



welcome

2019 Member Handbook

Aetna Better Health® of New Jersey
Your NJ FamilyCare plan



aetnabetterhealth.com/nj

Dear Member,

Thank you for choosing Aetna Better Health of New Jersey, your NJ FamilyCare health plan. We are an Aetna health plan with more than 30 years of experience providing Medicaid services 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 services 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 or 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 Member Services	1-855-232-3596, TTY 711 Representatives available 24 hours a day, 7 days a week
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: DentaQuest	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
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 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 Support (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.

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 is 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 is 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 and help you:

- Find a PCP, PCD, specialist, vision provider, or pharmacy in your area
- Contact us with 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, DentaQuest

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

Your ID card tells providers that they should not ask you to pay for your covered services unless you are a NJ FamilyCare C or D member. Some NJ FamilyCare C and D members must pay co-payments for certain services.

All members still have a state-issued Health Benefit Identification Card (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®		aetna	
NJ FamilyCare A			
Member ID# XXXXXXXXXXXXX	Date of Birth 00/00/0000		Sex X
Member Name Last Name, First Name			
PCP Last Name, First Name		Effective Date 00/00/0000	
PCP Phone 000-000-0000			
Dental Benefit*			
CO-PAYS			
PCP \$0	Brand \$0	RxBIN: 610591	CVS/caremark
ER \$0	Generic \$0	RxPCN: ADV	
RxGRP: RX8829			
Pharmacist Use Only: 1-855-319-6286			
www.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)
*DentaQuest 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:
Aetna Better Health of New Jersey
PO Box 61925, Phoenix, AZ 85082-1925
To verify member eligibility:
1-855-232-3596
Electronic Claims: Payer ID 46320
NJBACK1

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

Look at your card to make sure the name 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. During the time before you join our health plan, you will get benefits through Medicaid Fee-For-Service or the health plan you are currently enrolled in. Coverage with us will start on the first day of the month after you are approved for NJ FamilyCare eligibility. 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).

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 an 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. If your PCP does not participate in Aetna Better Health of New Jersey, you may need to change to a different PCP who is in the plan.

Information about NJ FamilyCare

NJ FamilyCare is a program for adults and children who meet certain state/federal guidelines. There are multiple 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 you need. 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. The Plan 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 letter. 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 health 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. Your good cause will need to be approved by DMAHS.

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, 7 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

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 DMAHS 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 (for NJ FamilyCare C and D).

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. 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 0-6 years old), you can search the online provider search linked on our Dental Benefits page at 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 17 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.

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 dentist). NJ Smiles is a dental program especially for children from 0-20 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 to 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 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**.

Prior Authorization

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 62 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 we use are also 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” 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, pedodontist (children’s dentist), or participating dental specialist
- 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**.

Getting specialist 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 or PCD 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 an out-of-network 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 another 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 a Medicaid contracted vendor. 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 business 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 or PCD's office is closed, or on a weekend, call the office anyway. An answering service will make sure the PCP or PCD gets your message. The PCP or PCD will call you back to tell you what to do. Be sure your phone accepts blocked calls. Otherwise, the PCP or PCD may not be able to reach you.

You can even call the PCP or PCD in the middle of the night. You might have to leave a message with the answering service. The PCP or PCD 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 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
- Earache
- 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 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 DentaQuest Member Services at **1-855-225-1727** (TTY: **711**) to schedule an appointment. If you want to choose or change your PCD to another dentist in our provider network, call Member Services toll-free at **1-855-232-3596**, TTY **711**. If you need help scheduling an appointment with the PCP or PCD, please call Member Services at **1-855-232-3596**, TTY **711**. For more information on routine dental care, go to the Dental Care Services section on page 46.

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 47.

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>You should NOT go to the emergency room for urgent/ sick care.</p>	<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>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>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>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> <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>

Types of care	What to do
<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 • Toothaches • 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
<p>Specialist referrals</p> <p>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

Types of care	What to do
Initial Pediatric Appointments	You should call your provider to get a visit within the timeframe below: <ul style="list-style-type: none"> • Within 90 days of enrollment
Dental Appointments	You should call your dentist to get a visit within the timeframe below: <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
Mental Health/Substance Use Disorder Appointments	You should call your provider to get a visit within the timeframe below: <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

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.

These services are listed as FFS. Aetna Better Health of New Jersey does not pay for these services, but NJ FamilyCare does.

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

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Abortion and related services	FFS	FFS	FFS	FFS
Acupuncture	Covered	Covered	Covered	Covered
Allergy testing	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Audiology	Covered	Covered	Covered	Covered
Blood and plasma products	Covered	Covered		Covered
Bone mass measurement (Bone density)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Case/care management	Covered	Covered	Covered	Covered
Chiropractor services Check with your PCP for clearance (Manual manipulation of spine)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization \$5 co-pay per visit for NJ FamilyCare C	Covered with prior authorization \$5 co-pay per visit for NJ FamilyCare D
Clinic services	Covered	Covered	Covered Co-pays may apply to NJ FamilyCare C	Covered Co-pays may apply to NJ FamilyCare D
Colorectal screening exams	Covered Member age 50 and over may self-refer to network providers.	Covered Member age 50 and over may self-refer to network providers.	Covered Member age 50 and over may self-refer to network providers.	Covered Member age 50 and over may self-refer to network providers.
Court-ordered services	Covered Call Member Services for more information.	Covered Call Member Services for more information.	Covered Call Member Services for more information.	Covered Call Member Services for more information.

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Dental services, Provided through DentaQuest Regular diagnostic and preventive services, fillings, treatment for dental emergencies and other routine services are covered and do not require prior authorization. Services which require prior authorization include: crowns, bridges, full dentures, partial dentures, gum treatments, root canal and complex oral surgery. Fixed bridge work and implant services require demonstration of medical necessity.	Covered	Covered	Covered \$5 per visit (no co-pay for diagnostic and preventive care) for NJ FamilyCare C	Covered \$5 per visit (no co-pay for diagnostic and preventive care) for NJ FamilyCare D
Orthodontic services, provided through DentaQuest	Covered Age limits apply, covered up to age 21 (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)	Covered Age limits apply, covered up to age 21 (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)	Covered Age limits apply, covered up to age 19 (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)	Covered Age limits apply, covered up to age 19 (Only medically necessary orthodontic services are covered. Your dentist must explain the reason for the care.)
Diabetic education	Covered with prior authorization			

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Diabetic supplies and equipment	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Durable Medical Equipment (DME)/assistive technology devices	Covered Prior authorization required if greater than \$500.	Covered Prior authorization required if greater than \$500.	Covered Prior authorization required if greater than \$500.	Covered Prior authorization required if greater than \$500.
DCP&P residential treatment	FFS	FFS	FFS	FFS
Educational or special remedial services	FFS	FFS	FFS	FFS
Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and immunizations (0-21 yrs. of age)	Covered	Covered	Covered	Covered
Emergency room care	Covered	Covered	Covered \$10 per visit for NJ FamilyCare	Covered \$35
Emergency ground and air medical transportation	Covered	Covered	Covered	Covered
Routine eye exams and optometrist services March Vision	Covered Member may self-refer one routine eye exam per year.	Covered Member may self-refer one routine eye exam per year.	Covered \$5 co-pay for NJ FamilyCare C Member may self-refer one routine eye exam per year.	Covered \$5 co-pay Member may self-refer one routine eye exam per year.

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Eyeglasses (lenses and frames) Members may self-refer March Vision	Covered Generic frames or \$100 allowance for name-brand frames (see page 48 for limitations)	Covered Generic frames or \$100 allowance for name-brand frames (see page 48 for limitations)	Covered Generic frames or \$100 allowance for name-brand frames (see page 48 for limitations)	Covered Generic frames or \$100 allowance for name-brand frames (see page 48 for limitations)
Family planning basic services (Self-referral reproduction health procedures/devices)	Covered Member may self-refer to participating Ob/Gyn. FFS when furnished by a non-participating provider.	Covered Member may self-refer to participating Ob/Gyn. FFS when furnished by a non-participating provider.	Covered Member may self-refer to participating Ob/Gyn. FFS when furnished by a non-participating provider.	Covered Member may self-refer to participating Ob/Gyn. FFS when furnished by a non-participating provider.
Federally Qualified Health Care Centers (FQHCs)	Covered	Covered	Covered \$5 co-pay for non-preventive services for NJ FamilyCare C	Covered \$5 co-pay for non-preventive services
Genetic testing and counseling	Covered with prior authorization			
Hearing exams	Covered	Covered	Covered	Covered
Hearing aids and batteries	Covered with prior authorization			
Hemodialysis	Covered with prior authorization			
HIV/AIDS testing	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Home health care	Covered with prior authorization			
Hospice	Covered with prior authorization			
Immunizations	Covered	Covered	Covered	Covered
Infertility testing and services	Not covered	Not covered	Not covered	Not covered
Inpatient hospitalization (acute care, rehabilitation and special hospitals)	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.	Covered Includes acute care, rehabilitation, special hospitals, room and board. Non-emergency admissions require prior authorization.
Lab tests and X-rays Members will be notified of results within 24 hours for urgent and emergent cases and within 10 business days for routine cases	Covered with prior authorization			
Mammograms (Screening)	Covered Member may self-refer. Baseline for women 35-39 and annual for women 40+.	Covered Member may self-refer. Baseline for women 35-39 and annual for women 40+.	Covered Member may self-refer. Baseline for women 35-39 and annual for women 40+.	Covered Member may self-refer. Baseline for women 35-39 and annual for women 40+.
Medical day care	Covered with prior authorization	Not covered	Not covered	Covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Medical supplies	Covered	Covered	Covered	Limited Call Member Services at 1-855-232-3596, TTY 711.
Methadone and methadone maintenance	Methadone for pain management is covered by Aetna Better Health.	Methadone for pain management is covered by Aetna Better Health.	Methadone for pain management is covered by Aetna Better Health.	Methadone for pain management is covered by Aetna Better Health.
Nuclear medicine	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Nurse Practitioners/ Certified Nurse Midwives	Covered	Covered	Covered \$5 co-pay for non-preventive services for NJ FamilyCare C.	Covered \$5 co-pay for non-preventive services.
Nursing Facility Services i.e. rehabilitation in this setting	Covered	Covered	Covered	Covered
Obstetrical/ maternity care	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer. \$5 co-pay for first prenatal care visit and for non-preventive services for NJ FamilyCare C.	Covered Member may self-refer. \$5 co-pay for first prenatal care visit and for non-preventive services.
Organ transplant evaluation	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Organ transplants (Includes donor and recipient costs. Experimental organ transplants not covered)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Orthotics	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Outpatient hospital services	Covered with prior authorization excluding mental health visits.	Covered with prior authorization	Covered with prior authorization excluding mental health visits. \$5 per visit that is not for preventive care for NJ FamilyCare C.	Covered with prior authorization excluding mental health visits. \$5 per visit that is not for preventive care.
Outpatient surgery, same day surgery, ambulatory surgical center	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Over-the-counter (OTC) drugs Refer to our Drug Formulary	Covered with a prescription	Covered with a prescription	Covered with a prescription	Covered with a prescription
Pain management services	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Pap smears and pelvic exams	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.
Parenting/child birth education	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.	Covered Member may self-refer.

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Personal care (in home) / aide services	Covered with prior authorization with limitations	Covered with prior authorization with limitations	Not covered	Not covered
Podiatry care – medically necessary (office-based, non-surgical)	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization. \$5 per visit	Covered with prior authorization. \$5 per visit.
Podiatry care – routine preventive (office-based, non-surgical)	Not covered	Not covered	Not covered	Not covered
Podiatry care – surgical	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization	Covered with prior authorization
Post-acute care	Covered	Covered	Covered	Covered
Prescription drugs Refer to our Drug Formulary	Covered	Covered	Covered \$1 for generic, \$5 for brand name	Covered \$1 for generic, \$5 for brand name
Preventive health care and counseling and health promotion	Covered	Covered	Covered	Covered
Primary care provider (PCP) visits	Covered	Covered	Covered \$5 co-pay for non-preventive services for NJ FamilyCare C.	Covered \$5 co-pay for non-preventive services. \$10 co-pay for non-office hours and home visits.
Private duty or skilled nursing care	Covered with prior authorization for ages 0-20	Covered with prior authorization for ages 0-20	Covered with prior authorization for ages 0-20	Covered with prior authorization for ages 0-20

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Prostate screening exams	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer	Covered Annual for men 50+ if family history, annual at age 40. Member may self-refer
Prosthetics	Covered with prior authorization			
Radiation/ chemotherapy/ hemodialysis	Covered with prior authorization			
Radiology scans (MRI, MRA, PET)	Covered with prior authorization			
Rehabilitation/ cognitive rehabilitation (Outpatient occupational therapy/ physical therapy/ speech therapy)	Covered	Covered	Covered	Covered
Respite care	Not Covered – Waiver only	Not Covered – Waiver only authorization	Not covered	Not covered
Second medical/ surgical opinions	Covered	Covered	Covered	Covered
Skilled nursing facility care (LTC)	Covered with prior authorization	Covered with prior authorization	Not covered	Not covered
Sleep apnea studies	Covered with prior authorization			

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Sleep therapy	Covered with prior authorization			
Smoking cessation products	Covered	Covered	Covered	Covered
Speech tests	Covered with prior authorization			
Thermograms and thermography	Covered with prior authorization			
Transportation – emergency (air and ground)	Covered	Covered	Covered	Covered
Transportation ambulance, invalid coach (non-emergency)	FFS	FFS	FFS	FFS
Transportation – non-emergency (bus, train, car service, etc.)	FFS	FFS	FFS	FFS
Urgent care	Covered Care required within 24 hours.			
Behavioral Health				
Adult Mental Health Rehabilitation	FFS	Covered with prior authorization	Not covered	Not covered

Benefits	NJ FamilyCare A and ABP	DDD Clients	NJ FamilyCare B and C	NJ FamilyCare D
Atypical antipsychotic drugs within the Specific Therapeutic Drug Classes H7T and H7X	Covered Prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance use disorder conditions each month. Drugs with weekly prescriptions will be counted as one per month.	Covered Prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance use disorder conditions each month. Drugs with weekly prescriptions will be counted as one per month.	Covered Prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance use disorder conditions each month. Drugs with weekly prescriptions will be counted as one per month.	Covered Prior authorization may be required from your provider if you need more than four prescriptions for mental health and/or substance use disorder conditions each month. Drugs with weekly prescriptions will be counted as one per month.
Inpatient psychiatric hospital	Covered with prior authorization	Covered with authorization	Covered with prior authorization	Covered with prior authorization
Inpatient substance use disorder – Acute Hospital (diagnosis, treatment and detoxification)	Covered with prior authorization			
Intermediate Care Facilities/ Intellectual Disability (ICF/ID)	FFS	FFS	Not covered	Not covered
Outpatient Mental Health	FFS	Covered with prior authorization	FFS	FFS \$25 co-pay per visit
Outpatient substance use disorder (diagnosis, treatment and detoxification)	FFS	Covered with prior authorization	FFS	FFS \$5 co-pay per visit

Behavioral health services

Most NJ FamilyCare members can get mental health and substance use disorder services from any Medicaid-approved provider by using their state-issued HBID card. 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 covered service will need to be coordinated between the NJ FamilyCare-approved provider and the Plan. This includes certain drugs that may require your provider to get a prior authorization before the prescription is filled. Your provider must call us for approval before you can get any drugs that need a prior authorization.

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 26. 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 problem, you may contact:

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

If you are a non-DDD member and need access to substance use services, the state uses a dedicated Interim Management Entity (IME). The IME can be reached at **1-844-276-2777**.

If you are a non-DDD member and need to access mental health services you may also contact your local Medical Assistance Customer Center (MACC) from the list below.

Medical Assistance Customer Centers

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

For addiction services and referrals for adults 18 years and older, call the New Jersey Addiction Services Hotline at **1-844-276-2777**.

- If you need to reach an Aetna Better Health of New Jersey care manager at **1-855-232-3596**, (TTY/TDD **711**). See page 52 for information about how our care managers can help you.
- For mental health services for adults 18 years and older, call your PCP or the New Jersey Division of Mental and Addiction Health Services at **1-800-382-6717** (TTY/TDD **1-877-294-4356**) during business hours. For after-hour service, open until 8 pm, call NJ Mental Health Cares toll-free at **1-866-202-4357** (TTY/TDD **1-877-294-4356**).

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. Please call **911** or visit the nearest ER if you have thoughts of hurting yourself or others.

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
- 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
- Services provided in a state inpatient psychiatric facility 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

Premiums for NJ FamilyCare D members and co-payments for NJ FamilyCare C and D members

Premiums for NJ FamilyCare D members

A premium is a monthly payment you pay to get health care coverage. NJ FamilyCare D members, except Alaskan Native and Native American Indians under the age of 19, make these monthly payments.

This payment will go toward your family cost-share that is computed once every 12 months. Your family cost-share is based on your total family income. If you have a monthly payment and do not pay it, you will be disenrolled.

Co-payments for NJ FamilyCare C and D members

A co-payment (or co-pay) is the amount you need to pay for a covered service. NJ FamilyCare C and D members, except Alaskan Native and Native American Indians under the age of 19, have co-pays. The amount of the co-pay is on your ID card.

After you exceed your family cost-share, you will not have to pay a co-pay when you get more services. You will get a new member ID card from us after your family cost-share is met. Remember, your family cost-share with your co-pay should not be more than five percent of your total family income. You should always ask for a receipt when you pay a co-pay. Keep track of what you spend on co-pays as well as your premiums. Once you exceed your five percent cost-share amount, call the HBC at **1-800-701-0710**, TTY **1-800-701-0720**, for help.

NJ FamilyCare C and D co-payments

Service	NJ FamilyCare C and D co-payment
Outpatient hospital clinic visits	\$5 for each visit that is not for preventive services
Emergency room services	\$10 per visit / \$35 "D"
Physician services	\$5 per visit (except for well-child visits, lead screening and treatment, immunizations, prenatal care or pap smears)
Independent clinic services	\$5 per visit except for preventive services
Podiatrists services	\$5 per visit
Optometrist services	\$5 per visit
Chiropractor services	\$5 per visit
Drugs	\$1 for generic drugs, \$5 for brand name drugs
Nurse midwives	\$5 per visit except for prenatal care visits
Dentist	\$5 per visit except for diagnostic and preventive services
Nurse Practitioners	\$5 per visit except for preventive

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. 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. 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.
 - 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 physicians 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 64 for more on member appeals.

Send written appeals to:

Aetna Better Health of New Jersey
Attn: Grievance and Appeals Dept.
3 Independence Way, Suite 400
Princeton, NJ 08540-6626
Call: **1-855-232-3596**
Fax: **1-844-321-9566**

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 26.

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 64.

Aetna Better Health of New Jersey's Dental Home Program

Aetna Better Health now has a program to ensure every child between ages 0 and 20 has a primary care dentist (PCD) and a dental home. 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 an oral exam, dental cleaning, fluoride treatment and all needed x-rays. We also cover any other dental procedures your child needs. Additional preventive dental services are covered for children with special needs. You do not need a referral to see a dentist or a participating dental specialist. If specialty dental care is needed, we cover that too.

For a listing of NJ Smiles providers (for children 0-6 years old), you can search the online provider search linked on our Dental Benefits page at **www.aetnabetterhealth.com/newjersey/members/benefits/dental**.

Aetna Better Health of New Jersey works with DentaQuest to provide our members with dental care. You will get your dental and oral health care from a DentaQuest dentist. You do not need a referral to

see a dentist in the DentaQuest provider network. You may change your dentist or dental group at any time while continuing recommended treatment.

Call DentaQuest at **1-855-225-1727**, TTY **711** Monday through Friday from 8 a.m. to 5 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 and soft tissue in the mouth. These services include cleanings, fillings, root canals, dentures and oral surgery. Medical care usually includes services that are beyond involving only 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. 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 dental provider call DentaQuest at **1-855-225-1727**.

You may need a prior authorization for some dental services and specialty dental care. Your in-network dentist will help you get a prior authorization.

Dental emergencies

If you need emergency dental care, call your dentist. If you do not have a dentist, call DentaQuest at **1-855-225-1727** for assistance in finding a dentist. 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. You do not need a referral or the Plan's prior approval before you get emergency dental care. Call the Plan to let us know you know received emergency dental care. You may also call the 24-hour Nurse Line at **1-855-232-3596** (TTY **711**) if you need help after business hours.

Dental emergencies include:

- A broken natural tooth
- A permanent tooth falls out
- Very bad pain in the gum around a tooth, and you are running a fever
- Oral and/or facial swelling and/or infection
- Acute prolonged facial swelling

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. 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 (unless prescription changes)

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
- 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**.

Pregnancy 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 her unborn child. Talk to your provider to see if you may have been exposed to lead.
- It is important that you do not smoke, drink alcohol, or take illegal drugs because they will harm you and your baby.

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.

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 newborn

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.

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
- Refer to a dentist by age one or when first tooth erupts
- 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

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: <ul style="list-style-type: none"> • MMR • Varicella • HepB • IPV

Age	Immunization
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 of age	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.

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

Children 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 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**.

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 ask for a referral for these programs. 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 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 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

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. Please call **911** or visit the nearest ER if you have thoughts of hurting yourself or others.

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

You still have to pay any Medicare co-pays or deductibles for non-covered benefits, MLTSS cost share and patient liability. This will be arranged directly between the member and the Assisted Living (AL) or Adult Family Care (AFC) AFC facility. The amounts of these Room and Board charges are established by the state. Some members living in these settings may also have to pay a cost share. The amount of the cost share will be calculated by the County Welfare Agency, and is in addition to the Room and Board charges. If you have any questions, please talk to your Care Manager. There is a cost share in nursing homes.

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.

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 be 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** for help.

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
- 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 Member Advisory Committee (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 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 or our network providers, 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 are 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 **1-973-504-6200** 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, call Member Services toll-free at **1-855-232-3596**, TTY **711**. 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 health 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.

You can find out more about the rules on having other health insurance by going online to **www.state.nj.us/humanservices/dmahs/home/Medicaid-TPL-Coverage-Guide.pdf**. This guide, provided by the state of New Jersey, can help you understand how service payments work. If you would like a hard copy of this guide, call Member Services at **1-855-232-3596**, TTY **711**.

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 **www.state.nj.us/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 17 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.

www.nj.gov/humanservices/dmahs/home/Medicaid-TPL-Coverage-Guide.pdf

This chart will help you manage your benefits when you have both Medicare and Medicaid

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. See footnote on page 60.	Member is responsible for payment if properly informed and signed private contract. ² See footnote on page 60.	To avoid being responsible for medical bills, be sure to use providers who participate in Medicare.

If Service Is	Then	Provider Guidance
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.

If Service Is	Then	Provider Guidance
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 or you do not agree with a decision by us.

Some things you may file a grievance 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
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

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) calendar 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)

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. If we deny your request for a service (or request for us to pay for a service), or if we decide to reduce, suspend, or stop an ongoing service or a course of treatment you have been receiving, you can request an appeal. You can request an appeal verbally or in writing. However, if you call, you must follow up by sending us a written, signed appeal request. You have 60 calendar days from your Notice of Adverse Benefit Determination to request an Internal Appeal.

If you disagree with our decision to deny coverage for a service or item that you or your provider asked for, this is an appeal, and it will be automatically transferred to the Utilization Management Appeal process. The received date will be the same.

Continuation of Benefits during an Appeal

If you are appealing our decision to reduce, suspend, or stop an ongoing service or a course of treatment you have been receiving, those services will continue automatically during your appeal as long as the following conditions are met:

- You file your appeal in a timely fashion (within 60 calendar days from the date of the denial);
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- The services in question were ordered by an authorized provider;
- You file your appeal on or before the last day of the original authorized period, or within ten days of the letter notifying you of the plan's decision, whichever is later.

Have someone represent you in an appeal

You can have someone represent you when you file your appeal. This could be 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 an appeal for you. Include your name, member ID number from your ID card, the name of the person you want to represent you and what action you are appealing.

When we get the letter from you, the person you picked can represent you.

Internal Appeal

The Internal Appeal is the first stage of the appeal process. Your appeal will be reviewed by a provider with the same or like specialty as your treating provider. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service. The provider who reviews your appeal will not report to the provider who made the original decision about your case.

We will let you know our decision on your Internal Appeal within thirty (30) calendar days (unless your appeal was for urgent or emergency care, you are in the hospital, or your provider states that waiting up to 30 days for a decision could be harmful to your health, in which case we will make our decision within seventy-two (72) hours). We will send the results to you in writing.

The decision letter will:

- Explain our decision, and the reasoning behind it;
- Tell you about your right to request an External Independent Utilization Review Organization (IURO) Appeal, and how to do so; and
- Tell you about your right to request a State Fair Hearing and how to do so (if you are eligible).

You have the right to 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.

How to file

You can call or write us with your Internal Appeal. However, if you call, you must follow up by sending us a written, signed appeal request. If you ask, we can help you with your appeal.

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
3 Independence Way, Suite 400
Princeton, NJ 08540-6626

We will provide any member a reasonable opportunity to present evidence and testimony and make legal and factual arguments, either in person or in writing. Please inform us as soon as possible by calling **1-855-232-3596** (TTY: **711**) if you wish to present evidence or testimony in person, so that we can make the necessary arrangements. There is a limited amount of time to present additional information in writing or in person before the deadline for the appeal decision.

If you request an appeal, we will automatically provide, free of charge, a copy of your case file, which will include any medical records or other documentation directly related to your denial.

Tell us what happened

If you write to us, include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case and why you are asking for the appeal.

Your timeframes for filing

You or your representative need to file an Internal Appeal within sixty (60) calendar days from the date on our Notice of Adverse Benefit Determination letter.

How to ask for an expedited (quick) decision

If you or your provider feel the usual timeframe for an appeal to be decided (up to 30 calendar days) will harm your health, you can ask us to make an expedited (quick) decision. You or your provider can ask for an expedited decision by calling us. Aetna Better Health of New Jersey will call you with the decision within 72 hours and send you a letter with the decision.

You may also request an expedited decision for the following reasons: situations involving urgent or emergency care, an admission to a hospital, availability of care, continued hospital stay, and health care services for which you have received emergency services but have not yet been discharged from a hospital or other facility.

If it is determined that processing your Internal Appeal in the usual thirty (30) calendar day timeframe will not harm your health, your appeal will be decided within the usual timeframe. We will call you to let you know that your appeal will be processed in the usual timeframe, and we will send you a written acknowledgement letter within two (2) calendar days, stating that your appeal will be reviewed within thirty (30) days .

Next Steps: External (IURO) Appeal

If our decision on your Internal Appeal is not in your favor, you can request an appeal with an Independent Utilization Review Organization (IURO); this independent organization is not connected with our plan. Some services are eligible for Fair Hearing but not for external appeal (see page 67).

The following services are not eligible for an external (IURO) appeal:

- Adult Family Care
- Assisted Living Program
- Assisted Living Services -when the denial is not based on medical necessity
- Caregiver/Participant Training
- Chore Services
- Community Transition Services
- Home Based Supportive Care
- Home Delivered Meals

- PCA (Personal Care Assistant)
- Respite (Daily and Hourly)
- Social Day Care
- Structured Day Program when the denial is not based on Medical Necessity

How to File

The letter we send you explaining the outcome of your Internal Appeal will include a form called the **External Appeal Application**. To request an External (IURO) Appeal, you must fill out this form completely, and send it to the address below:

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

If the External Appeal Application is missing from the appeal adverse outcome letter, you should call the New Jersey Department of Banking and Insurance's toll-free telephone number (**1-888-393-1062**) to request a copy. You can also call that toll-free number with any questions about how to file an external appeal (please keep in mind, however, that you cannot request an External/IURO Appeal by phone).

Your timeframes for filing

You, or your representative, need to file an External Appeal within sixty (60) days from the date on our Internal Appeal Decision Letter.

What happens next?

The Independent Utilization Review Organization (IURO) will review your request. The IURO will send a letter telling you whether or not they have accepted your case for review.

If so, the IURO will make a decision as soon as possible, but not later than forty-five (45) calendar days after receipt of your request for IURO review. If the usual time for an Independent Utilization Review will harm your health, you can ask the IURO to make an expedited decision. The IURO will then make a decision within forty-eight (48) hours. The IURO will call you with their decision; if they cannot reach you, they will send you a letter with their decision within forty-eight (48) hours.

You can find more information at www.nj.gov/dobi/divisioninsurance/managedcare/umappeal.htm.

State Fair Hearing

If you are a NJ FamilyCare member A or a NJ FamilyCare ABP member, you may also ask for a State Fair Hearing. You may ask for a State Fair Hearing only after you have received a decision on your Internal Appeal. You must request a State Fair Hearing in writing within one-hundred-twenty (120) days of the date of the outcome letter from your Internal Appeal.

At the State Fair Hearing, you may represent yourself, or you may legally authorize someone else to represent you. You must ask for a State Fair Hearing in writing by contacting DMAHS at the following address:

State of New Jersey
Division of Medical Assistance and Health Services
Fair Hearing Unit
P.O. Box 712
Trenton, NJ 08625-0712
Or by faxing to **1-609-588-2435**

You can call the following number if you have questions: **1-609-588-2655**.

If your appeal was based on a decision to reduce, suspend, or stop an ongoing service or a course of treatment, and you file for a Medicaid State Fair Hearing, you have the right to request to have your services continue while your appeal is pending. You must ask, *in writing*, for your services to continue:

- Within ten (10) calendar days of the date of the notice of action letter following an adverse determination resulting from an internal appeal (if you choose to request a State Fair Hearing immediately following your Internal Appeal); or
- On or before the final day of the previously approved authorization for the services in question, whichever is later.

If the denial decision is upheld, you may have to pay for the cost of the services you requested to continue when you requested a State Fair Hearing.

OPTIONS: External (IURO) Appeal and State Fair Hearing (if you are a NJ FamilyCare A or ABP member)

Please note that once you have completed the Internal Appeal, you have access to both the External (IURO) Appeal and the State Fair Hearing. You can:

- Request an External (IURO) Appeal, wait until it is completed, and choose to pursue a State Fair Hearing if the outcome was not in your favor;
- Request an External (IURO) Appeal and a State Fair Hearing at the same time; or
- Request a State Fair Hearing without requesting an External (IURO) Appeal.

In order to get continued benefits while awaiting a fair hearing, you must request that your services continue within 10 days of the date of the appeal outcome letter

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**).

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:

- Failure to renew
- Committing fraud
- Regularly refusing to follow your provider's 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**).

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 B, C, D 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, your eligibility will be terminated.

NJ FamilyCare A/ABP/Medicaid Fee-For-Service members

To avoid a gap in your coverage, you must renew with NJ FamilyCare (Medicaid) every year. If you do not, you could lose both your NJ FamilyCare (Medicaid) and your Aetna Better Health of New Jersey coverage. To remain enrolled, respond promptly to XX Continuous enrollment means that if there is no break in your 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. Questions, call the HBC at **1-800-701-0710** (TTY: **1-800-701-0720**) of your local County Welfare Agency.

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 26. 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 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 22 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.

What do we mean when we use the words “health information”?

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

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

How we use and share your health information

Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be 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

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/nj.

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>.

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

Multi-language interpretation services

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

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

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

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).

Gujerati: 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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-385-4104** (رقم هاتف الصم 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).

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
Princeton, NJ 08540-6626

Member Services
1-855-232-3596 (TTY 711)



aetnabetterhealth.com/nj