HELPFUL INFORMATION

Aetna Better Health Member Services
1-866-638-1232 (toll free)

Services for Hearing Impaired (TTY)
Pennsylvania Relay 7-1-1

Physical Address
Aetna Better Health
2000 Market Street, Suite 850
Philadelphia, PA 19103

PA Enrollment Hotline
1-800-440-3989 (toll free)
Monday-Friday 8 a.m. – 6 p.m.
Saturday 8 a.m. – noon
TTY 1-800-618-4225

Compliance (Fraud and Abuse) Hotline
1-800-333-0119 (toll free)

PERSONAL INFORMATION

________________________________________
My Member ID Number

________________________________________
My PCP (Primary Care Practitioner)

________________________________________
My PCP's Phone Number

www.aetnabetterhealth.com/pennsylvania
Aetna Better Health received New Health Plan (NHP) Accreditation from the National Committee for Quality Assurance (NCQA).

The NCQA NHP Accreditation process evaluates how well all parts of a new health plan are managed in order to improve the health care for its members.
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www.aetnabetterhealth.com/pennsylvania
Member Services 1-866-638-1232 • Pennsylvania Relay at 7-1-1
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Welcome to Aetna Better Health

We work with people enrolled in the Commonwealth of Pennsylvania’s Medical Assistance program (Medicaid). We’re a subsidiary of Aetna, which has more than 150 years of experience in meeting members’ health care needs.

At Aetna Better Health, we believe in delivering the best care through a collaborative approach. We start by recognizing that our providers’ knowledge and expertise is essential for improving the effectiveness and efficiency of our programs and services.

We also believe that our members should have the opportunity to be leaders in their care. For those who want it, we use a model of care management that empowers you to decide what your health goals are. We work with you, your providers and caregivers to achieve your goals. This benefit comes at no cost to you.

We encourage taking an active role in your health. Make sure to have a checkup at least once a year starting at age 2 years. Younger children and infants should have at least 6 visits by the time they’re 15 months of age. By visiting your doctor regularly, he or she can detect any problems that may arise early. He or she can provide you the care you need to be as healthy as possible. Eat plenty of fruits and vegetables and get plenty of exercise. Also, if you need help to quit smoking we can help you.

And to further show our commitment to you, we invite the members to provide feedback for improving Aetna Better Health. We do this by asking members to participate in surveys, focus groups or serving on our Health Education Member Advisory Committee. By engaging our members and providers, we can work toward making the Aetna Better Health experience even better.

Welcome packet

You should receive a welcome packet in English and Spanish. This packet has:
• A welcome letter
• Member ID cards for each eligible member in your family (paper cards)
• Aetna Better Health Privacy Notice
• Aetna Better Health benefits and services brochure

Member ID cards

You’ll get an Aetna Better Health ID card when you join our health plan. If you didn’t get your card or if your card was lost or stolen, call Member Services at 1-866-638-1232 or if hearing impaired/TTY user call PA Relay 7-1-1. We’ll send you a new one.

You must have an Aetna Better Health ID card and a Pennsylvania ACCESS card to get health care services. Show both of these cards to your doctors. It tells them that you have benefits under the HealthChoices program. Keep both ID cards with you at all times. And, don’t let anyone else use your ID card.

Remember to show your Aetna Better Health and ACCESS ID cards when you go to the doctor, get prescriptions filled and get other benefits and services. Call Member Services if you have questions about how to use your ID cards.

This is what is on your Aetna Better Health ID card:
• Your name
• Your member ID number
• Your gender
• Your date of birth
• Your primary care provider’s (PCP) name
• Your PCP’s phone number
• Important phone numbers
• Important Information

*If you didn’t pick a PCP after 14 days of joining the plan, we picked one for you. You can call us at 1-866-638-1232 or PA Relay 7-1-1 if you need help choosing another PCP.
Here is a sample of an Aetna Better Health ID card (paper):

**AETNA BETTER HEALTH**

- **HealthChoices**
- **Member ID#** 000000000-00
- **Date of Birth** 00/00/0000
- **Member Name** Last Name, First Name
- **Sex** X
- **PCP** Last Name, First Name
- **PCP Phone** 000-000-0000
- **Effective Date** 00/00/0000
- **RxBin**: 610591
- **RxPCN**: ADV
- **RxGRP**: RX8813
- **Pharmacist Use Only**: 1-855-364-2970
- **www.aetnabetterhealth.com/pennsylvania**

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

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**Member confidentiality and privacy**

You’ll get a copy of the Aetna Better Health Privacy Notice in your Welcome Packet. The notice is also posted on our website. It tells you how we may use your information for health plan activities. It also tells how you can look at your records, get a copy of them or change them. Your health care information will be kept private and confidential. It’ll be given out only if the law allows or if you tell us to give it out.

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**Benefits and services brochure**

This brochure includes information about some of the benefits and services you get as an Aetna Better Health member. It also tells you about our special needs unit (case management) and special programs. You can find a copy of this brochure on our website at www.aetnabetterhealth.com/pennsylvania.

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**Member Handbook**

This member handbook explains your rights and responsibilities as a member and how to get health care services. In this handbook you’ll find:

- How to get health care services
- The role of your PCP
- How to get help with scheduling doctor appointments
- What to do in an emergency or urgent situation
- Services that are covered and not covered
- Complaints, Grievances & Appeals process
- Case Management programs
- Disease Management programs

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**Languages, formats and interpretive services**

You can get your welcome packet, the member handbook, other member materials and a list of providers in other languages or formats at no cost to you. All you have to do is call Member Services at **1-866-638-1232** or PA Relay **7-1-1**. A Member Services representative will process your request. He or she will call you when they send you your requested material. You can request member materials in:

- Any language
- Large print
- Braille
- Audiotape
- Compact disc (CD)
- DVD
- Computer diskette
- Electronic communication

All you have to do is call Member Services at **1-866-638-1232** or if hearing impaired/TTY user call PA Relay **7-1-1**. For more information about PA Relay, visit their website **http://parelay.net**.

You can also call us if you need sign language services or a translator. We’ll connect you with a language line service that can translate in any language. You can use this service when you’re at the doctor’s office. These services are at no cost to you.

We can also provide sign language services at no cost to you.

**Información importante sobre sus beneficios de atención médica. Llame a nuestro Departamento de Servicios al Miembro al **1-866-638-1232**, o si tiene impedimentos auditivos/TTY debe llamar al relé **7-1-1** de PA para obtener una versión traducida de este información.**

**Важная информация о льготах вашей программы здравоохранения. Позвоните в Службу поддержки членов по тел. +**1-866-638-1232**, или по номеру для людей с нарушениями слуха/TTY – PA Relay, **7-1-1**, чтобы получить переведенную версию данной информации.**

**Thông tin quan trọng về phúc lợi y tế của quý vị. Để có bản dịch về thông tin này, xin hãy gọi Ban Dịch vụ Thành viên của chúng tôi ở số **1-866-638-1232**, hoặc PA Relay số **7-1-1** dành cho người khiếm thính/dùng TTY.**
### Member Services

Our Member Services Department is here to help you. You can call us 24 hours a day, 7 days a week at 1-866-638-1232 or PA Relay 7-1-1.

Our staff can help you with questions about your benefits and how you get care. These are some of the questions they can answer:

- What are my rights and responsibilities?
- How can I find a PCP or specialist?
- How do I change my PCP?
- How and where can I get care?
- What are my benefits and health care services?
- What is an Advance Directive?
- How do I file a complaint or grievance?
- How do I get a Department of Public Welfare (DPW) fair hearing?

### Nurse Help Line

Your personal nurse helpline provides help and information 24 hours a day, every day of the year. This service is at no cost to you. Call Member Services at 1-866-638-1232 or TTY 7-1-1 and follow the prompts for the Nurse Help Line. You can call any time you or a member of your family is sick, hurt or needs medical advice. You can also ask questions about your health or medicine.

### Aetna Better Health website

You can find a lot of information on our website. And it’s easy to use. You can access:

- Member handbook, newsletters and other member materials
- Provider Directory to find a PCP or specialist in your area
- A list of participating pharmacies, dentists and eye doctors
- Benefit information
- Information on our case and disease management programs
- Tips on how to better manage your health and wellness
- Recommended screenings for children and adults
- Secure member portal to check member eligibility and benefits, status of a claim, status of prior authorization request and more!

Visit our website at www.aetnabetterhealth.com/pennsylvania.

### Enrollment

#### Choosing a HealthChoices plan

The Department of Public Welfare (DPW) PA Enrollment Services Hotline can give you information about HealthChoices plans offered in your area. This information is also available on the PA Enrollment Services website www.enrollnow.net.

They can help you sign up for a health plan and help you choose a PCP. They also have information on agencies that provide behavioral health services.

You can change your health plan at any time. It may take 2–6 weeks. You may continue to use your current plan until the new plan goes into effect. For help, call the PA Enrollment Specialist at 1-800-440-3989, TTY user 1-800-618-4225.

#### Your Pennsylvania ACCESS card

The DPW will send you a Pennsylvania ACCESS card. You must use this card to access services. Your doctor also uses this card to check your eligibility with the DPW. Use your ACCESS card to get services for:

- Women, Infants and Children (WIC)
- Medical Assistance Transportation Program (MATP)
- Behavioral health treatments (mental health and drug and alcohol services)
Call your case worker at your County Assistance Office if your ACCESS card is lost or stolen. You’ll get a new card. If you don’t know where your County Assistance Office is located, see the Appendix section for the locations and phone numbers.

Here is a sample of an ACCESS card:

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**Member information**
It’s important for us to have your correct information. This way, we can send you important messages. If you change your address, phone number or family size, call your case worker at the county assistance office.

**Losing benefits and services**
There are some ways that you can lose benefits and services or no longer get services from Aetna Better Health. These are some reasons:
- You’re no longer on Medical Assistance (MA).
- Your County Assistance Office tells you that your case is closed. You’ll be re-enrolled with us if your case reopens in less than six months.
- Your benefits change.
- You choose another health plan.
- You move to another county in Pennsylvania. Go to that County Assistance Office to see if you still have MA.
- You move out of Pennsylvania. Find out about MA in your new state.
- You’re in jail or a detention center.
- You commit medical fraud or misconduct and all DPW appeals have been used.
- You’re in a nursing home for more than 30 days.

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**Member rights and responsibilities**
You have rights and responsibilities. If your child is a member, he or she has the rights and responsibilities personally and through his or her parents, caretaker or legal guardian.

**Rights**

*You have the right to:*
- Fair treatment and respect.
- Privacy and to be treated with dignity.
- Covered services. Your race, ethnic group, original country, language, religion, gender identification and age don’t matter. Your mental or physical problems, sexual preference and family medical history don’t matter. Your ability to pay doesn’t matter.
- Good quality medical services that support your personal beliefs, medical condition and background.
- Get information from your provider about appropriate or medically necessary treatment options and alternatives for your condition(s) regardless of cost or benefit coverage in a manner appropriate to your ability to understand.
- Get information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Get information regarding the cost of your care.
- Get language services if you don’t speak English, if you’re deaf or if you have hearing problems. You can get written information in a different format.
Participate with the providers that make decisions about your health care. You can have a friend or family member help you with health care decisions when needed. Your rights include many things:

- Choosing your own participating PCP.
- Knowing about all your treatment choices and risks.
- Knowing if care or treatment is part of a research experiment before you have it.
- Saying no to experimental (unproven) treatments.
- Getting health information from your PCP.
- Getting information about medical procedures and who will do them.
- Choosing who can be with you for treatments and examinations.
- Asking to have a female in the room for breast and pelvic exams.
- Refusing a treatment, including leaving the hospital.
- Asking what happens if you refuse treatment. You don’t have to follow a treatment plan to be eligible for medical care.
- Stopping medications.
- Getting necessary and covered services from an out-of-network provider for as long as Aetna Better Health is unable to provide the service in circumstances where the plan cannot offer a choice of two qualified specialists.
- Getting a second opinion at no cost to you.
- Receiving medical services when admitted to an Emergency Room. Your treatment can’t be delayed because of the insurance you have or your ability to pay.

- Be free from any form of restraint or seclusion as a means of force, discipline, revenge or convenience.

Privacy. Your personal and medical information will only be given out as allowed by law. You have a right to:

- Getting a copy of your medical records.
- Asking for additions or corrections to the records.
- Asking how health care information is used.
- Talking to health care professionals and case managers in private.

Use all your member rights without being treated differently or losing any health care services by Aetna Better Health, its providers, or the Department of Public Welfare.

- Have an Advance Directive (living will and durable power of attorney) and receive notification of any change to an applicable State law as soon as possible, but no later than 90 days after the date it goes into effect. See page 34 for more information on Advance Directives.
- Voice Complaints and Grievances about Aetna Better Health and its services.
- Report concerns to Aetna Better Health about the organization.
- Make recommendations regarding the organization’s member rights and responsibilities policy.

Responsibilities
You have the responsibility to:

- Know the name of your PCP and your case manager if you have one
- Know about your health care and the rules for getting care
- Respect the health care professionals who give you care
- Tell Aetna Better Health about your concerns, questions or problems
- Give your health care providers all the information they need
- Ask for more information if you don’t understand your treatment or health condition
- Contribute to your own health by telling your provider about your health care concerns, needs and goals
- Follow plans and instructions for care that you agreed to with your providers
- Protect your member ID card and show it when you get services
- Tell us about any other insurance you have
- Tell us if you apply for other health care benefits
- Make appointments during office hours
- Be on time for appointments
- Call the provider’s office 24 hours ahead if you need to cancel an appointment
- Bring shots record to all appointments for children under 18 years old
- Other insurance
Third Party Liability (TPL)
You may have Aetna Better Health and other medical insurance. This other insurance may be known as “third party liability” coverage. It’s usually through other insurance companies and your medical treatments may be the result of a personal injury or an automobile accident. In most cases, a third party coverage insurance company will pay your PCP or other health care provider before Aetna Better Health pays.

It’s important that you tell us when you have one of these situations. Here are some examples of TPL:
- An automobile accident
- Court ordered judgments or settlements

Coordination of Benefits (COB)
Coordination of Benefits (COB) happens when a member has insurance coverage through employment or a family member’s employment. Aetna Better Health and the medical insurance companies work together to cover your expenses. Since Aetna Better Health is always the “payer of last resort,” all claims should be billed to the other (primary) insurance company first.

If you have a prescription for medication that’s from a provider who doesn’t participate in the Aetna Better Health provider network, you may be responsible for payment unless:
- Prior Authorization is received prior to filling medication
- Provider is part of your Medicare health plan provider network
- Provider and pharmacy is part of the third party carrier provider network

We’ll process your claims after the primary insurance makes their payment. We’ll make payments up to the Medicaid allowable amount.

Privacy

Authorization for use or disclosure of personal information
You can ask us to use or disclose your personal information by sending us a completed and signed copy of the “Authorization for Use or Disclosure of Personal Information form” located on our website. Call Member Services to request a printed copy.

Fraud and abuse
Sometimes members or providers may do dishonest things when they deal with Aetna Better Health. This is called fraud and abuse.

Provider fraud and abuse includes:
- Billing you for covered services (other than copayments)
- Offering gifts or money for services
- Offering services or supplies to use your ID number
- Giving services you don’t need
- Abuse by medical staff

Member fraud and abuse includes:
- Selling or lending your ID card
- Trying to get drugs or services you don’t need
- Forging or altering prescriptions

There are many ways you can report fraud and abuse. You can:
- Call our hotline at 1-800-333-0119.
- Call the MA Provider Compliance hotline at 1-866-379-8477.
- Complete the form on the Fraud and Abuse page on our website.
- Visit www.dpw.state.pa.us/. Click on Learn About DPW ➔ Fraud and Abuse ➔ MA Provider Compliance Hotline ➔ Response Form.

You can also report recipient fraud and abuse to the Office of Inspector General (OIG) at 1-800-932-0582. Or, go to their website at www.oig.state.pa.us/portal/server.pt/community/report_fraud/3775.

Don’t worry. You don’t have to give your name when reporting fraud and abuse.
Choosing your doctor(s)

The provider directory is a list of doctors and other health care providers, including, but not limited to:
• Primary Care Providers (PCP)
• Specialists
• Pharmacies
• Eye doctors
• Dentists
• Providers of ancillary services

The latest listings are at [www.aetnabetterhealth.com/pennsylvania](http://www.aetnabetterhealth.com/pennsylvania) under “find a provider.” You can also call Member Services and ask for the provider directory in another language or format.

Your Primary Care Practitioner (PCP)

Your PCP manages your health care. Your PCP can:
• Help you get what you need to stay healthy
• Advocate on your behalf in accessing health care services
• Coordinate your care

Regular visits help your PCP:
• Learn your health history
• Keep good health records
• Provide regular care
• Answer questions
• Give advice about healthy eating
• Give shots and screenings
• Get you other types of care
• Refer you to a specialist
• Find problems before they become serious
• Serve as a patient advocate

Choosing Your PCP

Use the provider directory to pick a PCP in our provider network. PCPs include:
• Family Practice - doctors treat adults and children
• General Practice - doctors treat adults and children
• Internal Medicine - doctors treat members older than age 18
• Pediatrician - doctors treat children from birth to age 18

Other health care professionals may assist in providing you with necessary care and treatment.

Some examples include:
• Physician Assistants (PA)
• Certified Nurse Midwives (CNM)
• Certified Registered Nurse Practitioners (CRNP)
• Medical residents

You can also pick a network OB/GYN as your PCP if he or she agrees. Remember to pick the right doctor for your new baby before he or she is born.

Members with special needs can ask for a specialist to be their PCP. The specialist needs to agree to be the PCP and must be in our network.

If you didn’t pick a PCP when you joined the health plan, we’ll remind you after seven days. If you didn’t pick a PCP after 14 days of joining the plan, we’ll pick a PCP for you and let you know who your PCP is. Call Member Services if you need help choosing your PCP.

Changing Your PCP

You can change your PCP at any time. Just call Member Services at 1-866-638-1232 or PA Relay at 7-1-1. You’ll get a new ID card with the new PCP’s name on it once you change your PCP with Member Services.

If we need to change your PCP, we’ll send you a letter notifying you about the change. If you have Medicare coverage, you have the right to seek Medicare-covered services from the Medicare provider of your choice.

Specialists

Your PCP may send you to another doctor if you have special problems. This doctor is called a specialist. Your PCP may set up something called a Standing Referral if you have a serious condition, disease or other special needs. You don’t need a new referral for each visit to the specialist if you have a standing referral. Examples of specialists include:
• Foot doctors
• Eye doctors
• Cancer doctors
• Surgeons
• Heart doctors
Choosing a network specialist

Our provider directory has a list of all types of network providers and their names, addresses, phone numbers, languages spoken, ages served and more. The latest directory is always at [www.aetnabetterhealth.com/pennsylvania](http://www.aetnabetterhealth.com/pennsylvania). Call Member Services if you need help locating a network specialist or if you’d like us to send you a printed copy.

Your PCP can also help you pick a specialist or help you schedule appointments with the specialist.

You can call Member Services and ask to see a provider that’s not in our network if:

- We don’t have a provider in our network to cover your necessary treatment in a timely manner. We’ll cover these services out of network for as long as we’re unable to cover the services in network.
- We only have one of a certain type of network specialist in our network.

The provider that’s not in our network must request a prior authorization. You can file a complaint or grievance if we deny the request for you to see a provider that’s not in our network.

If you also have Medicare coverage, you have the right to seek Medicare-covered services from a Medicare provider of your choice, even if out of network. Medicare coinsurance and deductible will be reimbursed regardless of the participating status.

Getting a second opinion

When a PCP or a specialist says you need surgery or treatment, you have the right to check with another specialist. This is called getting a second opinion. Your PCP will refer you to another network specialist for a second opinion. A second opinion is available at no cost to you, applicable co-pays will apply.

If we’re unable to provide a choice of two qualified specialists within the network, we’ll cover the services from an out-of-network provider. Services may continue until a network provider is available.

An out-of-network provider must request a prior authorization. You can file a complaint or grievance if we deny the request for you to see a specialist for a second opinion.

Appointments

Call Member Services for help scheduling an appointment. It’s important to keep your appointment with your doctor.

You can also call Member Services if you need help with transportation to your appointment. Most members are eligible for the Medical Assistance Transportation Program. If you need a ride to your doctor's appointments you can get one. To get rides to your appointments you have to sign up with the MATP program. Do this by calling the MATP office in your county. There is a list of these offices in Appendix II on page 53. Call Member Services if you need help setting up a ride through MATP.

There are times when PCPs and specialists are supposed to see members.
## Appointment standards

<table>
<thead>
<tr>
<th>PCP appointment times</th>
<th>APPOINTMENT STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency medical condition</td>
<td>You must be immediately seen or referred to an emergency facility.</td>
</tr>
<tr>
<td>Urgent medical condition</td>
<td>You must be seen within 24 hours.</td>
</tr>
<tr>
<td>These may need urgent care:</td>
<td></td>
</tr>
<tr>
<td>• Sore throats</td>
<td></td>
</tr>
<tr>
<td>• Colds</td>
<td></td>
</tr>
<tr>
<td>• Vomiting</td>
<td></td>
</tr>
<tr>
<td>• Rashes</td>
<td></td>
</tr>
<tr>
<td>• Bruises</td>
<td></td>
</tr>
<tr>
<td>• Sprains</td>
<td></td>
</tr>
<tr>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td>• Earaches</td>
<td></td>
</tr>
<tr>
<td>• Stomachaches</td>
<td></td>
</tr>
<tr>
<td>Routine appointment referral</td>
<td></td>
</tr>
<tr>
<td>You must be seen within 10 business days. You shouldn’t have to wait in your doctor’s office for more than 30 minutes. If your doctor has an emergency, you shouldn’t wait more than an hour.</td>
<td></td>
</tr>
<tr>
<td>Checkups or routine exams -</td>
<td></td>
</tr>
<tr>
<td>Call your PCP for a checkup when you sign up for Aetna Better Health.</td>
<td>You must be seen within 3 weeks of enrollment.</td>
</tr>
<tr>
<td>PCP or Specialist care</td>
<td></td>
</tr>
<tr>
<td>You must be seen within 7 days from your effective date of enrollment unless you’re already getting care from your specialist.</td>
<td></td>
</tr>
<tr>
<td>SSI or SSI-related consumer</td>
<td></td>
</tr>
<tr>
<td>PCP or Specialist care</td>
<td>You should be seen within 45 days of joining Aetna Better Health.</td>
</tr>
<tr>
<td>Specialty appointment referrals</td>
<td></td>
</tr>
<tr>
<td>Emergency medical condition</td>
<td>You must be seen immediately upon referral.</td>
</tr>
<tr>
<td>Urgent medical condition</td>
<td>You must be seen within 24 hours of referral.</td>
</tr>
<tr>
<td>These may need urgent care:</td>
<td></td>
</tr>
<tr>
<td>• Sore throats</td>
<td></td>
</tr>
<tr>
<td>• Colds</td>
<td></td>
</tr>
<tr>
<td>• Vomiting</td>
<td></td>
</tr>
<tr>
<td>• Rashes</td>
<td></td>
</tr>
<tr>
<td>• Bruises</td>
<td></td>
</tr>
<tr>
<td>• Sprains</td>
<td></td>
</tr>
<tr>
<td>• Diarrhea</td>
<td></td>
</tr>
<tr>
<td>• Earaches</td>
<td></td>
</tr>
<tr>
<td>• Stomachaches</td>
<td></td>
</tr>
</tbody>
</table>
Routine care - You need routine health care. It helps you stay healthy. Call your PCP for an appointment.

You must be scheduled within 15 business days for the following types of providers:
- Ear, nose and throat doctors (otolaryngology)
- Skin doctors (dermatology)
- Pediatric endocrinology
- Pediatric general surgery
- Pediatric infectious disease
- Pediatric neurology
- Pediatric pulmonology
- Pediatric rheumatology
- Dentist
- Orthopedic surgery
- Pediatric allergy and immunology
- Pediatric gastroenterology
- Pediatric hematology
- Pediatric nephrology
- Pediatric oncology
- Pediatric rehab medicine
- Pediatric urology

You must be seen within 10 business days of referral for all other specialists.

<table>
<thead>
<tr>
<th>EPSDT services</th>
<th>EPSDT screens</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>You must be seen within 45 days from the effective date of enrollment.</td>
</tr>
</tbody>
</table>

**Pregnant women appointment standards**

If you’re pregnant, see your obstetrician (OB) doctor or nurse midwife right away. You should also go if you think you might be pregnant. Early care helps you and your baby.

Keep seeing your OB regularly throughout your pregnancy and after your baby is born. You don’t need a referral from your PCP to see your OB. Your OB must schedule an appointment for you in the following time frames:

<table>
<thead>
<tr>
<th>OB APPOINTMENT STANDARDS</th>
</tr>
</thead>
<tbody>
<tr>
<td>First trimester</td>
</tr>
<tr>
<td>Second trimester</td>
</tr>
<tr>
<td>Third trimester</td>
</tr>
<tr>
<td>High-risk pregnancies</td>
</tr>
</tbody>
</table>
Ask Me 3™

Everyone needs help understanding his or her medical information. Every time you talk to your doctor or pharmacist use the Ask Me 3™ questions listed in this section to better understand your health. Asking these questions will help you stay well or get better. Write down the answers to your questions.

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

Call Member Services if you have questions about the Ask Me 3™ program.

Direct access and self-referral

You have the right to get some services without asking your PCP or getting a prior authorization. This is called direct access.

Members have direct access and can self-refer to Aetna Better Health providers for the following covered services:

- Routine and preventive care
- Women’s health care services including:
  - Gynecological and obstetrical providers
  - Preventive health care
    - Mammograms/breast exams
    - Pap tests
- Vision exams
- Dental services (if eligible)
- First visit with a chiropractor (other visits must be authorized)
- First visit with a physical therapist (other visits must be authorized)
- Emergency Care*
- Routine family planning services*

*You don’t need to see a network provider for self-referrals for family planning and emergency services.

Pre-approval/Prior authorization

Some services need pre-approval or prior authorization before you can get them. This includes all services by providers that aren’t in our network. Your provider can work with us and request a pre-approval or prior authorization. We’ll review the request and determine if the services are medically necessary.

Definition of “Medical Necessity”

A service or benefit is Medically Necessary if it is compensable under the Medical Assistance Program AND if it meets any one of the following standards:

- The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- The service or benefit will assist the member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

Determination of Medical Necessity for covered care and services, whether made on a Prior Authorization, Concurrent Review, Retrospective Review, or exception basis, must be documented in writing.

The determination is based on medical information provided by the Member, the Member’s family/caretaker and the Primary Care Practitioner (PCP), as well as any other Providers, programs, agencies that have evaluated the Member.

All such determinations must be made by qualified and trained Health Care Providers. A Health Care Provider who makes such determinations of Medical Necessity is not considered to be providing a health care service under HealthChoices.

Pre-approval/Prior authorization steps

You can speak to a person 24/7 to ask questions about the pre-approval/prior authorization process. Just call
Member Services at **1-866-638-1232** or PA Relay **7-1-1**. Clinical employees are available during normal business hours or you may leave a message.

An Aetna Better Health employee may call you or return your call to answer your questions about the pre-approval/prior authorization process. If they do, they’ll give you their name and title and tell you that they’re calling from Aetna Better Health.

These are the steps for pre-approval:
- Your provider requests the service. He or she must give us information about the services you need and supporting medical records.
- We review the information.
- An Aetna Better Health doctor will review the request if the request cannot be approved.
- You and your provider will get a letter when a service is denied or approved.
- If the request is denied, a letter will be sent to you and your provider within two business days, unless we need more information. The letter will say why we denied the service. If we deny a service, you or your provider can file a grievance. You can also ask for a DPW Fair Hearing.

We base our decisions only on appropriateness of care and service and existence of coverage. We don’t reward health care providers for denying, limiting or delaying benefits or health care services for our members. We also don’t give incentives to our staff making decisions about medically necessary services or benefits to provide less health care coverage and services.

### Services needing pre-approval/prior authorization

Review the list below or call us to see services that require pre-approval/prior authorization. All services by and visits to out-of-network providers need pre-approval except for family planning and emergency services.

<table>
<thead>
<tr>
<th>SERVICES THAT REQUIRE PRE-APPROVAL/PRIOR AUTHORIZATION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>All inpatient services:</strong></td>
</tr>
<tr>
<td>- Surgical and non-surgical</td>
</tr>
<tr>
<td>- Skilled nursing</td>
</tr>
<tr>
<td>- Rehabilitation</td>
</tr>
<tr>
<td>- Hospice</td>
</tr>
<tr>
<td>These are services where you must spend the night at a hospital or a hospital-like place to get care.</td>
</tr>
<tr>
<td><strong>Outpatient services:</strong></td>
</tr>
<tr>
<td>- Surgical services</td>
</tr>
<tr>
<td>Some surgical services require pre-approval. We can help you or your provider find out if your service must be pre-approved.</td>
</tr>
<tr>
<td>- Home-based services including hospice</td>
</tr>
<tr>
<td>This includes nurses and other people that came to your home to help take care of you or someone in your family.</td>
</tr>
<tr>
<td>- Therapy</td>
</tr>
<tr>
<td>All therapy services require pre-approval (except the first visit for an evaluation).</td>
</tr>
<tr>
<td>- Imaging</td>
</tr>
<tr>
<td>- MRI</td>
</tr>
<tr>
<td>- MRA</td>
</tr>
<tr>
<td>- Angiography</td>
</tr>
<tr>
<td>- PET Scan</td>
</tr>
<tr>
<td>- CT Scan</td>
</tr>
<tr>
<td>These are special types of x-ray tests. You can contact MedSolutions at <strong>1-800-575-4417</strong> for more information about imaging authorizations.</td>
</tr>
<tr>
<td>- Durable Medical Equipment (DME)</td>
</tr>
<tr>
<td>- Hospital beds</td>
</tr>
<tr>
<td>- Wheelchairs</td>
</tr>
<tr>
<td>- Oxygen</td>
</tr>
<tr>
<td>- CPAP</td>
</tr>
<tr>
<td>All other durable medical equipment may need to be pre-approved.</td>
</tr>
<tr>
<td>- Injectables</td>
</tr>
<tr>
<td>Injectable medicines that are given to you by a pharmacist.</td>
</tr>
</tbody>
</table>
## SERVICES THAT REQUIRE PRE-APPROVAL/PRIOR AUTHORIZATION

<table>
<thead>
<tr>
<th>Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthotics/Prosthetics</td>
<td>Implanted devices, electronic devices, implantable breast prosthetics, injectable bulking agents. These are medical tools that help the body work or heal better.</td>
</tr>
<tr>
<td>Transportation</td>
<td>Non-emergent ambulance transportation.</td>
</tr>
<tr>
<td>Other services</td>
<td>Sleep studies, osteopathic manipulation and chiropractic services (except for first evaluation visit), some hearing and vision services depending on the service, specialized multidisciplinary services, external feeding supply and formulas, additives, all pumps, supply based services depending on the service.</td>
</tr>
<tr>
<td>Dental services</td>
<td>The following dental procedures require prior authorization: Crowns, root canals, periodontal services, dentures and partial dentures, oral surgery, anesthesia, orthodontics. You can contact DentaQuest at 1-888-307-6548, TTY 1-800-466-7566 for more information about dental authorization requirements.</td>
</tr>
<tr>
<td>Pain management</td>
<td>Other injections, spinal injections, spinal implants, peripheral nerve procedures.</td>
</tr>
</tbody>
</table>

### How to get guidelines
You or your provider can find clinical practice guidelines on our website at [www.aetnabetterhealth.com/pennsylvania](http://www.aetnabetterhealth.com/pennsylvania). You can also request a copy of the utilization review or clinical practice guidelines that we use for making pre-approval decisions. All you have to do is send a written request to:

Aetna Better Health  
2000 Market Street, Suite 850  
Philadelphia, PA 19103  
Fax number: 1-877-363-8120

### Emergency vs. urgent care

#### What is an emergency?
The definition for emergency medical condition is a “medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part
This means that if you feel like your life is in danger or your health is at serious risk you should get medical help immediately. You don’t need pre-approval for emergency services.

To get treatment in an emergency you can:
- Call 911 for help
- Go to the nearest emergency room
- Call an ambulance to take you to the emergency room

Emergency conditions include:
- Sharp chest pains
- Passing out
- Poisoning
- Medicine or drug overdose
- Bleeding that will not stop
- Severe burns
- Broken bones
- Choking
- Danger of losing limb
- Life threatening condition
- Hard to breathe
- Not able to move
- Seizures

**How to get emergency medical care**

Remember, only use an emergency room when you have an emergency. If you do have an emergency, go to the nearest emergency room. You don’t need pre-approval for emergency ambulance transportation or emergency care in the hospital. The hospital must treat you if you have a medical emergency.

Emergency transportation is covered in emergencies. Call an ambulance or call 911 for help.

Don’t call the Medical Assistance Transportation Program (MATP) for emergency transportation.

Use MATP only when you need a ride to your doctor’s appointments. To get rides to your appointments you have to sign up with the MATP program. Do this by calling the MATP office in your county. There is a list of these offices in Appendix II on page 53.

Once you’re at the hospital, remember that you can say no to treatment. You can also ask for another hospital or refuse to go to another hospital.

Don’t use the emergency room for follow-up care. Instead, call your PCP for follow-up care. Only go back to the emergency room if your PCP tells you to. We may not cover follow-up care in the emergency room. You may get a bill.

**What is urgent care?**

The definition for urgent medical condition is “any illness, injury or severe condition which under reasonable standards of medical practice, would be diagnosed and treated within a twenty-four (24) hour period and if left untreated, could rapidly become a crisis or emergency medical condition.” Call your PCP if you have any of these:
- Sore throats
- Colds
- Vomiting
- Rashes
- Bruises
- Sprains
- Diarrhea
- Ear aches
- Stomach aches (may need urgent care, not usually emergencies)

Your doctor must give you an appointment within 24 hours if you need urgent care. If you cannot be seen by your doctor, go to an urgent care center. You can find a list of centers in your area on our website at www.aetnabetterhealth.com/pennsylvania. Remember, don’t use an emergency room for urgent care.

**After hours care (non-emergency)**

Call your PCP if you don’t need emergency care. Your PCP or an on-call provider is available 24 hours a day, 7 days a week. On call health care professionals such as medical residents, nurse practitioners and physician assistants may assist in providing you with the necessary care and treatment. Your doctor or on call health professional will tell you what to do.

**Out-of-service-area coverage**

There are times when you may be traveling away from home and you need care. Our service area is in certain counties in the State of Pennsylvania. When you’re out of our service area, you’re only covered for emergency services.
Go to the closest emergency room if you’re not in Pennsylvania and you think your life is in danger. Make sure you or someone with you shows them your Aetna Better Health and your Access ID cards. If you receive services in the Emergency Room and you’re admitted to the hospital while you are away from home, have the hospital call us to let us know.

We don’t cover routine care out of the service area or the country. If you’re out of the service area and need health care services, call your PCP and he or she will give you instructions on what to do. You can call us to find out if you are out of the service area.

Your benefits and covered services

Look at the chart below to see some of the covered health care services. This is not a full list. All covered services must be medically necessary.

Also, benefit limits and co-payments may apply to services you get. Benefit limits don’t apply to members under age 21 or members who are pregnant.

Covered benefit categories are:
- E01 - Recipients under 21 years of age (children regardless of their Medical Assistance category)
- E02 - Categorically Needy Recipients age 21 and older Medical Assistance
- E03 - General Assistance Chronically Needy Recipients age 21 and older
- E04 - Medically Needy Recipients age 21 and older (medical only with children)
- E05 - General Assistance Medically Needy ONLY Recipients age 21 and older (medical only, no children)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medical Assistance (E01, E02 &amp; E04)</th>
<th>General Assistance (E03 and E05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortions</td>
<td>Covered under certain circumstances. Call Member Services for more information.</td>
<td>Covered under certain circumstances. Call Member Services for more information.</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Ambulance transportation</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(emergency and medically necessary)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audiology</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>Not covered by Aetna Better Health You can access BH services through:</td>
<td>Not covered by Aetna Better Health You can access BH services through:</td>
</tr>
<tr>
<td></td>
<td>• Behavioral Health Managed Care Organizations</td>
<td>• Behavioral Health Managed Care Organizations</td>
</tr>
<tr>
<td></td>
<td>• Local county services</td>
<td>• Local county services</td>
</tr>
<tr>
<td>Bone mass measurement (bone density)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical Assistance (E01, E02 &amp; E04)</td>
<td>General Assistance (E03 and E05)</td>
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<td>---------------------------------------------</td>
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<td>----------------------------------</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>* Limited to evaluation and spinal</td>
<td></td>
<td>* Limited to evaluation and spinal</td>
</tr>
<tr>
<td>manipulations only</td>
<td></td>
<td>manipulations only</td>
</tr>
<tr>
<td>* The following are excluded:</td>
<td></td>
<td>* The following are excluded:</td>
</tr>
<tr>
<td>(1) Treatment other than manual manipulation</td>
<td></td>
<td>(1) Treatment other than manual</td>
</tr>
<tr>
<td>of the spine to correct a subluxation</td>
<td></td>
<td>manipulation of the spine to</td>
</tr>
<tr>
<td>(2) Physical therapy</td>
<td></td>
<td>correct a subluxation</td>
</tr>
<tr>
<td>(3) Traction procedures</td>
<td></td>
<td>(2) Physical therapy</td>
</tr>
<tr>
<td>(4) Physical examinations</td>
<td></td>
<td>(3) Traction procedures</td>
</tr>
<tr>
<td>(5) Consultations</td>
<td></td>
<td>(4) Physical examinations</td>
</tr>
<tr>
<td>(5) Consultations</td>
<td></td>
<td>(5) Consultations</td>
</tr>
<tr>
<td>Colorectal and prostate screening exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Dialysis</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>EPSDT services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency room care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Family planning services</td>
<td>Covered</td>
<td>Covered depending on medical</td>
</tr>
<tr>
<td></td>
<td></td>
<td>category (call Member Services).</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>HIV/AIDS testing</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Home health care</td>
<td>Covered</td>
<td>Covered Benefit Limit:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Limited to 30 visits/fiscal year</td>
</tr>
<tr>
<td>Hospice care</td>
<td>Covered</td>
<td></td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Inpatient hospitalization (acute care)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Benefit Limit:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Semi-private unless medically</td>
</tr>
<tr>
<td></td>
<td></td>
<td>necessary</td>
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<tr>
<td></td>
<td></td>
<td>* Limited to 1 acute inpatient</td>
</tr>
<tr>
<td></td>
<td></td>
<td>admits per fiscal year</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* Limited to 1 medical rehabilitation admits per fiscal year</td>
</tr>
<tr>
<td>Lab tests &amp; X-Rays</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Mammograms annual woman exam</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Obstetrical / Maternity care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Benefit</td>
<td>Medical Assistance (E01, E02 &amp; E04)</td>
<td>General Assistance (E03 and E05)</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>-------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>Organ transplant and evaluations</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>*Specific organ transplants are covered.</td>
<td></td>
<td>*Specific organ transplants are covered.</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(ambulatory surgical center, independent surgical center, short procedure unit)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain management services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pap smears and pelvic exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Podiatry care (medically necessary)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Primary Care Practitioner (PCP)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>As an extra benefit, we won’t apply the 18 visit benefit limitation to general assistance members</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetics and orthotics</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>*Foot orthotics – Ages &lt;16 limited to 4 pairs every 3 years provided the recipient has not received orthopedic shoes within the 365 days prior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Ages 16&gt; limited to 1 pair every 3 years provided the recipient has not received orthopedic shoes within the 365 days prior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic shoes – *Limited thru age 20 *Limited to 4 pair a year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiation / chemotherapy</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Radiology scans (MRI/MRA/PET)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Rehabilitative services – Outpatient: Physical / Occupational / Speech</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>*For adults 21 years of age and older the MA Program covers PT/OT/ST services when provided in the inpatient or outpatient hospital settings, a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) settings, or as a home health agency service</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### COVERED MEDICAL SERVICES

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Medical Assistance (E01, E02 &amp; E04)</th>
<th>General Assistance (E03 and E05)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td></td>
<td>°Limited to 30 consecutive days after which FFS covers</td>
<td>°Limited to 30 consecutive days after which FFS covers</td>
</tr>
<tr>
<td><strong>Call Member Services if you need help finding your coverage category</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fiscal year runs from July 1 to June 30</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

° Call Member Services if you need help finding your coverage category
°Fiscal year runs from July 1 to June 30

### COVERED VISION SERVICES

<table>
<thead>
<tr>
<th>Benefit</th>
<th>HealthChoices Members Under Age 21</th>
<th>HealthChoices Members Over Age 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision exams</td>
<td>Covered - Two visits per calendar year</td>
<td>Covered - Two visits per calendar year</td>
</tr>
<tr>
<td>Frames</td>
<td>Covered - Two per calendar year (Must be selected from select frame kits)</td>
<td>Covered - One per calendar year (must be selected from select frame kits)</td>
</tr>
<tr>
<td>Lenses</td>
<td>Covered Four lens per calendar year</td>
<td>Covered Two lens per calendar year</td>
</tr>
<tr>
<td>Single vision lens</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Bifocal lenses</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Trifocal lenses</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Polycarbonate lenses</td>
<td>Covered</td>
<td>Non-covered</td>
</tr>
<tr>
<td>Contact lenses</td>
<td>Covered*</td>
<td>Covered*</td>
</tr>
<tr>
<td>Replacements</td>
<td>Covered</td>
<td>Non-covered</td>
</tr>
</tbody>
</table>

* Contact lenses are covered in lieu of frame and lenses when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of:
  - Unilateral Aphakia
  - Keratoconus when vision with glasses is less than 20/40
  - Corneal transplant when vision with glasses is less than 20/40
  - Anisometropia that is greater than or equal to 4.00 diopter

We only pay for services that are our responsibility. Some services require pre-approval/prior authorization by your providers.

If you want counseling or referral services and your provider won’t help you because of an objection on moral or religious grounds, call us. We’ll help you find a provider for the covered services or get a nurse to help you get the right services. We’ll cover all Medically Necessary services for children under 21. You shouldn’t get a bill or have to pay for covered services. Call us if you do.
**Change of benefits**
We’ll notify you in writing prior to making any changes to benefits or services.

**Exclusions and limitations***
*Most exclusions and limitations don’t apply to members under 21 years of age if medically necessary.*

Call us for information about exclusions and limitations at 1-866-638-1232 or PA Relay TTY 7-1-1.

We only pay for covered services. Some services aren’t covered under the Medical Assistance (MA)/HealthChoices program. Services not covered include:
- Teeth braces for members 21 and older
- Cosmetic surgery
- Custodial care (nursing home)
- Experimental procedures or treatment
- Nursing home care for more than 30 days. After 30 days, members are part of the MA Fee-for-Service Program (ACCESS).
- Personal items or services in the hospital (like television or a phone)
- Gender reassignment surgery
- Hysterectomies for sterilization
- Infertility treatment
- Vasectomy and tubal ligation reversal
- Home modifications
- Respite care
- Services not covered by the Pennsylvania MA program
- Non-medical items or services
- Extended home nursing services

- Private duty nursing
- EPSDT home health services (This does not apply to services ordered for members who started these services before their 21st birthday)
- Covered services that aren’t medically necessary

**Your copays**
Some services require a copayment. A copayment is the part of the medical bill that you pay. A copayment is usually only a small amount of the cost of the service. Providers will ask you for the copayment amount when you get services.

The grid below shows you a listing of your copayments as an Aetna Better Health member. You don’t pay copayments if you:
- Are 18 and under
- Pregnant
- Reside in a nursing home

We’ll verify all the claims paid between January and June and between July and December each year to see how much you paid in copayments. If we find that you (not your household) paid more than your maximum in copayments in that six-month period, we’ll send you a refund for the amount over the maximum.

Below is a list of some of the copayments and the maximum you should pay. If you’re in Medical Assistance, look at the MA column. If you’re in General Assistance, look at the GA column.

Call us if you have questions on your copayments.
There are no copayments in certain situations. In some situations you may receive a bill from your provider for the co-pay amount if not paid at time of visit.

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medical Assistance</th>
<th>General Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance – per trip</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Dental care</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Per day</td>
<td>$3</td>
<td>$6</td>
</tr>
<tr>
<td>• Maximum with limits</td>
<td>$21</td>
<td>$42</td>
</tr>
</tbody>
</table>

www.aetnabetterhealth.com/pennsylvania
Member Services 1-866-638-1232 • Pennsylvania Relay at 7-1-1
## Schedule of Copayments by Assistance Category

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medical Assistance</th>
<th>General Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum Co-pay $90</td>
<td>Maximum Co-pay $180</td>
</tr>
<tr>
<td></td>
<td>within a 6 month period</td>
<td>within a 6 month period</td>
</tr>
<tr>
<td><strong>Medical centers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ambulatory Surgical Center</td>
<td>$3</td>
<td>$6</td>
</tr>
<tr>
<td>• Federal Qualified Health Center/Regional Health Center</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Independent medical/surgical center</td>
<td>$3</td>
<td>$6</td>
</tr>
<tr>
<td>• Short procedure unit</td>
<td>$3</td>
<td>$6</td>
</tr>
<tr>
<td><strong>Medical equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Purchase</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Rental</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Medical visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Certified nurse practitioner</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Chiropractor</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Doctor</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Optometrist</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>• Podiatrist</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Outpatient hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Per visit – outpatient surgical, except maternity</td>
<td>$3</td>
<td>$6</td>
</tr>
<tr>
<td>• Per visit – non-surgical or diagnostic</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>$1</td>
<td>$1</td>
</tr>
<tr>
<td>• Brand name</td>
<td>$3</td>
<td>$3</td>
</tr>
<tr>
<td><strong>X-rays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Per visit</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

### If you get a bill or statement

You shouldn’t get a bill from or have to pay a network provider for covered benefits or pre-approved services.

If your provider didn’t receive payment from us on a provided covered benefit or service, he or she is NOT allowed to bill you for what we didn’t pay. This is called balance billing.

Also, you don’t have to pay if we don’t pay a network provider for covered benefits or services.

Finally, you’re not liable to pay for a provided covered benefit or service in the event that we didn’t receive payment from the Department.

If you receive a bill from a network provider, you should call the health care provider listed on the bill and make sure they have all your insurance information. If the provider has your insurance information and you were billed or if you get a bill that you think you should not have gotten, call Member Services.

You may get billed for these services:
- Services by out-of-network providers
- Services without pre-approval or prior authorization
- Services not covered under the HealthChoices benefits programs
- Co-payments that are your responsibility billed by network providers
- Co-payments and deductible amounts over the medical assistance (MA) allowable when you have other insurance

We’re only liable for services that are our responsibility.
Benefit limit exception process
You or your provider can request a benefit limit exception. This means that you want us to approve services above your benefit limits for medical and dental services.

Your doctor or dentist must submit the benefit limit exception request with the following information:
• Your name, address and member ID number
• The service you need
• The reason you need the exception
• The provider’s or dentist’s name and phone number

A benefit limit exception can be granted if:
• You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR
• You have a serious chronic illness or health condition and without the additional service your health would get much worse; OR
• You would need more expensive services if the exception is not granted; OR
• It would be against federal law for Aetna Better Health to deny the exception.

We’ll let you know if we grant the benefit limit exception within the time listed below.
• If you or your provider request an exception before you receive the service, you’ll get a response within 21 days of the date we get the request.
• If you or your provider request a benefit limit exception before you receive the service, and your provider tells us you have an urgent need before the service begins, you’ll get a response within 48 hours of the date and time we get the request.
• If you or your provider request a benefit limit exception after you received the service, you’ll get a response within 30 days of the date that we get the request.

You can file a complaint or grievance or ask for a Fair Hearing with the Department of Public Welfare if we deny your request and aren’t happy with our decision.

For a medical benefit limit exception mail to:
Aetna Better Health
2000 Market Street, Suite 850
Philadelphia, PA 19103

For a dental benefit limit exception mail to:
DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092

Behavioral health services
Everyone receiving Medical Assistance in Pennsylvania can use the Behavioral Health System to get mental health and substance abuse services. We don’t cover behavioral health services. But, you can access behavioral health services—mental health and drug and alcohol services by calling the behavioral health–managed care organization (BH-MCO) in your county. To access these services, call the number listed in Appendix II for the agency in your county.

Call the toll-free number for the agency in your county to make an appointment. They can also help you with transportation to your behavioral health services if needed.

Your PCP can also help you get the behavioral health services you need. Remember to tell your PCP if you or someone in your family has behavioral health problems.

We, along with your PCP and behavioral health provider, will work to coordinate your care and help you to get the benefits you need. Call Member Services if you need help.
Dental services

Members under 21 years of age

Children under the age of 21 are eligible to receive all medically necessary dental services. Your child can go to any dentist that is a part of the DentaQuest network. You can find a dentist in your area by using the online provider directory at www.dentaquest.com or by calling DentaQuest Member Services at 1-888-307-6548 or PA Relay 7-1-1. Your child doesn’t need a referral for a dental visit. Your child’s PCP may refer children age 3 and above to a dental home as part of their regular EPSDT well child screens.

When medically necessary, we cover the following dental services for children under the age of 21:

- Anesthesia
- Orthodontics (braces)*
- Checkups
- Periodontal services
- Cleanings
- Fluoride treatments (topical fluoride varnish can also be done by a PCP or CRNP)
- Root canals
- Crowns
- Sealants
- Dentures
- Dental surgical procedures
- Dental emergencies
- X-rays
- Extractions (tooth removals)
- Fillings

*Note: If braces were put on before the age of 21, we’ll cover services until they’re completed or age 23, whichever comes first. As long as the patient remains eligible for Medical Assistance.

The following dental procedures require prior authorization:

- Crowns
- Root canals
- Periodontal services
- Dentures and partial dentures
- Oral surgery
- Anesthesia
- Orthodontics

Call DentaQuest Member Services at 1-888-307-6548 or PA Relay 7-1-1 for more information on your dental benefits or to locate a network provider. You can also find a list of dental providers on our website. Just click on “find a provider” and then “dental providers.”

Members 21 Years of age and older

Members 21 years of age and older may have limited dental benefits based on selected coverage category.

The following dental services are available to members over age 21:

- Periodic oral evaluations (2 per year)
- Dental cleanings (2 per year)
- Complete set of dentures (one set per lifetime)

A Benefit Limit Exception may be granted for the following services:

- Crowns and related services
- Root canals and other endodontic services
- Periodontal services
- Dentures above one per lifetime
- Additional cleanings and exams above the two-per-year limit

We can grant a benefit limit exception for dental services. Your dentist can ask for a benefit limit exception before the services start or after they’re finished. Your dentist can ask for the exception up to 60 days after your services are finished. Your dentist must send a written request by mail to:

DentaQuest
12121 North Corporate Parkway
Mequon, WI 53092

Read the Benefit Limit Exception section of this handbook on page 23 to learn about more about this process.
Pharmacy services

Prescriptions
If you need medicine, your doctor can choose one from our list of covered drugs (formulary) and write you a prescription.

If the medicine your doctor feels you need isn’t on our formulary and you cannot take any other medication except the one prescribed, your doctor may request an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception. Also, we may cover some over-the-counter (OTC) medicines when requested by your PCP.

Remember to fill all prescriptions at a pharmacy listed on our website. Just click on “find a provider” and then “pharmacy providers.”

Know your prescriptions
Tell your doctors about any medications you get from another doctor. You should also tell them about non-prescription or herbal medications you buy on your own. Ask these questions before you leave the office:
• Why am I taking this medication? What is it supposed to do for me?
• How should the medicine be taken? When? For how many days?
• What are the side effects or allergic reactions of the medicine and what should I do if a side effect happens?
• What will happen if I don’t take this medication?

Carefully read the drug information the pharmacy gives you when you fill your prescription. It explains what you should and shouldn’t do. It also lists the possible side effects.

Refills
The label on your medication bottle tells you how many refills your doctor ordered for you. If your doctor has ordered refills, you may only get one refill at a time. If your doctor didn’t ordered refills, you must call him or her at least five (5) days before your medication runs out. Talk to your doctor about getting a refill. The doctor may want to see you before giving you a refill.

Quick tips about pharmacy services
• Ask your doctor if we cover your prescription before you leave the office.
• Take your prescription to a pharmacy on the Aetna Better Health list to get it filled.
• If your doctor hasn’t ordered refills, call him or her at least five (5) days before you need a refill.
• Some prescriptions require your doctor to get prior approval before you can fill it at your pharmacy. For example, your doctor will need to call us if your medication is not on our formulary.
• We’ll allow the pharmacy to give you a one-time, 72 hour or a 15 day supply every 90 days for each new medicine that requires prior approval.
• Tell your pharmacist to begin the prior approval process with your provider.
• We must make a decision to approve or deny a prescription that requires a prior approval within 24 hours. If we cannot make a decision by the deadline, we’ll allow a 15-day supply for ongoing medication or 72-hour supply for new medication.
• Some medications have limits. This means that you may only get a specific number of pills or dosage within a certain number of days. These limitations are noted on the formulary list next to the medicine.

You can get a list of covered medications by calling Member Services or by visiting our website www.aetnabetterhealth.com/pennsylvania.

Member restriction
Sometimes, we find that some members over-use or abuse drugs or pharmacy services. We check with the Department of Public Welfare’s (DPW) guidelines and report our findings to their Bureau of Program Integrity (BPI).

With BPI approval, we can restrict a member for 5 years to see only their designated provider(s). If this happens, we’ll send the member a letter about the proposed restriction. This restriction stays when the member goes to another health plan.
After 5 years, the member’s services are reviewed again. The review decides if the restriction stays or if it can be removed. Results are sent to these people and places:

- Bureau of Program Integrity (BPI)
- Member
- Provider
- County Assistance Office

Call Member Services if you’d like to request a change to a different provider or pharmacy. It may take us up to 30 days to process your request.

Members may ask for a DPW fair hearing about the restriction program within 30 days of notification of restriction. A written request must be sent to:

Department of Public Welfare
Office of Medical Assistance Programs
Bureau of Program Integrity
Division of Program and Provider Compliance
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Phone number: 717-772-4627

**Vision services**

Vision care is provided by Block Vision. You can access vision care services by scheduling an appointment with an eye doctor in the Block Vision network. Call the Block Vision Care Member Services at 1-800-428-8789 or PA Relay 7-1-1 to help you find a doctor. You don’t need a referral. Just show your Aetna Better Health member ID and Access ID cards.

Here is a list of some vision care services:

You can get two eye checkups a year, unless more are medically necessary. There's no waiting period.

- Members under the age of 21 are eligible for two basic pairs of eyeglasses (frames and lenses) each calendar year. We cover replacement pairs if medically necessary.
- Members under the age of 21 can substitute contact lens pairs for one or both pairs of eyeglasses.
- Members age 21 and over can get one pair of standard eyeglasses or contact lenses per calendar year and are covered for one pair of eyeglass frames up to $20 each calendar year.
- Members age 21 and over with a diagnosis of aphakia (loss of the lens of the eye) can get two pairs of standard eyeglass lenses or contact lenses per calendar year and are covered for two pairs of eyeglass frames up to $20 each per calendar year.

**Tobacco cessation program**

You CAN quit smoking. We’re here to help.

We want to help you whether this is your first try at quitting or even if you’ve tried before. You can become smoke-free.

**Medicines**

We pay for medicines that can help you quit. Here are some of the medicines we cover:

- Zyban (Buproban)
- Bupropion SR
- Chantix®
- Nicorette (OTC nicotine gum)
- Commit (OTC nicotine lozenge)
- OTC and prescription strength Nicoderm (nicotine patch)

Call your doctor for an appointment to get medications to help you stop smoking.

**Counseling services**

We also cover counseling to help you quit smoking. Call us to help you arrange classes or counseling. Or, visit the Pennsylvania Department of Health website at: [www.portal.state.pa.us/portal/server.pt/community/smoke_free/14315/pre-approved_tobacco_cessation_registry/557673](http://www.portal.state.pa.us/portal/server.pt/community/smoke_free/14315/pre-approved_tobacco_cessation_registry/557673)

Counseling services can help with anxiety, depression or mental health while you’re trying to quit. Even if medicine or counseling didn’t work before, that doesn’t mean they’ll never work for you.
The Pennsylvania Department of Health also wants you to succeed. That’s why they created the Pennsylvania Free Quitline. Call the Pennsylvania Free Quitline today if you’re considering quitting smoking:
- **1-877-724-1090** (In-person quit counseling)
- **1-800-QUIT NOW** (Phone-based quit counseling)

Remember: People often try to quit several times before they succeed. Just because you have tried before, doesn’t mean it isn’t time to try again.

### New technology (medical procedures)

We’re always looking at new medical procedures and services to make sure you get safe, up-to-date and high-quality medical care. A team of doctors reviews new health care methods and decides if they should become covered services. Researched and studied investigational services and treatments are not covered services.

To decide if new technology will be a covered benefit or service, we’ll:
- Study the purpose of each technology
- Review medical literature
- Determine the impact of a new technology
- Develop guidelines on how and when to use the technology

### Early Periodic Screening, Diagnosis and Treatment Services (EPSDT)

EPSDT services help children up to 21 years old. We cover medically necessary services for children under 21 even if these services aren’t part of the HealthChoices benefits program.

EPSDT services are at no cost to members. EPSDT standard services include:
- Medical checkups
- Dental checkups
- Visit reminders
- Shots
- Blood and lab tests
- Vision checkups
- Hearing checkups
- Appointments
- Help getting to appointments
- Health education
- Developmental delay and Autism Spectrum screening
- Lead poisoning prevention
- Other services

Well checkups aren’t just for young children. They’re important at every age. Help your child stay healthy by scheduling well checkups for him/her. If you need help or have questions, call Member Services at **1-866-638-1232** or PA Relay **7-1-1** and ask to speak to our EPSDT coordinator. Our EPSDT coordinator knows what services and resources are available to your children.

The list below tells you how many well checkups your child needs each year.

**Medical checkup schedule:**

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of checkups</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-12 months</td>
<td>6 times a year</td>
</tr>
<tr>
<td>15-30 months</td>
<td>4 times a year</td>
</tr>
<tr>
<td>3-21 years</td>
<td>1 time a year</td>
</tr>
</tbody>
</table>
Maternal health care before, during and after pregnancy

If you’re planning a pregnancy, pregnant or just had a baby, you need special care and follow-up care. Call us if you need help finding a doctor, scheduling an appointment or if you have questions about our maternity care program. Your PCP can also help you.

Family planning services

Family planning services are the professional services provided by your PCP or OB/GYN doctor related to family planning. You can access these services by going to any network family planning doctor or clinic. You don’t need a referral. To pick a network doctor or clinic, call us or go to the provider directory on our website.

You can also use an out-of-network family planning doctor or clinic at no cost to you. Just show your Aetna Better Health member ID and Access ID cards.

You can access the following family planning services:
- Family planning exam
- Pap smear
- Gonorrhea and Chlamydia cultures
- Syphilis tests
- Pregnancy tests
- Rubella screen or immunization
- Breast exam
- Mammograms
- Human papilloma virus (HPV) vaccine
- Prescription and (OTC) birth control medication
- Birth control medical visits
- Education and counseling
- PCP in-office visits
- Sterilization, tubal ligation and vasectomy. Members must meet age and consent requirements. Treatment of birth control use problems. This includes emergency services.
- Physical exams and lab tests
- Birth control ordered at a family planning visit
- Get into special programs for pregnant members
- Help with care coordination
- Help you make appointments
- Get WIC program help

Once you’ve chosen a PCP, OB or midwife, schedule your first appointment. Early and regular prenatal care is very important for you and your baby’s health. Your PCP/OB or nurse midwife will tell you about:
- Regular prenatal care and services
- Special classes for moms-to-be
- What to expect during your pregnancy, good nutrition, exercise and other helpful advice
- Family planning services, birth control pills, condoms and getting your tubes tied

If you’re already seeing an out-of-network OB, you can still go to him or her. Tell your doctor that you’re a member and the doctor will need to call us for authorization to treat you.

During your pregnancy

It’s important for you to get care from the same doctor during your pregnancy. This doctor knows your medical history and will help you and your baby stay healthy during your pregnancy.

We also hope you’ll stay with the same health plan during your entire pregnancy. We have specially trained coordinators and nurses who can help you when you’re pregnant. The maternal health and EPSDT coordinators know what services and resources are available to you. They can help you make appointments, work with you to coordinate your care and tell you more about the benefits of being part of our maternity care program. Call Member Services at 1-866-638-1232 or PA Relay TTY 7-1-1 and ask to speak to our maternal health coordinator, our EPSDT coordinator or any of our case managers.

Childbirth classes can help with your pregnancy and delivery. These classes are available at no cost to members. Ask your doctor or nurse midwife about the classes. You can sign up for them at the hospital where your baby will be born.
**Text4baby™**

We want new and pregnant moms to sign up for text4baby. This program can help keep you and your baby healthy. Text4baby sends three text messages to your cell phone each week with expert health tips to help you through your pregnancy and your baby’s first year.

You’ll learn about things like prenatal care, good nutrition, infant care and more. This knowledge can help you give your baby the best possible start in life.

There’s no cost to sign up or to get text4baby messages as long as you have a participating mobile phone carrier. Visit our website at www.aetnabetterhealth.com/pennsylvania to sign up and to learn more about the program. Be a smart mom. Get text4baby!

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**Women, Infants and Children (WIC) Program**

The WIC program gives you:
- Help with breastfeeding questions
- Referrals to agencies
- Healthy food
- Healthy eating tips
- Fresh fruits and vegetables

These services are offered to eligible pregnant women, new mothers and young children at no cost to you.

We can help you get the information you need to sign up for WIC. You can also call directly to see if you and your child are eligible at 1-800-WIC-WINS or 1-800-942-9467.

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**Special needs**

**Early intervention for adults and children**

If you have special needs, we can help. Special needs include but aren't limited to the following:
- Adults or children with an ongoing physical, developmental, emotional or behavioral disabilities or conditions
- Adults and children who are homeless
- Children in substitute care and juvenile probation
- Adults and children with HIV/AIDS
- Adults or children that have a need for language, communication or mobility accommodations
- Adults or children that have a need to be accompanied or assisted while seeking or receiving care by an individual

PA CONNECT is a program that provides early intervention support and services for children who may have developmental delays. This program helps parents obtain the services your child may need. PA CONNECT will work with your doctor to support your child’s growth and development. For more information, call PA CONNECT at 1-800-692-7288.

You can ask for help if you have any special needs. Our Special Needs Unit and Case Managers can help you with your special health care and early intervention needs. We’ll work with providers and others to help you get medically necessary services. Call the Special Needs Unit directly at 1-855-346-9828 to speak to our Special Needs Unit staff.

**Case management**

Some members have special health care needs and medical conditions. Aetna Better Health Case Management includes nurses and social workers who work with many health care providers, agencies and organizations to get the services and the care that you need.

Our Case Management team can help you learn more about your condition. They can help you and your provider make a care plan that’s right for you.

We want to help! Call Member Services and ask to speak to someone on our Case Management team. Because it’s an opt-in program, you can choose to join or leave the program at any time.
Disease management

We offer disease management programs that can help you better manage your health. These programs educate you on your disease and give you tips on how to stay healthy. If you have one of the illnesses listed below, we can help you:

- Asthma
- Congestive Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Diabetes

We’ll give you information to read and the names and phone numbers of resources who can help you manage your illness. We’ll work with your doctor to come up with a care plan just right for you. The care plan will help you meet your goals and manage your illness.

It’s your choice to participate in a disease management program. You can ask to join by calling Member Services. Your PCP, specialist or other health care providers may also suggest that you join the program. Because it’s an opt-in program, you can choose to join or leave the program at any time.

Joining one of our disease management programs is important for your health. You can get information about any of our disease management programs by calling Member Services at **1-866-638-1232** or PA Relay **7-1-1**.
Out-of-plan services

We can help you coordinate services that are covered under different state programs. Here is a list of some out of plan services that we can help you with:

Transitional care homes
We can help your child get medical care after your child comes home from a transitional care home. We’ll:

- Work with your child’s doctors to get your child the right care
- Help find new doctors for care when needed
- Work with other people or agencies that help your child

You must still be living in the HealthChoices Zone to get help from us. Call Member Services for help.

Medical foster care services
Medical foster care services are home care for sick children. These children are in state custody.

We’ll help the child get medically necessary services by working with the providers and Medical Foster Care staff. Call Member Services if you have questions.

Support services for waivers

Support Services Waiver - or simply waiver - is a shortened term for the Medicaid Home and Community Based Waiver Program. Each waiver has its own unique set of eligibility requirements and services. Call us if you have questions about these waivers. Our nurses and social workers can help you.

AIDS waiver:
The AIDS waiver provides home and community-based services to eligible persons age 21 or older who have symptomatic HIV Disease or AIDS.

OBRA waiver:
Provides services to persons with severe developmental physical disabilities, such as cerebral palsy, epilepsy or similar conditions.

Independence waiver:
Provides support and services to persons with physical disabilities to help them to live in the community and remain as independent as possible.

Attendant care waiver:
Helps individuals with physical disabilities perform activities of daily living.

Consolidated waiver:
Provides services to eligible persons with intellectual disability so that they can remain in the community.

COMMCARE waiver:
For individuals who have a diagnosed traumatic brain injury. This is a type of head injury that can happen in a bad car accident or from a bad fall.

Autism waiver:
The Adult Autism waiver is a Medical Assistance program that provides home and community-based services to adults with an autism spectrum disorder. Specifically, it helps these adults participate in their communities in the way they want to.

Aging waiver:
Provides long care services to qualified older Pennsylvanians living in their homes and communities.

Infant, toddlers, and families waiver:
Provides services to children from birth to age three in need of early intervention services who would otherwise require the level of care provided in an Intermediate Care Facility (ICF).

LIFE (Living Independence for the Elderly):
Managed care program for frail, elderly recipients who’ve been determined to need “nursing facility level of care,” but wish to remain in their home and community as long as possible.

Person/Family directed support waiver:
Provides services to eligible persons with mental retardation so that they can remain in the community.
Quality programs

We have quality programs so that you can get the care you need. Some examples of quality programs may include:

- Surveying members and providers to measure satisfaction
- Calling members to remind them to get their care, like taking your child for their checkup
- Educating members by sending postcards or newsletters
- Reviewing the kind, amount and quality of services given to members
- Working with members who have serious health issues through case management
- Giving members information on the website about what health care costs
- Reminding providers and members about preventive health care
- Measuring standards like 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 correct information
- Working with your provider to get them all the information to give you or your child the care you need
- Reviewing calls and complaints from members
- Reviewing all aspects of the health plan with health plan staff, providers and members through committees

This list does not include all the quality programs.

Advance Directives

Your health is important and we hope you’re healthy for a very long time. However, if there ever comes a time where you’re not healthy and unable to make decisions about your care, it’s important to have an Advance Directive. Hospitals may ask if you have an Advance Directive.

Advance Directives are instructions about your medical care. They help doctors know what you want when you can’t say what you want or speak for yourself.

Advance Directives can say who makes medical decisions for you when you cannot. You can select any of the following to represent you:

- Family members
- A doctor
- Friend

Advance Directive information and forms can be found on our website. To make an Advance Directive:

- Sign and date your Advance Directive
- Get two people to witness and sign
- Give your doctor a copy for your medical records
- Keep a copy for yourself

Take a copy with you if you have to go to the hospital or the emergency room.

You can also talk to your provider for help. Call Member Services if your provider won’t carry out your Advance Directive. State law allows participating providers to object to carrying out an advance directive as a matter of conscience. We’ll help you or your representative find a provider that will help to carry out your Advance Directive instructions. You’ll get medical care even if you don’t have an Advance Directive.

You can ask for information about Pennsylvania’s Patient Self Determination Act. This law covers Advance Directives. We’ll also tell you about changes in the state’s law within 90 days of the change. We can also send you our written policies about Advance Directives, including a statement of any limitation we have implementing your Advance Directive as a matter of conscience. Call Member Services at 1-866-638-1232 or PA Relay TTY 7-1-1.

You can file a complaint if your Advance Directive isn’t followed.

There are two kinds of Advance Directives:

- Health Care Power of Attorney
- Living Will
Health Care Power of Attorney
This is a legal document. It says who can make medical decisions for you. It’s used when you cannot speak. This person doesn’t have to be a lawyer.

Living Will
This says what medical care you want. A Living Will works when you can’t speak. It says what care you do or don’t want. Living Wills speak for you when you’re in a coma or dying.

Clinical Sentinel Hotline (CSH)

The Department of Public Welfare (DPW) operates the Clinical Sentinel Hotline (CSH). The CSH makes sure that your Behavioral Health MCO and Aetna Better Health respond timely to your requests for medically necessary care and services. The CSH helps all Medical Assistance consumers who are enrolled in the HealthChoices Program.

The CSH allows you to speak to nurses who work for DPW. If you or your provider request medical care or services, and Aetna Better Health or your Behavioral Health MCO hasn’t responded in time to meet your needs, call the CSH. You can also call the CSH if your Behavioral Health MCO or Aetna Better Health denied you medically necessary care or services and won’t accept your request to file a grievance. You can also call the CSH if you have trouble getting shift home health services that we authorized.

You can call the CSH Monday through Friday between 9 a.m. and 5 p.m. at 1-800-537-8862. The CSH cannot provide or approve urgent or emergency medical care. You should call your PCP or go to your local hospital if you believe you need urgent or emergency care.

Member suggestions for changes in policies and procedures

Your opinion is important to us. If you have ideas about adding or changing a policy or procedure that would be helpful to all of members, call Member Services at 1-866-638-1232 or PA Relay 7-1-1.

Health Education Member Advisory Committee (HEMAC)

We have a committee that includes Aetna Better Health members. The committee is called the Health Education Member Advisory Committee (HEMAC). HEMAC meets at least four times a year to review member materials and discuss new programs. The committee allows you to give your feedback and make suggestions about the health plan, its programs and member materials.

We want you to join our committee. Call Member Services to join or fill out an application on our website at www.aetnabetterhealth.com/pennsylvania. If you don’t have transportation to attend the HEMAC meetings in person, we’ll pay for your public transportation.
APPENDIX I

Complaints, grievances & DPW fair hearings

If a provider or Aetna Better Health does something that you’re unhappy about or don’t agree with, you can tell Aetna Better Health or the Department of Public Welfare what you’re unhappy about or that you disagree with what the provider or Aetna Better Health has done. This section describes what you can do and what will happen.

Complaints

What is a complaint?

A complaint is when you tell us you are unhappy with Aetna Better Health or your provider, or don’t agree with a decision by Aetna Better Health.

Some things you may complain about:
• You’re unhappy with the care you are getting
• You cannot get the service or item you want because it’s not a covered service or item
• You haven’t gotten services that Aetna Better Health approved

What should I do if I have a complaint?

First level complaint

To file a complaint, you can:
• Call Aetna Better Health at 1-866-638-1232 or PA Relay 7-1-1 and tell us your complaint, or
• Write down your complaint and send it to us at:
  Aetna Better Health
  ATTN: Complaints and Grievance Department
  2000 Market Street, Suite 850
  Philadelphia, PA 19103
• Your provider can file a complaint for you if you give the provider your consent in writing to do so.

When should I file a first level complaint?

You must file a complaint within 45 days of getting a letter telling you that:
• Aetna Better Health has decided that you cannot get a service or item you want because it’s not a covered service or item
• Aetna Better Health will not pay a provider for a service or item you got
• Aetna Better Health didn’t decide a complaint or grievance you told us about within 30 days

You must file a complaint within 45 days of the date you should have gotten a service or item if you did not get a service or item. The time by which you should have received a service or item is listed below:
<table>
<thead>
<tr>
<th>New member appointment for your first examination...</th>
<th>We’ll make an appointment for you...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members with HIV/AIDS</td>
<td>with PCP or specialist no later than 7 days after you become a member of Aetna Better Health, unless you’re already being treated by a PCP or specialist.</td>
</tr>
<tr>
<td>Members who receive Supplemental Security Income (SSI)</td>
<td>with PCP or specialist no later than 45 days after you become a member of Aetna Better Health, unless you’re already being treated by a PCP or specialist.</td>
</tr>
<tr>
<td>Members under the age of 21</td>
<td>with PCP for an EPSDT screen no later than 45 days after you become a member of Aetna Better Health, unless you’re already being treated by a PCP or specialist.</td>
</tr>
<tr>
<td>All other members</td>
<td>with PCP no later than 3 weeks after you become a member of Aetna Better Health.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Members who are pregnant:</th>
<th>We’ll make an appointment for you...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant women in their first trimester</td>
<td>with OB/GYN within 10 business days of Aetna Better Health learning you’re pregnant.</td>
</tr>
<tr>
<td>Pregnant women in their second trimester</td>
<td>with OB/GYN provider within 5 business days of Aetna Better Health learning you’re pregnant.</td>
</tr>
<tr>
<td>Pregnant women in third trimester</td>
<td>with OB/GYN provider within 4 business days of Aetna Better Health learning you’re pregnant.</td>
</tr>
<tr>
<td>Pregnant women with high-risk pregnancies</td>
<td>with OB/GYN provider within 24 hours of Aetna Better Health learning you’re pregnant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointment with...</th>
<th>An appointment must be scheduled...</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PCP</strong></td>
<td>Within 24 hours</td>
</tr>
<tr>
<td>- Urgent medical condition</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>- Routine appointment</td>
<td>Within 3 weeks</td>
</tr>
<tr>
<td>- Health assessment/general physical examination</td>
<td></td>
</tr>
<tr>
<td><strong>Specialist (when referred by your PCP)</strong></td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td>- Urgent medical condition</td>
<td></td>
</tr>
</tbody>
</table>
Routine appointment with one of the following specialists:
- Otolaryngology
- Dermatology
- Pediatric endocrinology
- Pediatric general surgery
- Pediatric Infectious disease
- Pediatric neurology
- Pediatric pulmonology
- Pediatric rheumatology
- Dentist
- Orthopedic surgery
- Pediatric allergy & immunology
- Pediatric gastroenterology
- Pediatric hematology
- Pediatric nephrology
- Pediatric oncology
- Pediatric rehab medicine
- Pediatric urology
  
Routine appointment with all other specialists
  
Within 10 business days of referral

You may file **all other complaints at any time**.

**What happens after I file a first level complaint?**

After you file your complaint, you’ll get a letter from Aetna Better Health telling you that we’ve received your complaint and about the first level complaint review process.

You may ask Aetna Better Health to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Aetna Better Health.

You may attend the complaint review if you want to. You may come to our offices or be included by phone or videoconference. It will not affect our decision.

A committee of one or more Aetna Better Health’s staff who hasn’t been involved in the issue you filed your complaint about will review your complaint and make a decision. Your complaint will be decided no later than 30 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

If you need more information about help during complaint process, see page 36.

**What to do to continue getting services**

If you’ve been receiving services or items that are being reduced, changed or stopped and you file a complaint that is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that the services or items you have been receiving are not covered services or items for you, the service or items will continue until a decision is made.
Second level complaint

What if I don’t like Aetna Better Health’s decision?
If you don’t agree with our first level complaint decision, you may file a second level complaint with Aetna Better Health.

When should I file a second level complaint?
You must file your second level complaint within 45 days of the date you receive the first level complaint decision letter. To file a second level complaint, you can:
• Call Aetna Better Health at 1-866-638-1232 or PA Relay 7-1-1 and tell us your second level complaint, or
• Write down your second level complaint and send it to us at:
  Aetna Better Health
  ATTN: Complaints and Grievance Department
  2000 Market Street, Suite 850
  Philadelphia, PA 19103

What happens after I file a second level complaint?
You’ll receive a letter from Aetna Better Health telling you that we’ve received your complaint and telling you about the second level complaint review process.

You may ask Aetna Better Health to see any relevant information we have about your complaint. You may also send information that may help with your complaint to Aetna Better Health.

You may attend the complaint review if you want to. You may come to our offices or be included by phone or by videoconference. If you decide that you don’t want to attend the complaint review, it will not affect our decision.

A committee made up of three or more people, including at least one person who is not an employee of Aetna Better Health who hasn’t been involved in the issue you filed your complaint about, will review your complaint and make a decision. Your complaint will be decided no later than 45 days after we receive your complaint.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

If you need more information about help during complaint process, see page 36.

What to do to continue getting services
If you’ve been receiving services or items that are being reduced, changed or stopped because they’re not covered services or items for you and you file a second level complaint that is hand-delivered or postmarked within 10 days of the date on the first level complaint decision letter, the services or items will continue until a decision is made.
**External complaint review**

**What can I do if I still don’t like Aetna Better Health’s decision?**

If you don’t agree with Aetna Better Health’s second level complaint decision, you may ask for an external review by either the Department of Health or the Insurance Department. The Department of Health handles complaints that involve the way a provider gives care or services. The Insurance Department reviews complaints that involve Aetna Better Health policies and procedures.

You must ask for an external review within 15 days of the date you received the second level complaint decision letter. If you ask, the Department of Health will help you put your complaint in writing.

You must send your request for external review in writing to either:

- Pennsylvania Department of Health
  Bureau of Managed Care Operations
  Health and Welfare Building, Room 912
  625 Forster Street
  Harrisburg, PA 17120-0701
  Telephone: **1-888-466-2787**

  Or
- Pennsylvania Insurance Department
  Bureau of Customer Service
  1209 Strawberry Square
  Harrisburg, Pennsylvania 17120
  Telephone: **1-877-881-6388**

If you send your request for external review to the wrong department, it will be sent to the correct department.

The Department of Health or the Insurance Department will get your file from Aetna Better Health. You may also send them any other information that may help with the external review of your complaint.

You may be represented by an attorney or another person during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

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**What to do to continue getting services**

If you’ve been receiving services or items that are being reduced, changed or stopped because they’re not covered services or items for you and you file a request for an external complaint review that is hand-delivered or postmarked within 10 days of the date on the second level complaint decision letter, the services or items will continue until a decision is made.
Grievances

What is a grievance?
When Aetna Better Health denies, decreases or approves a service or item different than the service or item you requested because it’s not medically necessary, you’ll get a letter (notice) telling you Aetna Better Health’s decision.

A grievance is when you tell us you disagree with Aetna Better Health’s decision.

First level grievance

What should I do if I have a grievance?
To file a grievance, you can:
• Call Aetna Better Health at 1-866-638-1232 or PA Relay 7-1-1 and tell us your grievance, or
• Write down your grievance and send it to us at:

  Aetna Better Health
  ATTN: Complaints and Grievance Department
  2000 Market Street, Suite 850
  Philadelphia, PA 19103

• Your provider can file a grievance for you if you give the provider your consent in writing to do so.

NOTE: If your provider files a grievance for you, you cannot file a separate grievance on your own.

When should I file a first level grievance?
You have 45 days from the date you receive the letter (notice) that tells you about the denial, decrease or approval of a different service or item, to file your grievance.

What happens after I file a first level grievance?
After you file your grievance, you’ll get a letter from Aetna Better Health telling you that we’ve received your grievance and about the first level grievance review process.

You may ask Aetna Better Health to see any relevant information we have about your grievance. You may also send information that may help with your grievance to Aetna Better Health.

You may attend the grievance review if you want to. You may come to our offices or be included by phone or by videoconference. If you decide that you don’t want to attend the grievance review, it won’t affect our decision.

A committee of one or more Aetna Better Health staff, including a licensed doctor who hasn’t been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 30 days after we received your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

If you need more information about help during complaint process, see page 36.
What to do to continue getting services
If you’ve been receiving services or items that are being reduced, changed or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the date on the letter, (notice) telling you that the services or items you have been receiving are not covered services or items for you the services or items will continue until a decision is made.

Second level grievance

What if I don’t like Aetna Better Health’s decision?
If you don’t agree with our first level grievance decision, you may file a second level grievance with Aetna Better Health.

When should I file a second level grievance?
You must file your second level grievance within 45 days of the date you receive the first level grievance decision letter. To file a second level grievance, you can:
• Call Aetna Better Health at 1-866-638-1232 or PA Relay 7-1-1 and tell us your second level grievance, or
• Write down your second level grievance and send it to us at:
  Aetna Better Health
  ATTN: Complaints and Grievance Department
  2000 Market Street, Suite 850
  Philadelphia, PA 19103
• Your provider can file a complaint for you if you give the provider your consent in writing to do so.

What happens after I file a second level grievance?
You’ll receive a letter from Aetna Better Health telling you that we’ve received your grievance and telling you about the second level grievance review process.

You may ask Aetna Better Health to see any relevant information we have about your grievance. You may also send information that may help with your grievance to Aetna Better Health.

You may attend the grievance review if you want to. You may come to our offices or be included by phone or by videoconference. If you decide that you don’t want to attend the grievance review, it will not affect our decision.

A committee of three or more people including a doctor and at least one person who isn’t an employee of Aetna Better Health, who hasn’t been involved in the issue you filed your grievance about, will review your grievance and make a decision. Your grievance will be decided no later than 45 days after we receive your grievance.

A decision letter will be mailed to you within 5 business days after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

If you need more information about help during complaint process, see page 36.

What to do to continue getting services
If you’ve been receiving services or items that are being reduced, changed or stopped, and you file a grievance that is hand-delivered or postmarked within 10 days of the date on the letter, (notice) telling you that the services or items you have been receiving are not covered services or items for you the services or items will continue until a decision is made.
External grievance review

What can I do if I still don’t like Aetna Better Health's decision?
If you don’t agree with Aetna Better Health's second level grievance decision, you may ask for an external grievance review.

You must call or send a letter to Aetna Better Health asking for an external grievance review within 15 days of the date you received our grievance decision letter. To ask for an external grievance review, you can:
• Call Aetna Better Health at 1-866-638-1232 or PA Relay 7-1-1 and tell us your grievance, or
• Write down your second level grievance and send it to us at:
  Aetna Better Health
  ATTN: Complaints and Grievance Department
  2000 Market Street, Suite 850
  Philadelphia, PA 19103

We will then send your request to the Department of Health.

The Department of Health will notify you of the external grievance reviewer’s name, address and phone number. You’ll also be given information about the external grievance review process.

Aetna Better Health will send your grievance file to the reviewer. You may provide additional information that may help with the external review of your grievance to the review within 15 days of filing the request for an external grievance review.

You’ll receive a decision letter within 60 days of the date you asked for an external grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you don’t like the decision.

What to do to continue getting services
If you’ve been receiving services or items that are being reduced, changed or stopped, and you request an external grievance review that is hand-delivered or postmarked within 10 days of the date on the second level grievance decision letter, the services or items will continue until a decision is made.

You may call Aetna Better Health’s toll-free telephone number at 1-866-638-1232 or PA Relay 7-1-1 if you need help or have questions about complaints and grievances. You can also contact your local legal aid office at 1-800-322-7572 (www.palegalaid.net) or the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

If you need more information about help during complaint process, see page 36.
Expedited complaint

The expedited complaint will be decided by a licensed doctor who hasn’t been involved in the issue you filed your complaint about.

Aetna Better Health will call you with a decision within 48 hours of when we receive the letter from your doctor or dentist explaining how the usual timeframe for deciding your complaint will harm your health or within 3 business days of your request for an expedited (faster) complaint review, whichever is sooner. You’ll also receive a letter telling you the reason(s) for the decision and how to file an external complaint if you don’t like the decision. For information on how to file an external complaint see page 45.

Expedited grievance and expedited external grievance

A committee of three or more people, including a licensed doctor and at least one Aetna Better Health member, will review your grievance. The licensed doctor will decide your expedited grievance with help from the other people on the committee. No one on the committee will have been involved in the issue you filed your grievance about.

Aetna Better Health will call you with our decision within 48 hours of when we receive the letter from your doctor or dentist explaining how the usual timeframe for deciding your grievance will harm your health or within 3 business days of your request for an expedited (faster) grievance review, whichever is sooner. You will also receive a letter telling you the reason(s) for the decision and how to file an expedited external grievance if you don’t like the decision.

If you want to ask for an expedited external grievance review by the Department of Health, you must call Aetna Better Health at 1-866-638-1232 or Pennsylvania Relay at 7-1-1 within 2 business days from the date you get the expedited grievance decision letter. Aetna Better Health will send your request to the Department of Health within 24 hours after receiving it.

What kind of help can I have with the complaint or grievance processes?

If you need help filing your complaint or grievance, a staff member of Aetna Better Health will help you. This person can also represent you during the complaint or grievance process. You don’t have to pay for the help of a staff member. This staff member will not have been involved in any decision about your complaint or grievance.

You may also have a family member, friend, lawyer or other person help you file your complaint or grievance. This person can also help you if you decide you want to appear at the complaint or grievance review. For legal assistance you can contact your local legal aid office at 1-800-322-7572, visit (www.palegalaid.net) or call the Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org).

At any time during the complaint or grievance process, you can have someone you know represent you or act on your behalf. If you decide to have someone represent or act for you, tell Aetna Better Health, in writing, the name of that person and how we can reach him or her.

You or the person you choose to represent you may ask Aetna Better Health to see any relevant information we have about your complaint or grievance.

Persons whose primary language is not English

If you ask for language interpreter services, Aetna Better Health will provide the services at no cost to you.

Persons with disabilities
Aetna Better Health will provide persons with disabilities with the following help in presenting complaints or grievances at no cost, if needed. This help includes:

- Providing sign language interpreters
- Providing someone to help copy and present in formation
- Providing information submitted by Aetna Better Health at the complaint or grievance review in an alternative format. The alternative format version will be given to you before the review.

**Note:**
For some issues you can request a fair hearing from the Department of Public Welfare in addition to or instead of filing a complaint or grievance with Aetna Better Health. See below for the reasons you can request a fair hearing.

---

**Department of public welfare (DPW) fair hearings**

In some cases you can ask the DPW to hold a hearing because you’re unhappy about or don’t agree with something Aetna Better Health did or didn’t do. These hearings are called “fair hearings.” You can ask for a fair hearing at the same time you file a complaint or grievance or you can ask for a fair hearing after Aetna Better Health decides your first or second level complaint or grievance.

**What kind of things can I request a fair hearing about and by when do I have to ask for my fair hearing?**

<table>
<thead>
<tr>
<th>If you're unhappy because…</th>
<th>You must ask for a fair hearing…</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aetna Better Health decided to deny a service or item because it isn't a covered service or item</td>
<td>within <strong>30 days</strong> of getting a letter from Aetna Better Health telling you of this decision.</td>
</tr>
<tr>
<td>• Aetna Better Health decided to not pay a provider for a service or item you got and the provider can bill you for the service or item</td>
<td>within <strong>30 days</strong> of getting a letter from Aetna Better Health telling you of this decision.</td>
</tr>
<tr>
<td>• Aetna Better Health didn’t decide within 30 days a complaint or grievance you told Aetna Better Health about before</td>
<td>within <strong>30 days</strong> of getting a letter from Aetna Better Health telling you that we didn’t decide your complaint or grievance within the time we were supposed to.</td>
</tr>
<tr>
<td>• Aetna Better Health decided to deny, decrease or approve a service or item different than the service or item you requested because it wasn’t medically necessary</td>
<td>within <strong>30 days</strong> of getting a letter from Aetna Better Health telling you of this decision or within <strong>30 days</strong> of getting a letter from Aetna Better Health telling you its decisions after you filed a complaint or grievance about this issue.</td>
</tr>
<tr>
<td>• Aetna Better Health didn't provide a service or item by the time you should’ve received it. (The time by which you should have received a service or item is listed on page 48.)</td>
<td>within <strong>30 days</strong> from the date you should have received the service or item.</td>
</tr>
</tbody>
</table>

**How do I ask for a fair hearing?**

You must ask for a fair hearing in writing and send it to:

Department of Public Welfare  
Office of Medical Assistance Programs - HealthChoices Program  
Complaint, Grievance and Fair Hearings  
PO Box 2675  
Harrisburg, PA 17105-2675  

[www.aetnabetterhealth.com/pennsylvania](http://www.aetnabetterhealth.com/pennsylvania)  
Member Services 1-866-638-1232 • Pennsylvania Relay at 7-1-1
Your request for a fair hearing should include the following information:

- Member name
- Member social security number and date of birth
- A telephone number where you can be reached during the day
- If you want to have the fair hearing in person or by telephone
- Any letter you may have received about the issue you are requesting your fair hearing for

**What happens after I ask for a fair hearing?**

You’ll get a letter from the Department of Public Welfare’s Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You’ll receive this letter at least 10 days before the date of the hearing.

You may come to where the fair hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the fair hearing.

Aetna Better Health will also go to your fair hearing to explain why we made the decision or explain what happened.

If you ask, Aetna Better Health must give you (at no cost to you) any records, reports and other information we have that is relevant to what you requested your fair hearing about.

**When will the fair hearing be decided?**

If you ask for a fair hearing after a first level complaint or grievance decision, the fair hearing will be decided no more than 60 days after the Department of Public Welfare gets your request.

If you ask for a fair hearing and did not file a first level complaint or grievance, or if you ask for a fair hearing after a second level complaint or grievance decision, the fair hearing will be decided within 90 days from when the Department of Public Welfare gets your request.

If your fair hearing is not decided within 90 days from the date the Department of Public Welfare receives your request, you may be able to get your services until your fair hearing is decided. You can call the Department of Public Welfare at **1-800-798-2339** to ask for your services.

**What to do to continue getting services:**

If you have been receiving services or items that are being reduced, changed or stopped and your request for a fair hearing is hand-delivered or postmarked within 10 days of the date on the letter (notice) telling you that Aetna Better Health has reduced, changed or denied your services or items or telling you Aetna Better Health decision about your first or second level complaint or grievance, your services or items will continue until a decision is made.
Expediting fair hearing

What can I do if my health is at immediate risk?
If your doctor or dentist believes that using the usual timeframes to decide your fair hearing will harm your health, you or your doctor or dentist can call the Department of Public Welfare at 1-800-798-2339 and ask that your fair hearing be decided faster. This is called an expedited fair hearing. You will need to have a letter from your doctor or dentist faxed to 717-772-6328 explaining why using the usual timeframes to decide your fair hearing will harm your health. If your doctor or dentist does not send a written statement, your doctor or dentist may testify at the fair hearing to explain why using the usual timeframes to decide your fair hearing will harm your health.

The Bureau of Hearings and Appeals will contact you to schedule the expedited fair hearing. The expedited fair hearing will be held by telephone within 3 business days after you ask for the fair hearing.

If your doctor does not send a written statement and does not testify at the fair hearing, the fair hearing decision will not be expedited. Another hearing will be scheduled, and the time frame for the fair hearing decision will be based on the date you asked for the fair hearing.

If your doctor sent a written statement or testifies at the hearing, the decision will be made within 3 business days after you asked for the fair hearing.

You may call Aetna Better Health toll-free number at 1-866-638-1232 or Pennsylvania Relay at 7-1-1 if you need help or have questions about fair hearings, you can contact your local legal aid office at 1-800-322-7572 on line at www.palegalaid.net or call the Pennsylvania Health Law Project at 1-800-274-3258, online at www.phlp.org.
## Appendix II

### Important Phone Numbers

#### County Assistance Offices

There is a County Assistance Office (CAO) in every county in Pennsylvania. Their staff can help you apply for a variety of benefits, including health care, child care and home heating assistance. If you already have benefits, the CAO can tell you if you’re on general or medical assistance, as well as help you complete reapplication forms.

To contact your local CAO find your county in the chart below.

<table>
<thead>
<tr>
<th>County</th>
<th>Local phone number</th>
<th>Toll-free phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>717-334-6241</td>
<td>1-800-638-6816</td>
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<tr>
<td>Allegheny - Headquarters</td>
<td>412-565-2146</td>
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<tr>
<td>Armstrong</td>
<td>724-543-1651</td>
<td>1-800-424-5235</td>
</tr>
<tr>
<td>Beaver</td>
<td>724-773-7300</td>
<td>1-800-653-3129</td>
</tr>
<tr>
<td>Bedford</td>
<td>814-623-6127</td>
<td>1-800-542-8584</td>
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<tr>
<td>Berks</td>
<td>610-736-4211</td>
<td>1-866-215-3912</td>
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<tr>
<td>Blair</td>
<td>814-505-1531</td>
<td>1-866-812-3341</td>
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<tr>
<td>Bradford</td>
<td>570-265-9186</td>
<td>1-800-542-3938</td>
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<tr>
<td>Bucks</td>
<td>215-781-3300</td>
<td>1-800-362-1291</td>
</tr>
<tr>
<td>Butler</td>
<td>724-284-8844</td>
<td>1-866-256-0093</td>
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<tr>
<td>Cambria</td>
<td>814-533-2491</td>
<td>1-877-315-0389</td>
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<td>Cameron</td>
<td>814-486-3757</td>
<td>1-888-855-1824</td>
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<td>Carbon</td>
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<td>1-800-314-0963</td>
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<td>Centre</td>
<td>814-863-6571</td>
<td>1-800-355-6024</td>
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<td>Chester</td>
<td>610-466-1000</td>
<td>1-888-814-4698</td>
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<td>Clarion</td>
<td>814-226-1700</td>
<td>1-800-253-3488</td>
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<td>Clearfield</td>
<td>814-765-7591</td>
<td>1-800-521-9218</td>
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<tr>
<td>Clinton</td>
<td>570-748-2971</td>
<td>1-800-820-4159</td>
</tr>
<tr>
<td>Columbia</td>
<td>570-387-4200</td>
<td>1-877-211-1322</td>
</tr>
<tr>
<td>Crawford</td>
<td>814-333-3400</td>
<td>1-800-527-7861</td>
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<tr>
<td>Cumberland</td>
<td>717-240-2700</td>
<td>1-800-269-0173</td>
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<tr>
<td>Dauphin</td>
<td>717-787-2324</td>
<td>1-800-788-5616</td>
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<td>Delaware – Headquarters</td>
<td>610-447-5500</td>
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<td>Elk</td>
<td>814-776-1101</td>
<td>1-800-847-0257</td>
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<td>Erie</td>
<td>814-461-2000</td>
<td>1-800-635-1014</td>
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<td>Fayette</td>
<td>724-439-7015</td>
<td>1-877-832-7545</td>
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<td>Forest</td>
<td>814-755-3552</td>
<td>1-800-876-0645</td>
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<td>Franklin</td>
<td>717-264-6121</td>
<td>1-877-289-9177</td>
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<td>Greene</td>
<td>724-627-8171</td>
<td>1-888-410-5658</td>
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<td>Huntingdon</td>
<td>814-643-1170</td>
<td>1-800-237-7674</td>
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<td>Indiana</td>
<td>724-357-2900</td>
<td>1-800-742-0679</td>
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<tr>
<td>Jefferson</td>
<td>814-938-2990</td>
<td>1-800-242-8214</td>
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<td>Juniata</td>
<td>717-436-2158</td>
<td>1-800-586-4282</td>
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<tr>
<td>Lackawanna</td>
<td>570-963-4525</td>
<td>1-877-431-1887</td>
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<tr>
<td>Lancaster</td>
<td>717-299-7411</td>
<td>Not available</td>
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<tr>
<td>Lawrence</td>
<td>724-656-3000</td>
<td>1-800-847-4522</td>
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<tr>
<td>Lebanon</td>
<td>717-270-3600</td>
<td>1-800-229-3926</td>
</tr>
<tr>
<td>Lehigh</td>
<td>610-821-6509</td>
<td>1-877-223-5959</td>
</tr>
<tr>
<td>Luzerne – Headquarters</td>
<td>570-826-2100</td>
<td>1-866-220-9320</td>
</tr>
<tr>
<td>Lycoming</td>
<td>570-327-3300</td>
<td>1-877-867-4014</td>
</tr>
<tr>
<td>McKean</td>
<td>814-362-4671</td>
<td>1-800-822-1108</td>
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<tr>
<td>Mercer</td>
<td>724-983-5000</td>
<td>1-800-747-8405</td>
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<tr>
<td>Mifflin</td>
<td>717-248-6746</td>
<td>1-800-382-5253</td>
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<td>Monroe</td>
<td>570-424-3030</td>
<td>1-877-905-1495</td>
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<td>Montgomery</td>
<td>610-270-3500</td>
<td>1-877-398-5571</td>
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<td>Montour</td>
<td>570-275-7430</td>
<td>1-866-596-5944</td>
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<td>Northampton</td>
<td>610-250-1700</td>
<td>1-800-349-5122</td>
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<td>Northumberland</td>
<td>570-988-5900</td>
<td>1-800-368-8390</td>
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<td>Perry</td>
<td>717-582-2127</td>
<td>1-800-991-1929</td>
</tr>
<tr>
<td>Philadelphia – Headquarters</td>
<td>215-560-3283</td>
<td>Not available</td>
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<tr>
<td>Pike</td>
<td>570-296-6114</td>
<td>1-866-267-9181</td>
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<tr>
<td>Potter</td>
<td>814-274-4900</td>
<td>1-800-446-9896</td>
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<tr>
<td>Schuylkill</td>
<td>570-621-3000</td>
<td>1-877-306-5439</td>
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<tr>
<td>Snyder</td>
<td>570-374-8126</td>
<td>1-866-713-8584</td>
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<td>Somerset</td>
<td>814-443-3681</td>
<td>1-800-248-1607</td>
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<td>Sullivan</td>
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<td>Susquehanna</td>
<td>570-278-3891</td>
<td>1-888-753-6328</td>
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<td>570-724-4051</td>
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<td>Union</td>
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<td>Venango</td>
<td>814-437-4342</td>
<td>1-877-409-2421</td>
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<td>Warren</td>
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<td>1-800-403-4043</td>
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<tr>
<td>Washington</td>
<td>724-223-4300</td>
<td>1-800-835-9720</td>
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<tr>
<td>Wayne</td>
<td>570-253-7100</td>
<td>1-877-879-5267</td>
</tr>
<tr>
<td>Westmoreland – Headquarters</td>
<td>724-832-5200</td>
<td>1-800-905-5413</td>
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<tr>
<td>Wyoming</td>
<td>570-836-5171</td>
<td>1-877-699-3312</td>
</tr>
<tr>
<td>York</td>
<td>717-771-1100</td>
<td>1-800-991-0929</td>
</tr>
</tbody>
</table>
Behavioral Health Services

Everyone receiving Medical Assistance in Pennsylvania can use the Behavioral Health System to obtain Mental Health and Substance Abuse services. Aetna Better Health doesn’t cover behavioral health services. But, you can access Behavioral Health Services—Mental Health and Drug and Alcohol services by calling the behavioral health-managed care organization (BH-MCO) in your county. To access Mental Health or Substance Abuse services, call the number listed below for the agency in your county.

<table>
<thead>
<tr>
<th>County</th>
<th>Provider &amp; Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adams</td>
<td>Community Care Behavioral Health 1-866-738-9849</td>
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<tr>
<td>Allegheny</td>
<td>Community Care Behavioral Health 1-800-553-7499</td>
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<tr>
<td>Armstrong</td>
<td>Value Behavioral Health of PA 1-877-688-5969</td>
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<td>Beaver</td>
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<td>Bedford</td>
<td>Community Care Behavioral Health 1-866-773-7891</td>
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<td>Berks</td>
<td>Community Care Behavioral Health 1-866-292-7886</td>
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<td>Blair</td>
<td>Community Care Behavioral Health 1-855-520-9715</td>
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<td>Bradford</td>
<td>Community Care Behavioral Health 1-866-878-6046</td>
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<td>Bucks</td>
<td>Magellan Behavioral Health 1-877-769-9784</td>
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<td>Butler</td>
<td>Value Behavioral Health of PA 1-877-688-5971</td>
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<td>Cambria</td>
<td>Value Behavioral Health of PA 1-866-404-4562</td>
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<td>Clearfield</td>
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<td>Clinton</td>
<td>Community Care Behavioral Health 1-855-520-9787</td>
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<td>County</td>
<td>Provider &amp; Phone Number</td>
</tr>
<tr>
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<tr>
<td>Columbia</td>
<td>Community Care Behavioral Health 1-866-878-6046</td>
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<tr>
<td>Crawford</td>
<td>Value Behavioral Health of PA 1-866-404-4561</td>
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<tr>
<td>Cumberland</td>
<td>PerformCare 1-888-722-8646</td>
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<td>Dauphin</td>
<td>PerformCare 1-888-722-8646</td>
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<td>Delaware</td>
<td>Magellan Behavioral Health 1-888-207-2911</td>
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<td>Elk</td>
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<td>Lehigh</td>
<td>Magellan Behavioral Health 1-866-238-2311</td>
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<td>Luzerne</td>
<td>Community Care Behavioral Health 1-866-668-4696</td>
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<td>County</td>
<td>Provider &amp; Phone Number</td>
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<tr>
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<tr>
<td>Lycoming</td>
<td>Community Care Behavioral Health 1-855-520-9787</td>
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<tr>
<td>McKean</td>
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<td>Value Behavioral Health of PA 1-866-404-4561</td>
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<td>Mifflin</td>
<td>Community Care Behavioral Health 1-866-878-6046</td>
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<tr>
<td>Monroe</td>
<td>Community Care Behavioral Health 1-866-473-5862</td>
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<tr>
<td>Montgomery</td>
<td>Magellan Behavioral Health 1-877-769-9782</td>
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<tr>
<td>Montour</td>
<td>Community Care Behavioral Health 1-866-878-6046</td>
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<tr>
<td>Northampton</td>
<td>Magellan Behavioral Health 1-866-238-2312</td>
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<td>Northumberland</td>
<td>Community Care Behavioral Health 1-866-878-6046</td>
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<tr>
<td>Perry</td>
<td>PerformCare 1-888-722-8646</td>
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<tr>
<td>Philadelphia</td>
<td>Community Behavioral Health 1-888-545-2600</td>
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<td>Pike</td>
<td>Community Care Behavioral Health 1-866-473-5862</td>
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<td>Potter</td>
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<td>Snyder</td>
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<td>Somerset</td>
<td>Community Behavioral Health Network 1-866-773-7891</td>
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<td>Sullivan</td>
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<td>Susquehanna</td>
<td>Community Care Behavioral Health 1-866-668-4696</td>
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<td>Union</td>
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<tr>
<td>Venango</td>
<td>Value Behavioral Health of PA 1-866-404-4561</td>
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</table>
Medical Assistance Transportation Program (MATP)

Most members are eligible for the Medical Assistance Transportation Program. If you need a ride to your doctor’s appointments you can get one. The Department of Public Welfare (DPW) provides this service at no cost to you.

To get rides to your appointments you have to sign up with the MATP program. Do this by calling the MATP office in your county. There is a list of these offices below.

Call Member Services if you need help setting up a ride through MATP. Call 911 if you have an emergency and need an ambulance.

<table>
<thead>
<tr>
<th>County</th>
<th>Provider &amp; Phone Number</th>
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<tbody>
<tr>
<td>Warren</td>
<td>Community Care Behavioral Health 1-866-878-6046</td>
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<td>Washington</td>
<td>Value Behavioral Health of PA 1-877-688-5976</td>
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<td>Wayne</td>
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<td>Westmoreland</td>
<td>Value Behavioral Health of PA 1-877-688-5977</td>
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<td>Wyoming</td>
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<tr>
<td>York</td>
<td>Community Care Behavioral Health 1-866-542-0299</td>
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<tr>
<td>Dauphin</td>
<td>717-232-7009</td>
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<tr>
<td>Delaware</td>
<td>610-490-3960</td>
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<td>Elk</td>
<td>1-866-282-4968</td>
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<td>Erie</td>
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<td>Fayette</td>
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<td>Huntingdon</td>
<td>814-641-6408</td>
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<td>Indiana</td>
<td>724-463-3235</td>
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<td>Jefferson</td>
<td>814-938-3302</td>
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<td>Juniata</td>
<td>717-242-2277</td>
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<tr>
<td>Lackawanna</td>
<td>570-963-6482</td>
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<tr>
<td>Lancaster</td>
<td>717-291-1243</td>
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<tr>
<td>Lawrence</td>
<td>724-652-5588</td>
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<td>Lebanon</td>
<td>717-273-9328</td>
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<tr>
<td>Lehigh</td>
<td>610-253-8333</td>
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<td>Luzerne</td>
<td>570-288-8420</td>
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<td>McKean</td>
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<tr>
<td>Mercer</td>
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<td>Monroe</td>
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<td>Philadelphia</td>
<td>267-515-6400</td>
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<tr>
<td>York</td>
<td>717-846-7433</td>
</tr>
</tbody>
</table>

**MATP does not provide emergency transportation or other transportation needing an ambulance.**

**Vision Services:** Block Vision Care Member Services 1-800-428-8789 or PA Relay 7-1-1

**Dental Services:** DentaQuest Member Services 1-888-307-6548 or PA Relay 7-1-1.