pregnant, see your doctor for prenatal care immediately. You should not drink alcohol or smoke, especially if you are pregnant. Also, children should receive all of their shots. We can help you take care of your health through preventive care services. These services include:

- Yearly checkups and exams.
- Vision and hearing screenings.
- Routine pediatric shots (immunizations).
- Family planning services
- Nutrition.
- Regular oral exams, usually every 6 months.
- Education and counseling.
- Pre-natal and postpartum services.
- Screening examinations for children from birth to age 19.
- Health education services.

If you receive a bill

Let Aetna Better Health know if you receive a bill for your care of any covered services. Call Member Services at **1-866-316-3784**, TTY **711**, or send the bills to Aetna Better Health right away. Do not throw it away or ignore it. Let us know if you actually received the services listed on the bill. Also include a brief description of the service. Don't forget to give us a phone number. We may need to contact you if we have any questions.

Send to:

Aetna Better Health of Michigan
Attn: Member Services
1333 Gratiot Avenue Suite 400
Detroit, Ml 48207

Other insurance

If you have any other health insurance, Aetna Better Health needs to know. To update your insurance information, call Member Services at **1-866-316-3784**, TTY **711**.

New medical technology

Aetna Better Health reviews new technologies to see if they can be used for our members. Our doctors look at new treatments as they become available to see if they should be added to our benefit plan. Aetna Better Health reviews the services area listed below at least once a year:

- Medical services.
- Behavioral health services.
- Pharmacy.
- Medical equipment.

Member out-of-pocket costs (copays)

As an Aetna Better Health of Michigan member, you will not have any copays or deductibles with your benefits. Aetna Better Health will pay for all of your covered services.

There are no copayments, deductibles or any other out of pocket cost for covered services. You should not sign any paperwork or agree to pay for any services that are covered by the health plan.

If you ask for or receive any services that are not covered through Aetna Better Heath, you may have to pay for them yourself.

Download our mobile app

Now you can find a provider, see your handbook, check claims, order a new ID card and see your current medications on your cell phone. Aetna Better Health of Michigan has launched a mobile app! It is easy to use and right on your cell phone.

You can download the mobile app at **AetnaBetterHealth.com/Michigan**.

Through the mobile app you have access to:

- Find a provider
- View the member handbook
- Check claims
- Order a new ID card
- See your current medications

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

Section 7: General services not covered by your plan

Services not covered by Aetna Better Health of Michigan:

- Any health care provided outside of the service area and not authorized by the Plan (except emergency services).
- Cosmetic services and surgery.
- Dental services except for pregnant and postpartum women. Pregnant and postpartum women are eligible for dental coverage through Aetna Better Health.
- Elective termination of pregnancy (abortion) and related services (see Certificate of Coverage for more information).
- Fees, costs and expenses incurred by a person who donates an organ or tissue (unless the recipient is a Plan member or the donor's health plan does not cover the expenses).
- Infertility treatment or related services.
- Long term rehabilitative treatment.
- Personal comfort items such as telephone, television and similar items.
- Testing to determine parentage or DNA testing.
- Private duty nursing services in the home.

Women, Infants and Children (WIC)

WIC is a food supplemental program for young women and children. This means that WIC helps you save on groceries so you have more to spend on other things your family needs. You may qualify if:

- You have a child under age 5.
- You are pregnant or breastfeeding.

WIC is a free service to families who qualify. WIC offers health education, nutrition information and coupons. The coupons are for free healthy food. Some of our medical offices offer WIC services.

WIC also offers referrals for:

- medical and dental care.
- health insurance.
- childcare.
- housing utility help.
- other services that can benefit the whole family.

You can participate in WIC if you:

- Have a nutritional need.
  – WIC staff can help you determine this.
- Have a family income within WIC guidelines or have Medicaid coverage
- Have a child less than 5 years of age, or are pregnant or recently had a baby or are breast feeding a baby.

To learn more about WIC services and referrals, call **211**. You can also get information at **www.michigan.gov/WIC**.

Services prohibited or excluded under Medicaid:

- Elective abortions and related services (see Certificate of Coverage for more information).
- Experimental/investigational drugs, procedures or equipment.
- Elective cosmetic surgery.
- Treatment of infertility.

Other exclusions are listed in the Certificate of Coverage (COC)

If you have questions on whether a procedure is covered, talk with your PCP or call Member Services at **1-866-316-3784**, TTY **711**.

Section 8: Emergency services and urgent care

When an unexpected illness or injury occurs that is not an emergency, your first choice should be to call your primary care provider (PCP). When this is not possible, there are other choices for care. It is important to recognize a true medical emergency and be familiar with other choices. You do not need permission to go to the emergency room.

If you need medical care that is urgent, but not an emergency call your PCP. Your PCP will have 24 hours a day seven days a week coverage. You can also call our 24-Hour Nurse Line at **1-866-711-6664**, TTY **711**. You'll find help from a registered nurse who can answers your health care questions. You can also go to an urgent care center.

Medical emergency

A medical emergency is a serious medical condition resulting from an injury or illness. Emergencies arise suddenly and unexpectedly. They require immediate care and treatment to avoid placing your health in serious harm. Examples of a medical emergency include:

- Chest pain
- Unconsciousness (blacking out)
- Poisoning

- Severe cuts or burns
- A serious accident
- Trouble breathing
- Sudden onset of severe pain
- Convulsions or seizures
- Severe or unusual bleeding
- Any vaginal bleeding in pregnancy

If you're ever in a medical emergency, go immediately to the nearest emergency room at the nearest hospital. If you need help getting to an emergency room fast, call **911**.

Prudent layperson and emergency services

A prudent layperson is a person who does not have medical training. However, this person uses his or her everyday experience to make a decision regarding whether emergency medical treatment

is needed. A prudent layperson will be considered to have acted reasonably, if another layperson would have made the same decision in the same situation. Aetna Better Health of Michigan uses this guideline when they cover emergency services based on symptoms.

Urgent care

Urgent care is for an unexpected illness or injury that is not life threatening. However, it requires fast medical attention. After-hours care facilities are available in some areas for medical conditions not considered a medical emergency.

Examples of urgent care include:

- Most broken bones
- Cuts
- Burns
- Sprains
- Mild to moderate bleeding

Examples of conditions that are NOT usually urgent or don't require emergency care:

- Colds and flu
- Headaches
- Sinus congestion
- Sore throat
- Rash
- Toothache

Section 9: Routine screening, testing, and cancer-related checkups

Wellness care for adults

It's important to see your primary care provider (PCP) or OB/GYN for a yearly physical (checkup). The purpose of a yearly checkup is to get preventive screenings that may find health problems early. Yearly checkups and preventive screenings are important because you may look healthy and feel well and still have a health problem. Our members may see any Aetna Better Health of Michigan OB/GYN doctor without a referral.

If you are pregnant, see your PCP right away for prenatal care. Do not smoke, drink alcohol, or take any drugs not prescribed by your PCP. It is unhealthy for you and your baby.

We can help you stay healthy with preventive services such as:

- Routine checkups every year.
- Preventive screenings such as pap smears, mammograms, prostate exams, and colonoscopies.
- Family planning services.
- Shots except those required for travel.
- Nutrition education and counseling.
- Health education services.
- Vision and hearing screenings.

Set up an appointment for a checkup each year.

Family planning services

Aetna Better Health covers family planning services. Services include:

- Pregnancy testing.
- Pap smear test.
- Routine preventative primary services that are family planning related.
- Birth control services and supplies.
- Sexually transmitted diseases (STD) testing and treatment.
- Testicular and prostate cancer screening.

You do not need a referral to get family planning services. You can get family planning services from any doctor or clinic.

Wellness care for children

Children should get checkups regularly. The first well-child visit will be in the hospital when a baby is born. You must set up a well-visit with your child's PCP when your child is:

3-5 days old	12 months old
1 month old	15 months old
2 months old	18 months old
4 months old	24 months old
6 months old	30 months old
9 months old	

Set up annual well-child visits with your child's PCP starting when your child is 2 years old.

Immunizations

Immunizations (shots) are needed to help the body fight disease. It's important for your child to get their shots on time. Children must have a record of these shots in order to begin school. You'll be required to provide a record of your child's shots when you enroll them in school.

All of the recommended immunization for children aged 0-18 years include:

- Measles, mumps, and rubella (MMR).
- Polio (IPV).
- Varicella (chickenpox).
- Hepatitis A.
- Rotavirus.
- Tetanus diphtheria, pertussis (TDap).
- Hepatitis B (Hep B).
- Diphtheria, tetanus, pertussis (DTap).
- Human papillomavirus (HPV).
- Hib meningitis (Hib).
- Meningococcal.
- Pneumococcal (PCV).

Set up an appointment with your child's PCP or a federally qualified health center (FQHC) for this service.

Immunization program

Our immunization program helps parents get their children the shots they need. You may get a call or a letter reminding you it's time for your child to get his/her shots. We also print reminders and information about shots on our website and in our newsletters.

EPSDT (Early Periodic Screening, Diagnosis and Treatment)

EPSDT is a special health program that covers health screening and treatment for members age 19 and younger. The EPSDT program providers regularly schedule health checkups, test and shots that are appropriate for your child's age. They also provide the care needed to treat any health problems found during an EPSDT checkup. Routine EPSDT checkups are a good way to keep your child healthy. These checkups are important because some children may look healthy and feel well and still have health problems.

EPSDT checkups include:

- Health history and physical exam, including school and sports physicals
- Shots to help prevent illness
- Health education and guidance
- Hearing, vision and dental screening assessment
- Physical and mental developmental/behavioral assessments
- Crucial lab tests, including lead screening

Make sure to set up your child's EPSDT checkup with their PCP.

Preventive services for young women

Our members may see any Aetna Better Health of Michigan OB/GYN doctor without a referral:

- Female members who are sexually active should have a pap smear every year to screen for cervical cancer.
- Female members, age 16 and older, who are sexually active, should have a chlamydia test every year. They should also be screened for sexually transmitted diseases (STD).

It is important for patients who test positive to repeat chlamydia testing after treatment. It is also important for the partner to receive treatment. Sexual partners should contact their doctor. The Expedited Partner Therapy (EPT) program is another way for partners to get treated. For information about the EPT program or other STD issues, contact your doctor. Or contact your local health department, Michigan Department of Health and Human Services STD Program or **michigan.gov/hivstd**.

Preventive health guidelines

Aetna Better Health of Michigan takes an active role in the health of its members. We have preventive health guidelines to assist you in staying healthy. Screening tests can find diseases early when they are easier to treat. Talk to your doctor about which ones apply to you and how often you should be tested, or contact Member Outreach at **1-855-737-0770**.

Keep your children healthy at any age

Even if children aren't sick, they need to see the doctor regularly. You can see a pediatric provider for covered services needed to provide routine and preventive health care services without getting a referral. Well-child visits can help children stay healthy. Screening tests can find diseases early when they are easier to treat.

Follow the schedule below to know how often to take your child to the doctor for a well-child visit. These visits may include screening tests. Your child's doctor can give these tests on schedule, as long as you bring your child in regularly according to the schedule. If your child has missed some well-child visits, don't worry, but don't delay.

Suggested schedule for well-child visits*	
Child's age	When to visit
By 1 year of age, your child should at least have 5 well-child visits.	At 2 to 4 weeks of age At 2 months of age At 4 months of age At 6 months of age At 9 months of age
Up to 2 years old	At 12 months of age At 14 to 15 months of age At 16 to 19 months of age At 23 to 25 months of age
3 to 21 years old	Every year

**A different schedule may be used. Ask your pediatrician.*

Screening test	Why it's performed	When it should be done
Evaluation and screening may vary, based on your doctor's judgment.		
Health history	To check for certain illnesses that may run in your family. To discuss any new health problems your child has.	First visit and updated at all visits.
Complete physical	Important measurements will be checked such as height, weight, blood pressure, and sensory screening (3 years old and up). If your child is under 2, his or her head circumference will be measured periodically.	Portions of this test are done at all visits.
Growth and development assessment	To make sure your child's growth and developmental milestones are right for his or her age. To help your doctor learn how your child speaks, thinks, moves and relates to others.	Portions of this test are done at all visits.
Nutrition discussion	To make sure your child is exercising and eating a well-balanced diet.	All visits.
Hearing and vision screening	To check for hearing and vision problems.	Every year for children ages 3 to 11. Beginning at age 12, every other year through age 21.
Immunizations (shots)	To protect your child from disease.	
Lab tests	To check for serious diseases and conditions. Sexually active adolescents will be routinely offered pregnancy and HIV testing as appropriate. Screening for sexually transmitted diseases will also be done once sexual activity has begun.	**Lead:** 1 and 2 years old; more often if you live in a community with high lead levels. **Sickle cell:** Part of newborn screening done between 2 and 4 weeks. **Anemia:** Done at 9 months and all visits from 2 years old on. **Tuberculosis:** Between 1 to 2 years of age; 3 to 10 years of age and 11 to 21 years of age.
Health education and counseling	The doctor will discuss childcare, nutrition and safety to help your child stay healthy. At later ages, he or she will talk to your child about school, friends and family experiences, the dangers of smoking, drug and alcohol use and unsafe sex.	Done at all visits in different ways, depending on your child's age.

Screening tests for men

A helpful guide to what tests you need and when:

- **Obesity:** Have your body mass index (BMI) calculated to screen for obesity. (BMI is a measure of body fat based on height and weight.)
- **High cholesterol:** Have your cholesterol checked regularly starting at age 35. If you are younger than 35, talk to your doctor. You may need to have it checked earlier or more often if:
  - You have diabetes.
  - You have high blood pressure.
  - Heart disease runs in your family.
  - You smoke.
- **High blood pressure:** Have your blood pressure checked at least every year.
- **Prostate cancer:** Have a test for prostate cancer starting at age 40. If you have a family history of prostate cancer, you may need to be screened earlier.
- **Colorectal cancer:** Have a test for colorectal cancer starting at age 50. Your doctor can help you decide which test is right for you. If you have a family history of colorectal cancer, you may need to be screened earlier.
- **Diabetes:** Talk with your doctor about testing for diabetes as part of your yearly exam.
- **Depression:** Your emotional health is as important as your physical health. If you have felt "down," sad, or hopeless over the last 2 weeks, you may be depressed. If you have little interest or pleasure in doing things, you also may be depressed. Talk to your doctor about being screened for depression.
- **Sexually transmitted diseases:** All adolescent and young adult males who are sexually active and have high risk factors should be tested for chlamydia and other sexually transmitted diseases (STDs) yearly.
- **HIV:** Talk to your doctor about HIV screening if you:
  - Have had unprotected sex.
  - Have used or now use injection drugs.
  - Have past or present sex partners who are HIV-infected, are bisexual, or use injection drugs.
  - Are being treated for sexually transmitted diseases.
  - Had a blood transfusion before 1985.
- **Abdominal aortic aneurysm:** If you are over 65 and have ever smoked, you may need to be screened for abdominal aortic aneurysm. This is an abnormally large or swollen blood vessel in your abdomen.

Screening tests for women

A helpful guide to what tests you need and when

- **Obesity:** Have your body mass index (BMI) calculated to screen for obesity. (BMI is a measure of body fat based on height and weight.)
- **Breast cancer:** Have a mammogram every 1 to 2 years starting at age 52.
- **Cervical cancer:** You may need a pap smear every 1 to 3 years if you:
  – Have ever been sexually active.
  – Are between the ages of 21 and 65.

Talk to your doctor about how often you should be screened.

- **High cholesterol:** Have your cholesterol checked regularly starting at age 45. If you are younger than 45, talk to your doctor about whether to have your cholesterol checked if:
  – You have diabetes.
  – You have high blood pressure.
  – Heart disease runs in your family.
  – You smoke.
- **High blood pressure:** Have your blood pressure checked at least every year.
- **Colorectal cancer:** Have a test for colorectal cancer starting at age 50. Your doctor can help you decide which test is right for you. If you have a family history of colorectal cancer, you may need to be screened earlier.
- **Diabetes:** Have a test for diabetes if you have high blood pressure or high cholesterol.
- **Depression:** Your emotional health is as important as your physical health. If you have felt "down," sad, or hopeless over the last 2 weeks, you may be depressed. If you have felt little interest or pleasure in doing things, you also may be depressed. Talk to your doctor about being screened for depression.
- **Osteoporosis** (thinning of the bones): Have a bone density test beginning at age 65 to screen for osteoporosis. If you are between the ages of 60 and 64, talk to your doctor about being tested.
- **Chlamydia and other sexually transmitted diseases:** A yearly chlamydia screening is suggested for sexually active females ages 25 or younger. A screening is also recommended for older women who are at increased risk for infection. Also, talk to your doctor about being tested for other STDs.
- **HIV:** Have a test to screen for HIV infection if you:
  – Have had unprotected sex.
  – Are pregnant.
  – Have used or now use injection drugs.
  – Exchange sex for money or drugs or have sex partners who do.
  – Have past or present sex partners who are HIV-infected, are bisexual, or use injection drugs.
  – Are being treated for sexually transmitted diseases.
  – Had a blood transfusion before 1985.

Section 10: Grievance and appeals

Complaint, grievance and appeal procedures

We want to keep our members happy. We know there are times when members have questions or concerns about the service that they receive. When this happens, feel free to call Member Services at **1-866-316-3784** TTY **711**. We will try to clear up any concerns as quickly as possible.

If you're still not happy, we have procedures for addressing your concerns. For a more complete explanation of the grievance and appeal process, please see Section 10 of the Certificate of Coverage. You may also call Member Services at **1-866-316-3784**, TTY **711** or visit **AetnaBetterHealth.com/Michigan**.

Grievance and Appeals Program (GAP)

You may occasionally encounter problems with the Plan. You may have difficulty scheduling appointments. There may be long wait times in your doctor's office. The quality of service may not be as expected. You may have a disagreement with one of your care providers. You may have a denial of service.

Member Services resolves most member concerns during the initial call or within 3 business days. However, if this is not the case, the Plan has a formal process for dealing with problems you encounter. This is called the Grievance and Appeals Program (GAP).

What are grievances and appeals?

A grievance may occur when you are upset about the quality, availability, or delivery of services that you received. You may file an appeal if Member Services does not resolve your grievance. You can also file an appeal if you are not happy with the decisions covering or paying for services.

It is your right to ask us to investigate your concern or to review our decision. Aetna Better Health can help members with filing grievances and appeals. This includes providing services for members who have a hard time with hearing. This also includes providing interpreters for members who do not speak English.

How to file a grievance

You can file a grievance in writing or over the phone. You can mail or deliver your grievance to: Aetna Better Health of Michigan ATTN: Appeals Coordinator 1333 Gratiot Avenue, Suite 400 Detroit, Ml 48207 or you can call **1-866-316-3784**, TTY **711**.

A grievance can be filed at any time. If you send your grievance to us in writing, we will send you a letter within three days of receiving your grievance. The letter will let you know we have received it. Our staff reviewing your grievance will not have been previously involved in any prior decisions about your grievance. Aetna Better Health will make sure that the staff reviewing your grievance has the needed qualifications to review your grievance/appeal.

With your permission, someone else may ask for a grievance on your behalf. This person can be a friend, a relative, a doctor or an attorney. This person is called an Authorized Representative. Aetna Better Health has 90 calendar days from when a grievance is received to respond to it. In the case someone else submits an appeal for you, Aetna will resolve it within 30 days of receipt of the Authorized Representative Form naming that person for you.

When can I ask for an appeal?

If we make a decision about your grievance that you are not happy with, you can file an appeal. You have 60 calendar days from the date that we made the decision to file one (1) appeal. This may be the date on the "Adverse Action Notice" that you received. You can start the process by calling Member Services. However, you must follow up with a letter. If you need help filing your appeal, Member Services will help you.

With your permission, someone else may ask for a grievance or appeal on your behalf. This person can be a friend, a relative, a doctor or an attorney. This person is called an Authorized Representative. Aetna Better Health has 30 calendar days from when an appeal is received to resolve it.

You can file an appeal before you have a service, if you already know that we will not cover or pay for the service. You can also file an Appeal after you have received a service and we have declined to cover it.

If you wish to present a grievance/appeal or to contact the Appeals Coordinator, you can call toll free at **1-866-316-3784**, TTY **711**.

Your appeal request should include:

- Name.
- Aetna Better Health ID number.
- Date of birth.
- Details on the matter you want reviewed (include types of services or disputed claims) and explanation of why we should reverse our decision with copies of any information that will support your request.
- When you were scheduled to receive services, or when you received the services.
- Name of provider(s) that ordered services.
- If you have an authorized representative, you should also send us the Authorized Representative Form. We cannot begin to review your appeal until we receive the Authorized Representative form.
- If you send the Authorized Representative form to us during the timeframe that you have to send us a grievance/appeal, we will start to process your appeal. If we do not get the form in the timeframe, we will close your appeal.

We may tell you that we need more time to look at your grievance/appeal or obtain additional information from your treating provider. If it's in your best interest, we will only use up to 14 more calendar days to review your grievance/appeal. We will only do this if it is in your best interest.

Within 3 working days of receipt of your grievance/appeal, the Appeals Coordinator will send a letter to you or your authorized representative. This letter will let them know that we have received the grievance/appeal. We will send written notice of our decision to you or your authorized representative within the correct timeframe after your grievance/appeal is received.

Aetna has interpreter services available. If you need them to complete a grievance or appeal, you can access these services by contacting Aetna Member Services. You also have the right to provide information for your appeal in person, as well as in writing.

Expedited (fast) urgent grievance/appeals

You or your authorized representative (which may include the treating provider) may file an urgent grievance/appeal in writing or orally concerning an urgent care claim. If your treating provider asks for an urgent grievance/appeal for you, we will treat it like it is urgent. Urgent appeals must be filed within 10 days of receiving an adverse action notice.

If you ask us for an urgent grievance/appeal but your doctor does not send us information about that request, we will check to see if it is really urgent. If it's not urgent, we will handle it like a regular grievance/appeal and send you an answer within the timeframes explained above.

Your urgent grievance/appeal should include:

- Name.
- Aetna Better Health ID number.
- Date of birth.
- Details on the matter you want reviewed (include types of services or disputed claims).
- An explanation of why we should reverse our decision with copies of any information that will support your request.
- Date of service.
- Name of provider(s).
- If you have an authorized representative, other than your doctor, you should also send us the Authorized Representative Form within the first 48 hours. This form should include the authorized representative's mailing address and telephone number. If you cannot send the form because of an emergency or because of your health, we will go ahead with your grievance/appeal. We will also talk with your Authorized Representative if it is in your best interest. We will only talk to your authorized representative about your grievance/appeal.

You will be notified, if there aren't enough facts provided with the urgent grievance/appeal. We will notify you or your authorized representative by phone of the facts needed.

If you or Your Authorized Representative asks for more time when we are looking at your urgent grievance/appeal, the grievance/appeal will have to be moved to the regular timeframe. We will send you a letter within 2 days to tell you this. If you or Your Authorized Representative want us to look at the grievance/appeal quickly again, you can ask us to do so. We will give you an answer within 72 hours.

When the information is received, a hearing will be scheduled with an Appeals Committee. The hearing will take place within 48 hours of your request. Your grievance/appeal will be resolved within 72 hours of your request. If the facts are not received, the Appeal Committee will make a decision based on the information available.

Your rights – continuing your benefits

During the time that we are processing your grievance/appeal you may be entitled to continuation of benefits. While your Patient Right to Independent Review Act (PRIRA) review or your State Fair Hearing is pending, you may be entitled to continuation of benefits as well. If the denial is upheld, you may be responsible for payment of these benefits. Please refer to Section 10.4 of your Certificate of Coverage for more information.

State Fair Hearing

Within 120 days of the Adverse Action Notice in response to your Appeal, you have the right to request a State Fair Hearing through the Michigan Department of Health and Human Services. You also have the right to a State Fair Hearing if we do not respond to your grievance/appeal within the timeframes explained above. If you need help completing the Request for State Fair Hearing form, call Member Services at **1-866-316-3784**, TTY **711**. This request can be submitted during the appeals process. Submit your request to:

Michigan Office of Administrative Hearings and Rules (MOAHR) for the
Department of Health and Human Services
P.O. Box 30763
Lansing, Ml 48909
1-877-833-0870

Your rights – Patient Right to Independent Review Act (PRIRA)

You have the right to use the PRIRA process. You can send a PRIRA appeal to the Michigan Department of Insurance and Financial Services (DIFS):

- After you have used our Grievance and Appeal Program, and we have sent you our final decision for a non-urgent appeal. You must request a PRIRA review within 127 days of your receipt of our final decision

- When you ask us for an urgent grievance or appeal regarding an Adverse Determination and we do not think it is urgent. You must request PRIRA review within 10 days from when we tell you it is not urgent
- When you ask us for an urgent grievance/appeal regarding an Adverse Determination, you can also ask for an expedited PRIRA appeal within 10 calendar days of filing with us.

You should use the "Health Care Request for External Review Form" that we provide to you. This form can also be found at: **www.michigan.gov/documents/cis_ofis_fis_0018_25078_7.pdf**.

To qualify for PRIRA review:

- You must have received an Adverse Determination and a final decision from Aetna Better Health (except in urgent cases explained above)
- You must have been covered by us on the date of service in question
- The service you requested must reasonably appear to have been a Covered Service in the Certificate of Coverage
- You must have exhausted their grievance/appeal rights with us except in the case of an Urgent/Expedited Grievance/Appeal

If an expedited PRIRA review is required, DIFS will finish it within 72 hours after your written request was submitted. If you need help completing the "Health Care Request for External Review Form," call Member Services at **1-866-316-3784**, TTY **711**.

Your PRIRA review request can be sent by fax to **517-284-8838**. You can also send it by UPS or U.S. mail to:

DIFS, Health care Appeals Section Office of General Counsel
P.0. Box 30220, Lansing, Ml 48909-7720
1-877-999-6442

Delivery service to:

Office of General Counsel Health Care Appeals Section Department of Insurance and Financial Services, 530 W. Allegan St., 7th Floor Lansing. Ml 48933-1521

Your PRIRA review request must include a copy of the Final Adverse Determination from Aetna Better Health, any pertinent documentation about your case, such as:

- bills
- benefits
- explanations
- medical records
- correspondence
- research materials that support your position, etc.

It's your responsibility to submit this documentation; DIFS does not contact medical providers for this information. You should always send copies; not the originals.

You do not need to hire a lawyer to request a PRIRA review. You can authorize someone to act on your behalf, such as:

- a clergy
- a friend
- a family member
- your doctor
- a lawyer

DIFS will notify you within 5 business days of receiving your request for PRIRA review if they will accept your case. If DIFS accepts your case for review, they may tell you that it needs to get a recommendation from an Independent Review Organization. An Independent Review Organization is an entity that can perform an unbiased medical review of your case.

If DIFS does not need to consult with an Independent Review Organization, you can expect to receive a decision within 14 calendar days after DIFS accepted your request for review. If DIFS has to consult with an Independent Review Organization, the Independent Review Organization has 14 calendar days after it gets the case from DIFS to make a recommendation to DIFS. DIFS then has 7 business days to send its decision to you.

If you disagree with the DIFS decision, you can appeal to the circuit court of the county in which you live, or the Circuit Court of Ingham County.

PRIRA review does not apply to issues of termination or cancellation.

If you have questions about PRIRA reviews, you can call the Appeals Coordinator at **1-866-316-3784** or DIFS at **1-877-999-6442**.

Section 11: Confidentiality and privacy

Medical records

A Member or Authorized Representative of a Member may review the records of the Plan relating solely to the Member, at the offices of the Plan. This review must be during regular business hours. It must also beat an appointed time agreed to by the Plan and requested by the Member for that purpose. The Plan must reasonably grant such requests.

Your privacy matters

We respect your privacy. As required by the Health Insurance Portability and Accountability Act (HIPAA), Aetna, and each member of the Aetna family of companies (an "Affiliate"), is giving you important information about how your medical and personal information may be used and about how you can access this information. **Please review the following Notice of Privacy Practices carefully**. If you have any questions, please call Member Services at **1-866-316-3784**, TTY **711**.

Notice of privacy practices

Para recibiresta notificacion en espanol por favor llamaral numero gratuito de Member Services (Servicios a Miembros) que figura en su tarjeta de identificacion.

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.

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

How we use and share your health information

Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you are no longer with our plan, with your okay, we will give your health information to your new doctor.

Family and friends: We may share your health information with someone who is helping you. They may be helping with your care or helping pay for your care. For example, if you have an accident, we may need to talk with one of these people. If you do not want us to give out your health information, call us at **1-866-316-3784**.

If you are a minor and don't want us to give your health information to your parents, call us at **1-866-316-3784**. 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 you can access or enroll in to help you with your health problems. Materials are available to members. 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.

Reasons that we will need your written okay

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

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

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

What are your rights

You have the right to look at your health information.

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

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

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

You have the right to get a list of people or groups that we have shared your health information with. You have the right to ask for a private way to be in touch with you.

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

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

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

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

- We will tell you if we do this in a letter.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- We don't have to agree. But, we will think about it carefully.
- You have the right to know if your health information was shared without your okay.
- We will tell you if we do this in a letter.

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

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

You also have the right to send us a complaint. If you think your rights were violated write to us at: Aetna Better Health of Michigan, Member Services department 1333 Gratiot Avenue, Suite 400, Detroit, Ml 48207

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

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

Protecting your information

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

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

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

The Authorization to Release Protected Health Information form is available on the on the Aetna Better Health website at **AetnaBetterHealth.com/Michigan/Members/Medicaid**.

Will we change this notice

By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. You can get a copy of the most recent notice on our web site at **AetnaBetterHealth.com/Michigan**.

Section 12: Definitions

1.1 **ABUSE** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

1.2 **ADVERSE DETERMINATION** means the PLAN'S denial or limited authorization of a requested service, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Determination also includes (a) the failure to provide services in a timely manner, (b) any entire or partial reduction, suspension, or termination of a benefit or previously authorized service, or(c) failure to act within specified timeframes when addressing appeals and grievances. An Adverse Determination based, in whole or in part, on medical judgment includes the failure to authorize or cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.

1.3 **APPEAL** means the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan or Dental Plan. You can appeal if your plan:

- Denies your request for:
  - — A health care service
  - — A supply or item
  - — A prescription drug that you think you should be able to get
  - — A dental service
  - — A dental appliance or device
- Reduces, limits or denies coverage of:
  - — A health care service
  - — A supply or item
  - — A prescription drug you already got
  - — A dental service
  - — A dental appliance or device
- Your plan stops providing or paying for all or part of:
  - — A service
  - — A supply or item
  - — A prescription drug you think you still need
  - — A dental service
  - — A dental appliance or device
  - — Does not provide timely health or dental services .

1.4 **ATTENDING PHYSICIAN** means any Physician responsible for managing the Member's care during a hospitalization or institutionalization.

1.5 **BUSINESS DAY** means Monday through Friday, except those days identified by the state as a holiday.

1.6 **CHRONIC** means a health condition that is prolonged or lingering in duration.

1.7 **COPAYMENTS** mean an amount you are required to pay as your share of the cost for a medical service or supply or dental service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug
- A dental visit
- A dental appliance or device

A copayment is usually a set amount. You might pay $2 or $4 for a doctor's or dental visit or prescription drug.

1.8 **COSMETIC SERVICES AND SURGERY** means medical or surgical services (i) performed to reshape normal structures of the body in order to improve the Member's appearance and self-esteem; (ii) from which no significant improvements in physiological function could reasonably be expected; (iii) that do not meaningfully promote the proper function of the body (iv) that do not prevent or treat illness or disease; or (v) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

1.9 **COVERAGE** or **COVERED** means the entitlement of a Member to services provided in this Certificate of Coverage, subject to the terms, conditions, limitations, and exclusions herein, including the following: (i) health services must be provided when the Certificate of Coverage is in effect; (ii) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Certificate of Coverage occur; (iii) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Certificate of Coverage, and (iv) health services must be Medically Necessary, and must not be listed in Section 7 as an Exclusion.

1.10 **COVERED SERVICES** means the health care services described at Section 6 of this Agreement and all supplemental benefits described in Attachments to this Agreement, if any, to the extent such services are required to be provided under policies of the Michigan Medicaid program.

1.11 **DENTAL INSURANCE** means a type of coverage that pays for dental costs for people. It can pay the person back for costs from dental injury or treatment. It can also pay the provider directly. Dental insurance requires the payment of premiums (see premium) by the person getting the insurance.

1.12 **DENTAL PLAN** means a plan that offers health care services to members who meet state eligibility rules. The state contracts with certain dental organizations to provide dental services for those who are eligible. The state pays the premium on behalf of the member.

1.13 **DENTAL SERVICES** means oral health services provided by a person licensed under state law to practice dentistry.

1.14 **DURABLE MEDICAL EQUIPMENT**
Equipment and supplies ordered by a health care provider for everyday or extended use. This may include:
- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics
- Blood pressure cuffs

1.15 **EFFECTIVE DATE** means the date when the Member is entitled to receive Covered Services under this Agreement, as determined by the Medicaid program.

1.16 **ELECTIVE SURGICAL PROCEDURE** means a treatment technique performed through surgery which is a Covered Service under Section 6.0 of this Certificate of Coverage and which is one of several optional medical treatments available, relative to the particular condition, which are acceptable under the current standards of Physicians or Health Professionals in the community.

1.17 **ELIGIBILITY APPLICATION** means the form signed by the Member to obtain Medicaid/Public Assistance services under this Agreement for himself or herself and eligible Dependents.

1.18 **EMERGENCY DENTAL CONDITION** means a dental injury or condition so serious that you would seek care right away to avoid harm.

1.19 **EMERGENCY MEDICAL CONDITION** means an illness, injury or condition so serious that you would seek care right away to avoid harm.

1.20 **EMERGENCY MEDICAL TRANSPORTATION** means ambulance services for an emergency medical condition.

1.21 **EMERGENCY ROOM CARE** means care given for a medical emergency when you think that your health is in danger **OR** care given for a dental emergency that requires dental treatment right away.

1.22 **EMERGENCY SERVICES** means review of an emergency medical or dental condition and treatment to keep the condition from getting worse.

1.23 **ENROLLEE** means a Medicaid beneficiary who is currently enrolled in a managed care organization in a given managed care program.

1.24 **EXCLUDED SERVICES** means health care services or dental services that your plan doesn't pay for or cover.

1.25 **EXPERIMENTAL AND INVESTIGATIONAL** means those health products or services that meet one of the following conditions: (a) any drug or device that is not approved for use by the Food & Drug Administration ("FDA"); any drug classified by the FDA as

investigational new drug ("IND"); any drug requiring preauthorization that is proposed for off-label prescribing; (b) any health product or service that is subject to Investigational Review Board ("IRB") review or approval; (c) any health product or service that is the subject of a clinical trial that meets criteria for Phase I, II, or III, as set forth by FDA regulations; or (d) any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-reviewed medical literature and generally recognized by academic experts.

1.26 **FORMULARY** means a listing of prescription drugs approved by the PLAN for coverage under this Agreement, dispensed by a pharmacy to Members. This list is subject to periodic review and change by the PLAN. The Formulary is available for review in Participating Providers' offices, on the PLAN'S website, at **AetnaBetterHealth.com/Michigan** or by contacting the PLAN'S Member Service department.

1.27 **FRAUD** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself or some other person.

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

1.29 **GRIEVANCE AND APPEAL PROGRAM** means the procedure under which a Member must file any Appeal or Grievance involving the PLAN, a Participating Provider Center, or any Participating Physician, Participating Health Professional, or other Participating Provider.

1.30 **HABILITATION SERVICES AND DEVICES** mean health care services that help a person keep, learn or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

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

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

1.32 **HEALTH PROFESSIONAL** means a podiatrist, dentist, nurse, optometrist, or other individual licensed or certified to practice a health care profession other than medicine or osteopathy by the state in which he or she is located.

1.33 **HOME HEALTH CARE** means health care services that a health care provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

1.34 **HOSPICE SERVICES** means a special way of caring for people who are terminally ill and provide support to the person's family.

1.35 **HOSPITAL** means an institution, operated pursuant to law, which (a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic, and surgical techniques by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVII of the Social Security Act (Medicare program). A facility that is primarily a place for rest, custodial care, or care of the aged, a nursing home, convalescent home, or similar institution is NOT a Hospital.

1.36 **HOSPITALIZATION** means care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

1.37 **HOSPITAL OUTPATIENT CARE** means care in a hospital that usually does not need an overnight stay.

1.38 **IDENTIFICATION CARD** means the card issued by the PLAN to each Member for purposes of identifying such individuals. The rights and responsibilities attendant to Members issued an Identification Card are set forth in Section 3.3 of this Certificate of Coverage.

1.39 **INDIAN HEALTH CARE PROVIDER** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

1.40 **INFERTILITY** means the inability of a woman to conceive a pregnancy after six (6) months of unprotected intercourse with a man, or the inability of a woman to carry a pregnancy to live birth as evidenced by three consecutive miscarriages (spontaneous abortions).

1.41 **MEDICAID HEALTH PLAN** means a plan that offers health care services to members who meet state eligibility rules. The state contracts with certain Health Maintenance Organizations (HMOs) to provide health services for those who are eligible. The state pays the premium on behalf of the member.

1.42 **MEDICALLY NECESSARY** means health care services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or Symptom

OR

Dental services or supplies that meet accepted standards of dental practices needed to diagnose or treat an oral health:

- Injury
- Condition
- Disease or Symptom

1.43 **MEMBER** means any person entitled to Covered Services under this Agreement in accordance with its terms and conditions.

1.44 **MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES** or **MDHHS** means the administrative agency responsible for administering the Medicaid program in Michigan.

1.45 **NETWORK** means health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

OR

Dental providers contracted by your plan to provide dental services. This includes:

- Dentists
- Dental Specialists

1.46 **NETWORK CENTER ASSOCIATION OR CENTER** means a partnership, corporation or association that has entered into a services arrangement or other arrangement with Physicians and Health Professionals (a majority being physicians) and which has additionally contracted with the PLAN to provide or arrange for the provision of Covered Services to Members.

1.47 **NETWORK PROVIDER/PARTICIPATING PROVIDER** means a health care provider or dental provider that has a contract with the plan as a provider of care.

1.48 **NON-PARTICIPATING/OUT-OF-NETWORK PROVIDER** means a health care provider or dental provider that **does not** have a contract with the Medicaid health plan as a provider of care.

1.49 **DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES ("DIFS").** The agency that oversees financial institutions, insurance companies, and securities in the state of Michigan. DIFS can assist Members if they have questions, complaints, or concerns about credit unions, insurance companies, banks, securities, and health maintenance organizations ("HMOs").

1.50 **OUT-OF-AREA SERVICES** means those Covered Services provided when a Member is temporarily absent from the Service Area that are immediately required as a result of an unforeseen illness, injury, or condition, and it is not reasonable for Member to obtain such Covered Services through the PLAN in the PLAN'S Service Area due to the circumstances.

1.51 **PARTICIPATING**, when used with Physician, Health Professional, Hospital or Skilled Nursing Facility or other individual, facility or health care entity means that the person or entity has entered into a direct or indirect written agreement with the PLAN to provide health services to Members. "Participating" refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers delivered to Members in connection with the Agreement. The participation status of Providers may change from time to time.

1.52 **PHYSICIAN** means any doctor duly licensed and qualified to practice medicine (M.D.) or osteopathy (D.O.) in the state of Michigan.

1.53 **PHYSICIAN SERVICES** means health care services provided by a person licensed under state law to practice medicine

1.54 **PLAN** means Aetna Better Health of Michigan, Inc.

1.55 **PREAUTHORIZATION** means approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment
- Prescriptions
- Dental services
- Dental appliances or devices

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

1.56 **PREMIUM** means the amount paid for health care and/or dental benefits every month. Medicaid Health Plan and Dental Plan premiums are paid by the state on behalf of eligible members.

1.57 **PRESCRIPTION DRUG COVERAGE** means a health insurance or plan that helps pay for prescription drugs and medications.

1.58 **PRESCRIPTION DRUGS** means drugs and medications that require a prescription by law by a licensed Provider.

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

1.60 **PROVIDER** means a person, place or group that's licensed to provide health care like doctors, nurses and hospitals.

OR

A person, place or group that's licensed to provide dental services like dentists.

1.61 **RECONSTRUCTIVE SURGERY** means surgery that is performed on abnormal structures of the body which are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or diseases and which is performed to improve function or to approximate a normal appearance.

1.62 **REHABILITATION SERVICES AND DEVICES** means rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury.

These services can be done inpatient or outpatient and may include:
- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

1.63 **SERVICE AREA** means the geographic area in which the PLAN has been authorized by the state of Michigan to provide or arrange for the provision of Covered Services to Members. Service Area is subject to change.

1.64 **SKILLED NURSING CARE** means Services in your own home or in a nursing home provided by trained:
- Nurses
- Technicians or,
- Therapists

1.65 **SKILLED NURSING FACILITY** means an institution that is licensed by the state in which it is located to provide skilled nursing services, and which has entered into an Agreement with the PLAN to provide such services to Members.

1.66 **SPECIALIST** means a licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

OR

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

1.67 **STATE** means the single state agency for the Medicaid program.

1.68 **TRANSPLANT NETWORK** means the group of Providers designated by the PLAN to provide transplant services and treatment to Members. The Transplant Network is developed and managed by the PLAN'S corporate parent, Aetna Better Health of Michigan.

1.69 **URGENT CARE** means care for an illness, injury or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

OR

Care for a dental injury or condition bad enough to seek care soon but not bad enough that it needs emergency room care. Urgent dental care can be treated with a quick dental appointment.

1.70 **URGENT/EXPEDITED GRIEVANCE/APPEAL** means a Grievance/Appeal that requires immediate attention, within seventy-two (72) hours of request because the time frame for the non-Urgent/non-Expedited Appeal process (i) could seriously harm the Member's life or health, or if the Member is pregnant, the life or health of the fetus; (ii) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain or health risk that could not be adequately managed without care or treatment.

Section 13: Certificate of Coverage

Aetna Better Health of Michigan Medicaid
Program Certificate of Coverage

Welcome to Aetna Better Health of Michigan.

We are extremely pleased to have you as a member in our health plan and look forward to serving you. We have built a strong network of area doctors, hospitals, and other providers to offer abroad range of services for your medical needs.

As an Aetna Better Health of Michigan member, it is important that you understand the way your benefits and coverage works. This Certificate of Coverage contains the information you need to know about your coverage with us. You should also review the enclosed Member Handbook. The Member Handbook contains important information about your coverage with us. The Certificate of Coverage and Member Handbook are also on our website at **AetnaBetterHealth.com/Michigan**.

Please take a few minutes to read these materials. Make sure your covered family members are also aware of the provisions of your coverage. Our Member Service department is available to answer any questions you may have about your coverage. You can reach Member Service at **1-866-316-3784**, Monday through Friday, 8 AM through 5 PM., EST.

We look forward to serving you.

Sincerely,

Beverly A. Allen
Executive Director

Aetna Better Health of Michigan Medicaid
Program Certificate of Coverage

The Agreement between Aetna Better Health of Michigan Inc. (hereafter called the "PLAN", "We", "Us", or "Our") and You and, if applicable, Your Dependents as Members of the PLAN (hereafter called "You" or "Member") is made up of this Certificate of Coverage, and any amendments (collectively "this Agreement" or "the Agreement").

No person or entity has any authority to waive any Agreement provision or to make any changes or amendments to this Agreement unless approved in writing by an officer of the PLAN, and the resulting waiver, change, or amendment is attached to the Agreement. You are subject to all terms, conditions, limitations, and exclusions in this Agreement and to all the rules and regulations of the PLAN.

THIS AGREEMENT SHOULD BE READ AND RE-READ IN ITS ENTIRETY. Many of the provisions of this Agreement are related to each other; therefore, reading just one or two provisions may give You a misleading impression. Many words used in this Agreement have special meanings. These words will appear capitalized and are defined for You in Section 1 of this Agreement, "Definitions." By using these definitions, You will have a clearer understanding of Your coverage.

From time to time, this Agreement may be amended. When that occurs, We will notify you by U.S. mail. The amended agreement or new Certificate of Coverage will be placed on our website at **AetnaBetterHealth.com/Michigan**. If you would like a copy mailed to you, you may contact Customer Service at **1-866-316-3784**. You should keep this document in a safe place for Your future reference.

This Agreement and all riders attached to it contain the terms and provisions pursuant to which medical and hospital services will be arranged for by the PLAN to Members (as defined below) eligible for such Coverage (as defined below) under the Michigan Medicaid program ("Medicaid program").

SECTION 1.0 – DEFINITIONS

1.1 **ABUSE** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

1.2 **ADVERSE DETERMINATION** means the PLAN'S denial or limited authorization of a requested service, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Determination also includes (a) the failure to provide services in a timely manner, (b) any entire or partial reduction, suspension, or termination of a benefit or previously authorized service, or(c) failure to act within specified timeframes when addressing appeals and grievances. An Adverse Determination based, in whole

or in part, on medical judgment includes the failure to authorize or cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.

1.3 **APPEAL** means the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan or Dental Plan. You can appeal if your plan:

- Denies your request for:

— A health care service
— A supply or item
— A prescription drug that you think you should be able to get
— A dental service
— A dental appliance or device

- Reduces, limits or denies coverage of:

— A health care service
— A supply or item
— A prescription drug you already got
— A dental service
— A dental appliance or device

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

— A service
— A supply or item
— A prescription drug you think you still need
— A dental service
— A dental appliance or device
— Does not provide timely health or dental services .

1.4 **ATTENDING PHYSICIAN** means any Physician responsible for managing the Member's care during a hospitalization or institutionalization.

1.5 **BUSINESS DAY** means Monday through Friday, except those days identified by the state as a holiday.

1.6 **CHRONIC** means a health condition that is prolonged or lingering in duration.

1.7 **COPAYMENTS** mean an amount you are required to pay as your share of the cost for a medical service or supply or dental service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug
- A dental visit
- A dental appliance or device

A copayment is usually a set amount. You might pay $2 or $4 for a doctor's or dental visit or prescription drug.

1.8 **COSMETIC SERVICES AND SURGERY** means medical or surgical services (i) performed to reshape normal structures of the body in order to improve the Member's appearance and self-esteem; (ii) from which no significant improvements in physiological function could reasonably be expected; (iii) that do not meaningfully promote the proper function of the body (iv) that do not prevent or treat illness or disease; or (v) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.

1.9 **COVERAGE** or **COVERED** means the entitlement of a Member to services provided in this Certificate of Coverage, subject to the terms, conditions, limitations, and exclusions herein, including the following: (i) health services must be provided when the Certificate of Coverage is in effect; (ii) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Certificate of Coverage occur; (iii) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Certificate of Coverage, and (iv) health services must be Medically Necessary, and must not be listed in Section 7 as an Exclusion.

1.10 **COVERED SERVICES** means the health care services described at Section 6 of this Agreement and all supplemental benefits described in Attachments to this Agreement, if any, to the extent such services are required to be provided under policies of the Michigan Medicaid program.

1.11 **DENTAL INSURANCE** means a type of coverage that pays for dental costs for people. It can pay the person back for costs from dental injury or treatment. It can also pay the provider directly. Dental insurance requires the payment of premiums (see premium) by the person getting the insurance.

1.12 **DENTAL PLAN** means a plan that offers health care services to members who meet state eligibility rules. The state contracts with certain dental organizations to provide dental services for those who are eligible. The state pays the premium on behalf of the member.

1.13 **DENTAL SERVICES** means oral health services provided by a person licensed under state law to practice dentistry.

1.14 **DURABLE MEDICAL EQUIPMENT**
Equipment and supplies ordered by a health care provider for everyday or extended use. This may include:
- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics
- Blood pressure cuffs

1.15 **EFFECTIVE DATE** means the date when the Member is entitled to receive Covered Services under this Agreement, as determined by the Medicaid program.

1.16 **ELECTIVE SURGICAL PROCEDURE** means a treatment technique performed through surgery which is a Covered Service under Section 6.0 of this Certificate of Coverage

and which is one of several optional medical treatments available, relative to the particular condition, which are acceptable under the current standards of Physicians or Health Professionals in the community.

1.17 **ELIGIBILITY APPLICATION** means the form signed by the Member to obtain Medicaid/Public Assistance services under this Agreement for himself or herself and eligible Dependents.

1.18 **EMERGENCY DENTAL CONDITION** means a dental injury or condition so serious that you would seek care right away to avoid harm.

1.19 **EMERGENCY MEDICAL CONDITION** means an illness, injury or condition so serious that you would seek care right away to avoid harm.

1.20 **EMERGENCY MEDICAL TRANSPORTATION** means ambulance services for an emergency medical condition.

1.21 **EMERGENCY ROOM CARE** means care given for a medical emergency when you think that your health is in danger **OR** care given for a dental emergency that requires dental treatment right away.

1.22 **EMERGENCY SERVICES** means review of an emergency medical or dental condition and treatment to keep the condition from getting worse.

1.23 **ENROLLEE** means a Medicaid beneficiary who is currently enrolled in a managed care organization in a given managed care program.

1.24 **EXCLUDED SERVICES** means health care services or dental services that your plan doesn't pay for or cover.

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- Condition
- Disease or Symptom

OR

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- Pharmacies

OR

Dental providers contracted by your plan to provide dental services. This includes:

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- Dental Specialists

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

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A person, place or group that's licensed to provide dental services like dentists.

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- Technicians or,
- Therapists

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

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OR

Care for a dental injury or condition bad enough to seek care soon but not bad enough that it needs emergency room care. Urgent dental care can be treated with a quick dental appointment.

1.70 **URGENT/EXPEDITED GRIEVANCE/APPEAL** means a Grievance/Appeal that requires immediate attention, within seventy-two (72) hours of request because the time frame for the non-Urgent/non-Expedited Appeal process (i) could seriously harm the Member's life or health, or if the Member is pregnant, the life or health of the fetus; (ii) in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain or health risk that could not be adequately managed without care or treatment.

SECTION 2.0 – ELIGIBILITY

2.1 **MEMBER ELIGIBILITY**. MDHHS is responsible for making all determinations regarding who is eligible to enroll in Medicaid managed care plans. The Michigan Department of Health and Human Services ("MDHHS") determines Medicaid eligibility. Most changes by MDHHS will be made on a calendar month basis. The PLAN shall be responsible for Member until the date of disenrollment. To be eligible to enroll as a Member a person must:

2.1.1 Meet the eligibility criteria established for Medicaid as determined by MDHHS

2.1.2 Reside within the Service Area; and

2.1.3 Be determined by MDHHS to be appropriate for enrollment in a managed care plan, such as the PLAN

2.2 **LOSS OF MEDICAID ELIGIBILITY**. Effective on the date a Member covered by this Agreement loses his or her eligibility under the Medicaid Program, coverage under this Agreement shall terminate. In the case of an inpatient hospital admission, payment for services will continue until the Member is discharged from the hospital. If the person regains Medicaid eligibility within ninety (90) days from the date eligibility was terminated, the PLAN will accept automatic re-enrollment of the person on a prospective basis as determined by MDHHS.

SECTION 3.0 – ENROLLMENT AND COVERAGE EFFECTIVE DATES

3.1 **ENROLLMENT**. MDHHS is responsible for determining a person's eligibility for enrollment with the PLAN and will provide all enrollment materials to Members. At the time of birth, newborns of women enrolled with the PLAN are automatically enrolled as Members for at least the month in which the birth occurs and may be eligible for a longer period.

3.1.1 **ENROLLMENT PROCESS AND COLLECTED INFORMATION**. MDHHS contracts with an enrollment services vendor to contact and educate general Medicaid beneficiaries about Medicaid managed care and to enroll and change enrollment for these beneficiaries. The PLAN does not administer the enrollment process, and a beneficiary is not deemed to be enrolled with the PLAN until the PLAN has received information from the enrollment services vendor. All enrollment and disenrollment determinations are made solely by MDHHS. A Member shall complete and provide to the PLAN or its Participating Physicians, Hospitals, Health Professionals or Skilled Nursing Facilities any forms (other than an Eligibility Application) that are reasonably requested, including medical questionnaires, and a Member shall assure that all information in such forms is true, correct and complete. If a Member intentionally submits any false or misleading information or omits any material fact, on such forms about him/herself or his/her family members, the PLAN

may ask MDHHS to terminate the Member's enrollment from the PLAN. At all times, the PLAN shall ensure that Member's health information is protected pursuant to state and federal law, including but not limited to the Health Insurance Portability and Accountability Act ("HIPAA").

3.2 **EFFECTIVE DATE OF COVERAGE**

3.2.1 **MDHHS DETERMINES EFFECTIVE DATE**. Coverage is effective on the first day of the month MDHHS notifies the PLAN of the Member's enrollment. For qualified newborns, coverage will be effective on the first day of the month of their birth.

3.2.2 **NOTICE OF EFFECTIVE DATE**. The PLAN will notify the Member of the Effective Date in writing.

3.2.3 **NO COVERAGE PRIOR TO EFFECTIVE DATE**. Consistent with Medicaid requirements, Members are not eligible for Coverage for services provided before the Effective Date. If a Member is an inpatient at a hospital or other health facility on the Effective Date, no Coverage will be provided by the PLAN until the Member is no longer an inpatient in a hospital or facility, except in the case of a qualified newborn.

3.2.4 **MEMBERS CHANGING COVERAGE**. Members who are changing from Fee-for-Service (FFS) Medicaid or from another health insurance plan to Aetna Better Health of Michigan can continue to receive services covered under their previous plan, in certain circumstances. Members may be able to keep their current providers during this time. For more information, contact Member Services at **1-866-316-3784**, TTY **711**.

3.3 **IDENTIFICATION CARDS**. The PLAN will issue Identification Cards to Members, and such Identification Cards are to be used for identification purposes only and must be presented whenever the Member obtains Covered Services. The PLAN'S non-emergency and emergency contact numbers are on the back of the Identification Card. Only the Member to whom the identification card is issued may use it. A person who is no longer eligible for Coverage or a person who is not designated as the Member on the Identification Card is not entitled to receive Covered Services and has no rights under the Identification Card. The Identification Card shall be returned to the PLAN at its request upon termination of Coverage or misuse.

If a Member misuses, or allows another person to use the Identification Card, or otherwise defrauds or attempts to defraud the PLAN, then the PLAN may request from MDHHS approval to terminate the Member, and Member may be subject to prosecution. The PLAN will report all suspected acts of fraud and abuse to applicable state agencies, including MDHHS's Medicaid Integrity Program Section.

SECTION 4.0 – TERMINATION

4.1 **CANCELLATION OF THE PLAN/MDHHS CONTRACT**. A Member's Coverage shall be subject to a transition plan in the event the contract between the PLAN and the state of Michigan under which this Coverage is provided is cancelled. If the contract between the PLAN and the state of Michigan is cancelled, then MDHHS is responsible for arranging for Members to be reassigned or enrolled in another comparable program. MDHHS is also responsible for setting a cancellation date.

4.2 **DISENROLLMENT BY MEMBER WITHOUT CAUSE**. Disenrollment by a Member is allowed during the initial 90 days of enrollment in the PLAN and during the annual open enrollment period. The Member may choose to enroll in another Medicaid health plan. MDHHS will notify the Member of the annual open enrollment period.

4.3 **DISENROLLMENT BY MEMBER FOR CAUSE**. Disenrollment by a Member is only allowed at certain times under MDHHS policy. To request disenrollment, a Member must follow the procedures established by MDHHS and the PLAN'S disenrollment procedures as approved by MDHHS. Member should contact the "Beneficiary Help Line" at **1-888-642-3195** to request the "MSA 176 Special Disenrollment" Form. Michigan Enrolls will mail the form to the Member. Member must show that he or she has contacted the PLAN to resolve the issue of concern. Member must also provide supporting physician documentation of the services that are being requested that the PLAN cannot make arrangements either within or out of network. Once Member has submitted a request for disenrollment to MDHHS, the Member's access to care and services through the PLAN will continue until he or she is informed in writing of the approval and approval effective date. If the disenrollment request is approved, the Member will be enrolled in another Medicaid health plan or in Medicaid Fee-for-Service as determined by MDHHS. If the request is denied, the Member will remain enrolled in the PLAN until the next open enrollment period. Members may request disenrollment under this Section 4.2 if the Member cannot change health plans because the Member has been enrolled for more than ninety (90) days, or the Member does not meet the timeframe guidelines for a medical exception, AND for any of the following reasons:

4.3.1 **Medical Reasons**: The Member's Provider must give MDHHS information to show that Member has a serious medical condition, and is under active treatment for that condition, and is receiving active treatment from a provider who no longer participates with the PLAN in which Member is enrolled. The Provider must state that he or she cannot safely transition care to another provider within the PLAN'S network, and that there is a need for the Member to remain with the provider who will not accept an out of network referral from the PLAN. The Provider must indicate the date they terminated their

contract with the PLAN, the last date they treated the Member, and if they accept Michigan Medicaid or participate with any other Medicaid health plans in the Member's county.

4.3.2 **Lack of Access Reasons**: Member can request disenrollment if the Member experiences a lack of access to Covered Services or Providers. Member must describe the Medically Necessary Covered Services that have been prescribed but that are inaccessible, or Member must describe why he or she believes that the PLAN has not provided the Member with a Provider who is experienced in dealing with Member's health care needs. Member must show that he or she has tried to work with the PLAN on the access to care or specialists issue and that the PLAN cannot make the necessary arrangements for care either within or out of network. Supporting physician documentation is also required.

4.3.3 **Quality of Care**: Member must have concerns with the quality of care the PLAN'S Participating Providers have rendered. Member must show that he or she has tried to work with the PLAN on the quality of care issue and that the PLAN cannot make the necessary arrangements for care either within or out of network. Supporting physician documentation is also required.

4.3.4 **Lack of Access to Primary Care**: Member must show that there are no PCPs in the PLAN'S Service Area that are within thirty (30) minutes or thirty (30) miles of where the Member lives, or that the PCPs in the PLAN'S Service Area that are within thirty (30) minutes or thirty (30) miles of where Member lives are not taking new patients or have discharged the Member as a patient. This will not apply, however, if the Member specifically asked to be assigned to a PCP outside of thirty (30) minutes or thirty (30) miles.

4.4 **PLAN-INITIATED DISENROLLMENT**. The PLAN will petition MDHHS for disenrollment of a Member for the below listed reasons. All disenrollments are subject to the prior approval of MDHHS. Before a Member is disenrolled under this section, the PLAN will attempt to resolve the problem with the Member. A Member will have the right to contest through the Grievance and Appeal Program any decision made by the PLAN to request disenrollment of a Member, except when disenrollment is because the Member no longer meets MDHHS enrollment requirements. If the PLAN'S request to disenroll is approved, and Member is disenrolled, the disenrollment will be effective within sixty (60) days from the date MDHHS received the complete request from the PLAN to disenroll the Member. If the Member exercises their appeal right, the date of disenrollment shall be no later than thirty (30) days after resolution of the appeal, or on such other date as set by MDHHS. The Plan will be responsible for the Member until the date of disenrollment:

4.4.1 Fraud, abuse of the PLAN, or other intentional misconduct, including but not limited to, alteration or theft of prescriptions, misrepresentation of

membership, or unauthorized use of benefits.

4.4.2 Member's behavior towards either the PLAN or a Provider causes violent or life-threatening situations involving physical acts of violence, physical or verbal threats of violence, or stalking.

4.4.3 A Member misuses the Identification Card as provided in Section 3.3.

4.4.4 Other actions inconsistent with PLAN membership involving the repeated use of Non-Participating Providers when Participating providers are available; discharge from the practices of available Participating Providers; repeated emergency room use for non-emergency services; and other situations that impede care. The PLAN will not request disenrollment based on the physical or mental health status of the Member. If the Member's physical or mental health is a factor in the violent behavior or action inconsistent with PLAN membership, the PLAN must provide proof of the PLAN'S actions to assist the Member in correcting the problem, including appropriate physical and mental health referrals. The PLAN will also document that continued enrollment seriously impairs the PLAN or providers to furnish services to the Member or other members. MDHHS may require additional information from the PLAN to determine the appropriateness of the disenrollment.

4.5 **MOVING OUT OF SERVICE AREA**. If a Member moves out of the Service Area after the Effective Date, the PLAN Coverage will remain in effect until the Member is disenrolled by MDHHS from the PLAN. The Member may be required to return to the PLAN'S Service Area to seek Medically Necessary Covered Services from Participating Providers, or the PLAN may Authorize the Member to seek Medically Necessary Covered Services outside of the PLAN'S Service Area. The PLAN may not pay for otherwise Covered Services provided outside of the Service Area if no Prior Authorization was obtained, except when Covered Services were rendered in response to an Emergency Medical Condition.

4.6 **LONG-TERM CARE FACILITIES**. The PLAN may initiate a disenrollment request if a Member is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than forty-five (45) days. The PLAN will remain responsible for the Member until the date of disenrollment.

SECTION 5.0 SELECTION OF PARTICIPATING PROVIDERS & FEDERALLY QUALIFIED HEALTH CENTERS ("FQHC")

5.1 **PRIMARY CARE PHYSICIAN & FQHC SELECTION**. Upon enrollment through Michigan Enrolls, the Member shall select a PCP and, as applicable, a FQHC. If the Member fails to select a PCP, within one month of the Member's effective date of enrollment, the PLAN will automatically assign a PCP to the Member until the Member makes an alternate selection. After enrollment, a Member may choose a different PCP from a list provided by the PLAN by contacting the PLAN'S Customer Care Call Center. If the PLAN

cannot honor the Member's choice of PCP, the PLAN will contact the Member to assist the Member in making another choice. Member-initiated PCP changes will be permitted at any time; however, the PLAN may limit such changes when they are being requested without cause.

5.2 **PROVIDER DIRECTORY**. Participating Physicians, Health Professionals (including mental health providers) and other providers are subject to change, from time to time, with respect to individual practitioners or institutions. Accordingly, the PLAN neither warrants nor guarantees the length of service of any of its Participating Physicians or other Participating Providers.

5.3 **PHYSICIAN/PATIENT RELATIONSHIP**. When, after reasonable efforts are made, a Member and the Member's PCP are unable to establish or maintain a satisfactory relationship as physician and patient, a Member may be required to choose another PCP with not less than thirty (30) days' notice, subject to the Member's rights under the Grievance and Appeal Program. A PCP must notify a Member of the reason for dismissal by means of a certified letter to the Member's current address of record. A copy must also be sent to the PLAN.

5.4 **CONTINUATION OF CARE FROM A TERMINATED PROVIDER**. In the event Your Provider's participation with PLAN ends for any reason other than fraud or quality of care issues, you may be able to continue getting care from the Provider in certain circumstances. If You have ongoing treatment with the Provider (a) You can continue care with the Provider for ninety (90) days; or (b) if You are in the second or third trimester of Your pregnancy, You can continue related care through the postpartum period; or (c) if You are terminally ill and were terminally ill before Your Provider knew of their termination, and You were getting treatment for the terminal illness before the Provider's termination, You may continue care with the Provider related to the terminal illness through the remainder of Your life. Your Provider must agree to accept payment from Us in the amount we paid them under their contract with Us. They must also meet our quality standards, provide us with necessary medical record information, and comply with our utilization review, prior authorization, referral, and treatment plan requirements.

SECTION 6.0 – COVERED SERVICES

6.1 **COVERED SERVICES GENERALLY**. Enrollment in the PLAN entitles Members to receive the Covered Services set forth below, so long as such Covered Services are (a) provided, arranged and/or approved by the PCP (if required by the PLAN), (b) Medically Necessary, (c) subject to the limitations and exclusions set forth in this Agreement, and (d) required to be provided under policies of the Medicaid program. The PLAN has the authority to arrange and/or Authorize those services that are Medically Necessary. Members and Providers must comply with the terms and conditions of the PLAN regarding Prior Authorization of services. Failure to secure Prior Authorization may

result in the PLAN'S denial of payment for otherwise Covered Services. If a Member needs to see a Specialist, the Member's PCP will arrange the visit and provide Member with the appropriate documentation to take to the visit. Members are responsible for consulting with their PCP before receiving medical care from another Provider except as otherwise specified in this document. Members may only seek care from Specialists in the PLAN'S network. If a Member seeks care from a Specialist without the required documentation from their PCP, the Member will be responsible for payment if the member is informed by the Specialist prior to receiving services. Visits to Providers who are not in the PLAN'S network must first be approved by the PLAN'S Health Services Department. For example, the PLAN may cover services provided by a Provider outside the PLAN network if no similar Provider is available in network, or the PLAN may cover services outside the network to ensure that a Member's care is not interrupted. Services received outside the network must be approved by the PLAN. Members with serious health conditions may need to see a Specialist to get the care they need. PCPs will refer their Members accordingly for such care.

Some Members with special health conditions need to have a Specialist as their PCP, and should contact Customer Service for more information about this option.

6.2 **PHYSICIAN AND HEALTH PROFESSIONAL SERVICES**. Physician services covered by the PLAN shall include:

6.2.1 All office visits for diagnosis and treatment of illness and injuries provided by a Member's PCP and all related services, supplies and immunizations.

6.2.2 Periodic physical examinations or health assessments as determined by the PCP.

6.2.3 Pediatric care, including well-child care and certified pediatric nurse practitioner services. Prior Authorization is not required for access to a pediatrician who is a Participating Physician for general pediatric services, but Prior Authorization is required for pediatric services when provided by a Physician who is not a Participating Physician for such services.

6.2.4 Gynecological and maternity care, including prenatal and postnatal care, delivery and other related obstetrical services, and nurse midwife services. Prior Authorization is not required for access to an obstetrician-gynecologist who is a Participating Physician for annual well woman examinations and routine obstetrical and gynecological services, but Prior Authorization is required for the services of a Physician who is not a Participating Physician for such services. Members who qualify for Medicaid due to pregnancy will be allowed access to out of network obstetrical and gynecological services without authorization if the member has an established relationship with that provider. These members will also be allowed access to out of network facilities without authorization for routine obstetrical and gynecological services if referred by the out of network obstetrician-gynecologist.

6.2.5 Necessary outpatient medical consultation and specialist care by a Participating Physician to whom a Member is referred by the PCP.

6.2.6 In-hospital and outpatient physician services, as deemed necessary for the care and treatment of the Member by the Attending Physician, including breast reconstruction surgery following a mastectomy.

6.2.7 Covered Services rendered by a Certified Nurse Midwife or Family Nurse Practitioner.

6.2.8 Members who are or become pregnant are able to access dental services during their pregnancy and postpartum period directly through their Medicaid Health Plan. Pregnant members will be able to see dentists that are contracted as part of the Aetna Better Health network. Members may also receive transportation to and from scheduled dental appointments.

To receive dental services the member must: Notify Aetna Better Health of the pregnancy and due date by calling the Member Services number at **1-866-316-3784** TTY **711**. Members should also notify their caseworker of their pregnancy and due date.

6.3 **WELL-CHILD CARE/EARLY & PERIODIC SCREENING. DIAGNOSIS. & TREATMENT PROGRAM ("EPSDT")**. These services are available to Members under the age of 21 to ensure access to health resources and assist parents/guardians in appropriately using health resources. No Prior Authorization is required if EPSDT services are rendered by a Participating Provider.

6.3.1 Screening Services shall include periodic well-child examinations, including assessment of health and developmental history; development & behavioral assessments; age appropriate unclothed physical examinations; height/weight/head circumference measurements; blood pressure examination for children aged 3 and over; immunization review and appropriate administration; health education including anticipatory guidance; nutritional assessment; hearing, vision, and dental assessment; blood lead testing for children under age 6; appropriate conference and counseling for parents/guardians; objective testing for developmental behavior, hearing, and vision according to the Medicaid periodicity schedule; laboratory services for tuberculin, hematocrit, hemoglobin, urinalysis; or other testing as may be ordered by Physician.

6.3.2 Vision Services will include diagnosis and treatment for defective vision, and may include eyeglasses as appropriate.

6.3.3 Dental Services shall include relief of pain and infections, restoration of teeth, and maintenance of dental health. The PLAN is responsible for screening and referral only.

6.3.4 Hearing Services shall include diagnosis and treatment for hearing defects, including hearing aids as appropriate.

6.3.5 Referral of children, as appropriate, to hearing and speech clinic; optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services; referral to community mental health services; and if a child is found to have elevated blood lead levels in accordance with MDHHS standards, the PLAN shall refer the child to the local health department for follow-up services that may include a study to determine the source of the lead poisoning.

6.3.6 Outreach Services by home visit, phone, or mail to those Members who are due or overdue for well-child visits.

6.4 **SECOND OPINIONS**. The right of a Member to obtain a second medical opinion from a Participating Physician with respect to a given condition.

6.5 **INPATIENT AND OUTPATIENT HOSPITAL SERVICES**. Inpatient and outpatient hospital care will be provided with no time limit, if it is provided and prescribed as Medically Necessary by the PCP or Attending Physician, and Authorized as such by the PLAN. Inpatient and Outpatient Hospital Services shall be obtained from a Participating Hospital or other participating facility and subject to the limitations and exclusions set forth in Sections 6.1,7.0 and 8.0 of this Agreement. Inpatient and outpatient hospital services covered by the PLAN shall include:

6.5.1 Semi-private room and board accommodations based upon availability. Such accommodations shall include general duty nursing care.

6.5.2 Private room and board accommodations only with PLAN authorization.

6.5.3 Inpatient therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units.

6.5.4 Use of operating and other surgical treatment rooms and equipment on an inpatient or outpatient basis.

6.5.5 All laboratory and other diagnostic tests (X-rays, EKGs, nuclear isotopes, ultrasounds, CAT, MRI, MRA, PET) on an inpatient or outpatient basis as described at Section 6.6 below.

6.5.6 Anesthetics, oxygen, drugs and other biologicals.

6.5.7 Radiation therapy, short-term rehabilitation services and other forms of therapy only as described in Section 6.6 below.

6.5.8 Additional services, supplies, equipment and special procedures, on an inpatient or outpatient basis, but excluding convenience items (e.g., telephone, television, etc.).

6.5.9 Skilled nursing care provided in a participating Skilled Nursing Facility to the extent required by MDHHS if the Member requires medical and skilled nursing care (not domiciliary care or custodial care), in the absence of which hospital confinement could be Medically Necessary.

6.6 **DIAGNOSTIC LABORATORY. X-RAY. AND IMAGING TESTS AND THERAPY (INPATIENT AND OUTPATIENT).** Diagnostic testing and therapy services covered by the PLAN shall include:

6.6.1 X-ray and laboratory tests, electrocardiograms and electroencephalograms.

6.6.2 Radiology services, including diagnostic and therapeutic isotopes and other radioactive materials used for therapeutic purposes.

6.6.3 Short-term physical therapy and medical rehabilitation services, including speech and functional occupational therapy from a Participating Provider, limited to the treatment of conditions that are subject to significant improvement through relatively short-term therapy, to the extent allowed by MDHHS. In order for such services to be covered by the PLAN, Member is required to obtain the prior approval and authorization of a PCP.

6.7 **EMERGENCY MEDICAL SERVICES**. For purposes of this Agreement, Emergency Medical Services means those services that are required as a result of an Emergency Medical Condition as defined in Section 1.13 of this Certificate of Coverage.

6.7.1 Emergency Medical Services include inpatient or outpatient services that are:

(a) furnished by a provider qualified to furnish emergency services, including Non-Participating Physicians and Health Professionals in the Service Area or outside of the Service Area; and

(b) necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.

6.7.2 Emergency transportation for Members shall be Covered.

6.7.3 Where it is Medically Necessary that the Member receive medical attention immediately from a Non-Participating Physician or Health Professional, Members receiving Emergency Medical Services are required to have the Provider contact the PLAN by telephone at the number listed on the Identification Card in this Agreement for Prior Authorization for subsequent follow-up care after the Emergency Medical Services have been provided. Treatment following screening and stabilization shall be deemed prior authorized if the PLAN does not respond within one (1) hour for a request for Prior Authorization being made by an emergency department. If the facility does not request prior authorization and the PLAN determines that services, other than those required to evaluate and/or stabilize the Member, were not required as the result of an Emergency Medical Condition, the PLAN will not be responsible for such care, payment or reimbursement for such services.

6.7.4 Accessing Emergency Medical and Urgent Care Services. Members requiring Emergency Medical Services and Urgent Care Services shall have access to such services through one of the following three available emergency service systems in addition to traditional **911** service.

6.7.4.1 Emergency Nurse Line. Information services shall be available and accessible to each Member on a twenty-four (24) hour-a-day, seven (7) day-a-week basis at **1-866-711-6664**. The Emergency Nurse Line is in contact with Participating Physicians and Health Professionals, hospitals, ambulances and other Participating Providers to facilitate the provision of such services. Any person may contact the Emergency Nurse Line by calling the hot line telephone number listed on the Member Identification Card for purposes of seeking assistance on behalf of a Member in the event of an Emergency.

6.7.4.2 Immediate Emergencies. In cases of an Emergency that requires immediate treatment before the PLAN'S Emergency Triage System can be contacted and/or before treatment can be secured through the PLAN, the Member may utilize a Non-Participating Physician, Health Professional, or other Provider within or outside the Service Area. Members are required to comply with the provisions of subsection 6.7.3 with respect to notifying the PLAN of such Emergency.

6.7.4.3 Urgent Care Center System. In case of an accident, injury, or illness of a less serious nature in which the Member is not at risk of death or permanent impairment and in instances in which the Member is in the Service Area, the Member shall be required to seek services from a PLAN Urgent Care Center within 24 hours of such accident, injury, or illness. A list of Participating Urgent Care Centers and their locations is provided in the Provider Directory.

6.8 **AMBULANCE/TRANSPORTATION**. The following are Covered Services:

6.8.1 Air and land ambulance services for Emergency Medical Conditions.

6.8.2 Ambulance services for management of shock, unconsciousness, heart attack or other condition requiring active medical management, en route to a Hospital, emergency room, or similar facility.

6.8.3 Ambulance services to transport a Member from one medical facility to another medical facility when necessary to provide medical care or services that the transferring facility cannot provide to the Member, except if Member is in an inpatient facility and is transferred to a substance abuse or psychiatric facility.

6.8.4 Non-emergency transportation may be provided by the PLAN when a Member

(a) has no other means of transportation available to receive Covered Services, (b) when a Member has urgent care needs at the office of the Member's PCP, or (c) when a Member is referred by the Member's PCP to another physician or provider. The transportation benefit does not include transportation to services that are not covered under the Medicaid program such as: dental office services (except as specifically provided in Section 6.2.8 and 6.3.3), services billed through community mental health services program or transportation to substance abuse services.

6.9 **HOSPICE CARE SERVICES**.

6.9.1 Hospice care services are available to the extent (a) authorized by the PCP, (b) Authorized by the PLAN and (c) the hospice program is operated under the direction of a Participating Physician and meets the standards of the National Hospice Organization or similar standards.

6.9.2 Covered Hospice Care Services include:

6.9.2.1 Room and board at a hospice Facility or nursing home services and supplies at a Participating Provider or in the Member's home;

6.9.2.2 Part-time home nursing care and home health and services up to a total of eight (8) hours per day;

6.9.2.3 Consultation and case management services by the Member's PCP;

6.9.2.4 Medical supplies and prescription drugs or medicines; and

6.9.2.5 Physical therapy.

6.10 **OUTPATIENT MENTAL HEALTH SERVICES**. Outpatient mental health services are covered by the plan for defined services.

6.11 **PODIATRIC SERVICES**. Services of a Participating podiatrist are covered when referred by the PCP for the diagnosis or treatment of injuries or diseases of the Feet. Limits on these services are consistent with Medicaid Fee-for-Service policy.

6.12 **HOME HEALTH SERVICES**. Services rendered at a Member's home that are Authorized by the PLAN, including:

6.12.1 Professional medical care services deemed necessary for the Member's care and treatment, with the exception of private duty nursing.

6.12.2 Subject to MDHHS limitations, intermittent home care nursing services (other than private duty nursing services) by a registered nurse or a licensed practical nurse, physical therapy services, occupational therapy services, nutrition education and guidance and part-time home health aide services, not including housekeeping or long-term custodial care services.

6.12.3 Home care medical supplies when deemed Medically Necessary by the PCP for the care and treatment of the Member during the Member's home confinement.

6.13 **PREVENTIVE HEALTH SERVICES**. Preventive health services covered by the PLAN shall include:

6.13.1 Periodic health assessment and screening by the PCP at intervals deemed appropriate for the age, sex and medical history of the Member, including well-child care. Well-child care is a clinical assessment of a child in the absence of illness to determine physical status and detect any abnormalities. (See EPSDT in Section 6.3)

6.13.2 Routine periodic childhood and adult immunizations in accord with the Advisory Committee on Immunization Practices Guidelines for all Members, either from the PCP or, without Prior Authorization from a local health department, excluding immunizations that are required only for travel.

6.13.3 Voluntary family planning service, including sexually transmitted disease testing and treatment. No Prior Authorization is required for these services.

6.13.4 Vision and hearing screening to determine the need for vision and hearing correction.

6.13.5 Health education and nutrition counseling services. Members maybe responsible for a nominal fee for education services beyond what is provided in this Agreement.

6.13.6 One (1) routine pelvic screening per year for women aged 18 and over.

6.13.7 One (1) routine breast cancer screening mammography exam during the period a woman is aged 35 through 39, and one exam every calendar year for women 40 or over.

6.14 **ORGAN AND TISSUE TRANSPLANTS.**

6.14.1 All organ and tissue transplants must receive Prior Authorization, and be performed at a Participating Provider Authorized by the PLAN. The PLAN will pay for transplant-related hospital, surgical, laboratory, and X-ray services. This benefit is limited to kidney transplants and corneal transplants. Other types of transplants, such as heart, lungs, heart-lungs, liver, pancreas, small bowel, and bone marrow including allogeneic, autologous, and peripheral stem cell harvesting, are covered on a patient-specific basis when Medically Necessary according to accepted standards of care.

6.14.2 The PLAN will also pay for hospital, surgical, laboratory and X-ray services incurred by an organ/tissue donor who is not a PLAN Member resulting from the transplant of an organ to a Member by the PCP only to the extent such services are not covered by any other medical plan

6.15 **CHIROPRACTIC SERVICES**. Services of a Participating chiropractor are Covered when referred by the PCP. Limits on these services are consistent with Medicaid fee for service policy.

6.16 **HEARING AND SPEECH SERVICES**. Services for the diagnosis or treatment of diseases or conditions of the ears when Authorized by the PCP, and audiometric examinations and hearing aid evaluation testing by a Participating Provider. The purchase and fitting of a hearing aid is available to all members. Repairs, maintenance and batteries for hearing aids are covered for all ages.

6.17 **VISION SERVICES**. The care and treatment of diseases and conditions of the eye when provided by the PCP or referred by the PCP to a Participating optometrist or

ophthalmologist, including:

6.17.1 Complete examination of the eye and refraction; corrective lenses, single vision, multifocal, cataract or contact lenses; and, up to the maximum approved amount, eye glass frames.

6.17.2 Repair or replacement of frames or lenses due to body growth, loss or breakage consistent with MDHHS policies.

6.17.3 Tinted prescription corrective lenses may be Covered if Prior Authorized by the PLAN.

6.18 **REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES**. Family Planning services, generally, are those medically approved diagnostic evaluations, drugs, supplies, devices, and related counseling for the purpose of voluntarily preventing or delaying pregnancy or for the detection or treatment of sexually transmitted diseases ("STDs"). These services shall be provided confidentially to Members of child-bearing age, including minors who may be sexually active, who voluntarily choose not to risk pregnancy, or wish to limit the number and spacing of their children.

6.18.1 History, physical examination, laboratory testing, advice and supervision related to family planning in accordance with generally accepted medical practices.

6.18.2 All sterilization procedures for Members shall be Authorized by the PLAN.

6.18.3 Contraceptive drugs, devices and supplies. Condoms shall be made available consistent with Medicaid fee-for-service policies.

6.18.4 Terminations of Pregnancy (abortions) and related services are covered only when

(a) a Physician certifies that the abortion is Medically Necessary to save the life of the mother; (b) the pregnancy is a result of rape or incest; (c) treatment is for medical complications occurring as a result of a PLAN approved abortion; or (d) treatment is for a spontaneous, incomplete, or threatened abortion or for an ectopic pregnancy. All terminations of pregnancy must be Prior Authorized by the PLAN.

6.18.5 Family planning services. No prior authorization for family planning services is required at family planning clinics.

6.18.6 Testing for Infertility; however, treatment for Infertility is not a Covered Service.

6.19 **ALLERGY TESTING AND TREATMENT**. Allergy testing and treatment services must be authorized by the PCP and Authorized by the PLAN and are limited to the following:

6.19.1 Routine testing procedures to determine or evaluate the source of an allergy.

6.19.2 Treatment and procedures to contract the allergy or render the Member insensitive to an allergen, including the provision and administration of allergy serum.

6.20 **DURABLE MEDICAL EQUIPMENT**. Durable Medical Equipment is defined as equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of injury; and (d) is appropriate for use in the home. In order for Durable Medical Equipment to be covered by the PLAN it must be prescribed by a Participating Physician or Health Professional as Medically Necessary to treat an existing injury or illness, it must be obtained from a supplier approved by the PLAN and the Durable Medical Equipment be Authorized by the PLAN. The PLAN reserves the right to Authorize the least costly Durable Medical Equipment that is medically effective for the injury or illness. Replacements of such Authorized Durable Medical Equipment due to normal usage is covered, but replacement due to loss; misuse or abuse is not a Covered Service. See Section 7.1.33 for Excluded Durable Medical Equipment.

6.21 **PROSTHETIC AND ORTHOTIC DEVICES**. Coverage is provided for basic Prosthetic Devices and Orthotic Devices and specialized features authorized by the PCP and Authorized by the PLAN. Prosthetic and Orthotic Devices must be ordered by the Attending Physician and obtained from a PLAN-approved supplier. A Prosthetic Device is a device that replaces a missing part of the body or assist in the performance of a natural function of the body without necessarily replacing a missing part. Orthotic Devices are those external devices that are designed to correct or assist in the prevention of a body defect, either of form or function. Breast prostheses are covered following a mastectomy.

6.21.1 Replacement or repair is covered when due to normal usage or body growth or change, but excluded from coverage are replacement and/or repair of Orthotic and Prosthetic Devices due to intentional damage, misuse or abuse and comfort and convenience items.

6.21.2 Corrective Prosthetic Devices such as cardiac pacemakers and joint replacements are covered when surgically attached or implanted during surgery authorized by the PLAN.

6.21.3 Dental appliances or non-rigid appliances including elastic stockings and garter belts.

6.22 **DRUGS AND MEDICAL SUPPLIES**. Covered benefits are listed herein. Members may fill their prescriptions at over 65,000 pharmacies nationwide, and at over 1,900 in Michigan. The PLAN uses a closed Formulary, which means that only drugs listed on the Formulary are covered (except with prior approval in special circumstances). For more facts regarding the Formulary or drugs that require the PLAN'S Prior Authorization, Members can call the PLAN at **1-866-316-3784**. When filling a prescription, Members shall present their Aetna Better Health of Michigan ID and MIHEALTH cards with the prescription at any Participating Pharmacy. The PLAN has contracted with Medco, a pharmacy benefit manager, to manage prescription drug coverage for Members. Members should be aware that they will need to use their cards for certain drugs covered by Medicaid, such as anti-psychotic and HIV/AIDS drugs.

6.22.1 Prescription Drugs, which are those medicinal substances which under federal law are required to bear on the package label the statement: "Caution: Federal law prohibits dispensing without a prescription," are Covered.

6.22.2 Selected over-the-counter analgesics, laxatives, antacids, non-supplement and family planning drugs, devices or supplies are covered when prescribed by and Authorized by the PCP.

6.22.3 Insulin, as well as necessary needles and syringes are covered when prescribed or Authorized by the PCP.

6.22.4 FDA-approved drugs used in anti-neoplastic therapy and the reasonable cost of administration, whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received FDA-approval if the following conditions are met: (a) the drug must be ordered by a Physician for treatment of a specific type of neoplasm; (b) the drug must be approved by the FDA for use in anti-neoplastic therapy; (c) the drug is used as part of an antineoplastic drug regimen; (d) current medical literature substantiates the drug's efficacy and recognized oncology organizations generally accept the treatment; and (e) the Physician has obtained informed consent from the Member for the treatment regimen which includes FDA approved drugs for off-label indications.

6.22.5 Coverage for an off-label use of a FDA-approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(1) Coverage for a drug applies if all of the following conditions are met:

(a) The drug is approved by the FDA.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(i) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(ii) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by one of the following:

(i) The American medical association drug evaluations.

(ii) The American hospital formulary service drug information.

(iii) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

(iv) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(2) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer or health maintenance organization documentation supporting compliance with subsection (1).

(3) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.

(4) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the FDA.

6.22.6 Medically necessary medical supplies such as catheters, test tape, clinic test, and similar supplies; bag frames and supplies for colostomies, ileostomies, and ureterostomies; and dressings and dressing supplies are Covered Services when ordered or authorized by the PCP.

6.23 **RESTORATIVE/REHABILITATIVE NURSING CARE**. Intermittent or short-term restorative or rehabilitative nursing care, in a nursing facility, as Authorized by the PLAN, for a period of up to forty-five (45) days per rolling twelve (12) month period. The PLAN shall also cover restorative or rehabilitative nursing care outside of a nursing facility.

6.24 ESRD. End-Stage Renal Disease Services, consistent with Michigan Medicaid program policies.

6.25 **WEIGHT REDUCTION SERVICES**. Weight reduction services and surgery are Covered to treat morbid obesity subject to Prior Authorization from the PLAN and documentation of compliance with the PLAN criteria from Member's Physician.

6.26 **PUBLIC HEALTH DEPARTMENTS. FEDERALLY QUALIFIED HEALTH CENTERS/RURAL HEALTH CENTERS**. Members may access covered services provided at public health departments without authorization. Members may also choose a federally qualified health center ("FQHC") or rural health center ("RHC") as their primary care physician.

6.27 **COMMUNICABLE DISEASES**. Members may receive treatment for communicable diseases such as AIDS/HIV, sexually transmitted diseases ("STDs"), tuberculosis, and vaccine-preventable communicable diseases, from local health departments without Prior Authorization from the PLAN.

6.28 **CHILD & ADOLESCENT HEALTH CENTERS & PROGRAMS**. Members may obtain Covered Services from Child & Adolescent Health Centers ("CAHCPs") without Prior Authorization from the PLAN.

6.29 **PERSONS WITH SPECIAL NEEDS**. Members with special health care needs are entitled to (a) an assessment to identify any special conditions that require ongoing case management services and (b) direct access to specialists as appropriate for the Member's condition and identified needs.

6.30 **DIABETES EQUIPMENT, SUPPLIES, TRAINING, and SERVICES**.

6.30.1 The PLAN will cover the following equipment, supplies and educational training related to the treatment of diabetes if determined to be Medically Necessary and prescribed by the Member's PCP or a Specialist Physician to whom the Member is Appropriately Referred: (a) blood glucose monitors for the legally blind; (b) continuous glucose monitoring systems (CGMS) for some individuals with Type 1 diabetes, test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices; (c) insulin syringes; (d) insulin pumps and medical supplies required for the use of an insulin pump; and (e) diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management training of their condition.

6.30.2 Coverage for diabetes self-management training shall be available subject to the following conditions:

(a) training is limited to completion of a certified diabetes education program should either of the following occur:

(i) training is considered Medically Necessary upon the diagnosis of diabetes by the Member's PCP or Specialist Physician to whom the Member is Appropriately Referred who is managing the Member's diabetic condition, and the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or

(ii) the Member's PCP or a Specialist to whom the Member is Appropriately Referred diagnoses a significant change with long term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.

(b) training shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the MDHHS. This training shall be conducted in a group-setting whenever practicable.

6.31 **TOBACCO CESSATION TREATMENT**. The PLAN will cover Tobacco Cessation Treatment including pharmaceutical and behavioral support. The PLAN may place a reasonable limit on the type and frequency of over-the-counter and prescription drugs covered under this benefit. Prior authorization is not required for over-the-counter agents, prescription inhalers, or nasal sprays. Prior authorization is required for prescription drugs other than inhalers and nasal sprays.

6.32 **OUT-OF-STATE SERVICES AUTHORIZED BY THE PLAN**. Prior authorization is required for the services of out-of-state hospitals and physicians, except for Emergency Medical Services necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.

6.33 **CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS).** The state of Michigan program that serves children, and some adults, with special health care needs. Enrollment in Aetna Better Health of Michigan entitles CSHCS Members to receive the Covered Services set forth in Section 6.0, Covered Services. In addition, CSHCS Members are entitled to receive the following Services, which are not covered by Aetna Better Health of Michigan but are covered by the state of Michigan through CSHCS:

6.33.1 Orthodontia services provided for certain qualifying diagnoses, such as Cleft Palate/Cleft Lip (must be medically necessary, related to the condition, and not for cosmetic purposes)"

6.33.2 Respite services (maximum of 180 hours per family during the 12-month eligibility period when a beneficiary requires skilled nursing and a CSHCS nurse consultant determines appropriate)"

6.33.3 Certain over-the-counter medications

6.33.4 Hemophilia drugs

6.33.5 Certain orphan drugs. These services will be coordinated by the local health department.

SECTION 7.0 EXCLUSIONS

7.1 **NON-COVERED SERVICES**. Services not listed in Section 6 are Excluded under the Agreement, unless required to be Covered by Medicaid program or Michigan law. Under the provisions of this Agreement, the following services shall not be Covered by the PLAN:

7.1.1 Services obtained by a member outside the PLAN Service Area and not authorized by the PLAN are not Covered, except for Emergency Medical Services as described in Section 6.7.

7.1.2 Dental (except pregnant and postpartum women), and vision services except as specifically provided in Sections 6.3, 6.8, 6.14, 6.17, and 6.18.

7.1.3 Private duty nursing services in the home.

7.1.4 Non-medical ancillary services such as vocational rehabilitation and employee counseling.

7.1.5 Cosmetic Services and Surgery; including but not limited to breast augmentation, refractive eye surgery, non-Medically Necessary reduction mammoplasty, rhinoplasty, spider or varicose vein repair.

7.1.6 Services not required to be provided to Medicaid recipients under the terms of the Comprehensive Health Care Program for Medicaid Beneficiaries.

7.1.7 Weight reduction whether by surgery or commercial or medical programs, except when Medically Necessary to treat morbid obesity, and authorized by the PLAN.

7.1.8 Acupuncture.

7.1.9 Faith healing.

7.1.10 Elective termination of pregnancy (abortion) and related services, except as set forth in Section 6.

7.1.11 Personal comfort items such as telephone, television and similar items.

7.1.12 Any and all infertility treatment or related services. This exclusion applies, without limitation, to services performed in connection with any non-coital form of conception such as artificial insemination, intrauterine insemination, in vitro fertilization (IVF), intrafallopian transfers, donor egg/donor sperm programs, pre-implantation genetic testing, embryo transplantation, reversal of voluntary sterilization, and any related diagnostic and therapeutic services unique to these technologies.

7.1.13 Services related in any way to surrogate parenthood, including, but not limited to, otherwise Medically Necessary obstetrical services.

7.1.14 Custodial or basic care (care that is or can be provided by individuals without specific health care skills, training, or licensure and is intended primarily for the purpose of meeting personal needs such as bathing, walking, dressing and eating) and domiciliary services (generally services for the purpose of maintaining or supporting a person's activities of daily living or basic needs for food, shelter, clothing and hygiene), including private duty or hourly nursing services, convalescent care services, and general housekeeping services provided on an inpatient, outpatient or in-home basis.

7.1.15 Food and nutritional supplements available without prescription.

7.1.16 Non-prescribed dietary supplements, vitamins, minerals, and infant formula.

7.1.17 Except as prescribed as treatment for diabetes, routine foot care such as treatment or trimming of corns, calluses, toe nails, evaluation and treatment of subluxations of the feet and flat feet; and pedicures.

7.1.18 Home births.

7.1.19 Home health aide services including routine, unskilled care; housekeeping services; private duty or hourly nursing services; home health care services provided by a person who ordinarily resides in the Member's home or is part of the Member's immediate family; and respite care, unless and only to the extent provided as part of covered hospice services.

7.1.20 Long-term rehabilitative treatment.

7.1.21 Fees, costs, and expenses incurred by a person who donates an organ or tissue, unless the recipient is a PLAN Member and the donor's own health benefit plan does not otherwise cover the expenses.

7.1.22 Speech therapy for foreign accent reduction or English as a second language.

7.1.23 Prosthetic hair, hair transplants or other services, procedures or supplies designed to enhance hair growth are excluded, regardless of diagnosis.

7.1.24 Testing to determine parentage or DNA testing.

7.1.25 Services Payable Under Other Programs. Services are excluded from coverage under the Agreement to the extent the services are provided, paid or payable:

7.1.25.1 Under an extended benefit provision of any other health insurance or health benefits plan, policy, program or certificate.

7.1.25.2 Under any policy, program, contract or insurance as provided under Section 8.2 of this certificate.

7.1.25.3 Under any school district and billed through the intermediate school district, veterans or public programs, including but not limited to Home & Community-Based Waiver Program Services.

7.1.25.4 Substance Abuse Services such as screening, detoxification, intensive outpatient counseling, and methadone treatment and other substance abuse pharmaceuticals indicated exclusively for substance abuse treatment and specified on MDHHS's pharmacy vendor's website under the "Classes for Psychotropic and HIV/AIDS Carve Out" at **https://michigan.fhsc.com**. Refer to the Member Handbook for instructions on how to access these services or call Customer Service at **1-866-316-3784**.

7.1.25.5 Mental Health Services for Members identified as being seriously mentally ill and requiring intensive or inpatient services are provided by the local Community Mental Health Service Program. Refer to the Member Handbook for instructions on how to access these services or call the PLAN'S Customer Service at **1-866-316-3784**.

7.1.25.6 Inpatient hospital psychiatric services. The PLAN will not Cover physician costs related to providing psychiatric admission histories and physicals, but if medical services are needed for care other than psychiatric care during a psychiatric inpatient admission, the PLAN will pay for Prior Authorized and Medically Necessary Covered Services.

7.1.25.7 Outpatient Partial Hospitalization Psychiatric Care.

7.1.25.8 Services, including therapies (speech, language, physical, occupational), provided to persons with developmental disabilities and billed through community mental health services program providers or intermediate school districts.

7.1.26 Non-emergent transportation, other than as provided in Section 6.9.

7.1.27 Over-the-counter medicines (other than as provided in Section 6.23.2). Standard "medicine cabinet" items, including but not limited to, first aid supplies.

7.1.28 Disposable medical supplies (other than as provided in Section 6.23).

7.1.29 Experimental and investigational services, which include any drug treatment, device, procedure, service or benefit which is experimental or investigational, with the exception of anticancer drugs as defined in Section 6.23.4 of this Agreement. For the purposes of this Agreement, a drug, treatment, device, procedure, service or benefit may be considered to be experimental or investigational if it meets any one of the following criteria: (a) it cannot be lawfully marketed without the approval of the Food and Drug Administration ("FDA") and such approval of the FDA was not granted at the time of the use or proposed use; (b) it is the subject of a current investigational new drug or new device application on file with the FDA; (c) it is being provided pursuant to a research, investigational or experimental stage or phase of a clinical trial as established, monitored or regulated by any state or federal government or agency; (d) it is being provided pursuant to a written protocol which describes among its objectives, determination of safety, efficacy, efficacy in comparison to conventional alternatives or toxicity; (e) it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services; (f) the predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; (g) if the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to determine safety, toxicity, efficacy, or efficacy in comparison to conventional alternatives; or (h) it is not investigational in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is "investigational or experimental." Without limiting the above the following are considered experimental or investigational and therefore are not Covered Services:

1. Fees associated with the care, services, supplies, devices or procedures, which are investigational or are in conjunction with research studies.
2. Medical services which are generally regarded by the medical community to be unusual, infrequently provided, and not necessary for the protection of health.
3. Services associated with organ or tissue transplantation that is considered experimental.

7.1.30 Organ donor-related services, except as stated in Section 6.15.

7.1.31 All health services rendered as a result of a court order, unless otherwise medically necessary, or during Member's incarceration in any jail or prison to extent services are payable by the court or jail or prison authorities.

7.1.32 Health services or prescription drugs not provided by a Participating Provider except approved referrals. Emergencies, and as otherwise stated herein.

7.1.33 Durable Medical Equipment, (a) Deluxe equipment such as motorized wheelchairs and beds, unless Medically Necessary; (b) Items not medical in nature; (c) Physicians' equipment such as stethoscopes and sphygmomanometers; (d) Comfort and convenience items such as bed boards, over bed tables, telephone arms and air conditioners; (e) Exercise and hygiene equipment such as exercycles, toilet seats and tub or shower seats; (f) Self-help devices not primarily medical in nature such as saunas, elevators, ramps and special telephone or communication devices; (g) Experimental or research equipment. Replacement of Durable Medical Equipment due to intentional damage by any individual is not a Covered Service.

7.1.34 Psychotropic & HIV/AIDS Drugs. The PLAN shall not Cover anti-psychotic classes and the H7Z class psychotropic drugs or drugs in the anti-retroviral classes, including protease inhibitors, and reverse transcriptase inhibitors. These drugs will be available via the Medicaid fee-for-service system and a copayment may be required. Members are required to use their MI HEALTH card to access these drugs.

7.1.35 Sterilization procedures unless Prior Authorized by the PLAN.

7.1.36 Intermittent or short term restorative or rehabilitative nursing care, in a nursing facility after a period of forty-five (45) days.

7.1.37 Traumatic Brain Injury Program Services.

7.1.38 Substance abuse treatment drugs as listed under the category "Classes for Psychotropic and HIV/AIDS Carve-Out" at **www.MICHIGAN.fhsc.com**. These medications will be reimbursed by MDHHS's pharmacy TPA through a point-of-service reimbursement system.

7.1.39 Maternal and Infant Health Program ("MIHP")

7.2 **OTHER EXCLUSIONS**

7.2.1 Care rendered by Member or a Member's family member or by a business entity that Member or a family member of Member controls.

7.2.2 Any service or supply, or portion of a charge thereof, for which Member has no financial liability, or that was provided free of charge.

7.2.3 Services and/or supplies obtained fraudulently.

7.2.4 Services and/or supplies rendered prior to Member's Effective Date.

7.2.5 Charges resulting from Member failing to appropriately cancel a scheduled appointment.

7.2.6 Services and/or supplies prohibited from being rendered by law or regulation.

7.2.7 Procedures to repair or remove varicose veins unless Medically Necessary.

SECTION 8.0 COORDINATION OF BENEFITS AND SUBROGATION

8.1 **COORDINATION IN GENERAL WITH OTHER INSURANCE**. By federal and state law, the Covered Services provided under this Agreement are secondary to benefits available under any other health benefit plan or plans (such as individual, group, employer-related, self-insured or self-funded plan or commercial carrier) to which a Member is eligible, the PLAN will identify and seek recovery from all other liable third parties.

8.2 **PLAN'S SUBROGATION RIGHTS**. The PLAN shall be subrogated and shall succeed to any Member's rights of recovery from a third party (such as automobile insurance, liability insurance, and worker's compensation insurance) for incurred services provided under this contract. The Member shall reimburse the PLAN to the extent of the amounts recovered by said Member as a result of any lawsuit, settlement, or otherwise, less the PLAN'S pro-rated share of attorney fees and costs sustained by the Member in obtaining such a recovery. If the attorney fees of the Member are to be paid on a contingency basis, the PLAN'S right of subrogation will be reduced by its pro-rata share of attorney fees which do not exceed twenty five (25) percent of any recovery. The Member shall, upon request by the PLAN, execute and deliver such instruments and papers as may be required to do whatever else may be necessary and reasonable to carry out this Section 8.2.

8.3 **COORDINATION WITH MEDICARE**. Members who become eligible for both Medicaid and Medicare coverage are ineligible for enrollment in the PLAN. The PLAN shall initiate disenrollment with MDHHS. When a Member is also enrolled in Medicare, Medicare will be the primary payer ahead of the PLAN. The PLAN will pay or otherwise coverall cost-sharing amounts incurred by the Member such as coinsurance and deductibles required by Medicare. Members who are eligible for Medicare must apply for Medicare coverage.

SECTION 9.0 MEMBER RIGHTS

9.1 **INSPECTION OF RECORDS**. A Member, parent, guardian or authorized representative of a Member may review the records of the PLAN relating solely to the Member or a minor Dependent of the Member who is also a Member, at the offices of the PLAN during regular business hours and at an appointed hour reasonably granted on request by the Member for that purpose.

9.2 **REFUSAL TO ACCEPT TREATMENT**. A Member may for personal or religious reasons refuse to accept the recommended treatment or procedures recommended by a Participating Physician (or Health Professional). Such refusal to accept treatment may be regarded as incompatible with the physician/patient relationship and as an impediment to the rendering of proper health care. If a Member refuses to accept recommended treatment and no reasonable alternative for treatment exists, the Member shall be so advised. If the Member still refuses recommended treatment, neither the PLAN nor the Physician shall have further responsibility to provide care for the condition being treated. The foregoing is subject to the Member's right to file a grievance in accordance with the Grievance and Appeal Program. The PLAN may request disenrollment when the member has been discharged from the practices of available PLAN providers due to actions inconsistent with PLAN membership.

9.3 **MEMBER'S RESPONSIBILITY FOR PAYMENT**. If the member receives any services from a Non-Participating hospital, Physician, Health Professional, Skilled Nursing Facility or other entity and is informed of the responsibility to pay prior to receiving services, the member is responsible for payment except in the case of a Medical Emergency or Urgent Care situation. If the services are authorized by the Member's PCP and approved by the Plan, the member is not responsible for payment.

9.4 **NON-PARTICIPATING PROVIDERS**. The PLAN shall reimburse Non-Participating Providers for Covered Services if the services (a) were Medically Necessary, (b) were Authorized by the PLAN, and (c) could not reasonably have been obtained from a Participating Provider, inside or outside of the state of Michigan on a timely basis. This shall be applicable to Non-Participating Providers located in and out of the state of Michigan. The PLAN shall pay claims from Non-Participating Providers at established Michigan Medicaid fees in effect on the date of service for paying Participating Medicaid providers as established by Medicaid policy. If Michigan Medicaid has not established a specific rate for the Covered Service, the PLAN must follow Medicaid policy for the determination of the correct payment amount.

9.5 **NOTICE OF CHANGE OF ADDRESS. OTHER COVERAGE. CHANGE IN ELIGIBILITY. LOSS OR THEFT OF IDENTIFICATION CARD**. Member agrees to notify the PLAN promptly, either in writing or by telephone, of any change in address or if the Identification Card is lost or stolen. Member agrees to give the PLAN notice of any other health benefit coverage under which the Member is covered at the time of enrollment or at any time thereafter while this Coverage is in effect, or any change in eligibility.

9.6 **AUTHORIZED FOR RELEASE AND RECEIPT OF INFORMATION**. Member agrees to allow the PLAN to obtain information from any provider of services that provides Covered Services to Member as may be reasonably necessary to administer Covered Services under this Agreement. By accepting Coverage under this Agreement, Member agrees to authorize such providers to provide reports and information to the PLAN and to other providers in connection with the care, treatment and physical condition of Member. This consent will terminate when Coverage terminates and all claims for Covered Services have been processed. Member agrees to provide a signed authorization to release medical records upon request by the PLAN. By signing the application for Medicaid coverage. Member has granted the PLAN permission to use Member health information consistent with the HIPAA Privacy Rule.

9.7 **CONFIDENTIALITY**. Confidentiality of Member information maintained by the PLAN will be protected in accordance with applicable state and federal statutes including HIPAA. Please refer to the PLAN'S Notice of Privacy Practices.

SECTION 10.0 GRIEVANCE AND APPEAL PROCEDURES

We take Your concerns seriously and we have procedures for responding to them. You can voice Your concerns, misunderstandings and/or dissatisfaction with any aspect of Our policies and procedures or care rendered by a Participating Provider, or if You are displeased with a decision We made regarding services you requested.

You can file a Grievance at any time. We have ninety (90) days after your Grievance is received to resolve it. If You receive an Adverse Determination in response to your Grievance, you can file an Appeal within sixty (60) days. We have thirty (30) days after your Appeal is received to respond to it. If You receive an Adverse Determination in response to your Appeal, you can request a State Fair hearing from MDHHS. You must request a State Fair hearing within 120 days of the Adverse Determination for your Appeal. If you need help completing the Request for State Fair Hearing form, call Customer Service at **1-866-316-3784**. This request can be submitted during the appeals process.

Submit your requests to:

Michigan Administrative Hearing System for the
Michigan Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909
1-877-833-0870

All Grievance/Appeal information will be provided to You in Your prevalent language. TTY/TDD (Teletypewriter/Telecommunication Device for the Deaf) and interpretive services will also be made available upon request.

10.1 **GRIEVANCES/APPEALS**. You may file a Grievance if You are upset about the quality of services that You received, or the relationship that You have with Us, or Your Provider, or if You are concerned about Your rights as a Member. You may also file an Appeal due to an Adverse Determination or denial of payment that We made such as when we:

- Deny or limit authorization of a service that You or Your Provider requests.
- Fail to make payment or provide, in whole or in part, a benefit to You.
- Fail to provide services in a timely manner.
- Reduce, either entirely or partially, suspend, or terminate a benefit or previously authorized service (except when reduction, suspension, or termination result from state or federal action).
- Fail to act within specified timeframes when We handle your Grievance/Appeal.
- Fail to authorize or Cover services because We think that the services are experimental, investigational, cosmetic, or not Medically Necessary or appropriate.

By filing a Grievance/Appeal with Us, You are asking Us to reconsider the decision that We made because You, or Your Authorized Representative, think that You are entitled to receive the requested service or have the service paid for, or have us do something differently. Your Provider may also file a Grievance/Appeal on Your behalf, provided that You complete and send to Us an Authorized Representative Form that gives Your permission for Your Provider to act on Your behalf. In the event of an Urgent/Expedited Grievance/Appeal, Your treating provider can file a Grievance/Appeal on Your behalf without submitting an Authorized Representative Form.

You can file a Grievance/Appeal before You receive the requested service. This is called a Pre-Service Grievance/Appeal. You can also file a Grievance/Appeal after You receive the requested service. This is called a Post-Service Grievance/Appeal. You or Your Provider can also file an Urgent/Expedited Grievance/Appeal if You think that the timeframes of the Grievance/Appeal process could seriously jeopardize Your life or health, or if You are pregnant, the life or health of Your fetus, or Your ability to attain, maintain, or regain maximum function. Please read below for more information about the Grievance and Appeals Process.

If you need help filing a Grievance/Appeal, We are here to help You. Please contact the Appeals Coordinator at **1-866-316-3784**, TTY **711**. If You send Your Grievance/Appeal to Us in writing, We will send You a letter acknowledging Our receipt of Your Grievance/Appeal within three (3) days of Our receiving it. We will contact You within ninety (90) days to let You know how Your Grievance was resolved. If you receive an Adverse Benefit Determination after you file a Grievance, you can file an Appeal. If You file an Appeal, we will contact you within 30 days to let you know if Your Appeal was resolved. If You need Your Grievance/Appeal reviewed on an Expedited basis because it involves a medical condition that requires an immediate response from Our Health Services Department, We will respond to Your Grievance/Appeal within forty-eight (48) hours of receiving it. The PLAN staff reviewing Your Grievance/Appeal will not have

been previously involved in any prior decisions about Your Grievance/Appeal. The PLAN will make sure that the staff reviewing Your Grievance/Appeal has the necessary qualifications to review Your Grievance/Appeal.

10.2 THE GRIEVANCE/APPEAL PROCESS

10.2.1 If You receive an Adverse Determination or denial of payment from Us, or if We did something you are dissatisfied with, You can dispute it using the Grievance/Appeal process described below. You can also have Your Provider act on Your behalf. To do that, You must complete an Authorized Representative form, which You can receive by calling Customer Service.

10.2.2 You can file a Grievance at any time. We have ninety (90) days after your Grievance is received to resolve it. If You receive an Adverse Determination in response to your Grievance, you can file an Appeal within sixty (60) days. We have thirty (30) days after your Appeal is received to respond to it. If You receive an Adverse Determination in response to your Appeal, you can request a State Fair hearing from MDHHS. You must request a State Fair hearing within 120 days of the Adverse Determination for your Appeal. At any time, you can contact the Appeals Coordinator at **1-866-316-3784**, TTY **711**.

10.2.3 You, or Your Authorized Representative, need to send Us a written request that includes Your name, the name of the treating Provider, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with, Your (or Your representative's) mailing address, an explanation of why We should reverse Our decision, and a copy of any information that will support Your request. You may also provide Us with any additional documents, records or information that is relevant to Your Grievance/Appeal.

10.2.4 If You have an Authorized Representative, You should also send us the completed Authorized Representative form. Such requests should be addressed to: Aetna Better Health of Michigan 1333 Gratiot Ave. Suite 400, Detroit, Ml 48207. Attn: Appeals Coordinator. If You would like to have an Authorized Representative act on Your behalf, We cannot begin to review Your Grievance/Appeal until We receive the Authorized Representative form. If We receive Your Grievance/Appeal without an Authorized Representative Form, We will not start to process Your Grievance/Appeal until We get this Form. You may submit an Authorized Representative Form at any time before the period in which You are entitled to submit a Grievance/Appeal to Us. Our timeframe to review Your Grievance/Appeal will begin on the day that We receive the Authorized Representative Form from You.

10.2.5 If You or Your representative cannot file a written Grievance/Appeal, You may contact Us so that We can obtain the above information and fill out the necessary documents to start Your Grievance/Appeal. You or your representative may request access to and copies of documents, records and information relevant to the Grievance/Appeal. We will provide you with that information free of charge. We will also provide You with assistance, if You need it, with completing the paperwork and other steps of Your Grievance/Appeal, for example, if You need an interpreter or a TTY/TTD capability.

10.2.6 Within three (3) working days of Our receipt of Your Grievance/Appeal, the Appeal Coordinator will send a letter to You or Your Authorized Representative confirming receipt of the Grievance/Appeal. The notice will also notify You or Your Authorized Representative of Your rights during the Grievance/Appeal process, including: information on how to contact the Appeal Coordinator who has been appointed to assist in resolving formal Grievances/Appeals; Your right to appear before the Appeal Committee; Your right to request a representative to act on Your behalf;

Your opportunity to participate in the hearing in person, via conference call, or other appropriate technology; and the right of reasonable access before and during the Grievances/Appeals process, upon request and free of charge, to all documents, records and other information considered during the Appeal process. You should contact the Appeal Coordinator if You or Your Authorized Representative would like to participate in the hearing. The Appeal Coordinator may also notify You or Your Authorized Representative of receipt of the Grievance/Appeal via telephone. If You or Your Authorized Representative expresses a desire to participate in the hearing, the Appeal Coordinator will send an additional letter to You or Your Authorized Representative with details about the hearing including the time, date, location and/or conference call telephone number into which You or Your Authorized Representative should dial.

10.2.7 If We determine that We need an extension in order to obtain additional information from your treating Provider, and it is in Your best interest, We will extend Our time period once during the Grievance/Appeal process for up to fourteen (14) calendar days with Your permission.

10.2.8 Depending on whether Your Grievance/Appeal involves a medical or non-medical issue, the Appeal Committee will be made up of the PLAN'S senior managers and/or the PLAN'S Medical Director, and other health professionals. No one on the Appeal Committee was involved in making the original decision about Your care, or reports to the person who made the original decision about Your care.

10.2.9 We will render a final decision within five (5) business days of the Appeal Committee meeting and within ninety (90) calendar days after the date the Grievance was received or thirty (30) calendar days after the date the Appeal was received. We will send written notice of Our decision to You or Your Authorized Representative within ninety (90) calendar days after the date the Grievance was received or thirty (30) calendar days after the date the Appeal was received. The notification will include:

- The specific reason(s) for the determination;
- Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
- Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;

- If the Grievance/Appeal decision is based on medical necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
- Notice of any further Grievance/Appeal rights
- A list of the persons on the Appeal Committee
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal;
- A statement of Your rights to request a State Fair Hearing, or appeal to the Michigan Office of Financial and Insurance Regulation, as may be applicable; and
- A statement of Your rights to continuation of health benefits during the time a State Fair Hearing is pending.

10.3 **URGENT/EXPEDITED GRIEVANCES/APPEALS**

10.3.1 You or Your Authorized Representative (which may include the treating Provider) may file an Urgent/Expedited Grievance/Appeal in writing or orally. The Urgent/Expedited Grievance/Appeal may be submitted verbally or in writing to: Aetna Better Health of Michigan Attn. Appeals Coordinator, 1333 Gratiot Ave. Suite 400 Detroit, Ml 48207. or verbally by calling The PLAN at **1-866-316-3784**, TTY **711**.

10.3.2 If You would like to have an Authorized Representative, other than Your treating Provider, act on Your behalf during an Urgent/Expedited Grievance/Appeal, and You are unable to submit an Authorized Representative Form to Us because of Your incapacity or an emergency circumstance, We may proceed with Your Grievance/Appeal and communicate with the purported Authorized Representative if it is in Your best interest and if the information disclosed is directly relevant to Your Grievance/Appeal.

10.3.3 To request an Urgent/Expedited Grievance/Appeal, You or Your Authorized Representative must give Us Your name, Your Provider's name, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with, Your (or Your Authorized Representative's) mailing address and telephone number, an explanation of why We should reverse our decision, and a copy of any information that will support Your request.

10.3.4 If there is insufficient information provided with the Urgent/Expedited Grievance/Appeal, We will notify You or Your Authorized Representative immediately by telephone of the information needed. If the necessary information is not received, the Appeal committee will make a decision based on the information available.

10.3.5 If a physician with knowledge of Your medical condition determines that a Grievance/Appeal involves Urgent/Expedited, We will treat your Grievance/Appeal as an Urgent/Expedited Grievance/Appeal. If You request an Urgent/Expedited Grievance/Appeal, but Your Provider does not also state that Your Grievance/Appeal should be handled

on an Urgent/Expedited basis, Our Medical Director will review Your Grievance/Appeal to determine if Your Grievance/Appeal qualifies as an Urgent/Expedited Grievance/Appeal. If We decide that Your Grievance/Appeal is not an Urgent/Expedited Grievance/Appeal and that it should be processed as a standard Grievance/Appeal, We will verbally notify You as soon as possible, and send You a letter within two (2) days. You will be able to Appeal Our decision to the Michigan Department of Insurance and Financial Services (DIFS) within ten (10) days.

10.3.6 If We proceed with Your Urgent/Expedited Grievance/Appeal, a hearing will be scheduled with an Appeal Committee to take place within forty eight (48) hours of Your request, and Your Grievance/Appeal will be resolved within seventy-two (72) hours of Your request. You and/or Your Authorized Representative may participate in the hearing. If You or Your Authorized Representative requests an extension during the Urgent/Expedited Grievance/Appeal, the Grievance/Appeal will have to be moved to the standard timeframe for Us to decide Your Grievance/Appeal. We will provide You with written confirmation of the transfer to the standard Grievance/Appeal timeframes within two (2) days of Your request for extension. If You or Your Authorized Representative chooses to withdraw the request for the extension, We will consider Your Grievance/Appeal on an urgent/expedited basis, within seventy-two (72) hours.

10.3.7 None of the individuals on the Appeal Committee will be someone who was involved in the original Adverse decision or who reports to someone who was involved in the original Adverse decision. You or Your Authorized Representative will be offered the opportunity to attend and participate in the Appeals Committee Meeting when your Appeal is considered by the Committee.

10.3.8 We will render a final decision and provide verbal and written notice of that decision within seventy-two (72) hours after the date the Grievance/Appeal was received. The notification will include:

- The specific reason(s) for the determination;
- Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
- Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
- If the Grievance/Appeal decision is based on Medical Necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
- Notice of any further Grievance/Appeal rights;
- A list of the persons on the Appeal Committee;
- A statement that You are entitled to receive, upon request and free of charge,

reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal;

- A statement of Your rights to request a State Fair Hearing, or appeal to the Department of Insurance and Financial Services, as may be applicable; and
- A statement of Your rights to continuation of health benefits during the time a State Fair Hearing is pending.

10.4 **CONTINUATION OF BENEFITS**.

During the time that We are processing Your Grievance/Appeal due to an Adverse Determination or while You are waiting for Your State Fair Hearing, You may be entitled to continuation of benefits pursuant to the Following:

10.4.1 As used in this section, "timely" Filing means Filing on or before the later of the Following:

(a) within ten (10) days of Us mailing the Adverse Determination, or (b) the intended effective date of Our proposed Adverse Determination.

10.4.2 We will continue Your benefits during the time of the Grievance/Appeal due to an Adverse Determination process or State Fair Hearing when:

10.4.2.1 You or Your Authorized Representative Files the Grievance/Appeal due to an Adverse Determination on a timely basis;

10.4.2.2 Your Grievance/Appeal due to an Adverse Determination involves the termination, suspension, or reduction of a previously authorized course of treatment;

10.4.2.3 Your services were ordered by an authorized provider;

10.4.2.4 The original period covered by the original authorization has not expired; and

10.4.2.5 You request extension of the benefits.

10.4.3 If, at Your request, We continue or reinstate Your benefits while the Grievance/Appeal due to an Adverse Determination is pending, the benefits must be continued until one of the Following occurs:

10.4.3.1 You withdraw the Grievance/Appeal.

10.4.3.2 Ten (10) days pass after We mailed the notice providing the resolution of the Grievance/Appeal in Our Favor, unless You, within the ten (10) day timeframe, have requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.

10.4.3.3 A State Fair Hearing officer issues a hearing decision adverse to You.

10.4.3.4 The time period or service limits of a previously authorized service has been met.

10.4.4 IF the Final resolution of the Grievance/Appeal due to an Adverse Determination upholds the original action. We may recover the cost of the services Furnished to You while the Grievance/Appeal was pending, to the extent that such services were Furnished solely because of the requirements of this section.

10.4.5 If We, or the State Fair Hearing officer, decide in Your Favor and reverse a decision to deny, limit, or delay services that were not Furnished while the Grievance/Appeal was pending, We must authorize or provide the disputed services promptly and as expeditiously as Your health condition requires.

10.4.6 If We, or the State Fair Hearing officer, reverse a decision to deny authorization of services, and You received the disputed services while the Grievance/Appeal was pending. We must pay for those services.

10.5 **YOUR RIGHTS UNDER THE PATIENT RIGHT TO INDEPENDENT REVIEW ACT ("PRIRA").** After You have used Our Grievance and Appeal Program for a Non-Urgent/Expedited Grievance/Appeal, and We have issued Our Final decision, You may seek external review through the Michigan Department of Insurance and Financial Services ("DIFS") pursuant to Michigan law within one hundred twenty seven (127) days of Your receipt of Our Final decision. In the case of an Urgent/Expedited Grievance/Appeal, You can also File a request for expedited external review with DIFS if You have First sent notice to Us. You should use the "Health Care Request for External Review Form" that We provide to You. This Form can also be Found at **www.michigan.gov/documents/cis_ofis_fis_0018_25078_7.pdf**.

To quality for PRIRA review:

- You must have received an Adverse Determination and a Final decision from Us
- You must have been covered by Us on the date of service in question
- The service You requested must reasonably appear to have been a Covered Service under this Agreement and
- You must have exhausted your Grievance/Appeal rights with Us except in the case of an Urgent/Expedited Grievance/Appeal.

10.5.1 You can request an Expedited PRIRA Review within ten (10) days of receipt of an Adverse Determination when it involved a medical condition for which a physician certifies that the time frame for completing a standard PRIRA review would seriously jeopardize Your life or health, or would jeopardize Your ability to regain maximum Function. if an Expedited PRIRA Review is necessary, it will be completed within seventy-two (72) hours after Your written request was submitted.

10.5.2 Your PRIRA Review request must be sent by fax to **1-517-284-8838** or by UPS or U.S. mail to:

- DIFS, Health care Appeals Section
  Office of General Counsel
  P.O. Box 30220
  Lansing, Ml 48909-7720
- Delivery service to:
  Office of General Counsel – Health Care Appeals Section
  Department of Insurance and Financial Services
  530 W. Allegan St., 7th Floor
  Lansing. Ml 48933-1521

It must include a copy of the Final Adverse Determination from the PLAN, any pertinent documentation about Your case, such as bills, benefits explanations, medical records, correspondence, research materials that support your position, etc.

IT IS YOUR RESPONSIBILITY TO SUBMIT THIS DOCUMENTATION; DIFS DOES NOT CONTACT MEDICAL PROVIDERS FOR THIS INFORMATION. YOU SHOULD ALWAYS SEND COPIES; NOT THE ORIGINALS.

10.5.3 You do not need to hire a lawyer to request a PRIRA Review. You can authorize someone to act on your behalf, such as a clergy, a friend, a family member, your doctor, or a lawyer.

10.5.4 DIFS will notify You within five (5) business days of receiving Your request for PRIRA Review if DIFS can handle Your case. If Your case is accepted by DIFS, DIFS will determine whether it needs to get a recommendation from an Independent Review Organization, which is an entity that can perform an unbiased medical review of Your case. If DIFS does not need to consult with an Independent Review Organization, You can expect to receive a decision from DIFS within fourteen (14) calendar days after Your request was accepted by OFIR for review. If DIFS has to consult with an Independent Review Organization, the Independent Review Organization has fourteen (14) calendar days after it receives the case from DIFS to make a recommendation to DIFS. DIFS then has seven (7) business days to issue its decision to You.

10.5.5 If You disagree with DIFS' decision, You can appeal to the Circuit Court of the county in which You live, or the Circuit Court of Ingham County.

10.5.6 PRIRA Review cannot be requested for complaints by Providers regarding claims payment or handling of reimbursement for services. PRIRA Review does not apply to issues of termination, cancellation, or the amount You have to pay for Coverage.

10.5.7 If You have questions about PRIRA Reviews, You can call the Appeals Coordinator at **1-866-316-3784**, TTY **711**, or DIFS at **1-877-999-6442**.

SECTION 11.0 GENERAL CONDITIONS

11.1 **ASSIGNMENT**. Assignment by a Member is prohibited.

11.2 **CIRCUMSTANCES BEYOND THE PLAN'S CONTROL**. In the event that, due to circumstances not reasonably within the control of the PLAN, including but not limited to complete or partial destruction of facilities, a major natural disaster, epidemic, war, riot, civil insurrection, labor dispute, disability of a significant part of a hospital or a disability of the PLAN personnel, or similar causes which delay or render impractical the rendition of services described in this Agreement, neither the PLAN nor any Participating Provider shall be liable for such delay or failure to provide services as a result of such circumstances. For purposes of this Section, the term "epidemic" shall mean an outbreak of a contagious disease that spreads rapidly by infection among a population throughout a particular geographic area.

11.3 **NOTICE**. Any notice required or permitted to be given by the PLAN hereunder shall be deemed to have been duly given if in writing and personally delivered, or if in writing and deposited in the United States Mail with postage prepaid, addressed to the Member at the last address of record on file at the principle office of the PLAN; such notice by the Member shall be deemed to have been given when so personally delivered or mailed, addressed to the PLAN at:

Aetna Better Health of Michigan
1333 Gratiot Ave., Suite 400
Detroit, Michigan 48207

11.4 **HEADINGS**. The catch line headings and captions in no way shall be considered to be a part of this contract, but are inserted only for the convenience of reference.

11.5 **GOVERNING LAW**. This contract is made and shall be interpreted under the laws of the state of Michigan and federal law, where applicable.

11.6 **EXECUTION OF CONTRACT**. The parties acknowledge and agree that the Member's signature or execution on a MDHHS Eligibility Application form shall be deemed to be the Member's execution of this Agreement.

11.7 **SEVERABILITY**. If any provision of the Agreement, on its effective date or thereafter, is determined to be in conflict with federal or Michigan law or applicable rules and regulations of the Michigan Office of Financial and Insurance Regulation, such provision shall be fully severable and the remaining provisions of the Agreement shall continue in full force and effect.

11.8 **WAIVER**. The waiver by either party of any breach of any provision of the Agreement shall be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right under this Agreement shall not operate as a waiver of such right.

11.9 **DISCLAIMER**. The PLAN contracts with independent physician groups who provide health care to Members and other patients. The PLAN does not directly furnish medical care, make medical judgments, or assume any responsibility for the physician's medical treatment of the Members.

11.10 **AMENDMENTS**. This Agreement may be amended from time to time, in writing in the form of a rider to this Agreement, as required due to changes in Medicaid program policies or coverages, or state and federal regulations.

Nondiscrimination Notice

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

Aetna:

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

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

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

Address:	Attn: Civil Rights Coordinator 4500 East Cotton Center Boulevard Phoenix, AZ 85040
Telephone:	**1-888-234-7358** (TTY **711**)
Email:	MedicaidCRCoordinator@aetna.com

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

Multi-language Interpreter Services

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

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

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-385-4104** (رقم هاتف الصم والبكم: **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)。

Syriac: [illegible] **1-800-385-4104** ([illegible] **711**)

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

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

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

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলায় কথা বলেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। আপনার পরিচয়পত্রের উল্টোদিকে থাকা নম্বরে অথবা **1-800-385-4104** (TTY: **711**) নম্বরে ফোন করুন।

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

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

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

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

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**).

Serbo-Croatian: Obaveštenje: Ako govorite srpski, usluge jezičke pomoći dostupne su vam besplatno. Pozovite broj na poleđini vaše identifikacione kartice ili broj **1-800-385-4104** (TTY – telefon za osobe sa oštećenim govorom ili sluhom: **711**).

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**).

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