



Welcome

Aetna Better Health[®] of Michigan
2024 Member Handbook

AetnaBetterHealth.com/Michigan



3258944-MI-EN

Aetna Better Health[®] of Michigan

Helpful Information

Our website

AetnaBetterHealth.com/Michigan

Member Services

1-866-316-3784 (TTY: 711)

Emergency

911

Vision (VSP)

1-800-877-7195

Dental

1-844-870-3976

Behavioral Health Services

1-866-827-8704

Personal Information

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My PCP's phone number

My Primary Care provider (PCP)

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Welcome to Aetna Better Health[®] of Michigan

Aetna Better Health has a contract with the Michigan Department of Health and Human Services to provide health care services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about Aetna Better Health. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting Member Services at **1-866-316-3784 (TTY: 711)**. You can also access this handbook on our website at [AetnaBetterHealth.com/Michigan](https://www.aetna.com/betterhealth/michigan). If there are major changes to the handbook, we will send you a letter at least 30 days before the changes are effective to tell you about the changes.

Aetna Better Health complies with applicable federal and state laws including:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91
- The Rehabilitation Act of 1973
- Title IX of the Education Amendments of 1972 (regarding education programs and activities)
- Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call Member Services at **1-866-316-3784 (TTY: 711)** for help getting an interpreter or to ask for our materials in another language or format to meet your needs. Aetna Better Health complies with all applicable federal and state laws with this matter.

¿Habla español? Por favor contacte a al **1-866-316-3784 (TTY: 711)**.

Hearing and Vision Impairment

TTY/TDD services are available free of charge if you have hearing problems. The TTY/TDD line is open 24/7 by calling **TTY: 711**.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call Member Services at **1-866-316-3784 (TTY: 711)** to request materials in a different format to meet your needs.

Aetna Better Health makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency
- Of diverse cultural and ethnic backgrounds
- With a disability
- Regardless of gender, sexual orientation, or gender identity

Important Numbers and Contact Information

Member Services Toll-Free Help Line	1-866-316-3784 - Monday to Friday 8 AM to 5 PM
Member Services Help Line TTY/TDD	711, 24 hours a day/7 days a week
Website	AetnaBetterHealth.com/Michigan
Address	28588 Northwestern Hwy, Ste 380B Southfield, MI 48034
24 Hour Toll-Free Nurse Line	1-844-711-6664 (TTY: 711)
Pharmacy Services	1-866-316-3784 (TTY: 711)
Transportation Services (non-emergency)	1-866-316-3784 Option 6
Dental Services	1-844-870-3976 Monday to Friday 8 AM to 8 PM
Vision Services	1-800-877-7195 Monday to Saturday 9 AM to 8 PM
Mental Health Services	1-866-827-8704 24 Hours a day
To file a complaint about a health care facility	1-866-316-3784 (TTY: 711)

To file a complaint about Medicaid services	1-866-316-3784 (TTY: 711)
To request a Medicaid Fair Hearing	Michigan Office of Administrative Hearings and Rules (MOAHR) for the Department of Health and Human Services P.O. Box 30763 Lansing, MI 48909 For questions, call 1-800-648-3397 Fax: 517-763-0146
Grievance and Appeals	Aetna Better Health of Michigan Attn: Appeals Coordinator PO Box 81139 5801 Postal Rd, Cleveland, OH 44181 Phone: 1-866-316-3784 (TTY: 711) Fax: 1-866-889-7517 Email: MIAppealsandGrievances@Aetna.com
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	For children under the age of 21 1-855-444-3911 Children's Protective Services (https://www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect/childrens) For adults 1-855-444-3911 Adult Protective Services (https://www.michigan.gov/mdhhs/adult-child-serv/abuse-neglect/adult-ps)
To report Medicaid fraud and/or abuse	1-800-447-8477
To find out information about domestic violence	1-866-316-3784 (TTY: 711) Domestic Violence Hotline: 1-800-799-7233 https://www.michigan.gov/mdhhs/safety-injury-prev/domestic-violence
To find information about urgent care	1-866-316-3784 (TTY: 711)
Michigan ENROLLS	1-888-367-6557
Michigan Beneficiary Help Line	1-800-642-3195 or TTY: 866-501-5656
MIChild Program	1-888-988-6300
MDHHS office locations and phone numbers	https://www.michigan.gov/mdhhs/inside-mdhhs/county-offices
Women, Infants and Children (WIC)	1-800-942-1636
Free service to find local resources. Available 24/7	2-1-1

Social Security Administration	1-800-772-1213 (TTY/TDD: 800-325-0778)
In an emergency	9-1-1
Suicide and Crisis Lifeline	9-8-8

Your State Issued Medicaid ID Card

When you have Medicaid, the Michigan Department of Health and Human Services will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit. You may need your mihealth card to get services that Aetna Better Health of Michigan does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.




If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at **1-800-642-3195**. This number is located on the back of your mihealth card.

It is important to keep your contact information up to date so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting www.michigan.gov/mibridges. If you do not have an account, you can create one by selecting "Register". Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.

Your Aetna Better Health of Michigan Member ID Card

You should have received your Aetna Better Health of Michigan ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.

Front Medicaid ID card

Aetna Better Health® of Michigan 

Name
Member ID/State Medicaid ID#
PCP
PCP Phone

.....

Copay: \$0
 RxBIN: 610591 RxPCN: ADV RxGROUP: RX8826 **CVS/caremark**

AetnaBetterHealth.com/Michigan
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MEMIMEDI

Back Medicaid ID card


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

IMPORTANT NUMBERS FOR MEMBERS	
Member Services	1-866-316-3784 (TTY 711)
Behavioral Health Crisis Line	1-866-827-8704
24 Hour Nurse Line	1-866-711-6664 (TTY 711)
Hearing Impaired	TTY 711
Dental	1-844-870-3976
IMPORTANT NUMBERS FOR PROVIDERS	
Pharmacy	1-855-432-6843
Eligibility	1-866-316-3784
Authorization	1-866-874-2567 (24 hours)
Behavioral Health	1-866-827-8704
Dental	1-844-870-3977

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

Submit Claims to PO Box 982963, El Paso, TX 79998-2963
 Payer ID 128MI MIMEDI

Front HealthyMI ID card

Aetna Better Health® of Michigan 

Name
Member ID/State Medicaid ID#
PCP
PCP Phone

.....

RxBIN: 610591 RxPCN: ADV RxGROUP: RX8826 **CVS/caremark**

AetnaBetterHealth.com/Michigan
 THIS CARD IS NOT A GUARANTEE OF ELIGIBILITY, ENROLLMENT OR PAYMENT. MIHEALI

Back HealthyMI ID card

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

IMPORTANT NUMBERS FOR MEMBERS	
Member Services	1-866-316-3784 (TTY 711)
Behavioral Health Crisis Line	1-866-827-8704
24 Hour Nurse Line	1-866-711-6664 (TTY 711)
Hearing Impaired	TTY 711
Dental	1-844-870-3976
IMPORTANT NUMBERS FOR PROVIDERS	
Pharmacy	1-855-432-6843
Eligibility	1-866-316-3784
Authorization	1-866-874-2567 (24 hours)
Behavioral Health	1-866-827-8704
Dental	1-844-870-3977

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

Submit Claims to PO Box 982963, El Paso, TX 79998-2963
 Payer ID 128MI MIHEALI

If you have questions about this coverage or need a new Aetna Better Health of Michigan Member ID card, you should call Member Services at **1-866-316-3784 (TTY: 711)**.

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care.
- Make sure all of your information is correct on both cards
- Call your local MDHHS office to change your records if your name or address changes
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card
- Do not let anyone else use your cards

Getting Help from Member Services

Our Member Services Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

Contact Us

You may call us at **1-866-316-3784** or **(TTY: 711)**, Monday to Friday 8 AM to 5 PM.

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical Emergency Help Line for assistance. Call **1-866-711-6664 (TTY: 711)**.

Our Website

You can visit our website at **[AetnaBetterHealth.com/Michigan](https://www.aetna.com/betterhealth/michigan)** to access online services such as:

- Provider network
- Frequently asked questions
- Contact phone numbers
- Email addresses

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

Confidentiality

Your privacy is important to us. You have rights when it comes to protecting your health information. Aetna Better Health recognizes the trust needed between you, your family, and your providers. Aetna Better Health's staff have been trained in keeping strict member confidentiality.

We respect your privacy. As required by the Health Insurance Portability and Accountability Act (HIPAA), Aetna and each member of the Aetna family of companies (an "Affiliate"), is giving you important information about how your medical and personal information may be used and about how you can access this information. Please review the following Notice of Privacy Practices carefully.

Manage Your Digital Health Records/Member Mobile Application

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

Through the mobile app you have access to:

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

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

Transition of Care

If you're new to Aetna Better Health, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through the pregnancy and post-partum period.

If you are an Aetna Better Health member and your doctor no longer participates with us, you can continue to see your doctor if you are receiving treatment for certain chronic diseases.

We will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition
- The doctor has a restriction, and you might be at risk
- The doctor is not willing to continue your care
- Care with the non-participating doctor was started after you enrolled in Aetna Better Health
- The doctor does not meet Aetna Better Health policies or criteria Aetna Better Health will help you choose new doctors and help you get services in our network. Your doctor may call Provider Services if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services.

Please contact us at **1-866-316-3784 (TTY: 711)** Monday to Friday 8 AM to 5 PM to request transition of care services or if you have any questions about your care.

Choosing A Primary Care Provider

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the health care provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member, or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor
- Family practice doctor
- Nurse Practitioner
- Internal medicine doctor
- Pediatrician doctor
- OB/GYN doctor

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists name, addresses, telephone number, office hours, languages spoken, specialty, and information about accessibility. It is located at:

[AetnaBetterHealth.com/Michigan/providers](https://www.aetna.com/betterhealth/michigan/providers). You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling Member Services at **1-866-316-3784 (TTY: 711)**. Remember provider information changes often. Visit our website for the most up-to-date information. Call Member Services if you need help finding a doctor.

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

If you have certain health care needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Member Services at **1-866-316-3784 (TTY: 711)** for more information.

Make sure you ask the provider office if they participate in the Aetna Better Health network.

Getting Care from Your Doctor

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at **1-866-316-3784 (TTY: 711)**.

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

Getting Care from a Specialist

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your doctor or call Member Services for more information. If you have special health care needs, you may not be required to obtain a referral or prior authorization as a condition to receive certain services from specialists in the network. Contact Member Services or your Care Manager for more information.

Out-of-Network Services

You must get most of your care from providers in our provider network. Aetna Better Health Member Services can help you find a provider in our network.

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure

that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

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

Out of State Services

All services out of the state require prior authorization.

Out of Country Services

Health care services provided outside the country are not covered by Aetna Better Health.

Physician Incentive Disclosure

Aetna has pay for quality incentive programs in place to improve health outcomes. For a copy of the Aetna Better Health Pay for Quality program contact Member Services at **1-866-316-2784** or a copy of the program can be found at:

[AetnaBetterHealth.com/content/dam/aetna/medicaid/michigan/provider/pdf/abhmi_2023_mi_p4q_incentive_program.pdf](https://www.aetnabetterhealth.com/content/dam/aetna/medicaid/michigan/provider/pdf/abhmi_2023_mi_p4q_incentive_program.pdf).

Prior Authorization

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve the service, we will notify the doctor and send you a written notice of the decision.

Aetna Better Health does not prevent our providers from:

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

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

Our utilization management (UM) program ensures you get the right care in the right setting when you need it. UM staff can help you and your doctors make decisions about your healthcare. Our UM program helps make sure you get the right services at the right place.

When we make decisions, it's important for you to remember the following:

- We make UM decisions by looking at your benefits and clinical guidelines for the most appropriate care and service. We consider your needs, evidenced based practice, and availability of care. You also must have active coverage.
- We don't reward doctors or other people for denying coverage or care.
- Our employees do not get any incentives to reduce the services you get.

If you have questions about UM, you can speak to someone by calling Member Services toll-free at **1-866-316-3784 (TTY: 711)**, 24 hours a day, 7 days a week. If you need Language translation or assistance, you can contact Member Services toll-free at **1-866-316-3784 (TTY: 711)**.

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from an Aetna Better Health network provider. Second opinions do not require prior authorization from us. Please call Member Services to learn how to get a second opinion. Aetna Better Health will help you obtain a second opinion from an out-of-network provider at no additional cost if an appropriate in-network provider is not available.

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a Aetna Better Health of Michigan member you do not have to pay co-pays for covered services under the Medicaid or Healthy Michigan Plan. See Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of

Coverage (COC) has the complete list of covered care. The Certificate of Coverage is included at the end of this Member Handbook. Also the COC and Member Handbook are also on our website at [AetnaBetterHealth.com/Michigan](https://www.aetna.com/betterhealth/michigan).

Make sure a service is covered before the service is done. You may have to pay for services not covered by Aetna Better Health under the Medicaid program.

Aetna Better Health does not deny reimbursement or coverage for services on any moral or religious grounds.

Telehealth/Telemedicine services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, and much more, you can connect with a doctor through your phone or computer to receive care where you are, when you need it. Doctors can diagnose, treat, and even prescribe medicine, if needed. Call your doctor's office to see if they offer telehealth services or contact Aetna Member Services for more information.

Covered services include:

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

Medically needed services include:

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

Medically needed services must:

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

Covered services

- Continuous glucose monitors for some individuals with Type 1 diabetes*
- Dental services are covered for adults age 21 and over
- Dental services are covered for Healthy Michigan members ages 19 and over
- Doula services
- Immunizations (shots)*.
- Inpatient and outpatient hospital services (including consultations)
- Intermittent or short-term restorative or rehabilitative services (in nursing facility), up to the first 45 days per year
- Maternity and newborn care
- Maternal infant health program
- Mental/behavioral healthcare (outpatient)
- Oral surgery
- Orthognathic surgery
- Out-of-state services authorized by the Plan
- Outpatient prescription drugs
- Over-the-counter drugs and supplies
- Pain management services
- Parenting and birthing classes
- Pharmacy services
- Podiatry services
- Prosthetics and orthotics/support devices
- Radiology examinations and laboratory procedures
- Reconstructive surgery
- Short-term rehabilitative therapy
- Skilled nursing facility
- Telehealth visits
- Temporomandibular joint syndrome (TMJS)
- Therapeutic services (speech, physical, occupational)
- Tobacco cessation including pharmaceutical and behavioral support
- Transplant services
- Transportation for medically needed covered services
- Treatment for sexually transmitted diseases (STD)*
- Vision services
- Weight loss services

**No prior authorization required.*

Prescription services

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

Member Services **1-866-316-3784 (TTY: 711)** | [AetnaBetterHealth.com/Michigan](https://www.aetnabetterhealth.com/michigan)

Aetna Better Health uses the MDHSS Preferred Drug List (PDL) and Common Formulary, which means that only drugs listed on the PDL or Common Formulary are covered (except with prior approval in special circumstances). For updates to our formulary please visit our website at [AetnaBetterHealth.com/Michigan](https://www.aetnabetterhealth.com/michigan). If you would like more information on the formulary or drugs that require our prior approval, Member Services can help. Just call **1-866-316-3784 (TTY: 711)**.

If you need a prescription filled, present your Aetna Better Health ID card with the prescription at any participating pharmacy. You will need to use your MIHEALTH card for certain drugs covered by the state. For example, anti-psychotic and HIV/AIDS drugs are covered by the state.

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with DentaQuest to provide your dental benefits. If you have any questions about your dental services, please contact DentaQuest at **1-844-870-3976 (TTY: 711)**.

Covered dental services include:

Aetna Better Health covers adult dental services including but not limited to:

- Preventive dental services
- Routine cleanings
- X-Rays
- Extractions
- Fillings
- Crowns
- Root Canals
- Dentures

For more information on dental services and prior approval requirements, call Aetna Member Services.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at **1-800-642-3195** for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: **1-800-936-0935**

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (deltadentalmi.com)
Phone: **1-866-696-7441**

Transportation Services

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services covered by your Medicaid health plan, and other covered services. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call Aetna Member Services **1-866-316-3784 (TTY: 711)** for more information and to schedule a ride. Please call 3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

- Your name, Medicaid ID number and date of birth
- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodation's, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.

Please be sure to call us as soon as possible if you need to cancel.

Emergency

If you need emergency transportation, call **911**.

Vision Services

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 24 months
- One pair of glasses every 24 months
- Eye glass frames
- Contact lenses

You do not need a referral to get eye care. If you need glasses or an eye exam, call Aetna's vision vendor, VSP at **1-877-666-2188**. You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Hearing Services

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams
- Medically necessary hearing aid evaluations and fittings
- Medically necessary hearing aids
- Hearing aids repairs
- Maintenance and replacement of batteries for hearing aids

If you need a hearing exam or think you need hearing aids, call Aetna Member Services **1-866-316-3784 (TTY: 711)**. You can also call a provider from our list of hearing providers.

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network and some out-of-network providers such as public health departments and federally qualified health clinics. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:

Family Planning	Prenatal and postpartum care
Pregnancy testing	Midwife services in a health care setting
Birth control and birth control counseling	Delivery care
HIV/AIDS testing and treatment of sexually transmitted diseases	Parenting and birthing classes
Pregnancy and maternity care, including the Maternal Infant Health Program	Mammograms and breast cancer services, such as treatment and reconstruction
Doula Services	Pap tests
Depression Screening	

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Aetna Member Services as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
(It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Aetna Member Services and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

Prenatal care and postpartum care are important for a healthy baby and mom. Aetna Better Health of Michigan offers prenatal and post-partum programs to help pregnant members have a healthy pregnancy and baby. It's important for you to visit your OB/GYN doctor as soon as you know that you are pregnant. Your doctor may have you come in for six or more visits during your pregnancy. Try to ensure that you make all of your visits.

Our outreach staff can help you make prenatal and postpartum appointments. If you are high-risk you may want to talk to our High-Risk OB care coordinator. If you want to learn more, call our Aetna Quality Improvement and Outreach Department (Member Outreach) at **1-855-737-0770 (TTY: 711)**. If you are pregnant, early and regular checkups can help protect you and your baby's health. Aetna Better Health of Michigan wants to make sure that you and your baby get the services you need. These services include:

- Routine pregnancy medical checkups
- Dental services
- Information about your hospital choices
- Information about pregnancy, labor and delivery
- HIV counseling and testing
- STI counseling, screening and support
- Support with accessing healthy food from GA Foods
- Help in applying for programs such as the Women, Infants and Children (WIC) program, low-or no-cost health insurance for your family
- Referrals for MIHP services
- Services after delivery
- Healthcare for your baby
- Family planning services
- Network Doula's and Midwives

Aetna Member Outreach can help make sure you and your baby receive the important health care you need while you are pregnant. If you are pregnant, call us at **1-855-737-0770 (TTY: 711)**. Also, to learn more about Maternal Infant Health Programs (MIHP) in your area you can visit www.michigan.gov/mihp, or contact us at **1-855-737-0770 (TTY:711)** or email the MIHP services at MIHP@michigan.gov

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know.

Call your local MDHHS office so your records can be updated. Also call Aetna Member Services to report the change. This starts the process of signing your baby up for health care services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Aetna Member Services if you need help.

Change in Family Size

When you experience a change in family size, contact Aetna Member Services to let us know and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

Prenatal teaching

- Childbirth education classes
- Nutritional support, education, and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking
- Help with substance abuse
- Personal care or home help services

Call Aetna Member Services for more information on how you can access these services.

Children’s Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child’s health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight and BMI checked. Providers can talk about health, safety and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development.

EPSDT checkups include:

Well-care visits	Physical and mental developmental/behavioral assessments
Health history and physical exam, including school and sports physicals	Crucial lab tests, including lead screening
Developmental screening	Nutrition assessment
Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children’s Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children’s Special Health Care Services (CSHCS).

CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from Aetna Better Health.

There is no cost for this program. It doesn’t change your child’s Aetna Better Health benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies.

MDHHS Family Center for Children and Youth with Special Health Care Needs:

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at **1-800-359-3722** from 8 AM to 5 PM Monday through Friday.

Local County Health Department:

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines and more. For help finding your local county health department, visit your county’s website or **Michigan.gov**. Call Member Services for assistance. Your local health department can also assist you by:

Finding Resources:

Community resources, schools, community mental health, respite care, financial support, childcare, Early On and the Women, Infants and Children (WIC) program.

Children's Special Needs Fund:

The Children's Special Needs fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts and mobility equipment. To see if you qualify for help from this fund call **517-241-7420**. The CSN Fund helps CSHCS families get items not covered by Medicaid or CSHCS.

To see if you qualify for help from the CSN Fund, call **517-241-7420**. Examples of help include:

- Wheelchair ramps
- Van lifts and tiedowns
- Therapeutic tricycles
- Air conditioners
- Adaptive recreational equipment
- Electrical surge upgrades for eligible equipment

Services that are not covered by Aetna Better Health and are only covered by CSHCS include:

Orthodontia services provided for certain diagnosis*.

- Respite services*
- Certain over-the-counter medications
- Hemophilia drugs
- Certain orphan drugs

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

The CSN Fund also can help with adult transition services. You can get help from the Family Center for Child and Youth with Special Health Care Needs by:

- Calling the CSHCS toll-free Family Phone Line at **1-800-359-3722**, Monday – Friday from 8 AM to 5PM.
- Services can include:
 - Parent-to-parent support network.
 - Parent/professional training programs.
 - Financial help to go to CSHCS medical condition conferences

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services.

Aetna Better Health CSHCS can help members with special health care needs transitioning from pediatric health care to adult health care services. We will help you by:

- Planning for members move to adult services early around 12 years old for better control of your condition
- Teaching members how to obtain health care and other services

Members will get new doctors and need to tell them about their health

- Learn to ask for what they need
- Learn to have an active role in their health
- Understand their condition

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

Members 18 and older must give doctors and insurance companies approval to speak to their parents. Adult members give approval by allowing others to be:

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

Finding a new doctor

- Members should ask their current doctor who they want them to see
- Aetna has a list of providers for members to choose from
- Members can change doctors anytime

Preventive Health Care for Adults

Preventive health care for adults is important to Aetna Better Health. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early.

Preventive health guidelines

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

Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings

You can also ask your doctor about:

- Immunizations
- HIV/AIDS testing and treatment of sexually transmitted diseases

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family’s health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you should and should not do to take control of your health are listed below.

Things you should do:	Things you should not do:
<ul style="list-style-type: none">• Eat healthy• Exercise• Get enough sleep• Manage your stress• Don’t smoke or use tobacco• Don’t use drugs or drink alcohol• Go to the dentist for regular cleanings and preventive services• Visit your doctor each year for yearly preventive care	<ul style="list-style-type: none">• Eat foods high in fat, sugar, and salt• Live an inactive lifestyle• Hold in your feelings or emotions if you’re feeling stressed or depressed• Use drugs, alcohol, or tobacco• Forget to set up your dentist visits for regular cleanings and preventive services• Forget to set up a yearly visit to your doctor• Avoid going to the doctor

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It’s spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don’t feel sick or show symptoms. When symptoms do appear, they’re often a sign of advanced liver disease. It’s important to get tested (screened) for Hepatitis C before it becomes severe, when it’s easier to treat. All adults should be

screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

Hospital Care

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

Emergency Care

Emergency care is for a life-threatening medical or dental situation or injury that a reasonable person would seek care right away to avoid severe harm. Here are some examples of emergencies:

Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)
Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call 911 or go to the emergency room. You do not need an approval from Aetna Better Health or your doctor before getting emergency care. You can

go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Urgent Care and after-hours care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office.

Routine Care

Routine care is for things like:

- Yearly wellness exams
- School physicals
- Health screenings
- Immunizations
- Vision and Hearing Exams
- Lab tests

Your doctor should set up a visit within 30 business days of request.

Mental Health and Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you.

Talk to your mental health provider to learn more. Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. If you feel you have a

substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Aetna Member Services.

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often
- Performing poorly at work or school
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.
- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down
- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substances effects
- Giving up or reducing important social, work, or recreational activities because of substance use
- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits call Behavioral Health Services **1-866-827-8704**. You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call [911](#). You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

Home Health Care, Skilled Nursing Services and Hospice Care

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan)
- Home health care services for members who are homebound
- Supplies and equipment related to home health care
- Hospice care

Care Coordination

Do you have a chronic health problem or disability? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through health care. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits

As a member of Aetna Better Health, you have your own care manager. This is part of our care management program. Your care manager is here to help you find the care and services you need. You'll get a call from your care manager soon after you are enrolled with Aetna Better Health Plan.

Do you have questions for your care manager? Just call your care manager directly or call the 24-hour Care Management line at **1-866-316-3784, ask for Case Management (TTY: 711)**, 24 hours a day, 7 days a week. Your care manager is there for you.

At times, you may not need much assistance from a case manager, but conditions can change and can be overwhelming. To offer you support, your doctor, hospital discharge planner or other provider or your caregiver may refer you to Case Management. A nurse on our health information line may also refer you. If you need help, do not wait for a referral. You can self-refer by calling us at **1-866-316-3784, (TTY: 711)** and **ask for Case Management**. Call Aetna Member Services for more information about the care coordination program.

Complex Care Management Program

If you have a complex health issue such as HIV, sickle cell anemia, Hepatitis C, or heart disease our Complex Care Management Program can help you. Our care coordinators will work with you and your doctors to make sure you get needed medical care. If you would like more information, call Care Management at **1-866-316-3784 (TTY: 711) ask for Case Management**. Our care coordinators are available to help members learn how to manage certain chronic conditions. These include asthma, diabetes, heart diseases and high-risk pregnancy. Members or their caregiver may ask to enroll or the Plan may enroll you. You may be enrolled by the plan based on information provided by your doctor or hospital, discharge planner, and Aetna Care Coordinator. If you are placed in this program and you do not want to be in the program, call Care Management at **1-866-316-3784 (TTY: 711) ask for Case Management**.

Community Health Workers (CHW)

Community Health Workers are the front-line public health workers within the community, assisting members with navigating health care. CHWs serve as a bridge between health care and social services by building trusting relationships. CHWs full range of services include:

- Meeting face to face to improve your access to health care
- Helping others find providers and set up visits
- Finding local support like food and housing
- Teaching ways to live a healthy life
- Helping with provider follow-up visits after going to the hospital or emergency room
- Helping set up rides for medical or pharmacy visits

Contact Aetna Member Services for more information.

Durable medical equipment

Some medical conditions need special equipment. Durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters and alcohol pads
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters and insulin pumps.
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed.

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call Aetna Member Services.

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency
- Seeing too many different doctors instead of your primary care doctor
- Getting more medicines than may be safe
- Activity that may indicate fraud

Using the right health services in the right amount helps us make sure you're getting the very best care.

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. Aetna Better Health can also help you. To get more information, call Aetna Member Services. We cover the following services to help you:

The following services are covered without prior authorization to help you quit smoking:

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

Here are other resources to help you quit:

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

Cost Sharing and Copayments

A copayment (sometimes called "co-pay") is a set dollar amount you are required to pay as your share of the cost for a medical service or supply. Aetna Better Health of Michigan does not require you pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan program.

You must go to a doctor in Aetna Better Health of Michigan Medicaid network, unless otherwise approved. If you go to a doctor that is not in Aetna Better Health of Michigan Medicaid network and did not get approval to do so, you may have to pay for those services. You should not receive a bill from your doctor for covered services within the plan's network. If you have questions about how co-pays may apply to you, contact member services at **1-866-316-3784 (TTY: 711)**, Monday through Friday, 8 AM to 5 PM.

Quality Improvement at Aetna Better Health® of Michigan.

Our Quality Management department wants to make sure you get good care and services.

- That includes:
 - Health management programs that work for you
- Easy access to quality medical and behavioral health care
- Help with any complex or chronic conditions or illnesses
- Support when you need it most
- High satisfaction with your doctors

Our quality improvement activities each year include:

- Contacting you to remind you to get care (like well-child and dental checkups)
- Letting you know about rewards you may be eligible for
- Sending you postcards or newsletters about health topics
- Reviewing the number, quality, and kinds of services you receive
- Reminding you and your doctors about preventive health care
- Ensuring that your doctor has all the information needed to care for you or your child

We have many more quality programs. You can call our Member Outreach Team at **1-855-737-0770 (TTY: 711)** or at the number on the back of your ID card to learn more about what we do to improve your care. We're also happy to give you a printed copy of our program goals and how we're doing. You can also read updates on our website at AetnaBetterHealth.com/Michigan/members/resources/quality_matters.

Services Covered by Medicaid not Aetna Better Health of Michigan

Aetna Better Health does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at **1-800-642-3195**.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
 - Screening and assessment
 - Detox
 - Intensive outpatient counseling
 - Other outpatient care
 - Methadone treatment

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, and live in Wayne, Oakland, and Macomb counties, call ModivCare at **1-866-569-1902** to arrange a ride. If you do not live in Wayne, Oakland, or Macomb counties, contact your local MDHHS office.

MDHHS office locations and phone numbers may be found at:
www.michigan.gov/mdhhs/inside-mdhhs/county-offices

Non-Covered Services

- Elective abortions and related services
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment
- Elective cosmetic surgery
- Services for the treatment of infertility

New medical technology

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

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

Additional Information for Healthy Michigan Plan Members

Healthy Behaviors

You may be eligible to participate in a healthy behavior incentive program. To get more information, call member services at **1-866-316-3784 (TTY: 711)**, Monday through Friday, 8 AM to 5 PM.

Rights and Responsibilities

You have rights and responsibilities as our member. Our staff will respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment and express preferences about treatment options
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you
- To file a grievance or appeal, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives regardless of cost or benefit coverage, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To request information on the structure and operation of the Aetna Better Health
- To make suggestions about our services and providers

- To make suggestions about our member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval

You have the Responsibility to:

- Review this handbook and Aetna Better Health Certificate of Coverage
- Make and keep appointments with your Aetna Better Health doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to <https://newmibridges.michigan.gov/>.

Grievances and Appeals

We want you to be happy with the services you get from Aetna Better Health and our providers. If you are not satisfied, you can file a grievance or appeal.

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often

handle the problem. If you have questions or need help Member Services at **1-866-316-3784 (TTY: 711)**.

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. Aetna Better Health has special procedures in place to help members who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

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

You can file your grievance on the phone by calling Aetna Better Health at **1-866-316-3784 (TTY: 711)**. You can also file your grievance in writing via mail or fax at:

Aetna Better Health of Michigan Attn: Appeals Coordinator
PO Box 81139
5801 Postal Rd,
Cleveland, OH 44181
Fax: **1-866-889-7517**
Email: **MIAppealsandGrievances@Aetna.com**

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling **1-866-316-3784 (TTY: 711)**. We will let you know when we have received your grievance. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your "representative." If you decide to have someone represent you or act for you, inform Aetna Better Health in writing with the name of your representative and their contact information. Your grievance will be resolved within 90 calendar days of submission. We will send you a letter of our decision.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an “Adverse Benefit Determination” letter from us. This letter will tell you the following:

- The adverse benefit determination the contractor has made or intends to make
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing/External Review and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

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

You can file your appeal on the phone by calling Aetna Better Health at **1-866-316-3784 (TTY: 711)**. You can also file your appeal in writing via mail or fax at:

Aetna Better Health of Michigan Attn: Appeals Coordinator
PO Box 81139
5801 Postal Rd,
Cleveland, OH 44181
Fax: 1-866-889-7517
Email: MIAppealsandGrievances@Aetna.com

You have several options for assistance. You may:

- Call Aetna Member Services and we will assist you in the filing process
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter their contact information or, 2) fill out the Authorized Representative Appeals form. You may call and request the form or find this form on our website at [AetnaBetterHealth.com/Michigan](https://www.aetna.com/betterhealth/michigan).

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service.

Aetna Better Health will send our decision in writing to you within 30 calendar days of the date we received your appeal request. Aetna Better Health may request an extension up to 14 more calendar days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

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

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

Things to keep in mind during the appeal process:

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

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision.

How Can You Withdraw an Appeal?

You have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. Aetna Better Health will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call Aetna Better Health at **1-866-316-3784 (TTY: 711)**.

What Happens Next?

After you receive the Notice of Internal Appeal Decision in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing Appeal within 10 calendar days of the date on the decision notice. If you do not win this appeal, you may be responsible for paying for the

services provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a Notice of Internal Appeal Decision from us within the required time frame.

Call Aetna Better Health at **1-866-316-3784 (TTY: 711)** if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days. If you have any questions, you can call MOAHR at **1-800-648-3397**.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send your request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section

P.O. Box 30220

Lansing, MI 48909-7720

Or call: **1-877-999-6442**

Fax: **517-284-8838**

Online: <https://difs.state.mi.us/Complaints/ExternalReview.aspx>

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources.

- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we can help. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to your care manager. If you don't have a care manager, and need help please call Aetna Member Services at **1-866-316-3784**. TTY users should call **TTY: 711**.

You also can also access resources at the following:

- Online through our website: aetnabetterhealth.com/michigan
- Online through the State of Michigan portal: <https://newmibridges.michigan.gov>
- Online through the Michigan 2-1-1 website: www.mi211.org

Women, Infants, and Children (WIC) is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Call **1-800-262-4784** to find a WIC clinic near you or call Aetna Member Services for assistance.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care coordinator about your health care. A care coordinator helps you:

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions
- Access community-based supports, services, and resources
- Understand your Medicaid benefits
- Connect with social supports such as food, housing, and employment resources
- Coordinate care for Maternity, Sickle Cell, Hep C, Children Special Health Care Services (CSHCS), Foster Care Members, Elevated blood lead levels, LGBTQ+ and other chronic conditions, such as Diabetes and Asthma.

If you are interested in joining this program, please call Aetna Member Services to be connected with a care coordinator.

Make Your Wishes Known: Advance Directives

Aetna Better Health supports your right to file an “Advance Directive” according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don’t want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a *durable power of attorney for health care*. To create one, you will need to choose a patient advocate.

This person carries out your wishes and makes decisions for you when you cannot. It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Aetna Member Services for more information and the forms you need to write an advance directive.

If your wishes aren’t followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170

Call: **517-373-9196**

Or click below:

<https://www.michigan.gov/lara/bureau-list/bpl>

Click on *File a Complaint*

If you have complaints about how Aetna Better Health follows your wishes, you may call the state of Michigan’s Department of Insurance and Financial Services. Call toll-free at **1-877-999-6442** or go to **<https://www.michigan.gov/difs>**.

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

Fraud

Fraud is purposefully misrepresenting facts. Here are some examples of fraud:

- Using someone else's member ID card
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from health care for people who need it. Here are some examples of waste:

- Using transportation services for non-medical appointments
- Doctors ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

- Using the emergency room for non-emergent health care reasons
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a doctor's office, hospital, or pharmacy
- Receiving services that are not medically necessary

You can help

We work to find, investigate, and prevent health care fraud. You can help. Know what to look for when you get health care services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you
- The type and date of service are the same type and date of service you received
- The diagnosis on your paperwork is the same as what your doctor told you

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name. Members also can call our Fraud and Abuse Hotline at 1-800-338-6361. You may also write to us at:

Aetna Better Health of Michigan
28588 Northwestern Hwy, Suite 380B,
Southfield, MI 48034

You may also report or get more information about health care fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: **1-855-MI-FRAUD (1-855-643-7283)**

Or visit: **michigan.gov/fraud** Information may be left anonymously

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service
- A supply or item
- A prescription drug that you think you should be able to get
- A dental service
- A dental appliance or device

Reduces, limits, or denies coverage of:

- A healthcare service
- A supply or item
- A prescription drug you already got
- A dental service
- A dental appliance or device

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

- A service
- A supply or item
- A prescription drug you think you still need
- A dental service
- A dental appliance or device

Does not provide timely medical services

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

- Oxygen equipment
- Wheelchairs

- Crutches
- Blood testing strips for diabetics
- Blood pressure cuffs

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger OR care given for a dental emergency that requires dental treatment right away.

Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Medical services that your plan doesn't pay for or cover.

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

Habilitation Services and Devices: Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

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

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

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

Hospice Services: Hospice is a special way of caring for people who are terminally ill and provide support to the person's family.

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

Medical Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or Symptom

OR

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

- Injury
- Condition
- Disease or Symptom

Network: Health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

OR

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

- Dentists
- Dental Specialists

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that *does not* have a contract with the Medicaid Health Plan as a provider of care.

Physician Services: Healthcare services provided by a person licensed under state law to practice medicine.

Plan: A plan that offers health care services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

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

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

Premium: The amount paid for health care and/or dental benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

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

Provider: A person, place or group that's licensed to provide health care like doctors, nurses, and hospitals OR a person, place or group that is licensed to provide dental services like dentists.

Referral: A request from a PCP for his or her patient to see another provider for care.

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

Specialist SPECIALITY CARE PROVIDER (SCP): A licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions OR a licensed dental specialist that focuses on a specific area of dentistry or a group of patients to diagnose, manage, prevent or treat certain types of dental symptoms and conditions.

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

Notice of Privacy Practices

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

This notice takes effect on October 1, 2015.

What do we mean when we use the words “health information”¹

We use the words “health information” when we mean information that identifies you.

Examples include your:

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

How we use and share your health information

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

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

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

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

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

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

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

A case manager may work with your doctor. They may tell you about programs or places that can help you with your health problem. When you call us with questions, we need to look at your health information to give you answers.

Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data

We may get information related to your race, ethnicity, language, sexual orientation and gender identity. We protect this information as described in this notice. We use this information to:

- Make sure you get the care you need
- Create programs to improve health outcomes
- Create health education information
- Let the doctors know about your language needs
- Address health care disparities
- Let member facing staff and doctors know about your pronouns

We do not use this information to:

- Determine benefits
- Pay claims
- Determine your cost or eligibility for benefits
- Discriminate against members for any reason
- Determine health care or administrative service availability or access

Sharing with other businesses

We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair, so they send a van instead of a car to pick you up.

Other reasons we might share your health information

We also may share your health information for these reasons:

- Public safety – To help with things like child abuse. Threats to public health.
- Research – To researchers. After care is taken to protect your information.
- Business partners – To people that provide services to us. They promise to keep your information safe.
- Industry regulation – To state and federal agencies. They check us to make sure we are doing a good job.
- Law enforcement – To federal, state and local enforcement people.
- Legal actions – To courts for a lawsuit or legal matter.

Reasons that we will need your written okay

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

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

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

What are your rights

You have the right to look at your health information.

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

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

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

You have the right to get a list of people or groups that we have shared your health information with.

You have the right to ask for a private way to be in touch with you.

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

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

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

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

- We will tell you if we do this in a letter.

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

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

You also have the right to send us a complaint. If you think your rights were violated, write to us at:

Aetna HIPAA Member Rights Team
P.O. Box 14079
Lexington, KY 40512-4079
FAX: **859-280-1272**

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address at **1-866-316-3784 (TTY: 711)**.

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

Protecting your information

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

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

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

Will we change this notice

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

Aetna Better Health of Michigan Medicaid

Program Certificate of Coverage

Welcome to Aetna Better Health® of Michigan.

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

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

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

We look forward to serving you.

Sincerely,

Teressa D. Smith, MBA
Chief Executive Officer

Aetna Better Health of Michigan Medicaid Program Certificate of Coverage

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

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

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

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

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

SECTION 1.0 – DEFINITIONS

- 11 **ABUSE** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary or that fail to meet

professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

- 12 **ADVERSE DETERMINATION** means the PLAN'S denial or limited authorization of a requested service, or a failure to provide or make payment (in whole or in part) for a benefit. An Adverse Determination also includes (a) the failure to provide services in a timely manner, (b) any entire or partial reduction, suspension, or termination of a

benefit or previously authorized service, or (c) failure to act within specified timeframes when addressing appeals and grievances. An Adverse Determination based, in whole or in part, on medical judgment includes the failure to authorize or cover services because they are determined to be experimental, investigational, cosmetic, not Medically Necessary or inappropriate.

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

- Denies your request for:
 - A health care service
 - A supply or item
 - A prescription drug that you think you should be able to get
 - A dental service
 - A dental appliance or device
- Reduces, limits or denies coverage of:
 - A health care service
 - A supply or item
 - A prescription drug you already got
 - A dental service
 - A dental appliance or device
- Your plan stops providing or paying for all or part of:
 - A service
 - A supply or item
 - A prescription drug you think you still need
 - A dental service

- A dental appliance or device
- Does not provide timely health or dental services.

- 14 **ATTENDING PHYSICIAN** means any Physician responsible for managing the Member’s care during a hospitalization or institutionalization.
- 15 **BUSINESS DAY** means Monday through Friday, except those days identified by the state as a holiday.
- 16 **CHRONIC** means a health condition that is prolonged or lingering induration.
- 17 **COPAYMENTS** mean an amount you are required to pay as your share of the cost for a medical service or supply or dental service or supply. This may include:
- A doctor’s visit
 - Hospital outpatient visit
 - Prescription drug
 - A dental visit
 - A dental appliance or device

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

- 18 **COSMETIC SERVICES AND SURGERY** means medical or surgical services (i) performed to reshape normal structures of the body in order to improve the Member’s appearance and self-esteem; (ii) from which no significant improvements in physiological function could reasonably be expected; (iii) that do not meaningfully promote the proper function of the body (iv) that do not prevent or treat illness or disease; or (v) done primarily to improve the appearance or diminish an undesired appearance of any portion of the body.
- 19 **COVERAGE** or **COVERED** means the entitlement of a Member to services provided in this Certificate of Coverage, subject to the terms, conditions, limitations, and exclusions herein, including the following: (i) health services must be provided when the Certificate of Coverage is in effect; (ii) health services must be provided prior to the date that any of the termination conditions listed under Section 4 of this Certificate of Coverage occur;

(iii) health services must be provided only when the recipient is a Member and meets all eligibility requirements specified in the Certificate of Coverage, and (iv) health services must be Medically Necessary and must not be listed in Section 7 as an Exclusion.

- 10 **COVERED SERVICES** means the health care services described at Section 6 of this Agreement and all supplemental benefits described in Attachments to this Agreement, if

any, to the extent such services are required to be provided under policies of the Michigan Medicaid program.

1.11 **DENTAL COVERAGE** means a type of insurance that pays for dental costs for people. It can pay the person back for costs from dental injury or treatment. It can also pay the provider directly.

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

1.13 **DURABLE MEDICAL EQUIPMENT**

Equipment and supplies ordered by a health care provider for everyday or extended use. This may include:

- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics
- Blood pressure cuffs

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

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

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

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

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

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

- 120 **EMERGENCY ROOM CARE** means care given for a medical emergency when you think that your health is in danger **OR** care given for a dental emergency that requires dental treatment right away.
- 121 **EMERGENCY SERVICES** means review of an emergency medical or dental condition and treatment to keep the condition from getting worse.
- 122 **ENROLLEE** means a Medicaid beneficiary who is currently enrolled in a managed care organization in a given managed care program.
- 123 **EXCLUDED SERVICES** means health care services or dental services that your plan does not pay for or cover.
- 124 **EXPERIMENTAL AND INVESTIGATIONAL** means those health products or services that meet one of the following conditions: (a) any drug or device that is not approved for use by the Food & Drug Administration (“FDA”); any drug classified by the FDA as investigational new drug (“IND”); any drug requiring preauthorization that is proposed for off-label prescribing; (b) any health product or service that is subject to Investigational Review Board (“IRB”) review or approval; (c) any health product or service that is

the subject of a clinical trial that meets criteria for Phase I, II, or III, as set forth by FDA regulations; or (d) any health product or service that is considered not to have demonstrated value based on clinical evidence reported by peer-reviewed medical literature and generally recognized by academic experts.

- 125 **FORMULARY** means a listing of prescription drugs approved by the PLAN for coverage under this Agreement, dispensed by a pharmacy to Members. This list is subject to periodic review and change by the PLAN. The Formulary is available for review in Participating Providers’ offices, on the PLAN’S website, at [AetnaBetterHealth.com/Michigan](https://www.aetna.com/betterhealth/michigan) or by contacting the PLAN’S Member Service department.
- 126 **FRAUD** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in unauthorized benefit to himself or some other person.

- 127 **GRIEVANCE** means a complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you are unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).
- 128 **GRIEVANCE AND APPEAL PROGRAM** means the procedure under which a Member must file any Appeal or Grievance involving the PLAN, a Participating Provider Center, or any Participating Physician, Participating Health Professional, or other Participating Provider.
- 129 **HABILITATION SERVICES AND DEVICES** mean health care services that help a person keep, learn or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:
- Physical and occupational therapy
 - Speech-language pathology
 - Services for people with disabilities
- 130 **HEALTH INSURANCE** is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance
- 131 **HEALTH PROFESSIONAL** means a podiatrist, dentist, nurse, optometrist, or other individual licensed or certified to practice a health care profession other than medicine or osteopathy by the state in which he or she is located.
- 132 **HOME HEALTH CARE** means health care services that a health care provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.
- 133 **HOSPICE SERVICES** means a special way of caring for people who are terminally ill and provide support to the person's family.
- 134 **HOSPITAL** means an institution, operated pursuant to law, which(a) is primarily engaged in providing services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic, and surgical techniques by or under the supervision of one or more Physicians; (b) has twenty-four (24) hour nursing services on duty or on call; and (c) is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Hospital Association, or certified under Title XVII of the Social Security Act (Medicare program). A

facility that is primarily a place for rest, custodial care, or care of the aged, a nursing home, convalescent home, or similar institution is NOT a Hospital.

- 135 **HOSPITALIZATION** means care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.
- 136 **HOSPITAL OUTPATIENT CARE** means care in a hospital that usually does not need an overnight stay.
- 137 **IDENTIFICATION CARD** means the card issued by the PLAN to each Member for purposes of identifying such individuals. The rights and responsibilities attendant to Members issued an Identification Card are set forth in Section 3.3 of this Certificate of Coverage.
- 138 **INDIAN HEALTH CARE PROVIDER** means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C.1603).
- 139 **INFERTILITY** means the inability of a woman to conceive a pregnancy after six (6) months of unprotected intercourse with a man, or the inability of a woman to carry a pregnancy to live birth as evidenced by three consecutive miscarriages (spontaneous abortions).
- 140 **MEDICAID HEALTH PLAN** means a plan that offers health care services to members who meet state eligibility rules. The state contracts with certain Health Maintenance Organizations (HMOs) to provide health services for those who are eligible. The state pays the premium on behalf of the member.
- 141 **MEDICALLY NECESSARY** means health care services or supplies that meet accepted standards of medicine needed to diagnose or treat:
- An illness
 - Injury
 - Condition
 - Disease or Symptom

OR

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

- Injury
- Condition
- Disease or Symptom

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

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

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

- Doctors
- Hospitals
- Pharmacies

OR

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

- Dentists
- Dental Specialists

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

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

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

1.48 **DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES(“DIFS”)**. The agency

that oversees financial institutions, insurance companies, and securities in the state of Michigan. DIFS can assist Members if they have questions, complaints, or concerns about credit unions, insurance companies, banks, securities, and health maintenance organizations (“HMOs”).

- 149 **OUT-OF-AREASERVICES** means those Covered Services provided when a Member is temporarily absent from the Service Area that are immediately required as a result of an unforeseen illness, injury, or condition, and it is not reasonable for Member to obtain such Covered Services through the PLAN in the PLAN’S Service Area due to the circumstances.
- 150 **PARTICIPATING**, when used with Physician, Health Professional, Hospital or Skilled Nursing Facility or other individual, facility or health care entity means that the person or entity has entered into a direct or indirect written agreement with the PLAN to provide health services to Members. “Participating” refers only to those Providers included in the network of Providers described in the Provider Directory of Health Care Providers delivered to Members in connection with the Agreement. The participation status of Providers may change from time to time.
- 151 **PHYSICIAN** means any doctor duly licensed and qualified to practice medicine (M.D.) or osteopathy (D.O.) in the state of Michigan.
- 152 **PHYSICIAN SERVICES** means health care services provided by a person licensed under state law to practice medicine
- 153 **PLAN** means Aetna Better Health of Michigan, Inc.
- 154 **PREAUTHORIZATION** means approval from a plan that is required before the plan pays for certain:
- Services
 - Medical equipment
 - Prescriptions
 - Dental services
 - Dental appliances or devices

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

- 155 **PREMIUM** means the amount paid for health care and/or dental benefits every month. Medicaid Health Plan and Dental Plan premiums are paid by the State on behalf of eligible members.
- 156 **PRESCRIPTION DRUG COVERAGE** means a health insurance or plan that helps pay for prescription drugs and medications.

- 157 **PRESCRIPTION DRUGS** means drugs and medications that require a prescription by law by a licensed Provider.
- 158 **PRIMARY CARE PROVIDER** or **PCP** means a licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a **primary care physician**. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and health care providers about your care and refer you to them.
- 159 **PROVIDER** means a person, place or group that is licensed to provide health care like doctors, nurses and hospitals.

OR

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

- 160 **RECONSTRUCTIVE SURGERY** means surgery that is performed on abnormal structures of the body which are caused by congenital defects, developmental abnormalities, trauma, infection, tumors or diseases and which is performed to improve function or to approximate a normal appearance.
- 161 **REHABILITATION SERVICES AND DEVICES** means rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:
- Physical and occupational therapy
 - Speech-language pathology
 - Psychiatric rehabilitation services
- 162 **SERVICE AREA** means the geographic area in which the PLAN has been authorized by the state of Michigan to provide or arrange for the provision of Covered Services to Members. Service Area is subject to change.
- 163 **SKILLED NURSING CARE** means Services in your own home or in a nursing home provided by trained:
- Nurses
 - Technicians or,
 - Therapists
- 164 **SKILLED NURSING FACILITY** means an institution that is licensed by the state in which it is located to provide skilled nursing services.

165 **SPECIALIST or SPECIALITY CARE PROVIDER (SCP)** means a licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

OR

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

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

167 **TELEHEALTH/TELEMEDICINE** means the use of electronic media to link members with health care professionals in different locations. The health care professional must be able to examine the member under live audio, video or both. The member must be able to interact with the provider at the time services are given.

168 **TRANSPLANT NETWORK** means the group of Providers designated by the PLAN to provide transplant services and treatment to Members.

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

OR

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

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

SECTION 2.0 – ELIGIBILITY

21 **MEMBER ELIGIBILITY.** MDHHS is responsible for making all determinations regarding who is eligible to enroll in Medicaid managed care plans. The Michigan Department of Health and Human Services (“MDHHS”) determines Medicaid eligibility. Most changes by MDHHS will be made on a calendar month basis. The PLAN shall be responsible for

Member until the date of disenrollment. To be eligible to enroll as a Member a person must:

- 22 Meet the eligibility criteria established for Medicaid as determined by MDHHS
- 23 Reside within the Service Area; and
- 24 Be determined by MDHHS to be appropriate for enrollment in a managed care plan, such as the PLAN
- 25 **LOSS OF MEDICAID ELIGIBILITY.** Effective on the date a Member covered by this Agreement loses his or her eligibility under the Medicaid Program, coverage under this Agreement shall terminate. In the case of an inpatient hospital admission, payment for services will continue until the Member is discharged from the hospital. If the person regains Medicaid eligibility within ninety (90) days from the date eligibility was terminated, the PLAN will accept automatic-enrollment of the person on a prospective basis as determined by MDHHS.

SECTION 3.0 – ENROLLMENT AND COVERAGE EFFECTIVE DATES

- 31 **ENROLLMENT.** MDHHS is responsible for determining a person’s eligibility for enrollment with the PLAN and will provide all enrollment materials to Members. At the time of birth, newborns of women enrolled with the PLAN are automatically enrolled as Members for at least the month in which the birth occurs and may be eligible for a longer period.
- 32 **ENROLLMENT PROCESS AND COLLECTED INFORMATION.** MDHHS contracts with an enrollment services vendor to contact and educate general Medicaid beneficiaries about Medicaid managed care and to enroll and change enrollment for these beneficiaries. The PLAN does not administer the enrollment process, and a beneficiary is not deemed to be enrolled with the PLAN until the PLAN has received information from the enrollment services vendor. All enrollment and disenrollment determinations are made solely by MDHHS. A Member shall complete and provide to the PLAN or its Participating Physicians, Hospitals, Health Professionals or Skilled Nursing Facilities any forms (other than an Eligibility Application) that are reasonably requested, including medical questionnaires, and a Member shall assure that all information in such forms is true, correct and complete. If a Member intentionally submits any false or misleading information or omits any material fact, on such forms about him/herself or his/her family members, the PLAN may ask MDHHS to terminate the Member’s enrollment from the PLAN. At all times, the Plan shall ensure that Member’s health information is protected pursuant to state and federal law, including but not limited to the Health Insurance Portability and Accountability Act (“HIPAA”).

33 EFFECTIVE DATE OF COVERAGE

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

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

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

37 **PREGNANT WOMEN COVERAGE.** Effective April 1, 2022, Members whose coverage is based upon their pregnancy will be eligible for benefits for 12 months following the month of delivery.

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

39 **IDENTIFICATION CARDS.** The PLAN will issue Identification Cards to Members, and such Identification Cards are to be used for identification purposes only and must be presented whenever the Member obtains Covered Services. The PLAN'S

non-emergency and emergency contact numbers are on the back of the Identification Card. Only the Member to whom the identification card is issued may use it. A person who is no longer eligible for Coverage or a person who is not designated as the Member on the Identification Card is not entitled to receive Covered Services and has no rights under the Identification Card. The Identification Card shall be returned to the PLAN at its request upon termination of Coverage or misuse.

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

SECTION 4.0 – TERMINATION

- 4.1 **CANCELLATION OF THE PLAN/MDHHS CONTRACT.** A Member’s Coverage shall be subject to a transition plan in the event the contract between the PLAN and the state of Michigan under which this Coverage is provided is cancelled. If the contract between the PLAN and the state of Michigan is cancelled, then MDHHS is responsible for arranging for Members to be reassigned or enrolled in another comparable program. MDHHS is also responsible for setting a cancellation date.
- 4.2 **DIENROLLMENT BY MEMBER WITHOUT CAUSE.** Disenrollment by a Member is allowed during the initial 90 days of enrollment in the PLAN and during the Member’s annual enrollment period. The Member may choose to enroll in another Medicaid health plan. MDHHS will notify the Member of the annual open enrollment period.
- 4.3 **DIENROLLMENT BY MEMBER FOR CAUSE.** Disenrollment by a Member is only allowed at certain times under MDHHS policy. To request disenrollment, a Member must follow the procedures established by MDHHS and the PLAN’S disenrollment procedures as approved by MDHHS. Member should contact the “Beneficiary Help Line” at **1-800-642-3195** to request the “MSA 176 Special Disenrollment” Form. Michigan Enrolls will mail the form to the Member. Member must show that he or she has contacted the PLAN to resolve the issue of concern. Member must also provide supporting physician documentation of the services that are being requested that the PLAN cannot make arrangements for either within or out of network. Once Member has submitted a request for disenrollment to MDHHS, the Member’s access to care and services through the PLAN will continue until he or she is informed in writing of the approval and approval effective date. If the disenrollment request is approved, the Member will be enrolled in another Medicaid health plan or in Medicaid Fee-for- Service as determined by MDHHS. If the request is denied, the Member will remain enrolled in the PLAN until the member’s next annual enrollment period. Members may request disenrollment under this Section 4.2 if the Member cannot change health plans because the Member has been enrolled for more than ninety (90) days, or the Member does not meet the timeframe guidelines for a medical exception, AND for any of the following reasons:
- 4.4 **Medical Reasons:** The Member’s Provider must give MDHHS information to show that Member has a serious medical condition, and is under active treatment for that condition, and is receiving active treatment from a provider who no longer participates with the PLAN in which Member is enrolled. The Provider must state that he or she cannot safely transition care to another provider within the PLAN’S network, and that there is a need for the Member to remain with the provider who will not accept an out of network referral from the PLAN. The Provider must indicate the date they terminated their contract with

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

- 45 **Lack of Access Reasons:** Member can request disenrollment if the Member experiences a lack of access to Covered Services or Providers. Member must describe the Medically Necessary Covered Services that have been prescribed but that are inaccessible, or Member must describe why he or she believes that the PLAN has not provided the Member with a Provider who is experienced in dealing with Member's health care needs. Member must show that he or she has tried to work with the PLAN on the access to care or specialists' issue and that the PLAN cannot make the necessary arrangements for care either within or out of network. Supporting physician documentation is also required.
- 46 **Quality of Care:** Member must have concerns with the quality of care the PLAN'S Participating Providers have rendered. Member must show that he or she has tried to work with the PLAN on the quality-of-care issue and that the PLAN cannot make the necessary arrangements for care either within or out of network. Supporting physician documentation is also required.
- 47 **Lack of Access to Primary Care:** Member must show that there are no PCPs in the PLAN'S Service Area that are within thirty (30) minutes or thirty (30) miles of where the Member lives, or that the PCPs in the PLAN'S Service Area that are within thirty (30) minutes or thirty (30) miles of where Member lives are not taking new patients or have discharged the Member as a patient. This will not apply, however, if the Member specifically asked to be assigned to a PCP outside of thirty (30) minutes or thirty (30) miles.
- 48 **PLAN-INITIATED DISENROLLMENT.** The PLAN will petition MDHHS for disenrollment of a Member for the below listed reasons. All disenrollments are subject to the prior approval of MDHHS. Before a Member is disenrolled under this section, the PLAN will attempt to resolve the problem with the Member. A Member will have the right to contest through the Grievance and Appeal Program any decision made by the PLAN to request disenrollment of a Member, except when disenrollment is because the Member no longer meets MDHHS enrollment requirements. If the PLAN'S request to disenroll is approved, and Member is disenrolled, the disenrollment will be effective within sixty (60) days from the date MDHHS received the complete request from the PLAN to disenroll the Member. If the Member exercises their appeal right, the date of disenrollment shall be no later than thirty (30) days after resolution of the appeal, or on such other date as set by MDHHS. The Plan will be responsible for the Member until the date of disenrollment:

- 4.81 Fraud, abuse of the PLAN, or other intentional misconduct, including but not limited to, alteration or theft of prescriptions, misrepresentation of membership, or unauthorized use of benefits.
- 4.82 Member's behavior towards either the PLAN or a Provider causes violent or life-threatening situations involving physical acts of violence, physical or verbal threats of violence, or stalking.
- 4.83 A Member misuses the Identification Card as provided in Section 3.3.
- 4.84 Other actions inconsistent with PLAN membership involving the repeated use of Non-Participating Providers when Participating providers are available; discharge from the practices of available Participating Providers; repeated emergency room use for non-emergency services; and other situations that impede care. The PLAN will not request disenrollment based on the physical or mental health status of the Member. If the Member's physical or mental health is a factor in the violent behavior or action inconsistent with PLAN membership, the PLAN must provide proof of the PLAN'S actions to assist the Member in correcting the problem, including appropriate physical and mental health referrals. The PLAN will also document that continued enrollment seriously impairs the PLAN or providers to furnish services to the Member or other members. MDHHS may require additional information from the PLAN to determine the appropriateness of the disenrollment.
- 4.9 **MOVING OUT OF SERVICE AREA.** If a Member moves out of the Service Area after the Effective Date, the PLAN Coverage will remain in effect until the Member is disenrolled by MDHHS from the PLAN. The Member may be required to return to the PLAN'S Service Area to seek Medically Necessary Covered Services from Participating Providers, or the PLAN may Authorize the Member to seek Medically Necessary Covered Services outside of the PLAN'S Service Area. The PLAN may not pay for otherwise Covered Services provided outside of the Service Area if no Prior Authorization was obtained, except when Covered Services were rendered in response to an Emergency Medical Condition.
- 4.10 **LONG-TERM CARE FACILITIES.** The PLAN may initiate a disenrollment request if a Member is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than forty-five (45) days. The PLAN will remain responsible for the Member until the date of disenrollment.

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

- 51 **PRIMARY CARE PHYSICIAN & FQHC SELECTION.** Upon enrollment through Michigan Enrolls, the Member shall select a PCP and, as applicable, a FQHC. If the Member fails to select a PCP, within one month of the Member's effective date of enrollment, the PLAN will automatically assign a PCP to the Member until the Member makes an alternate selection. After enrollment, a Member may choose a different PCP from a list provided by the PLAN by contacting the PLAN'S Customer Care Call Center. If the PLAN cannot honor the Member's choice of PCP, the PLAN will contact the Member to assist the Member in making another choice. Member-initiated PCP changes will be permitted at any time; however, the PLAN may limit such changes when they are being requested without cause.
- 52 **PROVIDER DIRECTORY.** Participating Physicians, Health Professionals (including mental health providers) and other providers are subject to change, from time to time, with respect to individual practitioners or institutions. Accordingly, the PLAN neither warrants nor guarantees the length of service of any of its Participating Physicians or other Participating Providers.
- 53 **PHYSICIAN/PATIENT RELATIONSHIP.** When, after reasonable efforts are made, a Member and the Member's PCP are unable to establish or maintain a satisfactory relationship as physician and patient, a Member may be required to choose another PCP with not less than thirty (30) days' notice, subject to the Member's rights under the Grievance and Appeal Program. A PCP must notify a Member of the reason for dismissal by means of a certified letter to the Member's current address of record. A copy must also be sent to the PLAN.
- 54 **CONTINUATION OF CARE FROM A TERMINATED PROVIDER.** In the event Your Provider's participation with PLAN ends for any reason other than fraud or quality of care issues, you may be able to continue getting care from the Provider in certain circumstances. If You have ongoing treatment with the Provider (a) You can continue care with the Provider for ninety (90) days; or (b) if You are in the second or third trimester of Your pregnancy, You can continue related care through the postpartum period; or (c) if You are terminally ill and were terminally ill before Your Provider knew of their termination, and You were getting treatment for the terminal illness before the Provider's termination, You may continue care with the Provider related to the terminal illness through the remainder of Your life. Your Provider must agree to accept payment from Us in the amount we paid them under their contract with Us. They must also meet our quality standards, provide us with necessary medical record information, and comply with our utilization review, prior authorization, referral, and treatment plan requirements.

SECTION 6.0 – COVERED SERVICES

61 **COVERED SERVICES GENERALLY.** Enrollment in the PLAN entitles Members to receive the Covered Services set forth below, so long as such Covered Services are

(a) provided, arranged and/or approved by the PCP or SCP (if required by the PLAN), (b) medically necessary, (c) subject to the limitations and exclusions set forth in this Agreement, and (d) required to be provided under policies of the Medicaid program. The PLAN has the authority to arrange and/or Authorize those services that are Medically Necessary. Members and Providers must comply with the terms and conditions of the PLAN regarding Prior Authorization of services. Failure to secure Prior Authorization may result in the PLAN'S denial of payment for otherwise Covered Services. If a Member needs to see a Specialist, the Member's PCP or Dental Provider will arrange the visit and provide Member with the appropriate documentation to take to the visit. Members are responsible for consulting with their PCP before receiving medical care from another Provider except as otherwise specified in this document. Members may only seek care from Specialists in the PLAN'S network. Visits to Providers who are not in the PLAN'S network must first be approved by the PLAN'S Health Services Department. For example, the PLAN may cover services provided by a Provider outside the PLAN network if no similar Provider is available in network, or the PLAN may cover services outside the network to ensure that a Member's care is not interrupted. Services received outside the network must be approved by the PLAN. Except in the case of emergency, failure to obtain prior authorization of services with a provider that is not in the Plan's network could result in the Member being responsible for payment for the services. Members with serious health conditions may need to see a Specialist to get the care they need. PCPs will refer their Members accordingly for such care.

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

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

- 621 All office or telehealth visits when deemed appropriate for diagnosis and treatment of illness and injuries provided by a Member's PCP and all related services, supplies and immunizations.
- 622 Periodic physical examinations or health assessments as determined by the PCP.
- 623 Pediatric care, including well-child care and certified pediatric nurse practitioner services. Prior Authorization is not required for access to a pediatrician who is a Participating Physician for general pediatric services, but Prior Authorization is

required for pediatric services when provided by a Physician who is not a Participating Physician for such services.

- 624 Gynecological and maternity care, including prenatal and postnatal care, delivery and other related obstetrical services, and nurse midwife services. Prior Authorization is not required for access to an obstetrician-gynecologist who is a Participating Physician for annual well woman examinations and routine obstetrical and gynecological services, but Prior Authorization is required for the services of a Physician who is not a Participating Physician for such services. Members who qualify for Medicaid due to pregnancy will be allowed access to out of network obstetrical and gynecological services without authorization if the member has an established relationship with that provider. These members will also be allowed access to out of network facilities without authorization for routine obstetrical and gynecological services if referred by the out of network obstetrician-gynecologist.
- 625 Necessary outpatient medical consultation and specialist care by a Participating Physician to whom a Member is referred by the PCP.
- 626 In-hospital and outpatient physician services, as deemed necessary for the care and treatment of the Member by the Attending Physician, including breast reconstruction surgery following a mastectomy.
- 627 Covered Services rendered by a Certified Doula, Nurse, Midwife or Family Nurse Practitioner.

63 **WELL-CHILD CARE/EARLY & PERIODIC SCREENING. DIAGNOSIS. &**

TREATMENT PROGRAM (“EPSDT”). These services are available to Members under the age of 21 to ensure access to health resources and assist parents/guardians in appropriately using health resources. No Prior Authorization is required if EPSDT services are rendered by a Participating Provider.

- 63.1 Screening Services shall include periodic well-child examinations, including assessment of health and developmental history; development & behavioral assessments; age appropriate unclothed physical examinations; height/weight/head circumference measurements; blood pressure examination for children aged 3 and over; immunization review and appropriate administration; health education including anticipatory guidance; nutritional assessment; hearing, vision, and dental assessment; blood lead testing for children under age 6; appropriate conference and counseling for parents/guardians; objective testing for developmental behavior, hearing, and vision according to the Medicaid periodicity schedule;

laboratory services for tuberculin, hematocrit, hemoglobin, urinalysis; or other testing as may be ordered by Physician.

- 632 Vision Services will include diagnosis and treatment for defective vision and may include eyeglasses as appropriate.
- 633 Dental Services shall include relief of pain and infections, restoration of teeth, and maintenance of dental health. The PLAN is responsible for screening and referral only.
- 634 Hearing Services shall include diagnosis and treatment for hearing defects, including hearing aids as appropriate.
- 635 Referral of children, as appropriate, to hearing and speech clinic; optometrist or ophthalmologist, or other appropriate provider for objective hearing and vision services; referral to community mental health services; and if a child is found to have elevated blood lead levels in accordance with MDHHS standards, the PLAN shall refer the child to the local health department for follow-up services that may include a study to determine the source of the lead poisoning.
- 636 Outreach Services by home visit, phone, or mail to those Members who are due or overdue for well-child visits.

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

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

- 65.1 Semi-private room and board accommodations based upon availability. Such accommodations shall include general duty nursing care.
- 65.2 Private room and board accommodations only with PLAN authorization.
- 65.3 Inpatient therapeutic and support care, services, supplies and appliances, including care in specialized intensive and coronary care units.

- 654 Use of operating and other surgical treatment rooms and equipment on an inpatient or outpatient Basis.
- 655 All laboratory and other diagnostic tests (X-rays, EKGs, nuclear isotopes, ultrasounds, CAT, MRI, MRA, PET) on an inpatient or outpatient basis as described at Section 6.6 below.
- 656 Anesthetics, oxygen, drugs and other biologicals.
- 657 Radiation therapy, short-term rehabilitation services and other forms of therapy only as described in Section 6.6 below.
- 658 Additional services, supplies, equipment and special procedures, on an inpatient or outpatient basis, but excluding convenience items (e.g., telephone, television, etc.).
- 659 Skilled nursing care provided in a participating Skilled Nursing Facility to the extent required by MDHHS if the Member requires medical and skilled nursing care (not domiciliary care or custodial care), in the absence of which hospital confinement could be Medically Necessary.

66 DIAGNOSTIC LABORATORY. X-RAY. AND IMAGING TESTS AND THERAPY

(INPATIENT AND OUTPATIENT). Diagnostic testing and therapy services covered by the PLAN shall include:

- 66.1 X-ray and laboratory tests, electrocardiograms and electroencephalograms.
- 66.2 Radiology services, including diagnostic and therapeutic isotopes and other radioactive materials used for therapeutic purposes.
- 66.3 Short-term physical therapy and medical rehabilitation services, including speech and functional occupational therapy from a Participating Provider, limited to the treatment of conditions that are subject to significant improvement through relatively short-term therapy, to the extent allowed by MDHHS. In order for such services to be covered by the PLAN, Member is required to obtain the prior approval and authorization of a PCP.

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

- 67.1 Emergency Medical Services include inpatient or outpatient services that are:

- (a) furnished by a provider qualified to furnish emergency services, including Non-Participating Physicians and Health Professionals in the Service Area or outside of the Service Area; and
- (b) necessary to evaluate or stabilize an Emergency Medical Condition found to exist using the prudent layperson standard.

6.72 Emergency transportation for Members shall be Covered.

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

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

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

6.74.2 Immediate Emergencies. In cases of an Emergency that requires immediate treatment before the PLAN'S Emergency Triage System can be contacted and/ or before treatment can be secured through the PLAN, the Member may utilize a Non-Participating Physician, Health Professional, or other Provider within or

outside the Service Area. Members are required to comply with the provisions of subsection 6.7.3 with respect to notifying the PLAN of such Emergency.

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

68 AMBULANCE/TRANSPORTATION. The following are Covered Services:

6.8.1 Air and land ambulance services for Emergency Medical Conditions.

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

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

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

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

69 HOSPICE CARE SERVICES.

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

6.9.2 Covered Hospice Care Services include:

- 6.921 Room and board at a hospice Facility or nursing home services and supplies at a Participating Provider or in the Member's home;
 - 6.922 Part-time home nursing care and home health and services up to a total of eight (8) hours per day;
 - 6.923 Consultation and case management services by the Member's PCP;
 - 6.924 Medical supplies and prescription drugs or medicines; and
 - 6.925 Physical therapy.
- 6.10 **OUTPATIENT MENTAL HEALTH SERVICES.** Outpatient mental health services are covered by the plan for defined services.
- 6.11 **PODIATRIC SERVICES.** Services of a Participating podiatrist are covered when referred by the PCP for the diagnosis or treatment of injuries or diseases of the Feet. Limits on these services are consistent with Medicaid Fee-for-Service policy.
- 6.12 **HOME HEALTH SERVICES.** Services rendered at a Member's home that are Authorized by the PLAN, including:
- 6.121 Professional medical care services deemed necessary for the Member's care and treatment, with the exception of private duty nursing.
 - 6.122 Subject to MDHHS limitations, intermittent home care nursing services (other than private duty nursing services) by a registered nurse or a licensed practical nurse, physical therapy services, occupational therapy services, nutrition education and guidance and part-time home health aide services, not including housekeeping or long-term custodial care services.
 - 6.123 Home care medical supplies when deemed Medically Necessary by the PCP for the care and treatment of the Member during the Member's home confinement.
- 6.13 **PREVENTIVE HEALTH SERVICES.** Preventive health services covered by the PLAN shall include:
- 6.131 Periodic health assessment and screening by the PCP at intervals deemed appropriate for the age, sex and medical history of the Member, including well-child care. Well-child care is a clinical assessment of a child in the absence of illness to determine physical status and detect any abnormalities. (See EPSD Tin Section 6.3)

- 6.132 Routine periodic childhood and adult immunizations in accord with the Advisory Committee on Immunization Practices Guidelines for all Members, either from the PCP or, without Prior Authorization from a local health department, excluding immunizations that are required only for travel.
- 6.133 Voluntary family planning service, including sexually transmitted disease testing and treatment. No Prior Authorization is required for these services.
- 6.134 Vision and hearing screening to determine the need for vision and hearing correction.
- 6.135 Health education and nutrition counseling services. Members may be responsible for a nominal fee for education services beyond what is provided in this Agreement.
- 6.136 Routine pelvic screening for women aged 18 and over.
- 6.137 Routine breast cancer screening mammography exam for women 40 or over.

6.14 ORGAN AND TISSUE TRANSPLANTS.

- 6.141 All organ and tissue transplants must receive Prior Authorization and be performed at a Participating Provider Authorized by the PLAN. The PLAN will pay for transplant-related hospital, surgical, laboratory, and X-ray services. Extrarenal organ transplants, such as heart, lungs, heart-lungs, liver, pancreas, small bowel, and bone marrow including allogeneic, autologous, and peripheral stem cell harvesting, are covered on a patient-specific basis when Medically Necessary according to accepted standards of care.
- 6.142 The PLAN will also pay for hospital, surgical, laboratory and X-ray services incurred by an organ/tissue donor who is not a PLAN Member resulting from the transplant of an organ to a Member by the PCP only to the extent such services are not covered by any other medical plan

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

6.16 **HEARING AND SPEECH SERVICES.** Services for the diagnosis or treatment of diseases or conditions of the ears when Authorized by the PCP, and audiometric examinations and hearing aid evaluation testing by a Participating Provider. The purchase and fitting of a

hearing aid is available to all members. Repairs, maintenance and batteries for hearing aids are covered for all ages.

6.17 **DENTAL SERVICES.** All enrollees ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid, are able to access dental services. Covered services include, but are not limited to; general dentistry, cleaning, check-ups, and other medically necessary services including X-Rays, extractions, fillings, crowns, root canals, dental scaling, dentures and planing services (one (1) per year).

6.18 **VISION SERVICES.** The care and treatment of diseases and conditions of the eye when provided by the PCP or referred by the PCP to a Participating optometrist or ophthalmologist, including:

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

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

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

6.19 **REPRODUCTIVE CARE AND FAMILY PLANNING SERVICES.**

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

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

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

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

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

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

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

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

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

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

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

621 DURABLE MEDICAL EQUIPMENT. Durable Medical Equipment is defined as equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of injury; and

(d) is appropriate for use in the home. In order for Durable Medical Equipment

to be covered by the PLAN it must be prescribed by a Participating Physician or Health Professional as Medically Necessary to treat an existing injury or illness, it must be obtained from a supplier approved by the PLAN and the Durable Medical Equipment be Authorized by the PLAN. The PLAN reserves the right to Authorize the least costly Durable Medical Equipment that is medically effective for the injury or illness.

Replacements of such Authorized Durable Medical Equipment due to normal usage is covered, but replacement due to loss; misuse or abuse is not a Covered Service.

See Section 7.1.33 for Excluded Durable Medical Equipment.

622 PROSTHETIC AND ORTHOTIC DEVICES. Coverage is provided for basic Prosthetic Devices and Orthotic Devices and specialized features authorized by the PCP and Authorized by the PLAN. Prosthetic and Orthotic Devices must be ordered by the Attending Physician and obtained from a PLAN-approved supplier. A Prosthetic Device is a device that replaces a missing part of the body or assist in the performance of a natural function of the body without necessarily replacing a missing part. Orthotic Devices are

those external devices that are designed to correct or assist in the prevention of a body defect, either of form or function. Breast prostheses are covered following a mastectomy.

- 6221 Replacement or repair is covered when due to normal usage or body growth or change but excluded from coverage are replacement and/or repair of Orthotic and Prosthetic Devices due to intentional damage, misuse or abuse and comfort and convenience items.
- 6222 Corrective Prosthetic Devices such as cardiac pacemakers and joint replacements are covered when surgically attached or implanted during surgery authorized by the PLAN.
- 6223 Dental appliances or non-rigid appliances including elastic stockings and garter belts.

623 DRUGS AND MEDICAL SUPPLIES. Covered benefits are listed herein. Members may fill their prescriptions at over 65,000 pharmacies nationwide, and at over 1,900 in Michigan. The PLAN uses a closed Formulary, which means that only drugs listed on the Formulary are covered (except with prior approval in special circumstances). For more facts regarding the Formulary or drugs that require the PLAN'S Prior Authorization, Members can call the PLAN at **1-866-316-3784**. When filling a prescription, Members shall present their Aetna Better Health of Michigan ID and MIHEALTH cards with the prescription at any Participating Pharmacy. The PLAN has contracted with CVS Caremark,

a pharmacy benefit manager, to manage prescription drug coverage for Members. Members should be aware that they will need to use their cards for certain drugs covered by Medicaid, such as anti-psychotic and HIV/AIDS drugs.

- 6231 Prescription Drugs, which are those medicinal substances which under federal law are required to bear on the package label the statement: "Caution: Federal law prohibits dispensing without a prescription," are Covered.
- 6232 Selected over-the-counter analgesics, laxatives, antacids, non-supplement and family planning drugs, devices or supplies are covered when prescribed by and Authorized by the PCP.
- 6233 Insulin, as well as necessary needles and syringes are covered when prescribed or authorized by the PCP.
- 6234 FDA-approved drugs used in anti-neoplastic therapy and the reasonable cost of administration, whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received FDA-approval if

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

6235 Coverage for an off-label use of a FDA-approved drug and the reasonable cost of supplies medically necessary to administer the drug.

- (1) Coverage for a drug applies if all of the following conditions are met:
 - (a) The drug is approved by the FDA.
 - (b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:
 - (i) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.
 - (ii) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.
 - (c) The drug has been recognized for treatment for the condition for which it is prescribed by one of the following:
 - (i) The American medical association drug evaluations.
 - (ii) The American hospital formulary service drug information.
 - (iii) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".
 - (iv) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

- (2) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer or health maintenance organization documentation supporting compliance with subsection (1).
- (3) This section does not prohibit the use of a copayment, deductible, sanction, or a mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the food and drug administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection shall not be more restrictive than for prescription coverage generally.
- (4) As used in this section:
 - (a) “Chronic and seriously debilitating” means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.
 - (b) “Life-threatening” means a disease or condition where the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome where the end point of clinical intervention is survival.
 - (c) “Off-label” means the use of a drug for clinical indications other than those stated in the labeling approved by the FDA.

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

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

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

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

627 **PUBLIC HEALTH DEPARTMENTS. FEDERALLY QUALIFIED HEALTH**

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

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

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

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

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

631.1 The PLAN will cover the following equipment, supplies and educational training related to the treatment of diabetes if determined to be Medically Necessary and prescribed by the Member's PCP or a Specialist Physician to whom the Member is Appropriately Referred: (a) blood glucose monitors for the legally blind; (b) continuous glucose monitoring systems (CGMS) for some individuals with Type 1 diabetes, test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices; (c) insulin syringes;

(d) insulin pumps and medical supplies required for the use of an insulin pump; and (e) diabetes self-management training to ensure that Members with diabetes are trained as to the proper self-management training of their condition.

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

- (a) training is limited to completion of a certified diabetes education program should either of the following occur:
 - (i) training is considered Medically Necessary upon the diagnosis of diabetes by the Member's PCP or Specialist Physician to whom the Member is Appropriately Referred who is managing the Member's diabetic condition, and the services are needed under a comprehensive plan of care to provide necessary skills and knowledge or ensure therapy compliance; or
 - (ii) the Member's PCP or a Specialist to whom the Member is Appropriately Referred diagnoses a significant change with long term implications in the Member's symptoms or conditions that requires changes in the Member's self-management or a significant change in medical protocol or treatment modality.
- (b) training shall be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the MDHHS. This training shall be conducted in a group-setting whenever practicable.

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

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

634 CHILDREN'S SPECIAL HEALTH CARE SERVICES (CSHCS). The state of Michigan

program that serves children, and some adults, with special health care needs. Enrollment in Aetna Better Health of Michigan entitles CSHCS Members to receive the Covered Services set forth in Section 6.0, Covered Services. In addition, CSHCS Members are entitled to receive the following Services, which are not covered by Aetna Better Health of Michigan but are covered by the state of Michigan through CSHCS:

- 6341 Orthodontia services provided for certain qualifying diagnoses, such as Cleft Palate/Cleft Lip (must be medically necessary, related to the condition, and not for cosmetic purposes)”
- 6342 Respite services (maximum of 180 hours per family during the 12-month eligibility period when a beneficiary requires skilled nursing and a CSHCS nurse consultant determines appropriate)”
- 6343 Certain over-the-counter medications
- 6344 Hemophilia drugs
- 6345 Certain orphan drugs. These services will be coordinated by the local health department.

SECTION 7.0 EXCLUSIONS

- 7.1 **NON-COVERED SERVICES.** Services not listed in Section 6 are Excluded under the Agreement, unless required to be Covered by Medicaid program or Michigan law. Under the provisions of this Agreement, the following services shall not be Covered by the PLAN:
 - 7.1.1 Services obtained by a member outside the PLAN Service Area and not authorized by the PLAN are not Covered, except for Emergency Medical Services as described in Section 6.7.
 - 7.1.2 Dental for minor members and vision services except as specifically provided in Sections 6.3, 6.8, 6.14,6.17, and6.18. Private duty nursing services in the home.
 - 7.1.3 Non-medical ancillary services such as vocational rehabilitation and employee counseling.
 - 7.1.4 Cosmetic Services and Surgery; including but not limited to breast augmentation, refractive eye surgery, non-Medically necessary reduction mammoplasty, rhinoplasty, spider or varicose vein repair.
 - 7.1.5 Services not required to be provided to Medicaid recipients under the terms of the Comprehensive Health Care Program for Medicaid Beneficiaries.
 - 7.1.6 Weight reduction whether by surgery or commercial or medical programs, except when Medically Necessary to treat morbid obesity, and authorized by the PLAN.
 - 7.1.7 Acupuncture.

- 7.1.8 Faith healing.
- 7.1.9 Elective termination of pregnancy (abortion) and related services, except as set forth in Section 6.18.
- 7.1.10 Personal comfort items such as telephone, television and similar items.
- 7.1.11 Any and all infertility treatment or related services. This exclusion applies, without limitation, to services performed in connection with any non-coital form of conception such as artificial insemination, intrauterine insemination, in vitro fertilization (IVF), intrafallopian transfers, donor egg/donor sperm programs, pre-implantation genetic testing, embryo transplantation, reversal of voluntary sterilization, and any related diagnostic and therapeutic services unique to these technologies.
- 7.1.12 Services related in any way to surrogate parenthood, including, but not limited to, otherwise Medically Necessary obstetrical services.
- 7.1.13 Custodial or basic care (care that is or can be provided by individuals without specific health care skills, training, or licensure and is intended primarily for the purpose of meeting personal needs such as bathing, walking, dressing and eating) and domiciliary services (generally services for the purpose of maintaining or supporting a person's activities of daily living or basic needs for food, shelter, clothing and hygiene), including private duty or hourly nursing services, convalescent care services, and general housekeeping services provided on an inpatient, outpatient or in-home basis.
- 7.1.14 Food and nutritional supplements available without prescription.
- 7.1.15 Non-prescribed dietary supplements, vitamins, minerals, and infant formula.
- 7.1.16 Except as prescribed as treatment for diabetes, routine foot care such as treatment or trimming of corns, calluses, toenails, evaluation and treatment of subluxations of the feet and flat feet, and pedicures.
- 7.1.17 Home births.
- 7.1.18 Home health aide services including routine, unskilled care; housekeeping services; private duty or hourly nursing services; home health care services provided by a person who ordinarily resides in the Member's home or is part of the Member's immediate family; and respite care, unless and only to the extent provided as part of covered hospice services.

- 7.1.19 Long-term rehabilitative treatment.
- 7.1.20 Fees, costs, and expenses incurred by a person who donates an organ or tissue, unless the recipient is a PLAN Member and the donor's own health benefit plan does not otherwise cover the expenses.
- 7.1.21 Speech therapy for foreign accent reduction or English as a second language.
- 7.1.22 Prosthetic hair, hair transplants or other services, procedures or supplies designed to enhance hair growth are excluded, regardless of diagnosis.
- 7.1.23 Testing to determine parentage or DNA testing.
- 7.1.24 Services Payable Under Other Programs. Services are excluded from coverage under the Agreement to the extent the services are provided, paid or payable:
 - 7.1.24.1 Under an extended benefit provision of any other health insurance or health benefits plan, policy, program or certificate.
 - 7.1.24.2 Under any policy, program, contract or insurance as provided under Section 8.2 of this certificate.
 - 7.1.24.3 Under any school district and billed through the intermediate school district, veterans or public programs, including but not limited to Home & Community-Based Waiver Program Services.
 - 7.1.24.4 Substance Abuse Services such as screening, detoxification, intensive outpatient counseling, and methadone treatment and other substance abuse pharmaceuticals indicated exclusively for substance abuse treatment and specified on MDHHS's pharmacy vendor's website under the "Classes for Psychotropic and HIV/AIDS Carve Out" at <https://michigan.fhsc.com>. Refer to the Member Handbook for instructions on how to access these services or call Customer Service at **1-866-316-3784**.
 - 7.1.24.5 Mental Health Services for Members identified as being seriously mentally ill and requiring intensive or inpatient services are provided by the local Community Mental Health Service Program. Refer to the Member Handbook for instructions on how to access these services or call the PLAN'S Customer Service at **1-866-316-3784**.

- 7.1.24.6 Inpatient hospital psychiatric services. The PLAN will not Cover physician costs related to providing psychiatric admission histories and physicals, but if medical services are needed for care other than psychiatric care during a psychiatric inpatient admission, the PLAN will pay for Prior Authorized and Medically Necessary Covered Services.
- 7.1.24.7 Outpatient Partial Hospitalization Psychiatric Care.
- 7.1.24.8 Services, including therapies (speech, language, physical, occupational), provided to persons with developmental disabilities and billed through community mental health services program providers or intermediate school districts.
- 7.1.25 Non-emergent transportation, other than as provided in Section 6.9.
- 7.1.26 Over-the-counter medicines (other than as provided in Section 6.23.2). Standard “medicine cabinet” items, including but not limited to, first aid supplies.
- 7.1.27 Disposable medical supplies (other than as provided in Section 6.23).
- 7.1.28 Experimental and investigational services, which include any drug treatment, device, procedure, service or benefit which is experimental or investigational, with the exception of anticancer drugs as defined in Section 6.23.4 of this Agreement. For the purposes of this Agreement, a drug, treatment, device, procedure, service or benefit may be considered to be experimental or investigational if it meets any one of the following criteria: (a) it cannot be lawfully marketed without the approval of the Food and Drug Administration (“FDA”) and such approval of the FDA was not granted at the time of the use or proposed use; (b) it is the subject of a current investigational new drug or new device application on file with the FDA; (c) it is being provided pursuant to a research, investigational or experimental stage or phase of a clinical trial as established, monitored or regulated by any state or federal government or agency; (d) it is being provided pursuant to a written protocol which describes among its objectives, determination of safety, efficacy, efficacy in comparison to conventional alternatives or toxicity; (e) it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services; (f) the predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings; (g) if the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to

determine safety, toxicity, efficacy, or efficacy in comparison to conventional alternatives; or (h) it is not investigational in itself pursuant to any of the foregoing criteria, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is “investigational or experimental.” Without limiting the above the following are considered experimental or investigational and therefore are not Covered Services:

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

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

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

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

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

7.133 Psychotropic & HIV/AIDS Drugs. The PLAN shall not Cover anti-psychotic classes and the H7Z class psychotropic drugs or drugs in the anti-retroviral classes, including protease inhibitors, and reverse transcriptase inhibitors. These drugs will be available via the Medicaid fee-for-service system and a copayment may be

required. Members are required to use their MI HEALTH card to access these drugs.

- 7.134 Sterilization procedures unless Prior Authorized by the PLAN.
- 7.135 Intermittent or short-term restorative or rehabilitative nursing care, in a nursing facility after a period of forty-five (45) days.
- 7.136 Traumatic Brain Injury Program Services.
- 7.137 Substance abuse treatment drugs as listed under the category “Classes for Psychotropic and HIV/AIDS Carve-Out” at www.MICHIGAN.fhsc.com. These medications will be reimbursed by MDHHS’s pharmacy TPA through a point-of-service reimbursement system.

72 OTHER EXCLUSIONS

- 721 Care rendered by Member or a Member’s family member or by a business entity that Member or a family member of Member controls.
- 722 Any service or supply, or portion of a charge thereof, for which Member has no financial liability, or that was provided free of charge.
- 723 Services and/or supplies obtained fraudulently.
- 724 Services and/or supplies rendered prior to Member’s Effective Date.
- 725 Charges resulting from Member failing to appropriately cancel a scheduled appointment.
- 726 Services and/or supplies prohibited from being rendered by law or regulation.
- 727 Procedures to repair or remove varicose veins unless Medically Necessary.

SECTION 8.0 COORDINATION OF BENEFITS AND SUBROGATION

8.1 COORDINATION IN GENERAL WITH OTHER INSURANCE. By federal and state law,

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

- 82 **PLAN'S SUBROGATION RIGHTS.** The PLAN shall be subrogated and shall succeed to any Member's rights of recovery from a third party (such as automobile insurance, liability insurance, and worker's compensation insurance) for incurred services provided under this contract. The Member shall reimburse the PLAN to the extent of the amounts recovered by said Member as a result of any lawsuit, settlement, or otherwise, less the PLAN'S pro-rated share of attorney fees and costs sustained by the Member in obtaining such a recovery. If the attorney fees of the Member are to be paid on a contingency basis, the PLAN'S right of subrogation will be reduced by its pro-rata share of attorney fees which do not exceed twenty-five (25) percent of any recovery. The Member shall, upon request by the PLAN, execute and deliver such instruments and papers as may be required to do whatever else may be necessary and reasonable to carry out this Section 8.2.
- 83 **COORDINATION WITH MEDICARE.** Members who become eligible for both Medicaid and Medicare coverage are ineligible for enrollment in the PLAN. The PLAN shall initiate disenrollment with MDHHS. When a Member is also enrolled in Medicare, Medicare will be the primary payer ahead of the PLAN. The PLAN will pay or otherwise cover all cost-sharing amounts incurred by the Member such as coinsurance and deductibles required by Medicare. Members who are eligible for Medicare must apply for Medicare coverage.

SECTION 9.0 MEMBER RIGHTS

- 91 **INSPECTION OF RECORDS.** A Member, parent, guardian or authorized representative of a Member may review the records of the PLAN relating solely to the Member or a minor Dependent of the Member who is also a Member, at the offices of the PLAN during regular business hours and at an appointed hour reasonably granted on request by the Member for that purpose.
- 92 **REFUSAL TO ACCEPT TREATMENT.** A Member may for personal or religious reasons refuse to accept the recommended treatment or procedures recommended by a Participating Physician (or Health Professional). Such refusal to accept treatment may be regarded as incompatible with the physician/patient relationship and as an impediment to the rendering of proper health care. If a Member refuses to accept recommended treatment and no reasonable alternative for treatment exists, the Member shall be so advised. If the Member still refuses recommended treatment, neither the PLAN nor the Physician shall have further responsibility to provide care for the condition being treated. The foregoing is subject to the Member's right to file a grievance in accordance with the Grievance and Appeal Program. The PLAN may request disenrollment when the member

has been discharged from the practices of available PLAN providers due to actions inconsistent with PLAN membership.

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

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

95 **NOTICE OF CHANGE OF ADDRESS. OTHER COVERAGE. CHANGE IN**

ELIGIBILITY.LOSS OR THEFT OF IDENTIFICATION CARD. Member agrees to

notify the PLAN promptly, either in writing or by telephone, of any change in address or if the Identification Card is lost or stolen. Member agrees to give the PLAN notice of any other health benefit coverage under which the Member is covered at the time of enrollment or at any time thereafter while this Coverage is in effect, or any change in eligibility.

96 **AUTHORIZED FOR RELEASE AND RECEIPT OF INFORMATION.** Member agrees to

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

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

SECTION 10.0 GRIEVANCE AND APPEAL PROCEDURES

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

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

Submit your requests to:

Michigan Administrative Hearing System for the Michigan Department of Health and Human Services

P.O. Box 30763
Lansing, MI 48909
1-877-833-0870

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

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

- Deny or limit authorization of a service that You or Your Provider requests.
- Fail to make payment or provide, in whole or in part, a benefit to You.
- Fail to provide services in a timely manner.

- Reduce, either entirely or partially, suspend, or terminate a benefit or previously authorized service (except when reduction, suspension, or termination result from state or federal action).
- Fail to act within specified timeframes when We handle your Grievance/Appeal.
- Fail to authorize or Cover services because We think that the services are experimental, investigational, cosmetic, or not Medically Necessary or appropriate.

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

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

If you need help filing a Grievance/Appeal, We are here to help You. Please contact the Appeals Coordinator at **1-866-316-3784 (TTY: 711)**. If You send Your Grievance/Appeal to Us in writing, We will send You a letter acknowledging Our receipt of Your Grievance/Appeal within three (3) days of Our receiving it. We will contact You within ninety (90) days to let You know how Your Grievance was resolved. If you receive an Adverse Benefit Determination after you file a Grievance, you can file an Appeal. If You file an Appeal, we will contact you within 30 days to let you know if Your Appeal was resolved. If You need Your Grievance/Appeal reviewed on an Expedited basis because it involves a medical condition that requires an immediate response from Our Health Services Department, We will respond to Your Grievance/Appeal within seventy-two

(72) hours of receiving it. The PLAN staff reviewing Your Grievance/Appeal will not have been previously involved in any prior decisions about Your Grievance/Appeal. The PLAN will make sure that the staff reviewing Your Grievance/Appeal has the necessary qualifications to review Your Grievance/Appeal.

102 THE GRIEVANCE/APPEAL PROCESS

- 1021 If You receive an Adverse Determination or denial of payment from Us, or if We did something you are dissatisfied with, You can dispute it using the Grievance/Appeal process described below. You can also have Your Provider act on Your behalf. To do that, You must complete an Authorized Representative form, which You can receive by calling Customer Service.
- 1022 You can file a Grievance at any time. We have ninety (90) days after your Grievance is received to resolve it. If You receive an Adverse Determination in response to your Grievance, you can file an Appeal within sixty (60) days. We have thirty (30) days after your Appeal is received to respond to it. If You receive an Adverse Determination in response to your Appeal, you can request a State Fair hearing from MDHHS. You must request a State Fair hearing within 120 days of the Adverse Determination for your Appeal. At any time, you can contact the Appeals Coordinator at **1-866-316-3784 (TTY: 711)**.
- 1023 You, or Your Authorized Representative, need to send Us a written request that includes Your name, the name of the treating Provider, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with, Your (or Your representative's) mailing address, an explanation of why We should reverse Our decision, and a copy of any information that will support Your request. You may also provide Us with any additional documents, records or information that is relevant to Your Grievance/Appeal.
- 1024 If You have an Authorized Representative, You should also send us the completed Authorized Representative form. Such requests should be addressed to: Aetna Better Health of Michigan Attn: Appeals Coordinator PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181 or email MIAppealsandGrievances@Aetna.com. If You would like to have an Authorized Representative act on Your behalf, We cannot begin to review Your Grievance/Appeal until We receive the Authorized Representative form. If We receive Your Grievance/Appeal without an Authorized Representative Form, We will not start to process Your Grievance/Appeal until We get this Form. You may submit an Authorized Representative Form at any time before the period in which You are entitled to submit a Grievance/Appeal to Us. Our timeframe to review Your Grievance/Appeal will begin on the day that We receive the Authorized Representative Form from You.
- 1025 If You or Your representative cannot file a written Grievance/Appeal, You may contact Us so that We can obtain the above information and fill out the necessary documents to start Your Grievance/Appeal. You or your representative may request access to and copies of documents, records and information relevant to the Grievance/Appeal. We will provide

you with that information free of charge. We will also provide You with assistance, if You need it, with completing the paperwork and other steps of Your Grievance/Appeal, for example, if You need an interpreter or a TTY/TTD capability.

- 1026 Within three (3) working days of Our receipt of Your Grievance/Appeal, the Appeal Coordinator will send a letter to You or Your Authorized Representative confirming receipt of the Grievance/Appeal. The notice will also notify You or Your Authorized Representative of Your rights during the Grievance/Appeal process, including: information on how to contact the Appeal Coordinator who has been appointed to assist in resolving formal Grievances/Appeals; Your right to appear before the Appeal Committee; Your right to request a representative to act on Your behalf;

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

- 1027 If We determine that We need an extension in order to obtain additional information from your treating Provider, and it is in Your best interest, We will extend Our time period once during the Grievance/Appeal process for up to fourteen (14) calendar days with Your permission.

- 1028 Depending on whether Your Grievance/Appeal involves a medical or non-medical issue, the Appeal Committee will be made up of the Plan's senior managers and/or the Plan's Medical Director, and other health professionals. No one on the Appeal Committee was involved in making the original decision about Your care, or reports to the person who made the original decision about Your care.

- 1029 We will render a final decision within five (5) business days of the Appeal Committee meeting and within ninety (90) calendar days after the date the Grievance was received or thirty (30) calendar days after the date the Appeal was received. We will send written notice of Our decision to You or Your Authorized Representative within ninety (90) calendar days after the date the Grievance was received or thirty (30) calendar days after the date the Appeal was received. The notification will include:

- The specific reason(s) for the determination;
- Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
- Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
- If the Grievance/Appeal decision is based on Medical Necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
- Notice of any further Grievance/Appeal rights
- A list of the persons on the Appeal Committee
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal;
- A statement of Your rights to request a State Fair Hearing, or appeal to the Michigan Office of Financial and Insurance Regulation, as may be applicable; and
- A statement of Your rights to continuation of health benefits during the time a State Fair Hearing is pending.

103 URGENT/EXPEDITED GRIEVANCES/APPEALS

- 103.1 You or Your Authorized Representative (which may include the treating Provider) may file an Urgent/Expedited Grievance/Appeal in writing or orally. The Urgent/Expedited Grievance/Appeal may be submitted verbally or in writing to: Aetna Better Health of Michigan Attn: Appeals Coordinator, PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181 or email MIAppealsandGrievances@Aetna.com. Or you can call us at **1-866-316-3784 (TTY: 711)**.
- 103.2 If You would like to have an Authorized Representative, other than Your treating Provider, act on Your behalf during an Urgent/Expedited Grievance/Appeal, and You are unable to submit an Authorized Representative Form to Us because of Your incapacity or an emergency circumstance, We may proceed with Your Grievance/Appeal and communicate with the purported Authorized Representative if it is in Your best interest and if the information disclosed is directly relevant to Your Grievance/Appeal.
- 103.3 To request an Urgent/Expedited Grievance/Appeal, You or Your Authorized Representative must give Us Your name, Your Provider's name, the date of service (if it already took place), a description of the service that was requested or received and denied by Us, or the action We took that You are dissatisfied with, Your (or Your

Authorized Representative's) mailing address and telephone number, an explanation of why We should reverse our decision, and a copy of any information that will support Your request.

- 1034 If there is insufficient information provided with the Urgent/Expedited Grievance/ Appeal, We will notify You or Your Authorized Representative immediately by telephone of the information needed. If the necessary information is not received, the Appeal committee will make a decision based on the information available.
- 1035 If a physician with knowledge of Your medical condition determines that a Grievance/ Appeal involves Urgent/Expedited, We will treat your Grievance/Appeal as an Urgent/ Expedited Grievance/Appeal. If You request an Urgent/Expedited Grievance/Appeal, but Your Provider does not also state that Your Grievance/Appeal should be handled on an Urgent/Expedited basis, Our Medical Director will review Your Grievance/Appeal to determine if Your Grievance/Appeal qualifies as an Urgent/Expedited Grievance/ Appeal. If We decide that Your Grievance/Appeal is not an Urgent/Expedited Grievance/ Appeal and that it should be processed as a standard Grievance/Appeal, We will verbally notify You as soon as possible, and send You a letter within two (2) days. You will be able to Appeal Our decision to the Michigan Department of Insurance and Financial Services (DIFS) within ten (10) days.
- 1036 If We proceed with Your Urgent/Expedited Grievance/Appeal, a hearing will be scheduled with an Appeal Committee to take place within forty-eight (48) hours of Your request, and Your Grievance/Appeal will be resolved within seventy-two (72) hours of Your request. You and/or Your Authorized Representative may participate in the hearing. If You or Your Authorized Representative requests an extension during the Urgent/Expedited Grievance/Appeal, the Grievance/Appeal will have to be moved to the standard timeframe for Us to decide Your Grievance/Appeal. We will provide You with written confirmation of the transfer to the standard Grievance/Appeal timeframes within two (2) days of Your request for extension. If You or Your Authorized Representative chooses to withdraw the request for the extension, We will consider Your Grievance/Appeal on an urgent/expedited basis, within seventy-two (72) hours.
- 1037 None of the individuals on the Appeal Committee will be someone who was involved in the original Adverse decision or who reports to someone who was involved in the original Adverse decision. You or Your Authorized Representative will be offered the opportunity to attend and participate in the Appeals Committee Meeting when your Appeal is considered by the Committee.

1038 We will render a final decision and provide verbal and written notice of that decision within seventy-two (72) hours after the date the Grievance/Appeal was received. The notification will include:

- The specific reason(s) for the determination;
- Reference to the specific Coverage provision on which the determination was based (i.e., reference to the specific section in Your Evidence of Coverage);
- Notice if an internal rule, guideline or protocol was utilized in making the determination, and if an internal rule, guideline or protocol was utilized in making the determination, notice that a copy of such rule, guideline, or protocol is available upon request and free of charge;
- If the Grievance/Appeal decision is based on Medical Necessity, experimental treatment or a similar exclusion (i.e., investigational, cosmetic, etc.), the specific clinical rationale for the determination;
- Notice of any further Grievance/Appeal rights;
- A list of the persons on the Appeal Committee;
- A statement that You are entitled to receive, upon request and free of charge, reasonable access to all documents, records, and other information relevant to Your Grievance/Appeal;
- A statement of Your rights to request a State Fair Hearing, or appeal to the Department of Insurance and Financial Services, as may be applicable; and
- A statement of Your rights to continuation of health benefits during the time a State Fair Hearing is pending.

104 **CONTINUATION OF BENEFITS.**

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

1041 As used in this section, “timely” Filing means Filing on or before the later of the Following:

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

1042 We will continue Your benefits during the time of the Grievance/Appeal due to an Adverse Determination process or State Fair Hearing when:

- 10421 You or Your Authorized Representative Files the Grievance/Appeal due to an Adverse Determination on a timely basis;

- 10422 Your Grievance/Appeal due to an Adverse Determination involves the termination, suspension, or reduction of a previously authorized course of treatment;
- 10423 Your services were ordered by an authorized provider;
- 10424 The original period covered by the original authorization has not expired; and
- 10425 You request extension of the benefits.

1043 If, at Your request, We continue or reinstate Your benefits while the Grievance/ Appeal due to an Adverse Determination is pending, the benefits must be continued until one of the Following occurs:

- 10431 You withdraw the Grievance/Appeal.
- 10432 Ten (10) days pass after We mailed the notice providing the resolution of the Grievance/Appeal in Our Favor, unless You, within the ten (10) day timeframe, have requested a State Fair Hearing with continuation of benefits until a State Fair Hearing decision is reached.
- 10433 A State Fair Hearing officer issues a hearing decision adverse to You.
- 10434 The time period or service limits of a previously authorized service has been met.

1044 IF the Final resolution of the Grievance/Appeal due to an Adverse Determination upholds the original action. We may recover the cost of the services Furnished to You while the Grievance/Appeal was pending, to the extent that such services were Furnished solely because of the requirements of this section.

1045 If We, or the State Fair Hearing officer, decide in Your Favor and reverse a decision to deny, limit, or delay services that were not Furnished while the Grievance/Appeal was pending, We must authorize or provide the disputed services promptly and as expeditiously as Your health condition requires.

1046 If We, or the State Fair Hearing officer, reverse a decision to deny authorization of services, and You received the disputed services while the Grievance/ Appeal was pending. We must pay for those services.

105 YOUR RIGHTS UNDER THE PATIENT RIGHT TO INDEPENDENT REVIEW ACT

(“PRIRA”). After You have used Our Grievance and Appeal Program for a Non-Urgent/Expedited Grievance/Appeal, and We have issued Our Final decision, You may seek external review through the Michigan Department of Insurance and Financial Services (“DIFS”) pursuant to Michigan law within one hundred twenty-seven

(127) days of Your receipt of Our Final decision. In the case of an Urgent/Expedited Grievance/Appeal, You can also File a request for expedited external review with DIFS if You have First sent notice to Us. You should use the “Health Care Request for External Review Form” that We provide to You. This Form can also be Found at www.michigan.gov/documents/cis_ofis_fis_0018_25078_7.pdf.

To qualify for PRIRA review:

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

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

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

DIFS, Health care Appeals Section Office of General Counsel

P.O. Box 30220

Lansing, MI 48909-7720

Delivery service to:

Office of General Counsel – Health Care Appeals Section Department of Insurance and Financial Services

530 W. Allegan St., 7th Floor

Lansing, MI 48933-1521

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

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

1053 You do not need to hire a lawyer to request a PRIRA Review. You can authorize someone to act on your behalf, such as a clergy, a friend, a family member, your doctor, or a lawyer.

1054 DIFS will notify You within five (5) business days of receiving Your request for PRIRA Review if DIFS can handle Your case. If Your case is accepted by DIFS, DIFS will determine whether it needs to get a recommendation from an Independent Review Organization, which is an entity that can perform an unbiased medical review of Your case. If DIFS does not need to consult with an Independent Review Organization, You can expect to receive a decision from DIFS within fourteen (14) calendar days after Your request was accepted by OFIR for review. If DIFS has to consult with an Independent Review Organization, the Independent Review Organization has fourteen

(14) calendar days after it receives the case from DIFS to make a recommendation to DIFS. DIFS then has seven (7) business days to issue its decision to You.

1055 If You disagree with DIFS' decision, You can appeal to the Circuit Court of the county in which You live, or the Circuit Court of Ingham County.

1056 PRIRA Review cannot be requested for complaints by Providers regarding claims payment or handling of reimbursement for services. PRIRA Review does not apply to issues of termination, cancellation, or the amount You have to pay for Coverage.

1057 If You have questions about PRIRA Reviews, You can call the Appeals Coordinator at **1-866-316-3784**, TTY **711**, or DIFS at **1-877-999-6442**.

SECTION 11.0 GENERAL CONDITIONS

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

11.2 **CIRCUMSTANCES BEYOND THE PLAN'S CONTROL.** In the event that, due to circumstances not reasonably within the control of the Plan, including but not limited to complete or partial destruction of facilities, a major natural disaster, epidemic, war, riot, civil insurrection, labor dispute, disability of a significant part of a hospital or a disability of the Plan personnel, or similar causes which delay or render impractical the rendition of

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Questions? Call Aetna Better Health Member Services at **1-866-316-3784 (TTY: 711)**.

Visit our website at [AetnaBetterHealth.com/Michigan](https://www.aetnabetterhealth.com/michigan)

services described in this Agreement, neither the Plan nor any Participating Provider shall be liable for such delay or failure to provide services as a result of such circumstances. For purposes of this Section, the term “epidemic” shall mean an outbreak of a contagious disease that spreads rapidly by infection among a population throughout a particular geographic area.

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

Aetna Better Health of Michigan
28588 Northwestern Hwy, Suite 380B
Southfield, MI 48034

- 11.4 **HEADINGS.** The catch line headings and captions in no way shall be considered to be a part of this contract but are inserted only for the convenience of reference.
- 11.5 **GOVERNING LAW.** This contract is made and shall be interpreted under the laws of the state of Michigan and federal law, where applicable.
- 11.6 **EXECUTION OF CONTRACT.** The parties acknowledge and agree that the Member’s signature or execution on a MDHHS Eligibility Application form shall be deemed to be the Member’s execution of this Agreement.
- 11.7 **SEVERABILITY.** If any provision of the Agreement, on its effective date or thereafter, is determined to be in conflict with federal or Michigan law or applicable rules and regulations of the Michigan Office of Financial and Insurance Regulation, such provision shall be fully severable, and the remaining provisions of the Agreement shall continue in full force and effect.
- 11.8 **WAIVER.** The waiver by either party of any breach of any provision of the Agreement shall be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right under this Agreement shall not operate as a waiver of such right.
- 11.9 **DISCLAIMER.** The Plan contracts with independent physician groups who provide health care to Members and other patients. The Plan does not directly furnish medical care, make medical judgments, or assume any responsibility for the physician’s medical treatment of the Members.

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

11.11 **CONFIDENTIALITY AND PRIVACY.**

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

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

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

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

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

Name.

Date of birth.

Health care you received.

Amounts paid for your care.

How we use and share your health information to help take care of you. We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical

tests. We may also remind you of appointments. We may share your health information with other people who give you care. This could be doctors or drug stores. If you are no longer with our plan, with your approval, we will give your health information to your new doctor.

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

If you are a minor and do not want us to give your health information to your parents or legal guardians, call us at **1-866-316-3784**. We can help in some cases if allowed by state law.

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

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

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

A case manager may work with your doctor. They may tell you about programs or places you can access or enroll in to help you with your health problems. Materials are available to members. When you call us with questions, we need to look at your health information to give you answers.

Sharing with other businesses. We may share your health information with other businesses. We do this for the reasons we explained above. For example, you may have transportation covered in your plan. We may share your health information with them to help you get to the doctor's office. We will tell them if you are in a motorized wheelchair, so they send a van instead of a car to pick you up.

Other reasons we might share your health information. We also may share your health information for these reasons:

Public safety –To help with things like child abuse. Threats to public health.

Research – To researchers. After care is taken to protect your information.

Business partners – To people that provide services to us. They promise to keep your information safe.

Industry regulation – To state and federal agencies. They check us to make sure we are doing a good job.

Law enforcement – To federal, state and local enforcement people.

Legal actions – To courts for a lawsuit or legal matter.

Reasons that we will need your written okay: Except for what we explained above, we will ask for Your approval before using or sharing your health information. For example, we will get Your approval:

For marketing reasons that have nothing to do with your health plan.

Before sharing any psychotherapy notes.

For the sale of your health information.

For other reasons as required by law.

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

What are your rights. You have the right to look at your health information. You can ask us for a copy of it. Contact Member Services **1-866-316-3784 (TTY: 711)** or visit our website [AetnaBetterHealth.com/Michigan](https://www.aetna.com/betterhealth/michigan)

- You can ask for your medical records. Call your doctor’s office or the place where you were treated. You have the right to ask us to change your health information.
- You can ask us to change your health information if you think it is not right. If we do not agree with the change you asked for. Ask us to file a written statement of disagreement.
- You have the right to get a list of people or groups that we have shared your health information with.

- You have the right to ask for a private way to be in touch with you. If you think the way we keep in touch with you is not private enough, call us. We will do our best to be in touch with you in a way that is more private.
- You have the right to ask for special care in how we use or share your health information. We may use or share your health information in the ways we describe in this notice. You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care.
- You have the right to know if your health information was shared without your approval. We will tell you if we do this in a letter.
- You can ask us not to use or share your information in these ways. This includes sharing with people involved in your health care. We do not have to agree. But we will think about it carefully.
- You have the right to know if your health information was shared without your approval. We will tell you if we do this in a letter. Call us toll free at **1-866-316-3784 (TTY: 711)**. to: Ask us to do any of the things above. Ask us for a paper copy of this notice. Ask us any questions about the notice.
- You also have the right to send us a complaint. If you think your rights were violated write to us at: Aetna Better Health of Michigan, Member Services department PO Box 81139, 5801 Postal Rd, Cleveland, OH 44181 or email to MIAppealsandGrievances@Aetna.com
- You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address. If you are unhappy and tell the Office of Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.



Nondiscrimination Notice

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

Aetna:

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

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

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

Address: Attn: Civil Rights Coordinator
 PO Box 818001, Cleveland OH 44181-8001

Telephone: **1-888-234-7358 (TTY: 711)**

Email: MedicaidCRCoordinator@Aetna.com

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

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

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

Multi-language Interpreter Services

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

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

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

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

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

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

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

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

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

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

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