



Welcome

Aetna Better Health® of New Jersey

Managed Long Term Services and Supports (MLTSS)

2020-2021 Member Handbook

Your NJ FamilyCare Plan

AetnaBetterHealth.com/NJ

86.05.352.1-NJ | 097-19-80



Aetna Better Health® of New Jersey

Dear Member,

Thank you for choosing Aetna Better Health of New Jersey, your NJ FamilyCare health plan. We are an Aetna Better Health plan with more than 30 years of experience providing Managed Long Term Services and Support to members of the community.

Joining our plan was a good decision. We have many providers ready to help keep you and your family well. We also have caring member service staff ready to answer your health care coverage questions.

This member handbook tells you about our plan. It is a good idea to take time to read it. Most of what you need to know about getting care is covered in this handbook. It will tell you about:

- Your primary care provider (PCP) with us
- What benefits are covered
- What to do in an emergency
- Your rights and responsibilities as a member
- How to renew your NJ FamilyCare coverage

You may have already received your Aetna Better Health of New Jersey identification card (ID). Your ID card tells you when your membership starts and the name of your PCP. Check your ID card right away. Call us at **1-855-232-3596, TTY: 711** if:

- You did not get an ID card from us
- Your name is not correct on the ID card
- The name of your PCP or any information on the card is not correct

If you have questions or problems getting services, we are here to help you. We are here 24 hours a day, 7 days a week. Our toll-free phone number is **1-855-232-3596, TTY: 711**.

To view this handbook online, find information about our programs and services or to look for a provider, go to our website at **AetnaBetterHealth.com/NJ**.

We look forward to providing your health care benefits!

In good health,



Glenn MacFarlane
Chief Executive Officer
Aetna Better Health of New Jersey

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Important Telephone Numbers

Aetna Better Health of New Jersey MLTSS Member Services	1-855-232-3596, TTY: 711 Representatives available 24 hours a day, 7 days a week
MLTSS Care Management Line	1-833-346-0122, TTY: 711 Access to MLTSS Care Management Team Monday through Friday 8 a.m. to 5 p.m.
Nurse line	1-855-232-3596, TTY: 711 Available 24 hours a day, 7 days a week
Prior Authorization	1-855-232-3596, TTY: 711
Dental Services: LIBERTY Dental Plan	1-855-225-1727, TTY: 711
Vision Services: MARCH Vision	1-844-686-2724, TTY: 1-877-627-2456
Language Services call Member Services	1-855-232-3596, TTY: 711 Representatives available 24 hours a day, 7 days a week
Grievances and Appeals	1-855-232-3596, TTY: 711
Pharmacy Services call Member Services	1-855-232-3596, TTY: 711 Representatives available 24 hours a day, 7 days a week
Prescriptions by Mail: CVS Caremark	1-855-271-6603, TTY: 1-800-823-6373 Monday through Friday 8 a.m. – 8 p.m. EST
Maternity Member Information	1-855-206-7516 (Care Management)
Fraud, Waste and Abuse Hotline	1-855-282-8272, TTY: 711
Health Benefits Coordinator (HBC)	1-800-701-0710, TTY: 1-800-701-0720
NJ Addiction Services Hotline Substance Use Services for NJ FamilyCare members (members who are not Division of Developmental Disabilities (DDD))	1-844-276-2777
Governor's Addiction Services Helpline	1-844-ReachNJ (1-866-824-2331) reachnj.gov

Mental Health Services for NJ FamilyCare members
(members who are not Division of Developmental Disabilities (DDD))

Contact your local Medical Assistance Customer Centers (MACC)

Camden MACC

**Burlington/Camden/Gloucester/Mercer/Salem/
Atlantic/Cape May/ Cumberland
856-614-2870**

One Port Center
2 Riverside Dr., Suite 300
Camden, NJ 08103-1018

Essex MACC

Essex/Hudson

973-648-3700
153 Halsey St.
4th Floor
Newark, NJ 07102-2807

Monmouth MACC

**Monmouth/Hunterdon/Middlesex/Ocean/Somerset/
Union**

732-863-4400

100 Daniels Way
1st Floor
Freehold, NJ 07728-2668

Passaic MACC

Passaic/Bergen/Morris/Sussex/Warren

973-977-4077
100 Hamilton Plaza
5th Floor
Paterson, NJ 07505-2109

Welcome to Aetna Better Health® of New Jersey

Welcome

Thank you for choosing Aetna Better Health of New Jersey. Our goal is to provide you with providers and services that will give you what you need and deserve:

- Quality health care
- Respect
- Excellent customer service

Our members include the following groups:

- Non-institutionalized Aid to Families with Dependent Children (AFDC)/Temporary Assistance for Needy Families (TANF) and related NJ FamilyCare members
- Supplemental Security Income (SSI) – Aged, Blind and Disabled (ABD) and related groups
- Clients of the Division of Developmental Disabilities (DDD) and Community Care Waiver (CCW)
- New Jersey Care – Aged, Blind and Disabled (ABD)
- NJ FamilyCare members
- Eligible Division of Child Protection and Permanency (DCP&P) formerly the Division of Youth and Family Services (DYFS) clients
- Members eligible for Managed Long Term Services and Supports (MLTSS)

Your member handbook

This is your member handbook. This is a guide to help you understand your health plan and benefits.

Throughout the handbook, when we refer to “the Plan,” we are referring to Aetna Better Health of New Jersey. You will want to read and keep this handbook. It will answer questions you may have right now and in the future such as:

- Your rights and responsibilities
- Your health care services
- Filing a grievance or appeal
- Getting information in a language other than English
- Getting information in other ways, like in large print
- Getting your medicines
- Getting medical supplies
- Health and wellness programs

Member Services

Member Services is here to help you. We are here 24 hours a day, 7 days a week. Our toll-free phone number is **1-855-232-3596**, **TTY: 711**. You can call this number from anywhere, even if you are out of town.

Call if you have questions about being a Plan member, what kind of care you can get or how to get care.

Member Services can:

- Help you choose or change a primary care provider (PCP) or a primary care dentist (PCD)
- Teach you and your family about managed care including the services available and the role of your PCP
- Explain your rights and responsibilities as a Plan member
- Help you get services, answer your questions or solve a problem you may have with your care
- Tell you about your benefits and services (what is covered and not covered)
- Assist you in making appointments
- Tell you about your PCP or PCD's medical and educational background, office locations and office hours
- Let you know what help may be available to you and your family in the area you live
- Tell you about fraud, waste and abuse policies and procedures and help you report fraud, waste and abuse.

Member Services needs your help, too. We value your ideas and suggestions to change and improve our service to you. Do you have an idea on how we can work better for you? Please call Member Services at **1-855-232-3596**, **TTY: 711**.

Or write to:

Aetna Better Health of New Jersey
Attention: Member Services
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

At times, we may hold special events for members to learn about the Plan. You will receive information about these events ahead of time. It is a good idea to come if you can. It will help you get to know us and learn about your health care services. Call our MLTSS Care Management Line to speak to a MLTSS representative Monday through Friday 8 a.m. to 5 p.m. at **1-833-346-0122**, **TTY: 711**.

24-hour nurse line

Another way you can take charge of your health care is by using our nurse line. Nurses are available 24 hours a day, 7 days a week to answer your health care questions.

The nurse line does not take the place of your PCP or PCD. But, if it's late at night or you can't reach your PCP or PCD, the nurses can help you decide what to do.

The nurses can also give you helpful hints on how to help you feel better and stay healthy. When a pain is keeping you awake, it's nice to know that, with this service, you won't be up alone. Call us at **1-855-232-3596, TTY: 711.**

Language services

Call **1-855-232-3596 TTY: 711** if you need help in another language. We will get you an interpreter in your language. This service is available at no cost to you. You can get this member handbook or other member material in another language. Call Member Services at **1-855-232-3596, TTY: 711.**

Other ways to get information

If you are deaf or hard of hearing, please call the New Jersey Relay at **711**. They can help you call our Member Services at **1-855-232-3596**.

If you have a hard time seeing or hearing, or you do not read English, you can get information in other formats such as large print or audio. Call Member Services at **1-855-232-3596, TTY: 711** for help.

Website

Our website is **AetnaBetterHealth.com/NJ**. It has information to help you get health care plus help you:

- Find a PCP, PCD, specialist, vision provider, or pharmacy in your area
- Send us questions through e-mail
- Get information about your benefits and health information
- View your member handbook

Service Area

We offer services statewide in all 21 counties.

Identification Card

Your identification (ID) card has the date your health care benefits start. This is the date that you can start getting services as a member of Aetna Better Health of New Jersey.

The ID card lists:

- Your name
- Member ID number
- Co-payment amounts, if you have them
- Your primary care provider's name and phone number
- On the back is important information like what you should do in an emergency
- How to reach Aetna's dental benefit manager, LIBERTY Dental Plan

You need to show your Plan ID card when you go to medical appointments, get prescriptions or get any other health care services.

All members still have a state-issued Health Benefit Identification (HBID) card for the services the Plan does not cover. Always carry your HBID card with you in case you need those services.

If you have Medicare coverage, you will also have separate Medicare ID cards. Everyone who has Medicare receives a card from the Centers for Medicare & Medicaid Services (CMS). This card from CMS is often referred to as the red, white and blue card. If you have Original Medicare, you'll use this card for your benefits. If you have Medicare coverage through a health plan, you'll use the ID card from your health plan. Keep your Medicare card in a safe place so you do not lose it. Please remember to take all of your health benefit cards with you to all provider visits and when visiting the pharmacy.

FRONT

Aetna Better Health® of New Jersey			
NJ FamilyCare Managed Long Term Services and Support (MLTSS)			
Member ID #	XXXXXXXXXXXX	Date of Birth	00/00/0000
Member Name	Last Name, First Name	Sex	X
PCP	Last Name, First Name	Effective Date	00/00/0000
PCP Phone	000-000-0000		
Dental Benefit*			
CO-PAYS			
PCP	\$0	Brand	\$0
ER	\$0	Generic	\$0
RxBIN:	610591		
RxPCN:	ADV		
RxGRP:	RX8829		
Pharmacist Use Only: 1-855-319-6286			
AetnaBetterHealth.com/NewJersey			
THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT.			
NJMED1			

BACK

Member Services / Servicios al Miembro (24/7): 1-855-232-3596, TTY 711, 24/7
Urgent Care: Call your primary care provider (PCP)
Atención de Urgencia: Llame a su proveedor de cuidado primario (PCP)
*LIBERTY Dental Plan Dental Services / Servicios de Dental: 1-855-225-1727
Emergency Care: If you are having an emergency, call 911 or go to the closest hospital. You don't need preapproval for emergency transportation or emergency care in the hospital.
Atención de Emergencia: Si tiene una emergencia, llame al 911 o vaya al hospital más cercano. No necesita aprobación previa para el transporte de emergencia o la atención de emergencia en el hospital.
Prior authorization is required for all inpatient admissions and selected outpatient services. To notify of an admission, please call 1-855-232-3596.
Se requiere autorización previa para todas las admisiones de internación y para ciertos servicios ambulatorios. Para notificar una admisión, llame al 1-855-232-3596.
Send Medical Claims: To verify member eligibility:
Aetna Better Health of New Jersey 1-855-232-3596
PO Box 61925, Phoenix, AZ 85082-1925 Electronic Claims: Payer ID 46320
NJMED1

Your ID card is for your use only – do not let anyone else use it.

Look at your card to make sure the name, address, and date of birth are correct. Call Member Services at 1-855-232-3596, TTY: 711 if:

- There is any information that is wrong.
- You did not receive the card.
- The card is lost or stolen.

Eligibility and Enrollment

You can be a Plan member as long as you are eligible for NJ FamilyCare. Your eligibility is decided by the State of New Jersey. The Division of Medical Assistance and Health Services (DMAHS) must approve your enrollment in our health plan. It may take between 30-45 days after you apply for your membership to start. Coverage with us will start on the first day of the month after you are approved for NJ FamilyCare eligibility. Until you are enrolled with us, you will continue to get benefits through Medicaid Fee-For-Service or the health plan in which you are currently enrolled.

To become an Aetna Better Health of New Jersey member, call a New Jersey State Health Benefits coordinator toll-free at 1-800-701-0710. People with hearing difficulties may call the State's TDD/TTY: number toll-free at 1-800-701-0720. Your membership must be verified and approved by the Division of Medical Assistance and Health Services (DMAHS).

Some Plan members are eligible for Managed Long Term Services and Supports (MLTSS). To qualify for MLTSS, you must meet the State's criteria for needing an institutional level of care, as well as meet certain financial requirements. You do not need to reside in a nursing facility or some other institutional facility to get MLTSS. You can get these services in your home or assisted living facility.

If you are under a provider's care when you join the Plan, let us know. We will work with you and your provider to make sure you get the continued care you need. Call Member Services at **1-855-232-3596**, **TTY: 711** for help.

When the State's Health Benefits Coordinator (HBC) helped you choose Aetna Better Health of New Jersey, you signed a Plan Selection Form (PSF).

This allows the release of your medical records with your signature or authorized person's signature. This form was sent to us. You also told the HBC if you were seeing any providers. Your Plan PCP will have to ask your past provider(s) to send your medical records. Having your past medical records helps your PCP give you the care you need.

Information about NJ FamilyCare

NJ FamilyCare is a program for adults and children who meet certain State/Federal guidelines. There are multiple different plans: A, B, C, D, ABP and MLTSS. The plan you are eligible for is based on your total family income, household size and level of care needed. If you have questions about NJ FamilyCare or how to enroll, please call the health benefit coordinator at **1-800-701-0710**, **TTY: 1-800-701-0720**. You must be enrolled with a Division of Medical Assistance and Health Services (DMAHS) contracted health plan to get services and benefits as a NJ FamilyCare member. Aetna Better Health of NJ is a contracted health plan. DMAHS approves your enrollment in NJ FamilyCare.

Confirmation of enrollment

When you enrolled with the Plan you received a welcome packet. It contained your ID card along with your effective date of enrollment. It will also show the name and phone number of the primary care provider (PCP) that you will go to for health care.

Changing health plans

Once you have enrolled in the Plan, you have 90 days to decide if you want to stay with us or change health plans. During these first 90 days, you can change health plans for any reason. You will need to call the State's Health Benefits Coordinator (HBC) at **1-800-701-0710**, **TTY: 1-800-701-0720 to change plans**. After the 90 days, and if you are still eligible for the NJ FamilyCare program, you will stay enrolled with us until the annual open enrollment period which is October 1 through November 15 each year. You can only change health plans outside of the open enrollment period if you show good cause. Contact the State Health Benefits Coordinator to request change and it will be determined if change can be made for good cause.

Reinstatement

If you lose eligibility for 60 days or less and then become eligible again, you will be re-enrolled with Aetna Better Health of New Jersey. We will assign you to your past PCP if they are still accepting patients.

Member Confidentiality and Privacy

We include a Notice of Privacy Practices in your welcome packet. It tells you how we use your information for health plan benefits. It also tells you how you can see, get a copy of or change your medical records. Your health information will be kept private and confidential. We will give it out only if the law allows or if you tell us to give it out. For more information or if you have questions, call us at **1-855-232-3596, TTY: 711**. You can also visit our website at **AetnaBetterHealth.com/NJ**.

Your Rights and Responsibilities

As a Plan member, you have rights and responsibilities. If you need help understanding your rights and responsibilities, call Member Services at **1-855-232-3596, TTY: 711**.

Your rights

As a member or the parent or guardian of a member, you have the right to:

- Be treated with courtesy, consideration, respect, dignity and need for privacy.
- Be provided with information about the Plan, its policies and procedures, its services, the practitioners providing care, member's rights and responsibilities, and to be able to communicate and be understood with the assistance of a translator if needed.
- Be able to choose a PCP within the limits of the plan network, including the right to refuse care from specific practitioners.
- Participate in decision-making regarding their health care, to be fully informed by the PCP, other health care provider or care manager of health and functional status, and to participate in the development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence.
- A candid discussion of appropriate or medically necessary treatment options for your condition(s) regardless of cost or benefit coverage, including the right to refuse treatment or medication.
- Voice grievances about the Plan or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of our choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers.
- File appeals about a Plan action or denial of service and to be free from any form of retaliation.
- Formulate advance directives.
- Have access to your medical records in accordance with applicable federal and state laws.

- Be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect.
- Be free of hazardous procedures.
- Receive information on available treatment options or alternative courses of care.
- Refuse treatment and be informed of the consequences of such refusal.
- Have services provided that promote a meaningful quality of life and autonomy for you, independent living in your home and other community settings as long as medically and socially feasible, and preservation and support of your natural support systems.
- Available and accessible services when medically necessary.
- Access care 24 hours a day, seven days a week for urgent and emergency conditions. For life-threatening conditions call 911.
- Be afforded a choice of specialist among participating providers.
- Obtain a current directory of participating providers in the Plan including addresses and telephone numbers, and a listing of providers who accept members who speak languages other than English.
- Obtain assistance and referral to providers with experience in treatment of patients with chronic disabilities.
- Be free from balance billing by providers for medically necessary services that were authorized by the Plan, except as permitted for co-payments in your plan.
- A second opinion.
- Prompt notification of termination or changes in benefits, series or provider network.
- Information about incentives we pay providers.
- Emergency care without prior approval.
- Family planning services from Aetna Better Health or any Medicaid provider.
- Decline care management services; Aetna Better Health still must manage your care.
- External appeal by an independent organization if you disagree with our decision on internal appeal (not all services qualify for review by Independent Utilization Review Organization (IURO)).
- Disenroll and transfer to another NJ FamilyCare managed care plan at any time for cause; change plans within the first 90 days of joining Aetna Better Health and during the annual enrollment October 1 to November 15.
- To request and receive information on services available.
- Have access to and choice of qualified service providers.
- Be informed of your rights prior to receiving chosen and approved services.
- Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability.
- Have access to appropriate services that support your health and welfare.
- To assume risk after being fully informed and able to understand the risks and consequences of the decisions made.
- To make decisions concerning your care needs.
- Participate in the development of and changes to your plan of care.

- Request changes in services at any time, including add, increase, decrease or discontinue.
- Request and receive from your MLTSS care manager a list of names and duties of any person(s) assigned to provide services to you under the plan of care.
- Receive support and direction from your MLTSS care manager to resolve concerns about your care needs and/or complaints about services or providers.
- Be informed of and receive in writing facility specific resident rights upon admission to an institutional or residential settings.
- Comprehensive dental care.
- Be informed of all the covered/required services you are entitled to, required by and/or offered by the institutional or residential setting, and any charges not covered by the managed care plan while in the facility.
- Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of nonpayment to the facility from available income as reported on the statement of available income for Medicaid payment.
- Have your health plan protect and promote your ability to exercise all rights identified in this document.
- Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian.
- Appeal or request Medicaid Fair Hearing regarding eligibility for MLTSS or participation in the personal preference program (PPP).

Your responsibilities

- Tell Aetna Better Health and its doctors and other providers what they need to know to provide your care.
- Follow your doctor's plans and instructions for your care.
- Read your Member Handbook and other plan mailings to learn how to work with Aetna Better Health.
- Use your ID cards when you go to health care appointments or get services and do not let anyone else use your card.
- Know the name and phone number of your PCP and your care manager.
- Know about your health care and the rules for getting care.
- Tell the Plan and your caseworker or the Health Benefit Coordinator (HBC) when you make changes to your address, telephone number, family size and other information.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- Be respectful to the health care providers who are giving you care.
- Schedule your appointments, be on time, and call if you are going to be late to or miss your appointment.

- Give your health care providers all the information they need.
- Tell the Plan and DMAHS about your concerns, questions or problems.
- Ask for more information if you do not understand your care or health condition.
- Follow your health care provider's advice.
- Tell us about any other insurance you have.
- Tell us if you are applying for or get any other health care benefits.
- Bring shot records to all appointments for children under 18 years old.
- Give your provider a copy of your living will or advance directive.
- Keep track of the cost-sharing amounts you pay.
- Provide all health and treatment related information, including, medication, circumstances, living arrangements, informal and formal supports to your care manager in order to identify care needs and develop a plan of care.
- Understand your health care needs and work with your care manager to develop or change goals and services.
- Work with your MLTSS care manager to develop or revise your plan of care to facilitate timely authorization and implementation of services.
- Ask questions when additional understanding is needed.
- Understand the risks associated with your decisions about care.
- Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to your MLTSS care manager.
- Tell your MLTSS care manager about any problem that occurs or if you are dissatisfied with the services being provided.
- Follow your health plan's rules and the rules of institutional or residential setting's rules including any costs you must pay.
- Meet with your MLTSS care manager at least quarterly.

Getting Care

Our members need to use one of our network providers to obtain all covered non-emergent health care services.

Provider directory

You can contact Member Services to obtain a provider directory. It is also online at **[AetnaBetterHealth.com/NJ](http://www.aetnabetterhealth.com/NJ)**. It lists health care providers and hospitals in our network. The directory has the names of PCPs, specialists, behavioral health, pharmacy, dental and vision providers in your area. For a listing of NJ Smiles providers (for children 0-3 years old), you can search the online provider search linked on our Dental Benefits page at **<http://www.aetnabetterhealth.com/newjersey/members/benefits/dental>**.

If you want help finding a provider for any of our services, call Member Services at **1-855-232-3596, TTY: 711**. We will be happy to help you. You can also call Member Services if you want a provider to be added to our network. We will try to make that happen.

You may see an out-of-network provider if you need special care and we do not have a network provider with the right specialty. The provider must first get approval from us to see you or you may have to pay for these services. See page 20 on getting pre-approval (service authorization) for services.

If you are unable to leave your home

If you can't leave your home to get care, we can help. Call Member Services at **1-855-232-3596, TTY: 711** if you are homebound. We will have a care manager work with you to make sure you get the care you need.

You may be eligible for home care and personal care. These can include but are not limited to:

- Home delivered meals
- Personal Emergency Response System
- Home based supportive care
- Chore services.

To learn more, view the Covered Services grid on page 23. Get direct access to our MLTSS care management department, just call 1-833-346-0122 (TTY: 711) for coordination of care.

Your primary care provider (PCP)

You will often hear the term PCP. Your PCP is a medical provider who will manage your health care. They will help you get all the covered services you need.

You should make an appointment to see your PCP when you join Aetna Better Health of New Jersey. We may contact you to help you schedule this visit. Your PCP's office may also contact you to schedule this visit. If you need help scheduling appointments call Member Services at **1-855-232-3596, TTY: 711**. Your PCP helps you get care from other health plan providers. They are responsible for coordinating your health care by:

- Learning your health history
- Keeping good health records
- Providing regular care
- Answering your questions
- Giving you advice about healthy eating
- Giving you needed shots and tests
- Getting you other types of care
- Sending you to a provider that has special training for your special health care needs
- Giving you support when you have problems with your health care

Types of primary care providers

The following are the types of primary care providers you can choose:

- **Family practice** – providers who treat adults and children
- **General practice** – providers who treat adults and children
- **Pediatrician** – providers who treat children from birth to age 21
- **Specialists** – providers who are trained, certified or licensed in a special area of health care
- **Ob/Gyn** - providers who treat women
- **Primary care dentists (PCD)** – providers who may be a general dentist or pedodontist (children’s dentists). NJ Smiles is a dental program especially for children from 0-3 years of age. NJ Smiles providers provide dental risk assessments, fluoride varnish application and referral to a primary care dentist for a comprehensive examination and treatment during well-child visits with your child’s PCP.

Sometimes PCPs have other health care providers in their office that you may see. Nurse practitioners, physician assistants, and registered nurses may be employed by your provider to help meet your health care needs.

If you see a specialist for special health care needs and you want the specialist to be your PCP, we can help. The Plan and your PCP will work together to help you see the PCP of your choice. Call Member Services at **1-855-232-3596, TTY: 711** for more information.

The provider’s office

Ask your provider and office staff the questions below. These questions can help you understand the care and services you may receive:

- What are your office hours?
- Do you see patients on weekends or at night?
- What kinds of special help do you offer for people with disabilities?
- (If you are hearing impaired) Do you have sign language interpreters?
- Will you talk about problems with me over the phone?
- Who should I contact after hours if I have an urgent situation?
- How long do I have to wait for an appointment?

Other questions to ask

Use the questions below when you talk to your provider or pharmacist. These questions may help you stay well or get better. Write down the answers to the questions.

Always follow your provider’s directions.

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

Quick tips about appointments

Call your provider early in the day to make an appointment. Let them know if you need special help.

- Tell the staff person your symptoms.
- Take your Plan ID card and other Medicaid and Medicare ID cards with you.
- If you are a new patient, go to your first appointment at least 30 minutes early so you can give them information about you and your health history
- Let the office know when you arrive. Check in at the front desk.

If you cannot go to your appointment, please call your provider's office 24 hours before the appointment time to cancel.

Your PCP

We believe that the PCP is one of the most important parts of your health care. We support you in choosing your PCP. You can select your PCP when you enroll with the Plan. You will be able to access care 24 hours a day, 7 days a week for urgent and emergency conditions. For life-threatening conditions, call **911**.

How do I pick my PCP?

- You need to pick a PCP that is in our Plan provider network. Our provider directory has a list of PCPs to pick from in your area. Our provider directory is online at **AetnaBetterHealth.com/NJ**. You can also request a hard copy of our provider directory. Just call Member Services toll-free at **1-855-232-3596, TTY: 711**.
- Each eligible family member does not have to have the same PCP.
- If you do not pick a PCP, we will pick one for you.

How do I change my PCP?

Your PCP is an important part of your health care team. We want you and your provider to work together. You may want to change your PCP for the following reasons:

- You want a male or a female provider
- You want a provider that speaks your language

If you want to choose or change your PCP to another provider in our provider network, call Member Services toll-free at **1-855-232-3596, TTY: 711**.

- In most cases, the PCP change will happen on the same day as your request.
- You will get a new Plan ID card with the name of your new PCP.

It is important for you to have a good relationship with your PCP. This will help you get the health care you need. Your PCP may ask us to change you to another provider if you do the following things:

- You miss appointments over-and-over again.
- You often do not follow your provider's advice.
- You or a family member hurts a provider or office staff member.
- You or a family member uses very bad language to a provider or office staff.
- You or a family member damages an office.

If your PCP asks that you be assigned a new PCP we will let you know. We will also call you to help you pick a new provider. If you do not pick a new provider we will pick one for you. You will get a new ID card with the new provider's name and telephone number on it.

Notice of provider changes or service locations

Sometimes we will have to change your PCP without talking to you first. If this happens, we will send you a letter, and then you can pick another PCP by calling Member Services. Your provider may decide they do not want to be a part of our provider network. They may move to another location. If you are not sure if a provider is in our network, check our website. You can also call Member Services toll-free at **1-855-232-3596, TTY: 711**.

Getting pre-approval (prior authorization) for services

The Plan must pre-approve some services before you can get them. We call this prior authorization. This means that your providers must get permission from us to provide certain services. They will know how to do this. We will work together to make sure the service is what you need.

Except for family planning and emergency care, all out-of-network services require pre-approval. You may have to pay for your services if you do not get pre-approval for services:

- Provided by an out-of-network provider
- That require pre-approval
- That are not covered by the Plan

The following are the steps for pre-approval:

1. Your provider gives the Plan information about the services they think you need.
2. We review the information.
3. You and your provider will get a letter telling you if the service is approved or denied.
4. **If the request cannot be approved**, the letter will explain why it is denied.
5. **If a service is denied**, you or your provider can file an appeal. Please see page 87 for more information on appeals.

Understanding your service approval or denial

We use certain guidelines to approve or deny services. We call these “clinical practice” guidelines. Some guidelines are used by other health plans across the country. Other guidelines are developed by a special team at Aetna that reviews current knowledge about health services. They help us make the best decision we can about your care. You or your provider can get a copy of the guidelines we use to approve or deny services. If you want a copy of the guidelines or do not agree with the denial of your services, please call Member Services at **1-855-232-3596, TTY: 711**.

Definition of “medically necessary services”

We use guidelines to offer services that meet your health care needs. “Medically necessary services” are services or benefits that are needed to take care of you. A service or benefit is medically necessary and is covered if it:

- Is reasonably expected to prevent the beginning of an illness, condition or disability
- Is reasonably expected to reduce or maintain the physical, mental or developmental effects of an illness, condition, injury or disability
- Will assist you in being able to improve or maintain performing your daily activities based on your condition, abilities and age.

Self-referral

You can get some services without needing the Plan’s prior approval. We call this self-referral. It is best to make sure your PCP knows about any care you get. You can self-refer to the following services:

- Emergency care
- Behavioral health
- Vision exams
- Dental care from a network general dentist or pedodontist (children’s dentist)
- Routine care from an Ob/Gyn
- Routine family planning services
- Mammograms and prostate/colon cancer screenings
- Specialists

Apart from family planning and emergency services, you must go to a Plan provider for your service to be covered. To find a provider, look in the provider directory online at **AetnaBetterHealth.com/NJ**. You can also call Member Services for help at **1-855-232-3596, TTY: 711**.

Covered Services

The tables on the next few pages show what services NJ FamilyCare and Fee-For-Service (FFS) covers and what services the Plan covers. If you are in NJ FamilyCare C or D, you may have to pay a co-payment at the visit. All services must be medically necessary. Your provider may have to ask us for prior approval before you can get some services.

Members will need to show both their Aetna Better Health of New Jersey ID card and their Medicaid card for services listed as FFS. If you have questions about coverage or getting services, call Member Services at **1-855-232-3596, TTY: 711**.

You may get these services through the provider of your choice in our network. Aetna Better Health of New Jersey or your PCP can help you find a provider if you need services.

Covered Services

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Abortions	Covered by FFS. Abortions and related services, including (but not limited to) surgical procedure; anesthesia; history and physical exam; and lab tests			
Acupuncture	Covered by ABH NJ			
Autism Services	Covered by ABH NJ Only covered for members under 21 years of age with Autism Spectrum Disorder. Covered services include physical, occupational, and speech therapies; augmentative and alternative communication services and devices; sensory integration services; and Applied Behavior Analysis (ABA) treatment.			
Blood and Blood Products	Covered by ABH NJ Whole blood and derivatives, as well as necessary processing and administration costs, are Covered by ABH NJ Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.			
Bone Mass Measurement	Covered by ABH NJ Covers one measurement every 24 months (more often if medically necessary), as well as physician's interpretation of results.			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Cardiovascular Screenings	<p>Covered by ABH NJ</p> <p>For all persons 20 years of age and older, annual cardiovascular screenings are Covered by ABH NJ. More frequent testing is covered when determined to be medically necessary.</p>			
Chiropractic Services	<p>Covered by ABH NJ</p> <p>Covers manipulation of the spine.</p>			
Colorectal Screening	<p>Covered by ABH NJ</p> <p>Covers any expenses incurred in conducting colorectal cancer screening at regular intervals for beneficiaries 50 years of age or older, and for those of any age deemed to be at high risk of colorectal cancer.</p>			
<i>Barium Enema</i>	<p>Covered by ABH NJ</p> <p>When used instead of a flexible sigmoidoscopy or colonoscopy, covered once every 48 months.</p>			
<i>Colonoscopy</i>	<p>Covered by ABH NJ</p> <p>Covered once every 120 months, or 48 months after a screening flexible sigmoidoscopy.</p>			
<i>Fecal Occult Blood Test</i>	<p>Covered by ABH NJ</p> <p>Covered once every 12 months.</p>			
<i>Flexible Sigmoidoscopy</i>	<p>Covered by ABH NJ</p> <p>Covered once every 48 months.</p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
<p>Dental Services</p>	<p>Covered by ABHNJ</p> <p>Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services.</p> <p>Examples of covered services include (but are not limited to): routine examinations, fillings, crowns, root planing and scaling, x-rays and other diagnostic imaging, extractions, cleanings/prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics.</p>	<p>Covered by ABHNJ</p> <p>Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services.</p> <p>Examples of covered services include (but are not limited to): routine examinations, fillings, crowns, root planing and scaling, x-rays and other diagnostic imaging, extractions, cleanings/prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics.</p>	<p>Covered by ABHNJ</p> <p>Covers diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical, as well as adjunctive services.</p> <p>Examples of covered services include (but are not limited to): routine examinations, fillings, crowns, root planing and scaling, x-rays and other diagnostic imaging, extractions, cleanings/prophylaxis, topical fluoride treatments, apicoectomy, dentures, and fixed prosthodontics.</p> <p>Orthodontics (with age restrictions and documentation of medical necessity) is also Covered by ABHNJ</p> <p><i>Orthodontics are covered up to age 19 for NJ FamilyCare C and D members.</i></p> <p>NJ FamilyCare C and D members have a \$5 copay per dental visit (except for diagnostic and preventive services).</p>	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Dental Services (Continued)	<p>Orthodontics (with age restrictions and documentation of medical necessity) is also Covered by ABHNJ</p> <p><i>Orthodontics are covered up to age 21 for NJ FamilyCare A and ABP members.</i></p>	<p>Orthodontics (with age restrictions and documentation of medical necessity) is also Covered by ABHNJ</p> <p><i>Orthodontics are covered up to age 19 for NJ FamilyCare B members.</i></p>		
Diabetes Screenings	<p>Covered by ABHNJ</p> <p>Screening is covered (including fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>			
Diabetes Supplies	<p>Covered by ABHNJ</p> <p>Covers blood glucose monitors, test strips, insulin, injection aids, syringes, insulin pumps, insulin infusion devices, and oral agents for blood sugar control. Covers therapeutic shoes or inserts for those with diabetic foot disease. The shoes or inserts must be prescribed by a podiatrist (or other qualified doctor) and provided by a podiatrist, orthotist, prosthetist, or pedorthist.</p>			
Diabetes Testing and Monitoring	<p>Covered by ABHNJ</p> <p>Covers yearly eye exams for diabetic retinopathy, as well as foot exams every six months for members with diabetic peripheral neuropathy and loss of protective sensations.</p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Diagnostic and Therapeutic Radiology and Laboratory Services	Covered by ABHNJ Covered, including (but not limited to) CT scans, MRIs, EKGs, and X-rays.			
Durable Medical Equipment (DME)	Covered by ABHNJ			
Emergency Care	Covered by ABHNJ Covers emergency department and physician services.		Covered by ABHNJ Covers emergency department and physician services. NJ FamilyCare C members have a \$10 copayment.	Covered by ABHNJ Covers emergency department and physician services. NJ FamilyCare D members have a \$35 copayment.
EPSDT (Early and Periodic Screening Diagnosis and Treatment)	Covered by ABHNJ Coverage includes (but is not limited to) well child care, preventive screenings, medical examinations, vision and hearing screenings and services (as well as any treatment identified as necessary as a result of examinations	Covered by ABHNJ For NJ FamilyCare B, C, and D members, coverage includes early and periodic screening and diagnostic medical examinations, dental, vision, hearing, and lead screening services. <i>For NJ FamilyCare B, C, and D members, coverage for treatment services identified as necessary through an examination is limited to those services that are available under the plan's benefit package, or specified services under the FFS program.</i>		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
EPSDT (Early and Periodic Screening Diagnosis and Treatment) (Continued)	<p>or screenings), immunizations (including the full childhood immunization schedule), lead screening, and private duty nursing services.</p> <p>Private duty nursing is covered for eligible EPSDT beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.</p>			
Family Planning Services and Supplies	<p>Covered by ABH NJ</p> <p>Covered services include medical history and physical examination (including pelvis and breast), diagnostic and laboratory tests, drugs and biologicals, medical supplies and devices (including pregnancy test kits, condoms, diaphragms, Depo-Provera injections, and other contraceptive supplies and devices), counseling, continuing medical supervision, continuity of care and genetic counseling.</p> <p>Services furnished by out-of-network providers are covered by Medicaid Fee-for-Service.</p> <p><i>Exceptions: Services primarily related to the diagnosis and treatment of infertility are not covered (whether furnished by in-network or out-of-network providers).</i></p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Federally Qualified Health Centers (FQHC)	<p>Covered by ABH NJ</p> <p>Includes outpatient and primary care services from community-based organizations.</p>			
Hearing Services/ Audiology	<p>Covered by ABH NJ</p> <p>Covers routine hearing exams, diagnostic hearing exams and balance exams, otologic and hearing aid examinations prior to prescribing hearing aids, exams for the purpose of fitting hearing aids, follow-up exams and adjustments, and repairs after warranty expiration. Hearing aids, as well as associated accessories and supplies, are Covered by ABH NJ</p>			
Home Health Agency Services	<p>Covered by ABH NJ</p> <p>Covers nursing services and therapy services by a registered nurse, licensed practical nurse or home health aide.</p>			
Hospice Care Services	<p>Covered by ABH NJ</p> <p>Covers drugs for pain relief and symptoms management; medical, nursing, and social services; and certain durable medical equipment and other services, including spiritual and grief counseling.</p> <ul style="list-style-type: none"> - Covered in the community as well as in institutional settings. - Room and board included only when services are delivered in institutional (non-residence) settings. Hospice care for enrollees under 21 years of age shall cover both palliative and curative care. <p>NOTE: Any care unrelated to the enrollee's terminal condition is covered in the same manner as it would be under other circumstances.</p>			
Immunizations	<p>Covered by ABH NJ</p> <p>Influenza, Hepatitis B, pneumococcal vaccinations, and other vaccinations recommended for adults are Covered by ABH NJ</p> <p>The full childhood immunization schedule is covered as a component of EPSDT.</p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Inpatient Hospital Care	<p>Covered by ABH NJ</p> <p>Covers stays in critical access hospitals; inpatient rehabilitation facilities; inpatient mental health care; semi-private room accommodations; physicians' and surgeons' services; anesthesia; lab, x-ray, and other diagnostic services; drugs and medication; therapeutic services; general nursing; and other services and supplies that are usually provided by the hospital.</p>			
Acute Care	<p>Covered by ABH NJ</p> <p>Includes room and board; nursing and other related services; use of hospital/Critical Access Hospital facilities; drugs and biologicals; supplies, appliances, and equipment; certain diagnostic and therapeutic services, medical or surgical services provided by certain interns or residents-in-training; and transportation services (including transportation by ambulance).</p>			
Psychiatric	<p><i>For coverage details, please refer to the Behavioral Health chart.</i></p>			
Mammograms	<p>Covered by ABH NJ</p> <p>Covers a baseline mammogram for women age 35 to 39, and a mammogram every year for those 40 and over, and for those with a family history of breast cancer or other risk factors. Additional screenings are available if medically necessary.</p>			
Maternal and Child Health Services	<p>Covered by ABH NJ</p> <p>Covers medical services, including related newborn care and hearing screenings.</p> <p>Also covers childbirth education, as well as lactation (breast feeding) supplies and support services.</p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Medical Day Care (Adult Day Health Services)	Covered by ABHNJ A program that provides preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory (outpatient) care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		
Nurse Midwife Services	Covered by ABHNJ		Covered by ABHNJ \$5 copayment for each visit (except for prenatal care visits)	
Nursing Facility Services	Covered by ABHNJ Members may have patient pay liability.	<i>Not covered for NJ FamilyCare B, C, or D members.</i>		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Long Term (Custodial Care)	Covered by ABHNJ Covered for those who need Custodial Level of Care (MLTSS). Members may have patient pay liability.	Not covered for NJ FamilyCare B, C, or D members.		
Nursing Facility (Hospice)	Covered by ABHNJ Hospice care can be covered in a Nursing Facility setting. <i>*See Hospice Care Services.</i>	Not covered for NJ FamilyCare B, C, or D members.		
Nursing Facility (Skilled)	Covered by ABHNJ Includes coverage for Rehabilitative Services that take place in a Nursing Facility setting.	Not covered for NJ FamilyCare B, C, or D members.		
Nursing Facility (Special Care)	Covered by ABHNJ Care in a Special Care Nursing Facility (SCNF) or a separate and distinct SCNF unit within a Medicaid-	Not covered for NJ FamilyCare B, C, or D members.		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Nursing Facility (Special Care) (Continued)	certified conventional nursing facility is covered for members who have been determined to require intensive nursing facility services beyond the scope of a conventional nursing facility.			
Organ Transplants	Covered by ABHNJ Covers medically necessary organ transplants including (but not limited to): liver, lung, heart, heart-lung, pancreas, kidney, liver, cornea, intestine, and bone marrow transplants (including autologous bone marrow transplants). Includes donor and recipient costs.			
Outpatient Surgery	Covered by ABHNJ			
Outpatient Hospital/Clinic Visits	Covered by ABHNJ		Covered by ABHNJ \$5 copayment per visit (no copayment if the visit is for preventive services).	
Outpatient Rehabilitation (Occupational Therapy, Physical Therapy, Speech Language Pathology)	Covered by ABHNJ Covers physical therapy, occupational therapy, speech pathology, and cognitive rehabilitation therapy.	Covered by ABHNJ Covers physical, occupational, and speech/language therapy. For NJ FamilyCare B, C, and D members, limited to 60 days per therapy per calendar year.		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Pap Smears and Pelvic Exams	<p>Covered by ABHNJ</p> <p>Pap tests and pelvic exams are covered every 12 months for all women, regardless of determined level of risk for cervical or vaginal cancers. Clinical breast exams for all women are covered once every 12 months. All laboratory costs associated with the listed tests are Covered by ABHNJ Tests are covered on a more frequent basis in cases where they are deemed necessary for medical diagnostic purposes.</p>			
Personal Care Assistance	<p>Covered by ABHNJ</p> <p>Covers health-related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.</p>	<p><i>Not covered for NJ FamilyCare B, C, or D members.</i></p>		
Podiatry	<p>Covered by ABHNJ</p> <p>Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.</p>		<p>Covered by ABHNJ</p> <p>Covers routine exams and medically necessary podiatric services, as well as therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.</p> <p>\$5 copayment per visit for NJ FamilyCare C and D members.</p>	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Podiatry (Continued)	<i>Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.</i>		<i>Exceptions: Routine hygienic care of the feet, such as the treatment of corns and calluses, trimming of nails, and care such as cleaning or soaking feet, are only covered in the treatment of an associated pathological condition.</i>	
Prescription Drugs	Covered by ABHNJ Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are Covered by ABHNJ		Covered by ABHNJ Includes prescription drugs (legend and non-legend, including physician administered drugs); prescription vitamins and mineral products (except prenatal vitamins and fluoride) including, but not limited to, therapeutic vitamins, such as high potency A, D, E, Iron, Zinc, and minerals, including potassium, and niacin. All blood clotting factors are Covered by ABHNJ For NJ FamilyCare C and D members, there is a \$1 copayment for generic drugs, and a \$5 copayment for brand name drugs.	
Physician Services - Primary and Specialty Care	Covered by ABHNJ Covers medically necessary services and certain preventive services in outpatient settings.		Covered by ABHNJ Covers medically necessary services and certain preventive services in outpatient settings. \$5 copayment for each visit (except for well-child visits in accordance with the recommended schedule of the American Academy of Pediatrics; lead screening and treatment, age-appropriate immunizations; prenatal care; and pap smears, when appropriate).	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Private Duty Nursing	<p>Covered by ABH NJ</p> <p>Private duty nursing is covered for members who live in the community and whose medical condition and treatment plan justify the need.</p> <p>Private Duty Nursing is only available to EPSDT beneficiaries under 21 years of age, and to members with MLTSS (of any age).</p>			
Prostate Cancer Screening	<p>Covered by ABH NJ</p> <p>Covers annual diagnostic examination including digital rectal exam and Prostate Specific Antigen (PSA) test for men 50 and over who are asymptomatic, and for men 40 and over with a family history of prostate cancer or other prostate cancer risk factors.</p>			
Prosthetics and Orthotics	<p>Covered by ABH NJ</p> <p>Coverage includes (but is not limited to) arm, leg, back, and neck braces; artificial eyes; artificial limbs and replacements; certain breast prostheses following mastectomy; and prosthetic devices for replacing internal body parts or functions. Also covers certified shoe repair, hearing aids, and dentures.</p>			
Renal Dialysis	<p>Covered by ABH NJ</p>			
Routine Annual Physical Exams	<p>Covered by ABH NJ</p>		<p>Covered by ABH NJ</p> <p>No copayments.</p>	
Smoking/Vaping Cessation	<p>Covered by ABH NJ</p> <p>Coverage includes counseling to help you quit smoking or vaping, medications such as Bupropion, Varenicline, nicotine oral inhalers, and nicotine nasal sprays, as well as over-the-counter products including nicotine transdermal patches, nicotine gum, and nicotine lozenges.</p>			

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Smoking/Vaping Cessation (Continued)	<p>The following resources are available to support you in quitting smoking/vaping:</p> <ul style="list-style-type: none"> • NJ Quitline: Design a program that fits your needs and get support from counselors. Call toll free 1-866-NJ-STOPS (1-866-657-8677) (TTY: 711), Monday through Friday, from 8 a.m. to 8 p.m. (except holidays) and Saturday, from 11 a.m. to 5 p.m., ET. The program supports 26 different languages. Learn more at njquitline.org. • NJ QuitNet: Free peer support and trained counselors, available 24 hours a day, seven days a week at quitnet.com. • NJ Quitcenters: Receive professional face-to-face counseling in individual or group sessions. Locate a center by calling 1-866-657-8677 (TTY: 711) or visit quitnet.com. 			
Transportation (Emergency) <i>(Ambulance, Mobile Intensive Care Unit)</i>	<p>Covered by ABH NJ</p> <p>Coverage for emergency care, including (but not limited to) ambulance and Mobile Intensive Care Unit.</p>			
Transportation (Non-Emergent) <i>(Non-Emergency Ambulance, Medical Assistance Vehicles/MAV, Livery, Clinic)</i>	<p>Covered by FFS.</p> <p>Medicaid Fee-for-Service covers all non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher). Livery transportation services, such as bus and train fare or passes, car service and reimbursement</p>	<p>Covered by FFS.</p> <p>Medicaid Fee-for-Service covers non-emergency transportation, such as mobile assistance vehicles (MAVs), and non-emergency basic life support (BLS) ambulance (stretcher).</p> <p>May require medical orders or other coordination by the health plan, PCP, or providers.</p> <p>Exceptions: Livery transportation services are not covered for NJ FamilyCare B, C, or D members.</p>		

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Transportation (Non-Emergent) (Continued)	for mileage, are also Covered by ABHNJ May require medical orders or other coordination by the health plan, PCP, or providers.			
Urgent Medical Care	Covered by ABHNJ Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse).		Covered by ABHNJ Covers care to treat a sudden illness or injury that isn't a medical emergency, but is potentially harmful to your health (for example, if your doctor determines it's medically necessary for you to receive medical treatment within 24 hours to prevent your condition from getting worse). NOTE: There may be a \$5 copayment for urgent medical care provided by a physician, optometrist, dentist, or nurse practitioner.	
Vision Care Services	Covered by ABHNJ Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses.		Covered by ABHNJ Covers medically necessary eye care services for detection and treatment of disease or injury to the eye, including a comprehensive eye exam once per year. Covers optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses.	

Service/Benefit	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Vision Care Services (Continued)	<p>Yearly exams for diabetic retinopathy are covered for member with diabetes.</p> <p>A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma.</p> <p>Certain additional diagnostic tests are covered for members with age-related macular degeneration.</p>		<p>Yearly exams for diabetic retinopathy are covered for member with diabetes.</p> <p>A glaucoma eye test is covered every five years for those 35 or older, and every 12 months for those at high risk for glaucoma.</p> <p>Certain additional diagnostic tests are covered for members with age-related macular degeneration.</p> <p>\$5 copayment per visit for Optometrist services.</p>	
Corrective Lenses	<p>Covered by ABHNJ</p> <p>Covers 1 pair of lenses/frames or contact lenses every 24 months for beneficiaries age 19 through 59, and once per year for those 18 years of age or younger and those 60 years of age or older.</p> <p>Covers one pair of eyeglasses or contact lenses after each cataract surgery with an intraocular lens.</p>			

Getting Specialty Care

Sometimes you may need care from a specialist. Specialists are providers who treat special types of conditions. For example, a cardiologist treats heart conditions. Your PCP can recommend a specialist to you. You can also look in the online provider directory at AetnaBetterHealth.com/NJ or call Member Services at **1-855-232-3596, TTY: 711**. We will help you find a specialist near you.

If a specialist is in our network, your PCP can refer you to go without asking us. If the specialist is not in our network, the specialist will have to contact us to get approval to see you. This is called prior authorization or service authorization. The specialists will know what to do. Some members may need to see a specialist on a long-term basis. This is called getting a “standing referral”. We can work with the specialist to make this happen. The specialist will have to contact us to get approval.

Getting a Second Opinion

You can get a second opinion from another provider when your PCP, PCD, or a specialist says you need surgery or other treatment. A second opinion is available at no charge to you. Your PCP or PCD can recommend a provider. You can also call Member Services at **1-855-232-3596, TTY: 711**. You do not need to ask us if you get a second opinion with a provider who is in our network. If the provider is not in our network, the specialist will have to contact us to get approval to see you. This is called prior authorization or service authorization. The specialists will know what to do.

If you don't have a PCP or PCD, we can help you find one near you. Call Member Services at **1-855-232-3596, TTY: 711**. You can also view our online provider directory at **AetnaBetterHealth.com/NJ**.

Transportation

For an emergency medical condition, call 911. The Plan covers ambulance rides on the ground and air transportation in a medical emergency for all members. Members can receive other non-emergency medical transportation services through Fee-For-Service (FFS). To find out more about getting a ride to your provider visits, call LogistiCare at **1-866-527-9933 (TTY: 1-866-288-3133)**. If you have any problems with the service you receive, you can call the LogistiCare Complaint Hotline at **1-866-333-1735**. Transportation appointments must be scheduled at least two days in advance.

Please have the following information when calling to schedule your transportation:

- Name of the provider
- Address
- Telephone number
- Time of appointment
- Type of transportation needed (e.g., regular car, wheelchair accessible van)

After Hours Care

Except in an emergency, if you get sick after the PCP's office is closed, or on a weekend, call the office anyway. An answering service will make sure the PCP gets your message. The PCP will call you back to tell you what to do. Be sure your phone accepts blocked calls. Otherwise, the PCP may not be able to reach you.

You can even call the PCP in the middle of the night. You might have to leave a message with the answering service. The PCP will call you back to tell you what to do.

If you are having an emergency, you should ALWAYS call 911 or go to the nearest emergency room.

We also have a nurse line available to help answer your medical questions. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. Call **1-855-232-3596**, **TTY: 711** and listen for the option for the nurse line.

Out-of-Service Area Coverage

There are times when you may be away from home and you or your child needs care. Aetna Better Health of New Jersey has providers only in New Jersey. We will cover services out of the area for special reasons. This may include:

- Very specialized services not available in the network
- Emergency Services
- Urgent Services when you are too far away to get back to the area

If you or your child needs care out of the area for urgent or emergency services, you do not need to contact us.

When you are out of our service area, you are only covered for emergency services or non-emergency situations when travel back to the service area is not possible, is impractical, or when medically necessary services could only be provided elsewhere. For services that are not urgent and not an emergency, the provider should contact us for our approval.

Full time students are covered while they reside out of state to go to school. The provider should contact us for our approval.

Routine care out of the service area or out of the country is not covered. If you are out of the service area and you need health care services, call your PCP's office. They will tell you what to do. The PCP's telephone number is on your ID card. If you need help with this, call Member Services at **1-855-232-3596**, **TTY: 711**.

Types of Care

There are three different kinds of health care you can get: emergency, urgent and preventive.

Emergency care

An emergency is something that comes up suddenly and needs action to get help or relief. A health emergency exists when there are sudden symptoms that suggest a serious risk to health if nothing is done. This can include severe pain, possible risks to an unborn baby, problems with breathing, severe injury and many other situations. Aetna Better Health of New Jersey uses the "prudent layperson" standard, which means that a reasonable person's judgement that there is a serious health risk is enough. If a pregnant woman has contractions and there is not enough time to get her to a network hospital to assure the health of mother and baby, that is also an emergency.

Emergency conditions include, but are not limited to:

- A woman in labor
- Bleeding that won't stop
- Broken bones
- Chest pains
- Choking
- Danger of losing limb or life
- Problem breathing
- Medicine or drug overdose
- Not being able to move
- Passing out (blackouts)
- Poisoning
- Seizures
- Severe burns
- Suicide attempts
- Throwing up blood

Emergency services are available 24 hours a day, 7 days a week. **If you are having an emergency, call 911 or go to the closest hospital.** Even if you are out of the service area, go to the closest hospital or call 911. The hospital does not have to be in our network for you to get care. You don't need pre-approval for emergency transportation or emergency care in the hospital.

If you feel like your life is in danger or your health is at serious risk, get medical help immediately. You do not need pre-approval for emergency services including screenings. To get treatment in an emergency, you can:

- Call 911 for help
- Go to the nearest emergency room

IMPORTANT: Only use the emergency room when you have a true emergency. If you have an emergency, call 911 or go to the hospital. If you need urgent or routine care, please call the PCP's number that is on your ID card. We will pay for the emergency care including screenings when your condition seems to fit the meaning of an emergency to a prudent layperson. We'll pay even if it is later found not to be an emergency. A prudent layperson is a person who knows what an average person knows about health and medicine. The person could expect if he or she did not get medical care right away, the health of the person would be in serious trouble.

Follow up after an emergency

After an emergency, you may need follow-up care. Call your PCP for follow-up care after you go to the emergency room. Do not go back to the emergency room for your follow-up care. Only go back to the emergency room if the PCP tells you to. Follow-up care in the emergency room may not be covered.

Urgent care

Urgent care is treatment for medical conditions that come on suddenly but are not emergencies. The conditions in the list below are not usually emergencies. They may need urgent care. Go to an urgent care center or call your PCP's office if you have any of these included but not limited to:

- Bruise
- Cold
- Diarrhea
- Ear ache
- Rash
- Sore throat
- Sprain
- Stomach ache (may need urgent care; not usually emergencies)
- Vomiting

How to get urgent care

Your provider must give you an appointment within 24 hours if you need urgent care. Do not use an emergency room for urgent care. Call the PCP's telephone number that is on your ID card. Day or night, your PCP or on call provider will tell you what to do. If the PCP is not in the office, leave a message with the answering service or the answering machine and the PCP will return your call.

24-hour nurse line

Aetna Better Health of New Jersey has a nurse line available to help answer your medical questions. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. Please call us at **1-855-232-3596**, **TTY: 711** and listen for the option for the nurse line.

Urgent Care Centers

Sometimes you need to get care after hours and your PCP's office is not open. Aetna Better Health of New Jersey has urgent care centers you can go to. You can look in the online provider directory at **AetnaBetterHealth.com/NJ** or call Member Services at **1-855-232-3596**, **TTY: 711**. We will help you find an urgent care center near you.

Routine care

Routine care, also known as **preventive care**, is health care that you need to keep you healthy or prevent illness. This includes regular dental exams and cleanings, immunizations (shots) and well-care visits. It's very important to see your provider and dentist often for routine care. To schedule routine care please call your PCP's telephone number that is on your ID card. You should visit your dentist twice a year. Call your PCD or LIBERTY Dental Plan Member Services at **1-855-225-1727 (TTY: 711)** to schedule an appointment. For more information on routine dental care, go to the Dental Care Services section on page 67.

If you need help scheduling an appointment with the PCP or PCD, please call Member Services at **1-855-232-3596**, **TTY: 711**.

The chart that follows gives you examples of each type of care and tells you what to do. Always check with your PCP or PCD if you have questions about your care.

If you have a medical emergency, call 911 or go to the nearest emergency room. For non-life threatening dental emergencies, call or visit your PCD. For more information on Dental Emergencies, see page 69.

Types of care	What to do
<p>Preventive – This is regular care to keep you or your child healthy. For example:</p> <ul style="list-style-type: none"> • Check-ups • Yearly exams • Shots/immunizations 	<p>Call your provider to make an appointment for preventive care. You can expect to be seen within 28 days.</p>
<p>Physicals</p>	<ul style="list-style-type: none"> • Routine physicals such as for school, camp or work. You will be seen within 4 weeks • Baseline physicals for new adult members. You should be seen within one hundred-eighty (180) days after initial enrollment. • Baseline physicals for new children members (under 21 years old) and adult clients of DDD. You should be seen within ninety (90) days after the effective date of enrollment, or in accordance with EPSDT guidelines.
<p>Urgent/sick visit – This is when you need care right away, but are not in danger of lasting harm or of losing life. For example:</p> <ul style="list-style-type: none"> • Sore throat • Flu • Migraines 	<p>Call your PCP. Even if it is late at night or on the weekends, the PCP has an answering service that will take your message. Your PCP will call you back and tell you what to do.</p> <p>You can also go to an urgent care center if you have an urgent problem and your provider cannot see you right away. Find an urgent care center in the provider directory on our website at AetnaBetterHealth.com/NJ or call Member Services.</p>

Types of care	What to do
<p>Urgent/sick visit (Continued)</p> <p>You should NOT go to the emergency room for urgent/sick care.</p>	<p>For urgent/sick visits, you can expect to be seen by a PCP:</p> <ul style="list-style-type: none"> • Within 24 hours when you need immediate attention but your symptoms are not life-threatening. • Within 72 hours when you have medical symptoms but do not need immediate attention.
<p>Emergency – This is when one or more of the following is happening:</p> <ul style="list-style-type: none"> • You are in danger of lasting harm or the loss of life if you do not get help right away. • For a pregnant woman, she or her unborn child is in danger of lasting harm or losing their life. • Bodily functions are seriously impaired. • You have a serious problem with any bodily organ or body part. <p>Medical emergencies include:</p> <ul style="list-style-type: none"> • Poisoning • Sudden chest pains – heart attack • Other types of severe pain • Car accident • Seizures • Very bad bleeding, especially if for pregnant women • Broken bones • Serious burns • Trouble breathing • Overdose 	<p>Call 911 or go to the nearest emergency room. You can go to any hospital or facility that provides emergency services and post-stabilization services.</p> <p>The provider directory at AetnaBetterHealth.com/NJ contains a list of facilities that provide emergency services and post-stabilization services. You can also call Member Services toll-free at 1-855-232-3596, TTY: 711 and ask for the name and location of a facility that provides emergency services and post-stabilization services.</p> <p>But you DO NOT have to call anyone at the health plan or call your provider before you go to an emergency room. You can go to ANY emergency room during an emergency – or for post-stabilization services.</p> <p>If you can, show the facility your Aetna Better Health of New Jersey ID and ask the staff to call your provider.</p> <p>You must be allowed to remain at the hospital, even if the hospital is not part of our provider network (in other words, not an Aetna Better Health of New Jersey hospital), until the hospital physician says your condition is stable and you can safely be transferred to a hospital within our network.</p>

Types of care	What to do
<p>Emergency (Continued)</p> <p>Dental emergencies include:</p> <ul style="list-style-type: none"> • A broken natural tooth • A permanent tooth falls out or is knocked out • Oral and/or facial swelling and/or infection • Pain from injury to the mouth or jaw • Heavy uncontrolled bleeding • A broken or dislocated jaw 	<p>Post stabilization care means covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition.</p> <p>Always call your PCP or PCD for follow-up after an emergency. Do not go back to the emergency room for follow-up care or treatment unless your PCP or PCD refers you.</p>
<p>What is not an emergency?</p> <p>Some medical conditions that are NOT usually emergencies:</p> <ul style="list-style-type: none"> • Flu, colds, sore throats, earaches • Urinary tract infections • Prescription refills or requests • Health conditions that you have had for a long time • Back strain • Migraine headaches • Toothache • Muscle pain <p>What are post-stabilization services?</p> <p>These are services related to an emergency medical condition. They are provided after the person's immediate medical problems are stabilized. They may be used to improve or resolve the person's condition.</p>	
<p>Pregnant women</p>	<p>You should call your provider to get a visit within the timeframe below:</p> <ul style="list-style-type: none"> • Three (3) weeks of a positive pregnancy test (home or laboratory) • Three (3) days of identification of high-risk • Seven (7) days of request in first and second trimester • Three (3) days of first request in third trimester

Types of care	What to do
<p>Specialist Referrals A visit with a medical specialist that is required by your medical condition as determined by your PCP.</p>	<p>You should call your provider to get a visit within the timeframe below:</p> <ul style="list-style-type: none"> • Within four (4) weeks or shorter as medically indicated. • Emergency or urgent appointments: within twenty-four (24) hours of referral
<p>Lab and Radiology Services</p>	<p>You should call your provider to get a visit within the timeframe below:</p> <ul style="list-style-type: none"> • Routine appointments: 3 weeks • Urgent care appointments: 48 hours
<p>Initial Pediatric Appointments</p>	<p>You should call your provider to get a visit within the timeframe below:</p> <ul style="list-style-type: none"> • Within 90 days of enrollment
<p>Dental Appointments</p>	<p>You should call your dentist to get a visit within the timeframe below:</p> <ul style="list-style-type: none"> • Emergency: no later than 48 hours or earlier as the condition warrants • Urgent care: within 3 days of request • Routine: within 30 days of request • No referral is needed for a network dentist
<p>Mental Health/Substance Use Disorder Appointments</p>	<p>You should call your provider to get a visit within the timeframe below:</p> <ul style="list-style-type: none"> • Emergency services immediately upon presentation at a service delivery site. • Urgent care appointments within twenty-four (24) hours of the request. • Routine care appointments within ten (10) days of the request
<p>Gender Transition Related Care</p>	<p>The Plan covers transition care for persons diagnosed with gender dysphoria. Gender dysphoria refers to the major distress one experiences over the gender they are born with. This distress causes afflicted individuals not to identify with the gender they were assigned at birth and may result in a strong desire to live life as the other gender.</p>

Types of care	What to do
Gender Transition Related Care (Continued)	<p>We are committed to providing needed services to help our members through the transition phase. More importantly, we carefully take into consideration, the gender goals of the patient, which may include:</p> <ul style="list-style-type: none"> • Counseling. • Hormone therapy. • Gender reassignment surgery. <p>Benefit Limits: Some services may require prior authorization. If you have questions about coverage or getting services, call Member Services at 1-855-232-3596, TTY: 711 and select Care Management prompt.</p>

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Mental Health	<p>Aetna Better Health of New Jersey covers a number of Behavioral Health benefits for you. Behavioral Health includes both Mental Health services and Substance Use Disorder Treatment services. Some services are covered for you by Aetna Better Health of New Jersey, while some are paid for directly by Medicaid Fee-for-Service (FFS). You will find details in the chart below.</p> <p>When requesting prior authorization or otherwise making arrangements to receive a BH service—members and providers should call the Interim Managing Entity (IME) for services covered by FFS at (1-844-276-2777). Members and providers should call Member Services for ABHNJ-covered services at (1-855-232-3596).</p>				
Adult Mental Health Rehabilitation (Supervised Group Homes and Apartments)	Covered by ABHNJ.	Covered by FFS.	Not covered for NJ FamilyCare B, C, and D members.		

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Inpatient Psychiatric	Inpatient Psychiatric services are Covered by ABHNJ for members in DDD, MLTSS, or FIDE SNP.	Covered by ABHNJ. Coverage includes services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF) , or critical access hospital.			
Independent Practitioner Network or IPN (Psychiatrist, Psychologist, or APN)	Covered by ABHNJ.	Covered by FFS.			
Outpatient Mental Health	Covered by ABHNJ.	Covered by FFS. Coverage includes services received in a General Hospital Outpatient setting, Mental Health Outpatient Clinic/Hospital services, and outpatient services received in a Private Psychiatric Hospital . Services in these settings are covered for members of all ages.			
Partial Care (Mental Health)	Covered by ABHNJ.	Covered by FFS. Limited to 25 hour per week (5 hours per day, 5 days per week). Prior authorization required.			
Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization	Covered by ABHNJ.	Covered by FFS. Admission is only through a psychiatric emergency screening center or post psychiatric inpatient discharge. Prior authorization required for Acute Partial Hospitalization.			

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Psychiatric Emergency Services (PES)/Affiliated Emergency Services (AES)	Covered by FFS for all members.				
<i>Substance Use Disorder Treatment</i>	The American Society of Addiction Medicine (ASAM) provides guidelines that are used to help determine what kind of substance use disorder (SUD) treatment is appropriate for a person who needs SUD services. Some of the services in this chart show the ASAM level associated with them (which includes "ASAM" followed by a number).				
Ambulatory Withdrawal Management with Extended On-Site Monitoring/ Ambulatory Detoxification <i>ASAM 2 – WM</i>	Covered by ABH NJ.	Covered by FFS.			
Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (Hospital-based) <i>ASAM 4 - WM</i>	Covered by ABH NJ for all members.				
Long Term Residential (LTR) <i>ASAM 3.1</i>	Covered by ABH NJ.	Covered by FFS.			

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Office-Based Addiction Treatment (OBAT)	Covered by ABHNJ. Covers coordination of patient services on an as-needed basis to create and maintain a comprehensive and individualized SUD plan of care and to make referrals to community support programs as needed.				
Non-Medical Detoxification/Non-Hospital Based Withdrawal Management <i>ASAM 3.7 – WM</i>	Covered by ABHNJ.	Covered by FFS.			
Opioid Treatment Services	Covered by ABHNJ.	Covered by FFS. Includes coverage for Methadone Medication Assisted Treatment (MAT) and Non-Methadone Medication Assisted Treatment . Coverage for Non-Methadone Medication Assisted Treatment includes (but is not limited to) FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications; substance use disorder counseling; individual and group therapy; and toxicology testing.			
Substance Use Disorder Intensive Outpatient (IOP) <i>ASAM 2.1</i>	Covered by ABHNJ.	Covered by FFS.			
Substance Use Disorder Outpatient (OP) <i>ASAM 1</i>	Covered by ABHNJ.	Covered by FFS.			

Service/Benefit	Members in DDD, MLTSS, or FIDE SNP	NJ FamilyCare Plan A/ABP	NJ FamilyCare Plan B	NJ FamilyCare Plan C	NJ FamilyCare Plan D
Substance Use Disorder Partial Care (PC) <i>ASAM 2.5</i>	Covered by ABH NJ.	Covered by FFS.			
Substance Use Disorder Short Term Residential (STR) <i>ASAM 3.7</i>	Covered by ABH NJ.	Covered by FFS.			

Managed Long Term Services and Supports (MLTSS)

MLTSS Benefits

- If you qualify for MLTSS benefits, you may be eligible for these services.
- Adult Family Care
- Assisted Living Services-Assisted Living Residence
- Assisted Living Services – Comprehensive Personal Care Home
- Assisted Living Program
- TBI Behavioral Management (Group and Individual)
- Caregiver/Participant Training
- Chore Services
- Cognitive Therapy (Group and Individual)
- Community Residential Services
- Community Transition Services
- Home Based Supportive Care
- Home Delivered Meals
- Medication Dispensing Device
- Non-Medical Transportation
- Nursing Facility Services (Custodial Care)
- Occupational Therapy (Group and Individual)
- Personal Emergency Response System
- Physical Therapy (Group and Individual)
- Private Duty Nursing (for individuals over the age of 21)

- Residential Modifications
- Respite
- Social Adult Day Care
- Speech, Language and Hearing Therapy (Group and Individual)
- Structured Day Program
- Supported Day Services
- Vehicle modifications

MLTSS Covered Services and Limitations

Benefit	Description	Limitations
Adult Family Care (AFC)	Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident.	Members who receive AFC do not receive Personal Care Assistant services, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/ Participant Training, Assisted Living, or Assisted Living Program.
Assisted Living Services – Assisted Living Residence	Assisted Living Residence (ALR) means a facility which is licensed by the Department of Health to provide apartment-style housing and group dining and to ensure that assisted living services are available when needed, for four or more adult persons unrelated to the facility owner.	Individuals that opt for Assisted Living Services in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living Services.

Benefit	Description	Limitations
Assisted Living Services – Comprehensive Personal Care Home	Comprehensive Personal Care Home (CPCH) means a facility which is licensed by the Department of Health to provide room and board and to ensure that assisted living services are available when needed, to four or more adults unrelated to the facility owner.	Individuals that opt for Assisted Living Services in an ALR/CPCH do NOT receive: Personal Care Assistant (PCA) services, Adult Day Health Services (ADHS), Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living Services.
Assisted Living Program	Assisted Living Program means the provision of assisted living services to the tenants/residents of certain publicly subsidized housing buildings. Assisted Living Programs (ALPs) are available in some subsidized senior housing buildings. Individuals receiving services from an ALP reside in their own independent apartments.	Members who are in the ALP do not receive Personal Care Assistant (PCA) services, Chore Service, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care.
TBI Behavioral Management (Group and Individual)	A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others.	Entry to this service is based on medical necessity criteria. The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who transitions into MLTSS.

Benefit	Description	Limitations
Caregiver/Participant Training	Instruction provided to a client and/or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including but not limited to: coping skills to assist the individual in dealing with disability; coping skills for the caretaker to deal with supporting someone with long term care needs; skills to deal with care providers and attendants.	Caregiver/Participant Training is not available to participants who have chosen Assisted Living Services, Assisted Living Program or Adult Family Care.
Chore Services	Services needed to maintain the home in a clean, sanitary and safe environment.	Chore services are not available to those who opt for Assisted Living Services, Assisted Living Program or Adult Family Care.
Cognitive Therapy (Group and Individual)	Therapeutic interventions for maintenance and prevention of deterioration which include direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses.	The member must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is assessed to be in need of cognitive therapy and who transitions to MLTSS.
Community Residential Services (CRS)	CRS is a package of services provided to a member living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. A CRS is a member's home.	The participant must have a diagnosis of TBI and meet MLTSS Nursing Facility Level of Care.
Community Transition Services	Services provided to a member that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of non-recurring, one-time transitional expenses.	Service is based on identified need as indicated in the plan of care, limited up to \$5,000 once per lifetime.

Benefit	Description	Limitations
Home Based Supportive Care (HBSC)	HBSC services are designed to assist MLTSS members with their Instrumental Activities of Daily Living (IADL) needs. Includes services such as, but not limited to the following: meal preparation, grocery shopping, money management, light housework, laundry.	HBSC is not available for those who have chosen Assisted Living Services (ALR, CPCH, ALP).
Home Delivered Meals	Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal.	Home-delivered meals are provided to a member residing in an unlicensed residence, only when the member is unable to prepare the meal, unable to leave the home independently, and there is no other caregiver, paid or unpaid, to prepare the meal. No more than one meal per day will be provided through the MLTSS benefit.
Medication Dispensing Device	This may include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions.	Must meet medical necessity. Medication Dispensing Device is for an individual who lives alone or who is alone for significant amounts of time per the plan of care. Individuals might not have a regular care giver for extended periods of time or would require extensive routine supervision.
Non-medical transportation	Transportation to gain access to community services and activities	
Nursing Facility Services (Custodial Care)	Service is offered to those in a nursing facility who require services which address the medical, nursing, dietary and psychosocial needs that are essential to obtaining and maintaining the highest physical, mental, emotional and functional status of the member.	The individual must meet Nursing Facility Level of Care as determined and/or authorized by the NJ Department of Human Services, Office of Community Choice Options or their designee.

Benefit	Description	Limitations
Physical Therapy (Group and Individual)	MLTSS Physical Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non-degenerative brain injury (TBI/ABI).	The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or be a former TBI waiver participant who is assessed to be in need of physical therapy and who transitions to MLTSS.
Occupational Therapy (Group and Individual)	MLTSS Occupational Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress that is at risk of being lost as a result of a traumatic or acquired non-degenerative brain injury (TBI/ABI). MLTSS Occupational Therapy is also intended to allow a member to acquire new skills that will allow them to function optimally in their current or future least restrictive environment.	The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or be a former TBI waiver participant who is assessed to be in need of occupational therapy and who transitions to MLTSS.
Personal Emergency Response System (PERS) – set up and monitoring	PERS is an electronic device that enables members at high risk of institutionalization to secure help in an emergency.	Must meet medical necessity. PERS is for an individual who lives alone or who is alone for significant amounts of time per the plan of care.
Private Duty Nursing	Private Duty Nursing services are provided in the community only (the home or other community setting of the member), and not in hospital inpatient or nursing facility settings. Members meeting a nursing facility level of care are eligible to receive this service.	Must meet medical necessity and obtain prior approval.

Benefit	Description	Limitations
Residential Modifications	Modifications made to a member's private primary residence to ensure their health, welfare and safety.	Participants living in licensed residences (ALR, CPCH, ALP, and Class B & C Boarding Homes) are not eligible to receive Residential Modifications. Residential Modifications are limited to \$5,000 per calendar year, \$10,000 lifetime.
Respite – Daily and Hourly	Services provided to members unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant.	Respite services are not provided to members that have paid caregivers. Respite has a limit of up to 30 days per calendar year.
Social Adult Day Care (SADC)	SADC is a structured community based program to provide health social and related support settings to adults with functional impairments.	Need must be identified in member's plan of care. SADC is not available to those members that reside in an assisted living facility.
Speech, Language and Hearing Therapy (Group and Individual)	MLTSS Speech, Language, and Hearing Therapy Services are intended to incrementally (minimal unpredictable changes over longer lengths of time) develop or improve skills, or prevent the loss of previously achieved/attained progress which is at risk of being lost as a result of a traumatic or acquired, non-degenerative brain injury (TBI/ABI).	The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or be a former TBI waiver participant who is assessed to be in need of speech, language and hearing therapy and who transitions to MLTSS.
Structured Day Program	A program of productive supervised activities, directed at the development and maintenance of independent and community living skills.	The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS.

Benefit	Description	Limitations
Structured Day Program (Continued)	Services will be provided in a setting separate from the home in which the member lives.	
Supported Day Services	A program of individual activities directed at the development of productive activity patterns.	The individual must have a diagnosis of acquired, non-degenerative, or traumatic brain injury or formerly a TBI waiver participant who is transitioning to MLTSS.
Vehicle Modifications	This service includes needed vehicle modification to a member or family vehicle as defined in an approved plan of care.	Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase of a vehicle.

Cell Phone Program

Eligible members can get Lifeline cell service PLUS an Android™ Smartphone at NO COST!

New Jersey Assurance Wireless Lifeline service customers receive:

- Free Monthly Data
- Unlimited Monthly Texts
- Free Monthly Minutes
- PLUS an Android Smartphone!

EXTRA Aetna Better Health of New Jersey Benefits include:

- Health tips and reminders by text
- Calls to Member Services that won't count against your monthly minutes
- One-on-one texting with your healthcare team

Already have Lifeline? It's easy to switch to Assurance Wireless today! Get Assurance Wireless Lifeline service + health extras from Aetna at no cost!

Learn more by visiting <https://www.aetnabetterhealth.com/newjersey/members/benefits/phones>

MLTSS Member Representative

Our MLTSS Member Representative is here to help you. The MLTSS Member Representative can talk to you, your family, and your providers about the MLTSS program. The MLTSS Member Representative can also help you with any issues you may have. This person will work with other Aetna Better Health of New Jersey staff to help resolve your issue. Contact the MLTSS Member Representative if you have questions about:

- Benefits
- How to get services
- Finding a provider
- How to solve an issue
- How to file a grievance or appeal

You can reach the MLTSS Member Representative by calling Member Services at **1-855-232-3596, TTY: 711**. We are here 24 hours a day, 7 days a week.

After Hours

Except in an emergency, if you get sick after the PCP's office is closed, or on a weekend, call the office anyway. An answering service will make sure the PCP gets your message. The PCP will call you back to tell you what to do. Be sure your phone accepts blocked calls. Otherwise, the PCP may not be able to reach you. You can even call the PCP in the middle of the night. You might have to leave a message with the answering service. It may take a while, but the PCP will call you back to tell you what to do.

If you are having an emergency, you should ALWAYS call **911** or go to the nearest emergency room.

We also have a nurse line available to help answer your medical questions. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. Call **1-855-232-3596, TTY: 711** and listen for the option for the nurse line.

If you have an urgent issue and need to reach your care manager after hours you can call Member Services. We can reach care management staff that will be able to help you.

You have the option to choose

The MLTSS program allows you to choose the services that meet your needs in various settings based on your desires, the cost of the services and the safest environment for you.

Community Transition Services

If you live in a nursing facility and wish to move out of the facility and into the community, your care manager will work with you to assess your ability and help you to move out of the facility.

If it is determined that you are able to move into the community, you may be able to use community transition services.

Please refer to the MLTSS Services and Limitations grid for coverage and limitations.

Money Follows the Person (MFP)

The Money Follows the Person Demonstration (MFP) is a special program. New Jersey's MFP program is called I Choose Home and it can assist you in moving from a long-term care facility (nursing home) to a residential setting in the community, such as:

- A home owned or leased by you or your family
- An apartment with an individual lease that includes living, sleeping, bathing, and cooking areas
- A residence in which four or fewer unrelated individuals live (such as adult family care or shared apartment)

For you to participate in the MFP program, you must:

- Have lived in a long-term care facility for at least 3 months;
- Be both Medicaid and MLTSS eligible prior to discharge;
- Have health needs that can be met through services available in the community; and
- Voluntarily consent to participation by signing a consent form.

The MFP program will assist you in transitioning from a long-term care facility by providing:

- Information to help you make an informed choice regarding transition and participation in the MFP program;
- Support to transition and help in arranging services in the community; and
- After you leave the facility, regular phone calls and visits from your care manager to make sure your move is satisfactory and your needs are being met.

The MFP program will assist you with locating a place to live and in arranging for medical, rehabilitative, home health or other services you may need in the community. For additional information about MFP call your care manager or call our MLTSS member services representative at **1-855-232-3596, TTY: 711**.

Critical Incidents

Critical Incidents are events that are unexpected occurrences involving death, serious physical or psychological injury, or the potential risk of injury or neglect. Critical incidents include but are not limited to the following:

- Unexpected death of a member
- Suspected physical, mental or sexual abuse and/or neglect of a member
- Suspected theft or financial exploitation of a member
- Severe injury sustained by a member
- Medication error involving a member
- Inappropriate/unprofessional conduct by a provider involving a member
- Member is at risk for harm of self or others
- Failure of member's back up plan
- Fall resulting in the need for medical treatment

Please contact your care manager immediately if you are aware of any of the above issues.

Medicare and Medicaid coverage

Your enrollment in the Plan will not affect your Medicare medical benefits. You can still have your provider visits, laboratory, pharmacy, and hospitalizations covered by Medicare.

If you have Medicare coverage, you should not cancel it. You may still have some Medicare co-pays and deductibles even after you enroll with the Plan. Unless already covered by Medicare, the Plan covers the following services when medically necessary:

- Medicare nursing home co-pays for days 21-100
- Durable medical equipment co-pays
- Any Medicare co-pay or deductible applicable to a covered benefit

MLTSS Cost Share and Patient Pay Liability (PPL)

You still have to pay any Medicare co-pays or deductibles for non-covered benefits. MLTSS Members residing in an Assisted Living (AL), in an Adult Family Care (AFC) or in a Nursing Facility (NF) setting may have a cost share as calculated by the County Welfare Agency and are responsible to pay the provider of services the cost share. This is in addition to the Room and Board charge established by the state. MLTSS Members residing in a Traumatic Brain Injury (TBI) group home will pay the group home directly for their portion of Patient Payment Liability for their care. You may contact your local County Welfare Agency if you have any questions regarding your cost share or patient pay liability.

Behavioral Health Services

MLTSS members will get most mental health and substance use disorder services from the Plan. Exclusions may apply. Members who are clients of the Division of Developmental Disabilities (DDD) and MLTSS will also get most mental health and substance use disorder services from the Plan.

The mental health and/or substance abuse services will need to be coordinated between the NJ FamilyCare-approved provider and the Plan. This includes certain drugs that require your provider to get a prior authorization before the prescription is filled if more than four prescriptions are needed in a month. Your provider must call us for approval before you can get any drugs that need a prior authorization.

MLTSS members and members who are clients of the Division of Developmental Disabilities (DDD) can get these services from the Plan:

- Inpatient admission to an acute hospital facility
- Outpatient individual, group and family therapy for both mental health and substance use disorders
- Partial Care/Partial Hospitalization/Acute Partial Hospitalization day programs for both mental health and substance use disorders
- Adult Mental Health Rehabilitation (supervised group homes and apartments)
- Hospital-based acute services for both mental health and substance use disorders
- Intensive Outpatient Services (IOP) for substance use disorders
- Inpatient Medical Detox/Medically Managed Inpatient Withdrawal Management (hospital)

- Short Term Residential Treatment for substance use disorders
- Non-hospital medically monitored withdrawal management
- Ambulatory Withdrawal Management for substance use disorders
- Medication Assisted Treatment for substance use disorders

See the covered services list on page 22. You can look in the provider directory to find a behavioral health services provider. It is at **AetnaBetterHealth.com/NJ**. You can also call Member Services at **1-855-232-3596, TTY: 711**. We will help find a provider near you.

If you think you or a member of your family needs help with a mental health or substance use disorder, you may contact:

- Your PCP
- The NJ Addiction Services at **1-844-276-2777**

Office Based Addiction Treatment (OBAT)

Aetna Better Health of NJ has a new program. The program is to assist members who want help with substance use including opioid, alcohol or poly-substance use. The program supports Medication Assisted Treatment (MAT). The new program is called Office Based Addiction Treatment (OBAT). This new program will allow providers including PCP's, OB/GYN's and specialists to participate in the program. Members will be able to go to the office of an OBAT provider and receive medication to assist with substance use. OBAT providers will have what is called a Navigator. The Navigator will work closely with our members. Responsibilities of the Navigator and provider include:

- Building relationships with community providers
- Developing a care plan with the member
- Scheduling following up visits
- Setting up appointments for counseling services
- Assisting with social services
- Assisting with recovery resources and supports
- Providing education to the member and family
- Referring to alternate levels of care as appropriate
- Coordination of care with Premier providers and Centers of Excellence as needed

OBAT providers can be found in our provider directory under Office Based Addiction Treatment (OBAT). Or you can call Member Services at **1-855-232-3596, TTY: 711** for assistance.

Peer Support Services

A peer support specialist is an individual who has a lived experience of substance use and/or mental health diagnoses and who has common life experiences as our members. Peer support specialists complete a certification in peer support. Peer support is provided in some provider settings to assist members in their path to recovery. In addition Aetna Better Health has a peer support specialist. Peer support services are non-clinical and include:

- Supporting members with their recovery goals
- Assisting with the development of coping skills, recovery action plans, wellness tools and problem solving
- Attending behavioral health and medical appointments to support the member in advocating for themselves with the provider and ensuring they get the best care
- Providing community resources
- Identifying healthcare needs
- Providing services that fit the members culture, language and religion

For Peer Support services please call Member Services at **1-855-232-3596, TTY: 711**.

Behavioral health crisis

If you have a behavioral health crisis, it is important you get help right away. You can call us 24 hours a day, 7 days a week for help. Call **1-855-232-3596, TTY: 711** and select option 9. We will connect you to a clinician who will assist you.

Non-Covered Services

There are services that are not part of your benefits. These services are not covered by NJ FamilyCare, either. If you receive these services you will have to pay for them. These services are listed below:

- All services your PCP or the Plan say are not medically necessary
- Cosmetic surgery, except when medically necessary and with prior approval
- Experimental organ transplants and investigational services
- Infertility diagnosis and treatment services, including sterilization reversals and related office (medical or clinic), drugs, lab, radiological and diagnostic services, and surgical procedures
- Rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient, including guest meals and lodging, telephone charges, travel expenses, take-home supplies and similar costs
- Respite care (NJ FamilyCare A members who qualify for MLTSS services may receive respite care as part of the MLTSS service package).
- Services that involve the use of equipment in facilities when the purchase, rental or construction of the equipment has not been approved by New Jersey law
- All claims that come directly from services provided by or in federal institutions
- Free services provided by public programs or voluntary agencies (should be used when possible)

- Services or items furnished for any sickness or injury that occurs while the covered member is on active duty in the military
- Payments for services provided outside of the United States and territories (pursuant to N.J.S.A. 52:34-13.2 and section 6505 of the Affordable Care Act of 2010, which amends section 1902(a) of the Social Security Act)
- Services or items furnished for any condition or accidental injury that arises out of and during employment where benefits are available (worker's compensation law, temporary disability benefits law, occupational disease law or similar laws); this applies whether or not the member claims or receives benefits and whether or not a third-party gets a recovery for resulting damages
- Any benefit that is covered or payable under any health, accident or other insurance policy
- Any services or items furnished that the provider normally provides for free
- Services billed when the health care records do not correctly reflect the provider's procedure code
- Respite Care unless in a waiver

Members Age 55 and Over

Medicaid benefits received after age 55 may be paid back to the state of New Jersey from your estate. This may include premium payments made on your behalf to the Plan.

Pharmacy Services

If you need medicine, your provider will choose one from the Plan's list of drugs. They will write you a prescription. Ask your provider to make sure that the drug they are prescribing is on our list of drugs or formulary.

If you are a new member to our plan you may be taking medicine that is not on our formulary list. You may get a one-time refill for a 34-day supply. We will send you and your provider a letter. The letter will tell you that a pre-approval is needed for your medicine. Talk with your provider to ask if you should continue with the same medicine or change to one that is on the formulary list.

Sometimes your provider will want to give you a drug that is not on our list or that is a brand name drug. Your provider may feel you need a medicine that is not on our list because you can't take any other drugs except the one prescribed. Your provider can request approval from us. Your provider knows how to do this.

All of your prescriptions will need to be taken to one of our network pharmacies. They are listed online at **[AetnaBetterHealth.com/NJ](https://www.aetna.com/betterhealth)**. You can also call Member Services to find a pharmacy in your area.

The Plan covers over-the-counter (OTC) drugs that are on our formulary. Some OTC drugs may have coverage rules. If the rules for that OTC drug are met, the Plan will cover the OTC drug. Like other drugs, OTC drugs need a prescription from a doctor if they are to be covered by the Plan.

Examples of OTC drugs we cover include but are not limited to: ibuprofen for child and adults, multivitamins and vitamins, antacids, and cold/cough/allergy medicines. Check our formulary for a full list of OTC drugs we cover. Our formulary is on our website at [AetnaBetterHealth.com/NJ](https://www.aetna.com/better-health/nj). You can also call Member Services toll-free at **1-855-232-3596, TTY: 711**. Have a list of your over-the-counter medicines ready when you call. Ask the representative to look up your medicines to see if they are on the list.

Prescriptions

Your provider or dentist will give you a prescription for medicine. Be sure and let them know about all the medications you are taking or have gotten from any other providers. You also need to tell them about any non-prescription or herbal treatments that you take, including vitamins. Before you leave your provider's office, ask these questions about your prescription:

- Why am I taking this medicine?
- What is it supposed to do for me?
- How should the medicine be taken?
- When should I start my medication and for how long should I take it?
- What are the side effects or allergic reactions of the medicine?
- What should I do if a side effect happens?
- What will happen if I don't take this medicine?

Carefully read the drug information the pharmacy will give you. It will explain what you should and should not do and possible side effects.

When you pick up your prescription make sure to show your Aetna Better Health of New Jersey ID card.

Prescription refills

The label on your medicine bottle tells you how many refills your provider has ordered for you. If your provider has ordered refills, you may only get one refill at a time. If your provider has not ordered refills, you must call them at least five (5) days before your medication runs out. Talk to them about getting a refill. Your provider may want to see you before prescribing a refill.

Mail order prescriptions

If you take medicine for an ongoing health condition, you can have them mailed to your home. CVS Caremark is your mail service pharmacy.

If you pick this option, your medicine will be sent to your home. You can schedule your refills. You will also be able to talk to a pharmacist if you have questions. Some of the features of home delivery are:

- Pharmacists check each order for safety:
- You can order refills by mail, by phone, online, or you can sign up for automatic refills; and
- You can talk with pharmacists by phone.

It's easy to start using mail service

Choose ONE of the following three ways to use mail service for a medicine that you take on an ongoing basis:

- **Call** CVS Caremark toll-free at **1-855-271-6603 TTY: 1-800-231-4403**, Monday through Friday, 8 a.m. to 8 p.m. (ET). They will let you know which of your medicines can be filled through CVS Caremark mail service pharmacy. CVS Caremark will then contact your provider for a prescription and mail the medicine to you. When you call, be sure to have:
 - Your Plan member ID card;
 - Your provider's first and last name and phone number; and
 - Your payment information and mailing address.
- Go online to www.caremark.com. Once you enter the needed information, CVS Caremark will contact your provider for a new prescription. If you haven't registered yet on www.caremark.com, be sure to have your member ID card handy when you register for the first time.
- Fill out and send a mail service order form. If you already have a prescription, you can send it to CVS Caremark with a completed mail service order form. If you don't have an order form, you can download it from the website. You can also request one by calling Member Services at **1-855-232-3596, TTY: 711**.
 - Have the following information with you when you complete the form:
 - Your Plan member ID card;
 - Your complete mailing address, including ZIP code;
 - Your prescribing provider's first and last name and phone number;
 - A list of your allergies and other health conditions; and
 - Your original prescription from your provider.

Quick tips about pharmacy services

- Ask if your prescription is covered by the Plan before leaving your provider's office.
- Take your prescription to a Plan pharmacy.
- If your provider has not ordered refills, call them at least five (5) days before you need a refill.

You can get a list of covered drugs by calling Member Services at **1-855-232-3596, TTY: 711** or online at **AetnaBetterHealth.com/NJ**.

Pharmacy Lock-In Program

Members who have a pattern of misusing prescription or over the counter (OTC) drugs may be required to use only one pharmacy to fill their prescriptions. This is called a "lock-in." Members, who have severe illnesses, see different providers and take different kinds of medicine may also be put into the Pharmacy Lock-in Program.

In the Pharmacy Lock-in Program, you would be able to choose one in-network pharmacy to get your prescriptions. If you do not pick a pharmacy, one will be selected for you. By using one pharmacy, the staff will get to know your health status. The staff will also be better prepared to help you with your health care needs. The pharmacist can also look at past prescription history. They will work with your provider if problems with medications occur.

Members in the Pharmacy Lock-in Program will only be able to get a 72-hour supply of medicine on or off our formulary from a different pharmacy if their chosen pharmacy does not have that medicine on hand. They can also do this in an emergency.

You will get a letter letting you know you are put in the Pharmacy Lock-in Program. If you do not agree with our decision to assign you to just one pharmacy, you can appeal it over the phone or in writing. You must follow up with your phone call by putting your appeal in writing to us. You also have the right to ask for a fast decision. A fast decision is called an expedited appeal. If your request meets expedited appeal requirements and you ask for it over the phone, you do not need to follow up in writing. Written appeals must be received by the Plan within 60 days of the date on the letter. See page 87 for more on member appeals.

Send written appeals to:

Aetna Better Health of New Jersey
Attn: Grievance and Appeals Dept.
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
Call:1-855-232-3596

Dental Care Services

Dental care is important to your overall health. You should have a dental exam when you join Aetna Better Health of New Jersey. Then you should see your dentist every six months. Aetna Better Health of New Jersey offers comprehensive dental benefits in order to help you and your family maintain good oral health. Your covered benefits include two preventive visits each year. Our comprehensive benefits include most other procedures. Some services may require prior authorization. You do not need a referral to see a network dental provider including dental specialists. Additional dental services are covered for children and adults with special needs. Be sure to complete all recommended treatment.

If you change Plans, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the new Plan even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.

For more information on dental and orthodontic covered benefits, refer to the covered services grid on page 22.

A Utilization Management (UM) appeal is a way for you to ask us to reconsider our decisions with regard to medically necessary services and any dental services that have been denied. For more information, please refer to page 87.

Aetna Better Health of New Jersey's dental home program

Aetna Better Health now has a program to ensure you and your family has a primary care dentist (PCD) and a dental home, available to all ages. The dental home is the office where your child will get his or her dental and oral health care. Your child's dental home delivers care in a complete and family-centered way. The dental home program is voluntary. If you do not want to be involved, you can ask us to take your child out of the program by calling Member Services at **1-855-232-3596 (TTY: 711)**. Removal from this program does not prevent your child from seeing a dentist.

Make an appointment today to keep your child's teeth healthy

Get your child started on good oral health by taking him or her to the dentist. Children should see the dentist for oral exams and preventive care when they get their first tooth or before their first birthday and every six months after that. We cover two routine/preventive dental visits each year. The visits include a dental cleaning, fluoride treatment and all needed x-rays. We also cover any other dental procedures your child needs. Additional dental services are covered for children with special needs. You do not need a referral to see a dentist. If specialty dental care is needed, we cover that too.

Dental Care for Members with Special Health Care Needs and children under the age of 5 may require treatment to be performed in a hospital setting/operating room or ambulatory surgical center facility setting as an outpatient member service. If your dental provider cannot provide this service, please contact LIBERTY Dental Plan at **1-855-225-1727** in order to help you locate a dental provider and coordinate this service.

For a listing of NJ Smiles Dental providers (for children 0-3 years old), you can search the online provider search linked on our Dental Benefits page at

[AetnaBetterHealth.com/NewJersey/members/benefits/dental](https://www.aetna.com/members/benefits/dental).

Aetna Better Health of New Jersey works with LIBERTY Dental Plan to provide our members with dental care. You will get your dental and oral health care from a LIBERTY Dental Plan dentist. You do not need a referral to see a dentist in the LIBERTY Dental Plan provider network. Call LIBERTY Dental Plan at **1-855-225-1727, TTY: 711**, Monday through Friday from 8 a.m. to 8 p.m. You can also call Aetna Better Health of New Jersey's Member Services at **1-855-232-3596, TTY: 711**, 24 hours a day, 7 days week.

Dental care includes services performed on teeth such as cleanings, fillings, root canals and dentures. Medical care usually includes services that do not directly involve the teeth such as a broken jaw or cancer of the mouth. You can contact member services if you need help to determine if services are considered dental or medical. You may change your dentist or dental group at any time while continuing recommended treatment. You can find a dental provider in the provider directory online at **[AetnaBetterHealth.com/NJ](https://www.aetna.com/NJ)**. You can also call us for help at **1-855-232-3596, TTY: 711**. Please show all your Plan ID cards when you go to your appointments. If you need help finding a dentist call LIBERTY Dental Plan at **1-855-225-1727, TTY: 711**.

You may need a prior authorization for some specialty dental care. Your in-network dentist will know how to get prior authorization.

Dental Emergencies

If you need emergency dental care call your dentist. You can also call LIBERTY Dental Plan at **1-855-225-1727 (TTY: 711)**. You can see a dentist who is not part of the Plan network for emergency dental care. If you are out of town and need emergency dental care, you can go to any dentist for care, or you can call LIBERTY Dental Plan at **1-855-225-1727 (TTY: 711)** for help in finding a dentist. You do not need a referral or the Plan's prior approval before you get emergency dental care.

Dental emergencies include:

- A broken natural tooth
- A permanent tooth falls out or is knocked out
- Oral and/or facial swelling and/or infection
- Pain from injury to the mouth or jaw
- Heavy uncontrolled bleeding
- A broken or dislocated jaw

Vision Care Services

Aetna Better Health of New Jersey uses MARCH Vision to give you vision services. You can call MARCH Vision at **1-844-686-2724, TTY: 1-877-627-2456**.

You do not need a referral to see a network vision provider. You can find a vision provider in the provider directory online at [AetnaBetterHealth.com/NJ](https://www.aetnabetterhealth.com/NJ). You can also call us for help at **1-855-232-3596, TTY: 711**.

Your covered services include:

- One routine eye exam every year
- One pair of glasses or contact lenses every two years

Show your Plan ID cards when you go to your appointments.

If you need help finding a provider call MARCH Vision at **1-844-686-2724, TTY: 1-877-627-2456**.

Family Planning Services

Members do not need a referral to get family planning services. You can go to any family planning provider or clinic whether it is in our network or not. You must show your Plan ID cards when you go to your appointments.

Aetna Better Health of New Jersey covers the following family planning services:

- Annual exams and pap smears
- Pregnancy and other lab tests
- Prescription and over the counter birth control medication and devices

- Birth control medical visits
- Education and counseling
- Treatment of problems related to the use of birth control including emergency services

For more information or to pick a network provider or clinic, call Member Services at **1-855-232-3596**, **TTY: 711**.

Maternity Care

Pregnant women need special care. It is important to get care early. If you are pregnant, call Member Services at **1-855-232-3596**, **TTY: 711** as soon as possible. They can help you with the following:

- Choosing a PCP or Ob/Gyn for your pregnancy (prenatal) care
- Getting you into special programs for pregnant members, such as childbirth classes
- Getting you healthy food through the Women Infants and Children (WIC) program

If you are not sure you are pregnant, make an appointment with your provider for a pregnancy test.

If you are pregnant and have chosen your pregnancy provider, make an appointment to see them. If you need help finding a provider, call Member Services at **1-855-232-3596**, **TTY: 711**.

Your provider must set up a visit for you within 7 days of your call if you are in the first or second trimester and within 3 days if you are in the third trimester and it is your first request. Your provider will tell you about the schedule for pregnancy visits. Keep all of these appointments. Early and regular care is very important for your and your baby's health. If you had a baby in the last month, you need a post-delivery checkup. Call your provider's office.

Your PCP or Ob/Gyn will help you with the following:

- Regular pregnancy care and services
- Special classes for moms-to-be, such as childbirth or parenting classes
- What to expect during your pregnancy
- Information about good nutrition, exercise and other helpful advice
- Family planning services, including birth control pills, condoms and tubal ligation (getting your tubes tied) for after your baby is born

Healthy pregnancy tips

- Your provider will tell you when you need to come back for a visit. It is important for you and your baby's health to keep all your provider appointments.
- Childbirth classes can help with your pregnancy and delivery. These classes are available at no cost to you. Ask your provider about the classes and how you can sign up for them.
- High lead levels in a pregnant woman can harm you and your unborn child. Talk to your provider about risk factors for lead exposure and having your blood level checked during pregnancy.
- It is important that you do not smoke, drink alcohol, or take illegal drugs because they will harm you and your baby. Members can access MomQuit Connection and Individual counseling.

After you have your baby

You should see your own PCP or Ob/Gyn within 3-8 weeks after your baby is born. You will get a well-woman checkup to make sure you are healthy. Your PCP will also talk with you about family planning.

Breastfeeding and lactation support

Breastfeeding offers many perks. It's the best food for Baby, can help protect against common childhood infections and lowers the risk of sudden infant death syndrome (SIDS). The World Health Organization recommends that:

- Moms start breastfeeding within an hour of birth
- For the first six months of life, babies get all their nutrition from breastfeeding
- After six months, babies get added nutrition from other safe foods while they keep breastfeeding
- You can breastfeed up to two years or more

Plan to get help breastfeeding

All moms can breastfeed with the right help. Many women can have problems in the beginning. It's just like learning any new skill. Ask your provider about how to find a breastfeeding or lactation support class. You can also get help from a lactation consultant, an expert with special training in breastfeeding. Here are just a few ways you can get help:

- Call the National Breastfeeding Helpline at **1-800-994-9662 (TDD: 1-888-220-5446)**.
- Call the La Leche League of Garden State at **1-877-452-5324**. Or you can find a local chapter <http://www.lllgardenstate.org/local-support.html>
- Call **1-800-328-3838** to see if you are eligible for the Women, Infants, and Children (WIC) program to get nutritious food. Or you can visit www.state.nj.us/health/fhs/wic.
- Call us at **1-855-232-3596 (TTY:: 711)**. We're here to help.

Get your no-cost breast pump

If breastfeeding, you'll want to empty your breasts regularly with feeding or a breast pump. This prevents your breasts from becoming full and painful. You can make life easier with a no-cost breast pump. Pump the breast milk when it works for you. Then Baby can get the best nutrition, no matter what your schedule. A breast pump also gives other family members the chance to feed and bond with Baby. Then ask to speak with your care coordinator. You can receive your no-cost breast pump up to two weeks before the birth of your Baby. We offer the Medela Pump In Style Advanced Breast Pump + Starter Kit. You do not need prior authorization, just call **1-855-232-3596 (TTY:: 711)** to get your no-cost breast Medela breast pump. You can also order your breast pump online at breastpumpsmedline.com. Be sure to select Aetna Better Health of New Jersey as your health provider in the drop-down menu.

Women, Infants and Children (WIC)

Here are some of the services the Women, Infants, and Children (WIC) program gives you at no cost to you:

- Help with breastfeeding questions
- Referrals to agencies
- Healthy food
- Healthy eating tips
- Fresh fruits and vegetables

If you need information about WIC you can call Member Services at **1-855-232-3596, TTY: 711**. You can also call WIC directly to see if you and your child are eligible at **1-800-328-3838** (Family Health Line) toll-free, **TTY: 711**.

Getting Care for Your Newborns

It is important to make sure your baby has medical coverage. When your baby is born, you must enroll them in Medicaid by calling the County Welfare Agency or Medical Assistance Customer Center (MACC). NJ FamilyCare members should call the NJ FamilyCare Program at **1-800-701-0710** or **TTY: at 1-800-701-0720**.

If you have questions or need help call Member Services at **1-855-232-3596, TTY: 711**.

Well-Baby and Well-Child

Regular well child check-ups, lab tests and shots are important.

EPSDT - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services

Your child's PCP will give them the care they need to stay healthy and treat serious illnesses early. These services are called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. EPSDT is a special program that checks children for medical problems as they develop. We cover routine well-baby and well-child care for children up to 21 years old.

Needed services are covered for children under 21 even if these services are not part of the benefits.

EPSDT services may include:

- A complete health history including physical, social and mental health development
- A complete unclothed physical exam including vision and hearing screening, dental inspection and nutritional assessment
- Lab tests
- Screening for progress in development
- Immunizations according to age, health history, and the schedule established by the Advisory Committee on Immunization Practices for Pediatric Vaccines
- Health education and guidance on health care

- Referrals for further diagnosis and treatment or follow-up care
- Screening for lead poisoning
- A check of the foods your child needs and advice about the right kind of diet for your child
- Checking for behavioral health and substance use disorder problems
- Private duty nursing when the EPSDT screening shows that your child needs this service.

We have PCPs who are specially trained to care for members under age 21. Call us if you need help picking the right PCP for your child.

Regular check-ups – Well-child EPSDT

Children should have regular check-ups and/or vaccines (shots) even when your child seems healthy. Check with your provider about your child’s vaccine schedule. It is important to find problems early so your child can get the care needed to prevent serious illness and to stay healthy.

Remember: All children must be up to date with their immunizations before they can start school.

Check-up schedule						
Infancy	Under 6 weeks	2 months	4 months	6 months	9 months	12 months
Early childhood	15 months	18 months	2 years			
Early childhood – Adolescence	Annually through ages 3-20					

Immunization (shot) schedule

The chart below summarizes the Centers for Disease Control and Prevention’s (CDC) recommended immunizations. You can get this information on their website at www.cdc.gov/vaccines/schedules/easy-to-read/index.html

Age	Immunization
Birth	HepB (hepatitis B)
1-2 months	HepB
2 months	<ul style="list-style-type: none"> • RV (Rotavirus) • IPV (polio) • PCV (pneumococcal) • DTaP (diphtheria, tetanus and pertussis) • Hib (Haemophilus influenza type b)
4 months	RV, DTaP, IPV, Hib, PCV
6 months	RV, DTaP, Hib, PCV
6-18 months	HepB, IPV, DTaP, Hib, influenza (every year)
12-15 months	Hib, MMR (measles, mumps and rubella), PCV, Varicella (chicken pox), DTaP
12-23 months	HepA (Hepatitis A)

15-18 months	DTaP, HepB
4-6 years	MMR, DTaP, IPV, Varicella
11-12 years	Tdap (Tetanus, Diphtheria, Pertussis) HPV (Human Papillomavirus) MCV4 (Meningococcal Conjugate) If your child is catching-up on missed vaccines he/she may need: • MMR • Varicella • HepB • IPV
13-18 years	If your child is catching-up on missed vaccines he/she may need: • Tdap • HPV • MCV4
16 years	Booster
Every year starting at 6 months old	Influenza

Care Management

Some members have special health care needs and medical conditions. Our care management unit will help you get the services and the care that you need. They can help you learn more about your condition. They will work with you and your provider to make a care plan that is right for you.

Our care management unit has nurses and social workers that can help you:

- Get services and care including information on how to get a referral to special care facilities for highly specialized care
- Work with health care providers, agencies and organizations
- Learn more about your condition
- Make a care plan that is right for you
- Access services after hours for crisis situations for enrollees with special needs
- Arrange services for children with special health care needs such as well-child care, health promotion, disease prevention and specialty care services.

If you need this kind of help from the care management unit please call Member Services **1-855-232-3596 (TTY:: 711)**.

Every Plan member is contacted soon after they enroll. When we talk to you we complete an Initial Health Screen (IHS). The IHS lets us learn more about your health care needs. We also get information about your past health care. Together the IHS and your health history let us know if you have special health care needs. If so, we will then contact you to do a Comprehensive Needs Assessment (CNA). We will attempt to contact you within 45 days of enrollment to complete the IHS.

Once the CNA is completed, an Individual Health Care Plan (IHCP) will be made to meet your specific health care needs. IHCPs help providers and our care managers make sure you get all the care you need. We will set up a mutually agreeable time to develop your plan. This will be done within 30 days after the CNA is completed.

Members with special needs

Members with special needs who are getting their care from an out-of-network provider may continue seeing the provider if it is determined to be in the best interest of the member child.

Members with special health care needs may need to see specialists on a long-term basis. Sometimes this is called a “standing referral”. The specialist must contact us for approval to make this happen. If it is in your best interest, you may have a specialist as your PCP. If you want a specialist to be your PCP, talk to the specialist about it. If one of our care managers has already talked with you about your special needs, he or she can help you make this change if the specialist agrees. If you have special needs and you have not talked with one of our care managers yet, call Member Services at **1-855-232-3596, TTY: 711** and ask to be transferred to a care manager.

You may have special needs and have an existing relationship with an out-of-network provider. Sometimes you can continue to see that provider if it is in your best interest. The provider must first get approval from us. If you have questions about care management, call your care manager or Member Services at **1-855-232-3596, TTY: 711**.

Dental Care for Members with Special Health Care Needs and children under the age of 5 may require treatment to be performed in a hospital setting/operating room or ambulatory surgical center facility setting as an outpatient member service. If your dental provider cannot provide this service, please contact LIBERTY Dental Plan at **1-855-225-1727** in order to help you locate a dental provider and coordinate this service.

Disenrollment

It is your right to disenroll from the MLTSS program at any time. Please call your care manager or the Aetna Better Health of New Jersey member advocate for more information; we would be happy to come out and talk to you about your decision and assist you with the process.

Your MLTSS care manager will give you the voluntary withdrawal form and after the form is completed, you will get the final copy of the form to keep. Voluntary disenrollment from the MLTSS program does not mean you will not be able to obtain NJ FamilyCare benefits. The Office of Community Choice Options (OCCO) will contact you if you request to withdraw from the MLTSS program to ensure you understand the withdrawal process. The OCCO will also contact you to discuss your loss of Medicaid upon your withdrawal from the MLTSS program if you are identified as being above the federal poverty level (FPL).

Role of the MLTSS care manager

Our MLTSS care managers visit members where they live. The care manager will ask you about your health and care needs. You can have family and others present to participate in the visit from your MLTSS care manager.

These visits are held based on where the member lives:

- If the member lives in a nursing home, the MLTSS care manager will visit every 180 days or more often if needed.
- If the member lives in a community alternative residential setting such as an assisted living facility, the MLTSS care manager will visit every 180 days or more often.
- If the member lives in his or her own home or family home in the community, the MLTSS care manager will visit every 90 days or more often.
- If the member resides in a pediatric special care nursing facility, the MLTSS care manager will visit every 90 days or more often

Once you are enrolled in MLTSS, you will receive information from Aetna Better Health of New Jersey about who your care manager is and how to contact him/her. Any time service is needed; call your care manager right away for assistance or to schedule a face-to-face assessment. The health plan will develop a back-up plan in the event that there is an interruption in your services or your care manager is not available; you will be given the opportunity to speak with another MLTSS care manager for help. If your MLTSS care manager is not visiting you as often as shown above, please call us immediately at **1-855-232-3596, TTY: 711** and we will help.

Your MLTSS care manager will help you and anyone you include in your care plan understand the MLTSS program and benefits you are allowed to receive. The care plan is developed with you, your advocate and your care manager.

Once the MLTSS care manager gets information about your health and care needs, the care manager will talk to you and others you have invited about how to meet your needs. Remember that MLTSS adds to the care that is already being provided. It is never meant to completely take away from involvement of family and others who might be helping you.

Your care manager will never make you move to any setting against your wishes. We will always work with you to live in the setting that will meet your needs. If you want to move to an assisted living or nursing home, your care manager will help you. If you want to stay at home, we will gladly work to find services and supports to meet your needs.

Once it is decided on what MLTSS services and supports you need, your care manager will coordinate and ensure that services are delivered. You should see your primary care provider (PCP) for other health care needs. If you need assistance in getting access to the other health care services you might need, your care manager will help you.

Disease Management

We have a disease management program to help if you have certain conditions. We have programs for many conditions, including but not limited to:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Heart failure (HF)
- Diabetes

Call us at **1-855-232-3596, TTY: 711** for help in managing your disease. We can help you or your child learn to manage these chronic conditions and lead a healthier life. You can learn about these programs in your member handbook and online at **AetnaBetterHealth.com/NJ**.

As a member you are eligible to participate if you are diagnosed with any of these chronic conditions, or at risk for them, you may be enrolled in our disease management program. You can also ask your provider to request a referral. If you want to know more about our disease management programs, call us **1-855-232-3596, TTY: 711**.

If you do not want to participate

You have the right to make decisions about your health care. If we contact you to join in one of our programs, you may refuse. If you are already in one of our programs, you may choose to stop at any time by contacting us at **1-855-232-3596, TTY: 711**.

Treatment of Minors

Members under 18 years old usually must have their parents' permission to get medical care. This does not apply to emancipated minors. An emancipated minor is a child who has been granted the status of adulthood by court order or other formal arrangement. There are some services you can get without your parents' permission. These services are:

- Treatment for sexually transmitted diseases
- Testing for HIV/AIDS
- Treatment for drug and alcohol abuse
- Medical treatment for sexual assault
- Prenatal care
- Birth control
- Abortion

Even though parental permission is not needed for some services, parents still may learn of the services. When we pay the provider for the service, parents can see the payment. They can also see what the service was and the name of the patient.

Also, the provider you see may want you to talk to your parents about the treatment.

- If the provider thinks it would be best for you, he or she may tell your parents about the treatment.
- If you have been sexually assaulted, the provider must tell your parents unless the provider feels it is in your best interest not to tell them.
- You can get treatment for alcohol abuse by a provider or an alcohol abuse counselor on your own. Some programs have their own rules and your parents may have to know and be part of your treatment. Treatment programs are not required to accept you for treatment.

New Medical Treatments

We are always considering new medical treatments. We want you to get safe, up-to-date and high-quality medical care. A team of providers reviews new health care methods. They decide if they should become covered services. Services and treatments that are being researched and studied are not covered services.

We take these steps to decide if new treatments will be a covered benefit or service.

- Study the purpose of each new treatment
- Review medical studies and reports
- Determine the impact of a new treatment
- Develop guidelines on how and when to use the new treatment

Health Tips

How you can stay healthy

It is important to see your PCP and dentist for preventive care. Talk to your providers. You can improve your health by eating right, exercising and getting regular check-ups. Regular well-visits may also help you stay healthy. Be sure to complete all recommended dental treatment.

Guidelines for good health

Here are some ways you can work to keep healthy:

- Be sure to read the newsletters we will send you from time to time in the mail.
- Be sure to read the special mailings we will send you when we need to tell you something important about your health care.
- Talk to your providers and ask questions about your health care.
- Keep dental appointments as scheduled; complete recommended treatment.
- If you have a care manager, talk to them and ask questions about your health care.
- Come to our community events.
- Visit our website at [AetnaBetterHealth.com/NJ](https://www.aetna.com/betterhealth).

If You Get a Bill or Statement

Most members do not have to pay to get benefits. You should not get a bill for the services you receive, unless your benefit package has co-pays.

You may get billed for services:

- If you received care from providers outside of our provider network and did not get prior approval from us (except emergency care)
- If you did not get pre-approval to receive certain services
- If the services are not covered
- If you have co-pays

If you get a bill that you think you should not have gotten, call Member Services at **1-855-232-3596**, **TTY: 711**. Please note that MLTSS members residing in an assisted living residence, nursing home or Community Residential Setting may have to pay for some of the cost. If you have questions, please contact your care manager.

Quality Improvement Programs

Our quality improvement program watches and checks the quality of care you receive. We want to make sure you have:

- Easy contact to quality medical and behavioral health care
- Health management programs that meet your needs
- Help with any chronic conditions or illness you have
- Support when you need it the most, like after hospital admissions or when you are sick

We also want to make sure you are happy with your health care providers and with the health plan. Some of our quality improvement programs include:

- Calling members to remind them to take their child for a well-care visit;
- Sending members helpful postcards and newsletters;
- Reviewing the quality of services given to members;
- Reminding providers and members about preventive health care;
- Measuring how long it takes for a member to get an Appointment;
- Monitoring phone calls to make sure your call is answered as quickly as possible and that you get the correct information; and
- Working with your PCP to get them all the information to provide the care needed.

This list does not include all the quality programs. You can call us to learn more about our quality improvement programs. We can tell you what we do to improve your care. You can request hard copies of information about our programs.

We Want to Hear from You

Your opinion is important to us. We want to hear your ideas that could be helpful to all of our members. We take your feedback seriously.

We have a group that is made up of people who are our members and their caregivers, just like you. This group is called the MLTSS Member Advisory Committee (MLTSS MAC). They meet during the year to review member materials, member feedback, changes and new programs. They tell us how we can improve our services. If you want to know more about the MLTSS MAC, call Member Services at **1-855-232-3596, TTY: 711**.

Other information for you

We will provide you information about our company structure and our operations. If you have any questions about us, our network providers and how we work with DMAHS/NJ FamilyCare, call Member Services at **1-855-232-3596, TTY: 711**.

Physician Incentive Plan

We do not reward providers for denying, limiting, or delaying coverage of health care services. We also do not give monetary incentives to our staff that make medical necessity decisions to provide less health care coverage or services.

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time he or she treats you (“fee for service”) or may be paid a set fee each month for each member whether or not the member actually receives services (“capitation”) or may receive a salary.

These payment methods may include financial incentive agreements to pay some providers more (“bonuses”) or less (“withholds”) based on many factors: member satisfaction, quality of care, and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other provider in our network is compensated, please call us at **1-855-232-3596, TTY: 711** or write to:

Aetna Better Health of New Jersey
Attention: Member Services
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make referrals to other health care providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care provider or facility when making a referral to that health care provider or facility.

If you want more information about this, contact your physician, chiropractor or podiatrist. If you believe that you are not receiving the information to which you are entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at **973-504-6200** or **1-800-242-5846**.

Your Information

It is very important for us to have your correct contact information. If we cannot reach you, you may not get important information from us.

If you change your address, phone number or family size, tell the Plan by calling all Member Services toll-free at **1-855-232-3596**, **TTY: 711**. You can also call your state caseworker at the County Welfare Office or the Health Benefits Coordinator at **1-800-701-0710**, **TTY: 1-800-701-0720** to let them know about the change.

When You have NJ FamilyCare and Other Insurance

Let us know if you have other insurance. The other insurance may be through Medicare, employment or a family member's employment. We will work with the other medical insurance companies to cover your expenses. Since Aetna Better Health of New Jersey is always the "payer of last resort", all claims should be billed to the other (primary) insurance company first. We will process your claims after the primary insurance makes their payment. Remember to show all of your insurance ID cards when you go to the provider, hospital or pharmacy.

Referrals with other insurance

Your PCP may refer you to another provider. You can learn more about referrals when you have other insurance online at:

https://www.nj.gov/humanservices/dmahs/home/Medicaid_TPL_Coverage_Guide.pdf.

- If the service is covered by your other insurance, you do not need to contact us for a prior authorization.
- If the service is NOT covered by your other insurance, the provider has to contact us for prior authorization. See page 20 for details.

Picking providers

If you have other insurance, you still may want to make sure the providers you see are also in our network. This is to help ensure that you will not be billed for Medicaid covered services. Call our Member Services at **1-855-232-3596**, **TTY: 711** if you have questions.

This chart will help you manage your benefits

If you have both Medicare and Medicaid, you should always choose providers in your Medicare provider network for Medicare covered, medically necessary services. When receiving Medicare covered services, all Medicare guidelines must be followed to ensure Medicare coverage. See www.medicare.gov for more information.

When you have both Medicare and Medicaid

If Service Is	Then	Provider Guidance
An approved, Medicare covered benefit (Examples: outpatient hospital service, primary care, specialists, lab tests, radiology)	Medicare is the primary payer and Medicaid Health Plan is the secondary payer.	Use a Medicare provider who does not need to be in your Medicaid Health Plan’s provider network.
Inpatient hospital care	Medicare is the primary payer and Medicaid Health Plan is the secondary payer.	Use a hospital that is affiliated with Medicare. If possible, use a hospital that is also in your Medicaid Health Plan provider network.
Emergency care received at a hospital emergency department	Medicare is the primary payer and Medicaid Health Plan is the secondary payer.	Go to the nearest hospital.
A medically necessary service which is not covered by Medicare but is covered by your Medicaid Health Plan (Examples: dental services, hearing aids, personal care assistant services, medical day care services, incontinence supplies, family planning services).	Medicaid Health Plan is the only payer.	Use a provider in your Medicaid Health Plan provider network.
Rendered by a provider who has opted out of Medicare for Medicare Parts A and B members ¹ and is not in your Medicaid Health Plan provider network	Member is responsible for payment if properly informed and signed private contract. ²	To avoid being responsible for medical bills, be sure to use providers who participate in Medicare.
Rendered to a Medicare Advantage Health Plan ³ member by an unapproved, uncovered out-of-network provider	Member is responsible for payment.	To avoid being responsible for medical bills, be sure to use providers who are in the Medicare Advantage Health Plan’s provider network.

A prescription drug covered under Medicare Part D	Medicare is the primary payer. Member must pay a small prescription co-pay, if applicable.	Use a Medicare participating pharmacy to receive prescription drugs.
A prescription drug not covered under Medicare Part D or creditable drug coverage ⁴	Member is responsible for payment ⁵ . Some exceptions apply. See footnote at the bottom of this page.	N/A
For nursing facility care, including short-term inpatient rehabilitation settings	Medicare and Medicaid cover some days in a nursing facility. For more information, contact SHIP at 1-800-792-8820 (TTY:: 711) Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY:: 1-877-486-2048) or your Medicaid Health Plan member services department.	Contact the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY:: 711) , Medicare at 1-800-MEDICARE (1-800-633-4227) (TTY:: 1-877-486-2048) or your Medicaid Health Plan member services department for guidance.

- ¹ A provider who has opted out of Medicare is one that does not accept Medicare beneficiaries for any services.
- ² Generally, when a service is rendered by a provider who has opted out of Medicare, and is not in your Medicaid Health Plan network, the service will not be covered by Medicare or your Medicaid Health Plan.
- ³ Medicare Advantage is a Medicare Health Plan which includes benefits covered under Medicare Parts A and B, and may include Medicare Part D and additional benefits.
- ⁴ Creditable drug coverage is coverage from an employer or union plan in place of Medicare Part D.
- ⁵ Exceptions: benzodiazepines, barbiturates, smoking cessation drugs, and certain vitamins are not covered by Medicare Part D but are covered by your Medicaid Health Plan. Co-pays do not apply.

When you have both other health insurance and Medicaid

If Service Is	Then	Provider Guidance
An approved, other health insurance covered benefit, including referrals from your other health insurance PCP	Other health insurance is the primary payer and Medicaid Health Plan is the secondary payer. A Medicaid Health Plan referral is not required.	Use a provider in your other health insurance provider network. Your Medicaid Health Plan ID card will have a Medicaid Health Plan PCP on it. You should still use your other health insurance PCP for all other health insurance covered services regardless of the Medicaid Health Plan PCP listed on your Medicaid Health Plan ID card.
A medically necessary service which may not be covered by other health insurance but is covered by your Medicaid Health Plan (Examples: incontinence supplies, personal care assistant services, medical day care services, family planning services)	Medicaid Health Plan is the primary payer.	Use a provider in your Medicaid Health Plan provider network.
Rendered by a provider that is not in your other health insurance provider network and is not in your Medicaid Health Plan provider network and was not authorized by your other health insurance	Member is responsible for payment.	To avoid being responsible for medical bills, be sure to use providers who are in your other health insurance’s provider network.
A prescription drug covered by your other health insurance	Other health insurance is primary payer. Medicaid Health Plan is secondary payer and covers the drug co-pay.	Use another health insurance participating pharmacy to receive prescription drugs.
A prescription drug not covered by your other health insurance, but covered by your Medicaid Health Plan	Medicaid Health Plan is only payer.	Use a pharmacy in your Medicaid Health Plan provider network.
A prescription drug not covered by your other health insurance or your Medicaid Health Plan.	Member is responsible for payment.	N/A

An inpatient stay in any other health insurance provider hospital	Other health insurance is the primary payer. Medicaid Health Plan is the secondary payer.	Use a hospital that is in your other health insurance provider network. If possible, use a hospital that is also in your Medicaid Health Plan provider network.
Emergency care received at a hospital emergency department	Other health insurance is the primary payer and Medicaid Health Plan is the secondary payer.	Go to the nearest hospital.
For nursing facility care	Other health insurance and your Medicaid Health Plan may both cover nursing facility care. For more information about payments, contact your other health insurance service representative or your Medicaid Health Plan member services department.	Use a facility that is in your other health insurance and Medicaid Health Plan provider networks.

Grievances and Appeals

We want you to be happy with services you get from us and our providers. We want you to let us know if you are unhappy. We take member grievances and appeals very seriously. We want to know what is wrong so we can make our services better.

We want to make sure you understand your rights related to grievances and appeals. If you need information in another language let us know. We will notify you in your primary language of these rights.

We can also provide information in alternate formats, such as Large Print, or braille.

Grievance

A grievance is when you tell us you are unhappy with us or your provider.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You have not gotten services that the Plan has approved.
- Your provider or a plan staff member did not respect your rights.
- You had trouble getting an appointment with your provider in a reasonable amount of time.
- Your provider or a plan staff member was rude to you.
- Your provider or a plan staff member was not sensitive to your cultural needs or other special needs you may have.

If you have a grievance about a provider or about the quality of care or services you have received, you should let us know right away. We have special procedures in place to help members who file grievances. We will do our best to answer your questions and to help resolve your issue. Filing a grievance will not affect your health care services or your benefits coverage.

If your grievance is a medical issue it will be reviewed by our clinical staff. Any issue suggesting a quality of care issue may be referred to the Quality Department for review.

How to file a grievance

You can submit a grievance by phone or in writing at any time.

Call us: 1-855-232-3596, TTY: 711

Fax us: 1-844-321-9566

Write to us:

Aetna Better Health of New Jersey
Attn: Grievance and Appeals
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

Tell us what happened

You can write to us with your grievance. Tell us in detail what happened. Include the date the incident happened, and the names of the people involved. Be sure to include your name and your member ID number. We may call you to get more information about your grievance.

Have someone represent you in a grievance

You can have someone represent you, such as a family member, friend or provider. You must agree to this in writing. Send us a letter telling us that you want someone else to represent you and file a grievance for you. Include your name, member ID number from your ID card, the name of the person you want to represent you and what your grievance is about.

When we get the letter from you, the person you picked can represent you. If someone else files a grievance for you, you cannot file one yourself about the same item.

Other grievance rights

You can send us any information that you feel is important to your grievance. You can also ask to see your file at any time throughout the process. **If you are unhappy with what we have decided with your grievance, you may file a grievance appeal.**

Timeframes for resolving your grievance

We will try to resolve your grievance right away. We may call you for more information. The plan will make a decision within the following timeframes:

- Thirty (30) calendar days of receipt for a standard grievance
- Three (3) business days of receipt for an expedited grievance

For grievances that require an expedited (quick) resolution, you may get a phone call from us with the resolution. You will get a letter from us within three (3) business days of receipt. The letter will include the resolution reached and the reasons for the resolution, along with our contact information if you have questions about the resolution.

Appeals (Utilization Management Appeals)

Utilization Management Appeal Process:

Service Denial/Limitation/Reduction/Termination based on Medicaid Necessity

You and your provider should receive a notification letter within 2 business days of any health plan decision to deny, reduce, or terminate a service or benefit. If you disagree with the plan's decision, you (or your provider, with your written permission) can challenge it by requesting an *appeal*. See the summary below for the timeframes to request an appeal.

Stages	Timeframe for Member/ Provider to Request Appeal	Timeframe for Member/Provider to Request Appeal with Continuation of Benefits for Existing Services	Timeframe for Appeal Determination to be reached	FamilyCare Plan Type
<p><u>Internal Appeal</u> The Internal Appeal is the first level of appeal, administered by the health plan. This level of appeal is a formal, internal review by health care professionals selected by the plan who have expertise appropriate to the case in question, and who were not involved in the original determination.</p>	60 calendar days from date on initial notification/ denial letter	<ul style="list-style-type: none"> On or before the last day of the current authorization; or Within ten calendar days of the date on the notification letter, <i>whichever is later</i> 	30 calendar days or less from health plan's receipt of the appeal request	A /ABP B C D
<p><u>External/IURO Appeal</u> The External/IURO appeal is an external appeal conducted by an Independent Utilization Review Organization (IURO).</p>	60 calendar days from date on Internal Appeal notification letter	<ul style="list-style-type: none"> On or before the last day of the current authorization; or Within ten calendar days of the date on the Internal Appeal notification letter, <i>whichever is later</i> 	45 calendar days or less from IURO's decision to review the case	A /ABP B C D

Medicaid Fair Hearing	120 calendar days from date on Internal Appeal notification letter	<ul style="list-style-type: none"> • <u>Whichever is the latest of the following:</u> • On or before the last day of the current authorization; <u>or</u> • Within ten calendar days of the date on the Internal Appeal notification letter, <u>or</u> • Within ten calendar days of the date on the External/IURO appeal decision notification letter 	A final decision will be reached within 90 calendar days of the Fair Hearing request.	A /ABP only
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Initial Adverse Determination

If Aetna Better Health of New Jersey decides to deny your initial request for a service, or to reduce or stop an ongoing service that you have been receiving for a while, this decision is also known as an *adverse determination*. We will tell you and your provider about this decision as soon as we can, often by phone. You will receive a written letter explaining our decision within two business days.

If you disagree with the plan’s decision, you, your provider (with your written permission) can challenge the decision by requesting an *appeal*. You or your provider can request an appeal either orally (by phone) or in writing. To request an appeal orally, you can **Call us: 1-855-232-3596, TTY: 711** 24 hours a day, 7 days a week.

Written appeal requests should be mailed to the following address:

Write to us:

Aetna Better Health of New Jersey
 Grievance and Appeals
 PO Box 81139
 5801 Postal Road
 Cleveland, OH 44181

You have **60 calendar days** from the date on the initial adverse determination letter to request an appeal.

Internal Appeal

The first stage of the appeal process is a formal internal appeal to the plan (called an Internal Appeal). Your case will be reviewed by a doctor or another health care professional, selected by Aetna Better Health of New Jersey who has expertise in the area of medical knowledge appropriate for your case. We will be careful to choose someone who was not involved in making the original decision about your care. We must make a decision about your appeal within 30 calendar days (or sooner, if your medical condition makes it necessary).

If your appeal is denied (not decided in your favor), you will receive a written letter from us explaining our decision. The letter will also include information about your right to an External Independent Utilization Review Organization (IURO) Appeal, and/or your right to a Medicaid State Fair Hearing, and how to request these types of further appeal. You will also find more details on those options later in this section of the handbook.

Expedited (fast) Appeals

You have the option of requesting an expedited (fast) appeal if you feel that your health will suffer if we take the standard amount of time (up to 30 calendar days) to make a decision about your appeal. Also, if your provider informs us that taking up to 30 calendar days to reach a decision could seriously jeopardize your life or health, or your ability to fully recover from your current condition attain, we must make a decision about your appeal within 72 hours.

External (IURO) Appeal

If your Internal Appeal is not decided in your favor, you (or your provider acting on your behalf with your written consent) can request an External (IURO) Appeal by completing the ***External Appeal Application*** form. A copy of the *External Appeal Application* form will be sent to you with the letter that tells you about the outcome of your Internal Appeal. You or your provider must mail the completed form to the following address within **60 calendar days** of the date on your Internal Appeal outcome letter:

New Jersey Department of Banking and Insurance
Consumer Protection Services
Office of Managed Care
P.O. Box 329 Trenton
NJ 08625-0329

You may also **fax** the completed form to 609-633-0807, or send it by **email** to **ihcap@dobi.nj.gov**. If a copy of the *External Appeal Application* is not included with your Internal Appeal outcome letter, please call **1-855-232-3596**, **TTY: 711** to request a copy.

External (IURO) Appeals are not conducted by the plan. These appeals are reviewed by an Independent Utilization Review Organization (IURO), which is an impartial third-party review organization that is not directly affiliated with either the plan or the State of New Jersey. The IURO will assign your case to an independent physician, who will review your case and make a decision. If the IURO decides to accept your case for review, they will make their decision within 45 calendar days (or sooner, if your medical condition makes it necessary).

You can also request an expedited, or fast, External (IURO) Appeal, just as you can with Internal Appeals. To request an expedited appeal, you or your provider should fax a completed copy of the *External Appeal Application* form to the Department of Banking and Insurance at 609-633-0807, and ask for an expedited appeal on the form in **Section V, Summary of Appeal**. In the case of an expedited External (IURO) Appeal, the IURO must make a decision about your appeal *within 48 hours*.

If you have questions about the External (IURO) Appeal process, or if you would like to request assistance with your application, you can also call the New Jersey Department of Banking and Insurance's toll-free telephone number at 1-888-393-1062 (select option 3).

Please note there are some services that the IURO will not review. If the letter you receive about the outcome of your appeal does not include information about your option to request an External (IURO) review, this is probably the reason. However, if you have questions about your options, you can call **1-855-232-3596, TTY: 711**

The External (IURO) Appeal is optional. You don't need to request an External (IURO) appeal before you request a Medicaid State Fair Hearing. Once your Internal Appeal is finished, you have the following options for requesting an External (IURO) Appeal *and/or* a Medicaid State Fair Hearing:

- You can request an External (IURO) Appeal, wait for the IURO's decision, and **then** request a Medicaid State Fair Hearing, if the IURO did not decide in your favor.
- You can request an External (IURO) Appeal **and** a Medicaid State Fair Hearing **at the same time** (just keep in mind that you make these two requests to different government agencies).
- You can request a Medicaid State Fair Hearing *without* requesting an External (IURO) Appeal.

Please note Medicaid Fair Hearings are only available to NJ FamilyCare Plan A and ABP members.

Medicaid State Fair Hearing

You have the option to request a Medicaid State Fair Hearing after your Internal Appeal is finished (and Aetna Better Health of New Jersey has made a decision). Medicaid State Fair Hearings are administered by staff from the New Jersey Office of Administrative Law. You have up to **120 calendar days** from the date on your **Internal Appeal outcome letter** to request a Medicaid State Fair Hearing. You can request a Medicaid State Fair Hearing by writing to the following address:

Fair Hearing Section
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, New Jersey 08625-0712

If you make an expedited (fast) Medicaid State Fair Hearing request, and you meet all of the requirements for an expedited appeal, a decision will be made within 72 hours of the day the state agency received your Medicaid Fair Hearing request.

Please note: the deadline for requesting a Medicaid State Fair Hearing is always 120 days from the date on the letter explaining the outcome of your *Internal Appeal*. This is true even if you request an External (IURO) Appeal in the meantime. The 120 day deadline to ask for a Medicaid State Fair Hearing always starts from the outcome of your *Internal Appeal*, not your External (IURO) Appeal.

Continuation of Benefits

If you are asking for an appeal because the plan is stopping or reducing a service or a course of treatment that you have already been receiving, you can have your services/benefits continue during the appeal process. Aetna Better Health of New Jersey will automatically continue to provide the service(s) while your appeal is pending, as long as all of the following requirements are met:

- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services were ordered by an authorized provider; and
- You (or your provider, acting on your behalf with your written consent) file(s) the appeal within **10 calendar days** of the date on the initial adverse determination letter, or on or before the final day of the original authorization, ***whichever is later***.

Your services will *not* continue automatically during a Medicaid State Fair Hearing. If you want your services to continue during a Medicaid State Fair Hearing, you must request that ***in writing*** when you request a Fair Hearing, and you must make that request within:

- **10 calendar days** of the date on the Internal Appeal outcome letter; ***or*** within
- **10 calendar days** of the date on the letter informing you of the outcome of your External (IURO) Appeal, if you requested one; ***or***
- On or before the final day of the original authorization, ***whichever is later***.

Please note if you ask to have your services continue during a Medicaid State Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of your continued services.

If you have any questions about the appeal process, you can contact our Member Services Department by calling **1-855-232-3596**, TTY: **711**

Pharmacy Lock-In Appeals

If you disagree with the pharmacy restriction, you may contact the Plan to file an internal appeal, either verbally or in writing.

Call us: 1-855-232-3596 (TTY: 711)

Fax us: 1-844-321-9566

Write to us:

Aetna Better Health of New Jersey
Grievance and Appeals
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

In the appeal, please let us know why you feel the pharmacy restriction is not appropriate or no longer valid. In addition, you may submit any documentation you have that supports this appeal. You will be notified in writing of the outcome of our appeal investigation.

If you are a FamilyCare A or ABP member, you also have the right to a Medicaid Fair Hearing (please see below section) regarding the pharmacy restriction. Please note that you only have 120 days from the date of the Plan's determination to request a Fair Hearing on the pharmacy restriction. If you choose to do so, you should file your Fair Hearing request at the same time you file your internal appeal with the Plan.

Fraud, Waste and Abuse

Sometimes members, providers and Plan employees may choose to do dishonest acts. These dishonest acts are called fraud, waste and abuse. The following acts are the most common types of fraud, waste and abuse:

- Members selling or lending their ID card to someone else
- Members trying to get drugs or services they do not need
- Members forging or altering prescriptions they receive from their providers
- Providers billing for services they didn't give
- Providers giving services members do not need
- Verbal, physical, mental, or sexual abuse by providers

Call our fraud, waste and abuse hotline to report these types of acts right away. You can do this confidentially. We do not need to know who you are. You can call us to report fraud, waste and abuse at **1-855-282-8272, TTY: 711**. You can also report suspected fraud, waste or abuse to the State of New Jersey by calling **1-888-937-2835**.

Disenrollment

We hope that you are happy with Aetna Better Health of New Jersey. If you are thinking about leaving, call us at **1-855-232-3596**, **TTY: 711** to see if we can help resolve any issues you are having. DMAHS will decide if you can disenroll. To disenroll from the Plan call the Health Benefits Coordinator (HBC) at **1-800-701-0710** (**TTY: 1-800-701-0720**). You can also send a written request to disenroll to Member Services at:

Aetna Better Health of New Jersey
Attn: Member Services
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

Disenroll from Aetna Better Health of New Jersey

As a new member you may disenroll from the Plan at any time during the first 90 days of your enrollment. After the first 90 days you are “locked in” as a Plan member unless there is good cause to disenroll. DMAHS will decide if you have good cause. It can take 30-45 days to process your disenrollment request. If you’d like to disenroll from the Plan, call the Health Benefit Coordinator (HBC) at **1-800-701-0710** (**TTY: 1-800-701-0720**). The HBC will tell you when you will be effective with your new health plan. You must keep using our providers until you are no longer a member with us.

Requests to disenroll

If you are a NJ FamilyCare member, you may disenroll:

- Any time during the first 90 days of enrollment
- During the state’s Open Enrollment period every October 1 through November 15
- For good cause at any time

The state will hold an Open Enrollment period every October 1 through November 15. If you choose a new health plan during the Open Enrollment period, the effective date will be January 1 and continue through the calendar year.

Disenrollment caused by a change in status

If your status changes, you may no longer be eligible for the Plan. DMAHS will decide if you are still eligible.

Some changes that can affect your benefits include:

- Change in address
- Employment change
- Moving out of the service area
- Death of a family member
- New family member

Some things that may cause you to be disenrolled from the Plan include:

- Committing fraud
- Regularly refusing to follow your providers instructions about treatment
- Not physically residing in the state of New Jersey for more than 30 days (except if you are a student)

If this happens, you will get a letter explaining the disenrollment process.

Enrollment and disenrollment are always subject to verification and approval by the New Jersey DMAHS. If you have any questions, you can call your State Health Benefits Coordinator at **1-800-701-0710 (TTY:/TDD 1-800-701-0720)**.

If you are not satisfied with the New Jersey DMAHS decision that there is not a good cause to disenroll you may file for a State Fair Hearing.

Renewing Your Coverage

You must renew each year to keep your insurance. You may lose coverage if you do not renew with NJ FamilyCare.

NJ FamilyCare members

The HBC will send your preprinted renewal application to your house. Fill it out and send it back to NJ FamilyCare. Call the HBC at **1-800-701-0710 (TTY:: 1-800-701-0720)** if you have any questions or need help. If you do not renew with the NJ FamilyCare program every year, you will be dropped from the program and may not be allowed to re-enroll.

Medicaid members

To avoid a gap in your coverage, you must renew with NJ FamilyCare (Medicaid) before your termination date. If you do not, you could lose both your New Jersey Medicaid and your Aetna Better Health of New Jersey coverage. To remain enrolled, call your County Welfare Agency (CWA) to make sure there is no break in your health coverage one month before your termination date. Continuous enrollment means that if there is no break in your NJ FamilyCare (Medicaid) coverage, your health plan enrollment will continue automatically. If you move, call your caseworker and inform them of your new address so that you receive your renewal application.

If you are a new parent, remember to sign up your newborn baby with your local CWA or NJ FamilyCare. To keep your benefits without any breaks, renew as soon as you get the notice from the CWA office or the NJ FamilyCare Program.

Advance Directives

If you are an adult, your provider should ask you if you have an advance directive. These are instructions about your medical care. They are used when you can't say what you want or speak for yourself due to an accident or illness.

You will get medical care even if you don't have an advance directive. You have the right to make your medical decisions. You can refuse care. Advance directives help providers know what you want when you can't tell them. Written advance directives in New Jersey fall into two main groups. It is up to you whether you want to have both or just one.

Proxy directive (durable power of attorney for health care)

This is a document you use to appoint a person to make health care decisions for you in the event you become unable to make them yourself. This document goes into effect whether your inability to make health care decisions is temporary because of an accident or permanent because of a disease. The person that you appoint is known as your "health care representative". They are responsible for making the same decisions you would have made under the circumstances. If they are unable to determine what you would want in a specific situation they are to base their decision on what they think is in your best interest.

Instruction directive (living will)

This is a document you use to tell your provider and family about the kinds of situations you would want or not want to have life-sustaining treatment in the event you are unable to make your own health care decisions. You can also include a description of your beliefs, values, and general care and treatment preferences. This will guide your provider and family when they have to make health care decisions for you in situations not specifically covered by your advance directive.

Advance directives are important for everyone to have, no matter what your age or health condition is. They let you say what type of end of life care you do and do not want for yourself.

If you have an advance directive:

- Keep a copy of your advance directive for yourself.
- Also give a copy to the person you choose to be your medical power of attorney.
- Give a copy to each one of your providers.
- Take a copy with you if you have to go to the hospital or the emergency room.
- Keep a copy in your car if you have one.

You can also talk to your provider if you need help or have questions. We will help you find a provider that will carry out your advance directive instructions. You can file a grievance if your advance directive is not followed.

Call Member Services at **1-855-232-3596**, **TTY: 711** for help. You may also visit www.state.nj.us/health/healthfacilities/documents/ltc/advance-directives.pdf for more information on advanced directives. If the state law changes, we will tell you about it within 90 days after the effective date of the change.

Common Questions

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

A. Call Member Services toll-free at **1-855-232-3596 (TTY:: 711)** to get a new ID card.

Q. How will I know the name of my PCP?

A. Your ID card will list the name and phone number of your PCP. This will be on the front of your ID card.

Q. Can I change my PCP if I need to?

A. Yes. Please call Member Services toll-free at **1-855-232-3596 (TTY:: 711)** for help. We will check if the new PCP is accepting new patients.

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

A. List of covered services begins on page 22. These pages also list non-covered services. You can also ask your provider. You can call Member Services for help at **1-855-232-3596, (TTY:: 711)**. You can also check online at **AetnaBetterHealth.com/NJ**.

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

A. If you get a bill, call the provider's office. Give the staff your information. If you keep getting a bill, please call Member Services for help at **1-855-232-3596 (TTY:: 711)**.

Q. What hospitals can I use?

A. We use many contracted hospitals. Check the provider directory online at **AetnaBetterHealth.com/NJ**. You can also call Member Services at **1-855-232-3596 (TTY:: 711)** to get a current list of our contracted hospitals.

Q. What is an emergency?

A. A medical emergency is when you have a serious medical problem. This means you are in danger of lasting harm or dying. If you have an emergency, go to the nearest hospital or call 911. If you are having a dental emergency, call your dentist first.

Q. Do you have urgent care?

A. Yes. If you have an urgent care need, call your PCP. At night or on weekends or holidays, your PCP's answering service will take your call. Your PCP will call you back and tell you what to do. See page 42 for more information on urgent care.

Q. How do I get services that are not covered by Aetna Better Health of New Jersey, but are covered by Medicaid-Fee-for-Service?

A. Call Member Services at **1-855-232-3596 (TTY:: 711)** and our staff will tell you how to get these services.

Notice of Privacy Practices

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

This notice takes effect on January 1, 2015.

What do we mean when we use the words “health information”? ^[1]

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 check-ups 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.

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

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

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

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

^[1] For purposes of this notice, “Aetna” and the pronouns “we,” “us” and “our” refer to all the HMO and licensed insurer subsidiaries of Aetna Inc. These entities have been designated as a single affiliated covered entity for federal privacy purposes.

A case manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. 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 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.

Call us toll free at **1-855-232-3596 (TTY:: 711)**, 24 hours a day, 7 days a week 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 New Jersey
Attn: Privacy Officer
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

You also can file a complaint with regard to your privacy with the U.S. Department of Health and Human Services, Office for Civil Rights. Call us toll free at **1-855-232-3596 (TTY:: 711)** to get the address.

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

Protecting your information

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

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

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

Will we change this notice?

By law, we must keep your health information private. We must follow what we say in this notice. We also have the right to change this notice. If we change this notice, the changes apply to all of your information we have or will get in the future. You can get a copy of the most recent notice on our web site at [AetnaBetterHealth.com/NewJersey](https://www.aetna.com/betterhealth.com/NewJersey).

Non-Discrimination 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>.

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Multi-Language Interpretation Services

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

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

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

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.

PORTUGUESE: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para o número que se encontra na parte de trás do seu cartão de identificação ou **1-800-385-4104 (TTY:: 711)**.

GUJARATI: ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર પર અથવા **1-800-385-4104** પર કોલ કરો (TTY: 711).

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)**.

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).

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

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)**.

FRENCH CREOLE: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd nan lang ou pale a ki disponib gratis pou ou. Rele nan nimewo ki sou do kat Idantifikasyon (ID) w la oswa rele nan **1-800-385-4104 (TTY: 711)**.

HINDI: ध्यान दें: यदि आप हिंदी भाषा बोलते हैं तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। अपने आईडी कार्ड के पृष्ठ भाग में दिए गए नम्बर अथवा **1-800-385-4104 (TTY: 711)** पर कॉल करें।

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)**.

FRENCH: ATTENTION: si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.

Appelez le numéro indiqué au verso de votre carte d'identité ou le **1-800-385-4104 (ATS: 711)**.

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

Aetna Better Health of New Jersey
3 Independence Way, Suite 400
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Member Services
1-855-232-3596 (TTY: 711)

[AetnaBetterHealth.com/NJ](https://www.aetna.com/nj)

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