Helpful information

Aetna Better Health® of Nevada
Member Services
1-866-815-3732 (toll-free)
24 hours a day, 7 days a week

Services for hearing and speech-impaired (TTY)
If you are hearing or speech impaired, call 711 from any phone for help calling Aetna Better Health.

Language services
If you do not speak English, call 1-866-815-3732, TTY 711, for help. We can get you an oral or sign language interpreter to help you talk during your doctor visits. Call Member Services 24 hours a day, 7 days a week

Alternative formats
If you have a hard time seeing, or you don’t read English, you can get information in other formats such as large print, audio or Braille. These services are at no cost to you.

Mailing address
Aetna Better Health of Nevada
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119

To report fraud or abuse
Hotline 1-866-815-3732

Nurse Line
1-866-815-3732
24 hours a day, 7 days a week

Behavioral Health Crisis Line
1-866-815-3732
24 hours a day, 7 days a week

Emergency (24 hours)
When you need emergency care, call 911 or go to the closest hospital. The hospital DOES NOT need to be in our network. You don’t need preapproval for emergency transportation or emergency care in the hospital.

Personal information

____________________
My member ID number

____________________
My PCP (Primary Care Provider)

____________________
My PCP's phone number

www.aetnabetterhealth.com/nevada
Nondiscrimination Notice

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

Aetna:

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

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

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

Address: Attn: Civil Rights Coordinator
4500 East Cotton Center Boulevard
Phoenix, AZ 85040

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

Email: MedicaidCRCoordinator@aetna.com

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

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


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)。

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


AMHARIC: የአማርኛ ከታደጋ ከሚ ከማስገባ ያለበት ከማስገባ ያለበት ለማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገባ ከሚ ከማስገبا 1-800-385-4104 (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。


PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا پاسپورت 1-800-385-4104 (TTY: 711).

SAMOA: UA’I MAI: ‘Afai e te tautala Gagana Fa’a Sāmoa, o lo’o iai ‘au’aunaga fesoasoani, e fai fua e lea se totogi mo’oe. Telefonimai i le númera i tua o lau pepa malō ID po’o i le 1-800-385-4104 (TTY: 711).


ILOKANO: PALAGIP: No Ilokano ti pagsaom, maipaay kenka a libre dagiti serbisio iti lenguauhe tapno maipeksam ti kayatmo iti bukodmo a pagsasa. Awagam ti numero nga adda iti likud ti ID card-mo wenno ti 1-800-385-4104 (TTY wenno kadagiti adda diperensia iti panagdengngegna: 711).
Dear Member,

Thank you for choosing Aetna Better Health® of Nevada as your Medicaid TANF or Nevada Check Up plan. We are an Aetna health plan. Aetna has been providing health care to families for over 150 years.

Joining our plan was a good decision. We have many providers ready to help keep you and your family well. We also have caring member services staff ready to answer your health care coverage questions. Our member services staff offers a concierge style service and will assist you with finding a doctor and scheduling an appointment.

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

• Your primary care provider or PCP
• What benefits are covered
• What to do in an emergency
• Your rights and responsibilities as a member

If there are Aetna Better Health of Nevada plan changes that will affect your access to services and information about the program, we will notify you at least 30 days before the effective date of the changes. We will also provide these notices in our semi-annual member newsletters.

You may have already received your Aetna Better Health of Nevada ID card. Your ID card tells you when your membership starts and the name of your PCP. Check your ID card right away. Call us at 1-866-815-3732 TTY 711 if:

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

If you have questions or problems getting services, we are here to help you. We are here to take calls 24 hours a day, 7 days a week. Our toll-free phone number is 1-866-815-3732 TTY 711. To view this handbook, find information about our programs and services, or to look for a provider, go to our website at www.aetnabetterhealth/nevada.

We look forward to providing your health care benefits!

Sincerely,

Mike Easterday
Chief Executive Officer
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Monday through Friday (8 a.m. to 5 p.m.)
Welcome

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

- Quality health care
- Respect
- Excellent concierge style customer service

Your member handbook

This is your member handbook. This is a guide to help you understand your health plan and benefits. The member handbook is sent to the head of household but each member will get a separate identification (id) card. Throughout the handbook, when we refer to “the Plan,” we are referring to Aetna Better Health of Nevada. You will want to read and keep this handbook which is updated at least once a year. A copy of this handbook can also be found on our website at www.aetnabetterhealth.com/nevada. It will answer questions you may have right now and in the future like:

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

Your handbook will also give you information like:

- Your right to obtain available and accessible health care services covered by Aetna Better Health
- How to get health care services, including out-of-plan services and how to access them
- Aetna Better Health’s address and telephone number and the days we are open and services are available
- The role of your primary care provider (PCP) or Primary Care Site and how you will be notified of your PCP selection
- How to request a list of current network PCPs
- Any limits on freedom of choice from network providers
- How to change your PCP
- Your rights and protections
- Detailed description of your benefits, how to obtain them and family planning services
- Prior authorization process
• How to request disenrollment (with or without cause)

Member Services
Member Services is here to help you. We are here to take calls 24 hours a day, 7 days a week and the office is open 8 a.m. to 5 p.m., Monday thru Friday. Our toll free phone number is **1-866-815-3732, TTY 711**. You can call this number from anywhere, even if you are out of town.

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

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

Member Services needs your help too. We value your ideas and suggestions to change and improve our service to you. Do you have an idea on how we can work better for you? Please call Member Services at **1-866-815-3732, TTY 711** or write to:

Aetna Better Health of Nevada
Attention: Member Services
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119

At times we may hold special events for members to learn about the Plan. You will receive information about these events ahead of time. It is a good idea to come if you can. It will help you get to know us and learn about your health care services.

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

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

The nurses can also give you helpful hints on how to help you feel better and stay healthy. When a pain is keeping you awake, it’s nice to know that, with this service, you won’t be up alone. Call us at **1-866-815-3732, TTY 711**.
Language services
Call 1-866-815-3732, TTY 711, if you need help in another language. We will get you an oral interpreter in your language 24 hours a day/7 days a week. This service is available at no cost to you.

You can get this member handbook or other member material in another language. Call Member Services at 1-866-815-3732, TTY 711.

Other ways to get information
If you are deaf or hard of hearing, please call the Nevada Relay at 711. They can help you call our Member Services at 1-866-815-3732, TTY 711.

If you have a hard time seeing or hearing, or you do not read English, you can get information in other formats such as large print, audio or Braille. Call Member Services at 1-866-815-3732, TTY 711 for help.

Website
Our website is www.aetnabetterhealth.com/nevada. It has information to help you get health care plus help you:

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

Secure web portal
To get the most out of your health plan benefits, sign up for our personalized, secure member web portal at www.aetnabetterhealth.com/nevada. The site lets you:

• Access health plan details - anytime, anywhere
• You can change your doctor
• Get a new member ID card
• Update your contact information
• Find out how and when to get referrals or authorizations for services and their cost

Find support where you need it most
At Aetna Better Health we offer benefits that help you get and stay healthy. You will find educational information, self-help tools and wellness programs.

Get personalized health information
Tell us about your health by completing a personal health history. We’ll let you know what your risks are and where you can improve. Then get access to the healthy lifestyle tips and self-help tools. They can help you meet goals like quitting smoking and weight management. You’ll also get the chance to track your progress on your way to hitting your goals.
Learn more about your pharmacy benefits

Get details about your pharmacy benefits and services. This information will help you make the best decisions about your care. You’ll get access to:

• Find in-network pharmacies
• Help asking for a drug not covered by your plan
• Order a refill for an unexpired, mail-order prescription
• Look up drug interactions, side effects and risks
• Determine financial responsibility for a drug
• Find out if generic substitutes are available

Get instant access to claims details

Tracking a claim is easy via our secure member portal. You’ll find details on your claim that include:

• Stage in process (status of the claim)
• Amount approved
• Amount paid
• Member cost
• Date paid

Mobile app

With the Aetna Better Health application, you can get on demand access to the tools you need to stay healthy. Find a doctor, request or view your Plan ID card or change your Primary Care Provider (PCP) at any time, from anywhere. It’s easy. Just download the app to your mobile device.

Mobile app features

• Find a provider
• View or request your Plan ID card
• Speak to a nurse
• Change your PCP
• View your claims and prescriptions
• Message Member Services for questions or support
• Update your phone number, address and other important member details
Download app
To get the mobile app, you can download it from Apple’s App Store or Google’s Play Store. Search for “Aetna Better Health” to locate the app. It is free to download and free to use. This application is available on certain devices and operating systems (OS).

Wellness centers
Our wellness centers will be available to all members—with no limits—as well as to caregivers, providers, community organizations, and other stakeholders supporting members. Doctor services will not be offered at regional wellness centers and services offered will not replace health care services that you get from your PCP and other specialists.

Some services that are offered and coordinated through the regional wellness centers are:

- Meeting spaces, computers and Internet
- Access to our community resources database
- Educational workshops on health and wellness related topics
- Educational materials
- Help with other community needs like housing

Call Member Services at 1-866-815-3732, TTY 711 for help finding one of our wellness center locations.

Service Area and Plans
We offer services in the following counties in Nevada:

- Clark
- Washoe

Aetna Better Health offers coverage to Medicaid Temporary Assistance for Needy Families (TANF) and Nevada Checkup members in these counties. TANF provides temporary assistance for needy families to care for the children in their own homes or in the homes of relative care-givers. Nevada Check Up provides low-cost, complete health care coverage to low income, uninsured children (birth through 18) who are not covered by private insurance or Medicaid. The only cost to the Nevada Check Up member is a quarterly premium which are determined by family size and income. See page 33 for more information on premiums. If you are on Medicaid and you live in urban Washoe County or Clark County, unless you are under the special Medicaid category of aged, blind or disabled, you have to pick one of the managed care programs like Aetna Better Health of Nevada as your plan.

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

The ID card lists:

- Your name
• Member ID number
• Your Primary Care Provider’s name and phone number
• On the back is important information like what you should do in an emergency

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

Some members still have a fee-for-service (FFS) Medicaid card for the services the Plan does not cover. Always carry your FFS Medicaid ID card with you in case you need those services.

Medicaid and Nevada Check Up members will get an ID card from the Nevada Division of Medical Assistance and Health Services (DHCFP). This card is for services covered by DHCFP that are not covered by the Plan.

Front of card:

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

Look at your card to make sure the name, address, and date of birth are correct. Call Member Services at 1-866-815-3732, TTY 711 if:

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

Eligibility and enrollment

NOTE: THIS HANDBOOK IS NOT A CERTIFICATE OF INSURANCE AND SHALL NOT BE CONSTRUED OR INTERPRETED AS EVIDENCE OF INSURANCE COVERAGE BETWEEN AETNA BETTER HEALTH AND THE MEMBER.

You can be a Plan member as long as you are eligible for Nevada Medicaid and Nevada Check Up. Aetna Better Health of Nevada does not follow any policy, practice, deny enrollment or discriminate against members eligible to enroll based on health status, the need for health services, race, color or national origin. Your benefits are decided by the State of Nevada. The Division of Welfare and Supportive Services (DWSS) approves your enrollment in our health plan.

If you are under a doctor’s care when you join the Plan, let us know. We will work with you and your doctor to make sure you get the continued care you need. Call Member Services at 1-866-815-3732, TTY 711 for help.

Confirmation of enrollment

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

Changing health plans

If you are new to Medicaid, you can change your plan within the first 90 days that you are enrolled into Aetna Better Health of Nevada for any reason. You can also change your plan during the annual open enrollment period which is held at least once every twelve (12) months. You will get a notice when it is open enrollment and at that time, you can change Plans or stay with the current plan. To request this type of change, submit a written request that includes a brief statement, your name, your Medicaid ID, your signature and the date. Mail this letter to Hewlett Packard Enterprise Services (HPES) at:

    HPES
    PO Box 30042
    Reno, NV 89520

Keep a copy of the request that you sent in the mail for your records. If your request to change your plan is approved, your new plan will become effective the first of the next possible month. This means that if HPES receives your request early in the month, your plan change will become effective the first of the next month. If HPES receives your request late in the month, your plan change will not become effective for another month.
After the ninety (90) days or when open enrollment is over, and if you are still eligible for Aetna Better Health, you will stay enrolled with us. If it is not open enrollment time, you can only change health plans if you show good cause. Your good cause will need to be submitted in writing to Aetna Better Health for approval. See page 17 for details on disenrollment.

**Reinstatement**
If you lose eligibility for two (2) months or less and then become eligible again, you will be re-enrolled with Aetna Better Health of Nevada. We will assign you to your past PCP if they are still accepting patients.

**Renewing your insurance**
You may lose coverage if you do not renew with DWSS. You must renew each year to keep your insurance.

The DWSS will send your preprinted renewal notice to your house. Fill it out and send it back to DWSS within the timeframe noted. Call the DWSS at 1-800-992-0900, TTY: 711 if you have any questions or need help. If you do not renew with the DWSS every year, you will be dropped from the program and may not be allowed to re-enroll.

To avoid a gap in your coverage, you must renew with the DWSS before your termination date. If you do not, you could lose your coverage. Continuous enrollment means that if there is no break in your Medicaid coverage and your health plan enrollment will continue automatically. If you move, call your caseworker and inform them of your new address so that you can confirm that you are still eligible and receive your renewal application.

If you are a new parent, remember to sign up your newborn baby with the DWSS within fourteen (14) days of delivering your baby. To keep your benefits without any breaks, renew as soon as you get the notice from the DWSS office.

**Disenrollment**
We hope that you are happy with Aetna Better Health of Nevada. If you are thinking about leaving, call us at 1-866-815-3732, TTY 711, to see if we can help resolve any issues you are having. If you still wish to disenroll and you are not new to Medicaid and within your first ninety (90) days of enrollment or it is not open enrollment period, you can submit a request to Aetna Better Health to disenroll for good cause. Call Member Services to request the disenrollment form and submit to:

Aetna Better Health of Nevada  
ATTN: Member Services  
Disenrollment Request  
475 E. Capovilla Ave, Suite 100  
Las Vegas, NV 89119

Reasons for disenrollment due to good cause are:

- If you move out of the service area
- Aetna Better Health does not, due to moral or religious objections, cover the service that you seek (DHCPs will notify you on where and how to obtain these services)
- You need related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member’s primary care
provider or another provider determines that receiving the services separately would subject the member to unnecessary risk
• DHCFP determination
• Other reasons including, but not limited to:
  - Poor quality of care
  - Lack of access to services covered under the contract
  - Lack of access to providers experienced in dealing with health care needs

We will respond to your request in writing within fourteen (14) calendar days of when we receive it with a Notice of Decision letter. If your request is denied, you can file an appeal by writing to us within sixty (60) days of the decision at:

Aetna Better Health of Nevada
Grievance System Manager
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119

If your appeal is denied by Aetna Better Health, you can request a State Fair Hearing. See page 64 for details on how to request a State Fair Hearing.

**Disenrollment caused by a change in status**
If your status changes, you may no longer be eligible for the Plan. DHCFP/DWSS will decide if you are still eligible.

Some changes that can affect your benefits include:
• Change in address
• Employment change
• Family status change

Some reasons that Aetna Better Health may also request that you are disenrolled from the plan include:
• Committing fraud
• If keeping you as a member seriously affects Aetna Better Health being able to give services to you or other members.
• Disenrollment due to the member relocating outside of Aetna Better Health’s service area
• If you are in a nursing home longer than forty-five (45) days
• If you have an acute hospital stay in a swing bed longer than forty-five (45) days
• If you are placed in a residential treatment facility (Medicaid members only)

If this happens, you will get a letter explaining the disenrollment process and how you can appeal the decision.
A member who was disenrolled solely because he or she loses Medicaid or Nevada Check Up eligibility will be auto-assigned as follows:

- by family affiliation (if other family members are enrolled);
- by history (assigned to the last vendor in which the member was enrolled);
- or randomly.

**Member confidentiality and privacy**

We include a Notice of Privacy Practices in this member handbook. It tells you how we use your information for health plan benefits. It also tells you how you can see, get a copy of or change your medical records. Your health information will be kept private and confidential. We will give it out only if the law allows or if you tell us to give it out. For more information or if you have questions, call us at 1-866-815-3732, TTY 711. You can also visit our website at www.aetnabetterhealth.com/nevada.

**Your rights and responsibilities**

As a Plan member, you have rights and responsibilities. They are listed below. Your doctor will also receive a copy of your rights and responsibilities. If you need help understanding your rights and responsibilities, call Member Services at 1-866-815-3732, TTY 711.

**Your rights**

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

- Get information about Aetna Better Health and the services we cover, the doctors who provide care, and the member rights and responsibilities.
- Be treated with respect and dignity.
- Privacy when you are at an office visit, getting treatment or talking to staff at the health plan.
- Not have your medical records shown to others without your approval, unless allowed by law.
- Be involved in deciding on the type of care you want or do not want.
- Have your doctor tell you how he or she plans to treat you. The doctor should tell you if other treatments can be used and the risks for each one no matter how much they cost or if Aetna Better Health will pay for it.
- Know the cost to you if you choose to get a service that Aetna Better Health does not cover.
- Tell us about your grievances and appeals about Aetna Better Health and the care you get from your doctors.
- Appeal a decision.
- Tell us about ways to improve our policies and procedures, including the member rights and responsibilities.
- Get covered benefits or services regardless of gender, race, ethnicity, age, religion, national origin, sexual orientation, physical or mental disability, type of illness or condition, ability to pay or ability to speak English.
- Pick a doctor who works with our provider network, including a specialist (from our network) as your PCP if you have a chronic condition.
At the time of enrollment with Aetna Better Health, you can continue treatment with Aetna Better Health on a transitional basis.

Find out what is in your medical records, or have an authorized representative find out what is in your medical record, as allowed by law, and request a copy of your medical records.

Request, or have an authorized representative request, an amendment or correction to your medical record in accordance with law.

Be a part of the decision making regarding your health care and say no to treatment or services and be told what may happen if you refuse the treatment. You can continue to get Medicaid and medical care even if you refuse treatment.

Refuse care from a doctor you were referred to and ask for a referral to a different doctor.

Receive information about how to submit a complaint, grievance, appeal, or request for a hearing about Aetna Better Health or the care received.

Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

Receive treatment and information that is sensitive to your cultural or ethnic background.

Get interpretation services if you do not speak English or have a hearing impairment to help you get the medical services you need.

Ask for materials to be presented in a manner or language that you understand at no cost to you.

Receive information about advance directives or a living will, which tell how to have medical decisions made for you if you are not able to make them for yourself.

Get emergency health care services without the approval of your primary care provider (PCP) or Aetna Better Health when you have a true medical emergency.

Be told in writing by Aetna Better Health when any of your health care services requested by your PCP are reduced, suspended, terminated or denied. You must follow the instructions in your notification letter.

Your responsibilities
You have the responsibility to:

- Give all information about your health to Aetna Better Health and your doctor. This includes immunization records for members under age twenty-one (21).
- Follow what you and your doctor agree to do. Make follow-up appointments. Take medicines and follow your doctor’s care instructions.
- Tell your doctor if you do not understand what they tell you about your health so that you and your doctor can make plans together about your care.
- Read this member handbook. It tells you about our services and how to file a grievance or appeal.
- Follow Aetna Better Health rules.
- Know the name of your PCP and case manager.
- Show your identification (ID) card to each doctor and pharmacy before getting health services.
- Protect your member ID card. Do not lose or share it with others.
- Use the emergency room (ER) for true emergencies only.
- Make and keep appointments with doctors. If you need to cancel an appointment, it must be done at least twenty-four (24) hours before your scheduled visit.
- Treat the doctors, staff and people providing services to you with respect.
- Schedule wellness check-ups. Members under twenty-one (21) years of age need to follow the Early Periodic Screening Diagnosis and Treatment (EPSDT) schedule.
• Get care as soon as you know you are pregnant. Keep all prenatal appointments.
• Tell Aetna Better Health and the DHCFP when your address changes. Call 775-684-3676. Then call Aetna Better Health Member Services toll-free at 1-866-815-3732. Tell them about family changes that might affect eligibility or enrollment. Some examples are change in family size, employment, and moving out of the state of Nevada.
• Tell Aetna Better Health if you have other health insurance, including Medicare or third party liability.
• Give your doctor a copy of your living will and/or advance directive.
• Report any on-going care corresponding to a plan of care at the time of enrollment

Getting care

Our members need to use one of our network providers to obtain health care services. Aetna Better Health of Nevada contracts with many different doctors to make sure you are able to access your care.

Provider directory
Our provider directory is available online at www.aetnabetterhealth.com/nevada and via hard copy upon request. It lists health care providers, and hospitals in our network. The directory has the names of PCPs, specialists, behavioral health, pharmacy, and vision providers in your area. The directory on our website is updated nightly so that you have the most current provider information to review.

If you want help finding a provider for any of our services, call Member Services at 1-866-815-3732, TTY 711. We will be happy to help you. You can also call Member Services if you want a provider to be added to our network. We will try to make that happen.

You may see an out-of-network provider if you need special care and we do not have a network provider with the right specialty. The provider must first get approval from us to see you or you may be billed. See page 33 on getting preapproval (prior authorization) for services.

If you are unable to leave your home
If you can’t leave your home to get care, we can help. Call Member Services at 1-866-815-3732, TTY 711, if you are homebound. We will have a case manager work with you to make sure you get the care you need.

Primary Care Provider (PCP) or Primary Care Site (PCS)
You will often hear the term PCP. Your PCP is a medical provider who will manage your health care. They will help you get all the covered services you need. A Primary Care Site is usually a clinic where a member chooses to access primary health care using a rotating staff of providers.

You should make an appointment to see your PCP when you join Aetna Better Health of Nevada. We may contact you to help you schedule this visit. Your PCP’s office may also contact you to schedule this visit. If you need help scheduling appointments call Member Services at 1-866-815-3732, TTY 711.

Your PCP helps you get care from other health plan providers. They are responsible for coordinating your health care by:
• Learning your health history
• Keeping good health records
• Providing regular care to find out if you are sick and treat your illness
• Answering your health care questions
• Giving you advice about healthy eating
• Giving you needed shots and tests
• Getting you other types of care
• Sending you to a provider that has special training for your special health care needs
• Giving you support when you have problems with your health care

Types of primary care providers
The following are the types of primary care providers you can choose:
• Family Practice – providers who treat adults and children
• General Practice – providers who treat adults and children
• Pediatricians – providers who treat children from birth to age 21
• Specialists – providers who are trained, certified or licensed in a special area of health care
• Behavioral Health Providers – providers who treat adults and children with behavioral health care needs
• Primary Care Site – A location, usually a clinic, where a member chooses to access primary health care using a rotating staff of providers

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

If you see a specialist for special health care needs and you want the specialist to be your PCP, we can help. The Plan and your PCP will work together to help you see the PCP of your choice. Call Member Services at 1-866-815-3732, TTY 711 for more information.

The provider’s office
Ask your provider and the office staff these questions. You will be better set for getting health care services.
• What are your office hours?
• Do you see patients on weekends or at night?
• What kinds of special help do you offer for people with disabilities?
• (If you are hearing impaired) Do you have sign language interpreters?
• Will you talk about problems with me over the phone?
• Who should I contact after hours if I have an urgent situation?
• How long do I have to wait for an appointment?

Other questions to ask
Use the questions below when you talk to your provider or pharmacist. These questions may help you stay well or get better. Write down the answers to the questions. Always follow your provider’s directions.

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

Quick tips about appointments

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

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

Your PCP or Primary Care Site (PCS)

We believe that the PCP is one of the most important parts of your health care. That is why we support you in choosing your PCP. You can select your PCP when you enroll with the Plan.

How do I pick my PCP?

- You need to pick a PCP that is in the Plan provider network. The provider directory has a list of PCPs to pick from in your area. Our provider directory is available online at [www.aetnabetterhealth.com/nevada](http://www.aetnabetterhealth.com/nevada). If you would like a print copy of the provider directory, call Member Services at 1-866-815-3732, TTY 711.
- Each eligible family member does not have to have the same PCP.
- If you do not pick a PCP, we will pick one for you.

How do I change my PCP or PCS?

Your PCP is an important part of your health care team. We want you and your doctor to work together.

You may want to change your PCP for the following reasons:

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

You can change your PCP at any time. If you want to choose or change your PCP to another doctor in our provider network, you can submit the request via the secure web portal or call Member Services toll-free at 1-866-815-3732, TTY 711.

- In most cases, the PCP change will happen the first day of the month following your request.
• You will get a new Plan ID card with the name of your new PCP.

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

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

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

Notice of provider changes or service locations
If a provider terminates with Aetna Better Health of Nevada and you are receiving your primary care from or seeing them on a regular basis, we will tell you within fifteen days of receiving notice of the termination. Sometimes we will have to change your PCP without talking to you first. If this happens, we will send you a letter, and then you can pick another PCP by calling Member Services if you do not like the one we chose. Maybe your doctor decides they do not want to be a part of our provider network. They may move to another location. If you are not sure if a provider is in our network, check our website. You can also call Member Services toll-free at 1-866-815-3732, TTY 711.

Getting specialist care

Sometimes you may need care from a specialist. Specialists are providers who treat special types of conditions. For example, a cardiologist treats heart conditions. Your PCP can recommend a specialist to you. You can also look in the online provider directory at www.aetnabetterhealth.com/nevada or call Member Services at 1-866-815-3732, TTY 711. We will help you find a specialist near you.

The out-of-network specialist will have to contact us to get approval to see you. This is called prior authorization. The specialists will know what to do. Some members may need to see a specialist on a long term basis. This is called getting a “standing referral”. We can work with the specialist to make this happen. The specialist will have to contact us to get approval if not in network.

Getting a second opinion

You can get a second opinion from another provider when your PCP or a specialist says you need surgery or other treatment. A second opinion is available at no charge to you. Prior authorization is required if using an out-of-network provider. Your PCP can recommend a provider. You can also call Member Services at 1-866-815-3732, TTY 711.

Transportation

If you have an emergency and have no way to get to the hospital, call 911 for an ambulance. The Plan covers ambulance rides on the ground in a medical emergency for all members.
Non-emergency transportation is not covered by the Plan. Nevada Medicaid covers transportation services to eligible Medicaid members to covered services that are medically necessary. LogistiCare provides the non-emergency transportation to any Medicaid covered service. If you have to cancel your doctor’s appointment, please remember to cancel your transportation as well. The doctor’s office will not cancel it for you. To find out more about getting a ride to your doctor visits, call LogistiCare 24 hours a day, 7 days a week, at 1-888-737-0833, TTY 711. To check on the status of your transportation, call 1-888-737-0829, TTY 711. Nevada Check Up members are not covered for non-emergency transportation services.

Transportation appointments must be scheduled 5 days in advance whenever possible. For urgent care trips, LogistiCare must provide you with a ride on the same day you call. Please have the following information when calling to schedule your transportation:

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

### Covered services

The Nevada DHCFP administers the benefits for recipients of Medicaid, Nevada Check Up and FFS Medicaid.

The tables on the following pages show what services Aetna Better Health of Nevada (Medicaid and Nevada Check Up members) covers. All services must be medically necessary. Your doctor may have to ask us for prior approval before you can get some services.

If you have questions about coverage or getting services, call Member Services at 1-866-815-3732, TTY 711.

You must tell us when you need these services. You may get these services through the provider of your choice according to Medicaid regulations. The Plan or your PCP can help you find a provider for these services. If you need these services, please call your PCP or Member Services for help.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Medicaid</th>
<th>Nevada Check Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abortion and related services</td>
<td>Covered for medically necessary abortions or in cases of incest or rape are covered. Prior authorization is required</td>
<td>Covered for medically necessary abortions or in cases of incest or rape are covered. Prior authorization is required</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Not covered, except when performed as anesthesia for an approved surgery.</td>
<td>Not covered, except when performed as anesthesia for an approved surgery.</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Audiology</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Benefits</td>
<td>Medicaid</td>
<td>Nevada Check Up</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Blood and plasma products</td>
<td>Not covered, except for administration and processing of blood, including fees for autologous blood donation.</td>
<td>Not covered, except for administration and processing of blood, including fees for autologous blood donation.</td>
</tr>
<tr>
<td>Bone mass measurement (Bone density)</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Case/care management</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Chiropractor services (Manual manipulation of spine)</td>
<td>Covered only for ages under 21 years with a diagnosis of spinal subluxation</td>
<td>Covered only for ages under 21 years with a diagnosis of spinal subluxation</td>
</tr>
<tr>
<td>Clinic services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Colorectal screening exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Court-ordered services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Dental services</td>
<td>Some basic dental services are covered at the local FQHC, please call the FQHC for availability of services or contact the state dental vendor at xxx-xxx-xxxx for a complete listing of dental services available to you</td>
<td>Some basic dental services are covered at the local FQHC, please call the FQHC for availability of services or contact the state dental vendor at xxx-xxx-xxxx for a complete listing of dental services available to you</td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Diabetic education</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Diabetic supplies and equipment</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)/assistive technology devices</td>
<td>Covered Prior authorization may be required.</td>
<td>Covered Prior authorization may be required.</td>
</tr>
<tr>
<td>Educational or special remedial services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Early and Periodic Screening Diagnostic and Treatment (EPSDT) services and immunizations (0 – 21 yrs. of age)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Benefits</td>
<td>Medicaid</td>
<td>Nevada Check Up</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
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</tr>
<tr>
<td>Emergency room care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Emergency ground medical transportation (Ambulance)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Routine eye exams and optometrist services</td>
<td>Covered Call Avesis at 1-844-557-2647</td>
<td>Covered Call Avesis at 1-844-557-2647</td>
</tr>
<tr>
<td>Eyeglasses (lenses and frames) Members may self-refer</td>
<td>Covered Call Avesis at 1-844-557-2647</td>
<td>Covered Call Avesis at 1-844-557-2647</td>
</tr>
<tr>
<td>Family planning basic services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(Self-referral reproduction health procedures/devices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FQHCs</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Genetic testing and counseling</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Hearing exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Hearing aids and batteries</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Hemodialysis</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>HIV/AIDS testing</td>
<td>Covered Member may self-refer.</td>
<td>Covered Member may self-refer.</td>
</tr>
<tr>
<td>Home health care</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Hospice</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Infertility testing and services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Inpatient hospitalization (acute care, rehabilitation and special hospitals)</td>
<td>Covered Includes acute care, rehabilitation, special hospitals, room and board.</td>
<td>Covered Includes acute care, rehabilitation, special hospitals, room and board.</td>
</tr>
<tr>
<td>Lab tests and X-rays</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Mammograms (Screening)</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Medical day care</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Medical supplies</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Benefits</td>
<td>Medicaid</td>
<td>Nevada Check Up</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Methadone and Methadone maintenance</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Nuclear medicine</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Nurse Practitioners/ Certified Nurse Midwives</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Nursing Facility Services, i.e. rehabilitation in this setting</td>
<td>Covered with benefit limitations</td>
<td>Covered with benefit limitations</td>
</tr>
<tr>
<td>Obstetrical/ maternity care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Organ transplant evaluation</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Organ transplants (Includes donor and recipient costs. Experimental organ transplants not covered)</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Orthotics</td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td>Outpatient hospital services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient surgery, same day surgery, ambulatory surgical center</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pain management services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Pap smears and pelvic exams</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Parenting/child birth education</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Personal care aide services</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Podiatry care</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>Covered/Preferred Drug List</td>
<td>Covered/Preferred Drug List</td>
</tr>
<tr>
<td>Preventive health care and counseling and health promotion</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>PCP visits</td>
<td>Covered</td>
<td>Covered</td>
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<tr>
<td>Benefits</td>
<td>Medicaid</td>
<td>Nevada Check Up</td>
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<tr>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td><strong>Private duty or skilled nursing care</strong></td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td><strong>Prostate screening exams</strong></td>
<td>Covered</td>
<td>Covered if medically necessary</td>
</tr>
<tr>
<td>Annual for men 50+; if family history, annual at age 40. Member may self-refer</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td><strong>Radiation/ chemotherapy/hemodialysis</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Radiology scans (MRI, MRA, PET)</strong></td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td><strong>Rehabilitation/ cognitive rehabilitation</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>(Outpatient occupational therapy/physical therapy/speech therapy)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Respite care</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Second medical/ surgical opinions</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Skilled nursing facility care (LTC)</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Sleep apnea studies</strong></td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td><strong>Smoking cessation products</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Speech tests</strong></td>
<td>Covered with prior authorization</td>
<td>Covered with prior authorization</td>
</tr>
<tr>
<td><strong>Transportation — emergency</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Transportation — non-emergency</strong></td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>(bus, train, car service, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Urgent care</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td><strong>Adult Rehabilitation</strong></td>
<td>Covered with limitations</td>
<td>Covered with limitations</td>
</tr>
<tr>
<td><strong>Inpatient psychiatric hospital services</strong></td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Benefits</td>
<td>Medicaid</td>
<td>Nevada Check Up</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>----------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Inpatient substance use</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient Mental Health</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Outpatient substance use</td>
<td>Covered</td>
<td>Covered</td>
</tr>
</tbody>
</table>

**Non-covered services**

There are services that are not part of your benefits. These services are not covered by Medicaid FFS, either. If you receive these services you will have to pay for them.

These services are listed below:

- All services your PCP or the Plan say are not medically necessary.
- Cosmetic surgery, except when medically necessary and with prior approval.
- Elective abortions
- Experimental organ transplants and investigational services.
- Infertility diagnosis and treatment services, including sterilization reversals and related office (medical or clinic), drugs, lab, radiological and diagnostic services, and surgical procedures.
- Inpatient hospitalization at a military or veteran’s hospital
- Rest cures, personal comfort and convenience items, services, and supplies not directly related to the care of the patient, including guest meals and lodging, telephone charges, travel expenses, take home supplies and similar costs.
- Respite care
- Services that involve the use of equipment in facilities when the purchase, rental or construction of the equipment has not been approved by Nevada law.
- All claims that come directly from services provided by or in federal institutions.
- Services provided in an inpatient psychiatric institution that is not an acute-care hospital
- Free services provided by public programs or voluntary agencies (should be used when possible).
- Services or items furnished for any sickness or injury that occurs while the covered member is on active duty in the military.
- Payments for services provided outside of the United States and territories (pursuant to Section 6505 of the Affordable Care Act of 2010, which amends Section 1902(a) of the Social Security Act).
- Services or items furnished for any condition or accidental injury that arises out of and during employment where benefits are available (worker’s compensation law, temporary disability benefits law, occupational disease law or similar laws); this applies whether or not the member claims or receives benefits and whether or not a third-party gets a recovery for resulting damages.
- Any benefit that is covered or payable under any health, accident or other insurance policy.
- Any services or items furnished that the provider normally provides for free.
- Services billed when the health care records do not correctly reflect the provider’s procedure code.
For Aetna Better Health members, these additional services are not covered:

- Intermediate Care Facilities/Intellectual Disability
- Personal care assistant services
- Medical day care services
- Chiropractic services
- Religious nonmedical institutions care and services
- EPSDT (except for well-child care, including immunizations and lead screening and treatments)
- Cosmetic services (except when medically necessary and with prior approval)
- Custodial care
- Special remedial and educational services
- Experimental and investigational services
- Acupuncture and acupuncture therapy (except when performed as a form of anesthesia in connection with covered surgery)
- Temporomandibular joint disorder (TMJ) treatment, including treatment performed by prosthesis placed directly in the teeth
- Recreational therapy
- Court-ordered services
- Biofeedback
- Radial keratotomy
- Dental and orthodontic services
- Home and Community Based Waiver Services
- Pre-Admission Screening and Resident Review (PASRR) and Level of Care (LOC) Assessments
- All services provided at Indian Health Service Facilities and Tribal Clinics

Call FFS Medicaid to ask about coverage on any of the services that Aetna Better Health does not cover.

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**Added Benefits and Services for members**

As a member of Aetna Better Health of Nevada, Medicaid and Nevada Check Up members will receive the following additional benefits and services at no cost (*+ see footnotes below):
<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telehealth</strong>+</td>
<td>Improved access to care using internet or mobile technology.</td>
</tr>
<tr>
<td><strong>Adult Vision Services</strong></td>
<td>Free eye exam every year, plus $80 toward glasses or contacts.</td>
</tr>
<tr>
<td><strong>Easy Access Disease Management Services</strong>+</td>
<td>Programs to help you if you have a chronic, long-term condition like asthma, lung disease, depression, diabetes or heart failure.</td>
</tr>
<tr>
<td><strong>Healthy Kids+, Teens+ and Adults</strong></td>
<td>Earn reloadable gift cards after completing regular checkups.</td>
</tr>
<tr>
<td><strong>Medication Adherence Program for Chronic Illness</strong>+</td>
<td>Help you understand your medications and simplify the refill process for you.</td>
</tr>
<tr>
<td><strong>Weight Loss Program</strong>+</td>
<td>Receive a starter kit, gift bags and reloadable gift cards as you lose weight.</td>
</tr>
<tr>
<td><strong>Tobacco-Free Youth+ and Adults</strong></td>
<td>Earn a reloadable gift card and receive help to stop smoking.</td>
</tr>
<tr>
<td><strong>Pregnancy Program</strong>+</td>
<td>Earn reloadable gift cards and baby supplies and items after completing regular checkups.</td>
</tr>
<tr>
<td><strong>School and sports physical exam</strong></td>
<td>No cost physical exams.</td>
</tr>
<tr>
<td><strong>Better Breathing Program</strong></td>
<td>Receive one rescue inhaler for home and a second for school.</td>
</tr>
<tr>
<td><strong>24-Hour Nurse Line</strong>+</td>
<td>Access to a nurse 24 hours a day, 7 days a week to answer your health care questions. The Nurse Line does not take the place of your PCP. But if it’s late at night or you can’t reach your PCP, the nurses can help you decide what to do.</td>
</tr>
<tr>
<td>Mental Health*+</td>
<td>See a mental health provider within 7 days of discharge and earn a reloadable gift card.</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Programs to help with gambling addiction*</td>
<td>Get help to stop gambling.</td>
</tr>
<tr>
<td>Aetna Better Living Regional Wellness Centers*+</td>
<td>Our Wellness Centers are one-stop shops where members, caregivers and providers can access our community resources and learn about healthy choices.</td>
</tr>
</tbody>
</table>

*Nevada Medicaid  +Nevada Check Up

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### Premiums for Aetna Better Health Nevada Check Up members

A premium is a monthly payment you pay to DHCFP to get health care coverage. Nevada Check Up members have to pay a quarterly premium but won’t have any co-pays or deductibles. The premiums range between $25 and $80 per quarter and are charged per family, not per child. For Native American Families who are members of federally recognized tribes, or an Eskimo, Aleut or other Alaska Native enrolled by the Secretary of the Interior, quarterly premiums are waived.

If you do not pay this quarterly payment, you will be disenrolled. If you have questions about your premium, call 1-775-684-3777 or toll-free at 1-877-543-7669.

### Members age 55 and over

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

### Getting preapproval (prior authorization) for services

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

You may have to pay for your services if you do not get preapproval for services:

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

If the preapproval for your services is denied, you can file an appeal about the decision. Please see page 61 for more information on Appeals.
Preapproval steps
Some services need pre-approval before you can get them. All services by providers that are not in our network need pre-approval except for family planning and emergency services. Following are the steps for preapproval:

- Your provider gives the Plan information about the services they think you need.
- We review the information.
- If the request cannot be approved, a Plan medical director will review the information.
- You and your provider will get a letter if a service is denied.
- Your letter will explain why if your request is denied.
- If a service is denied, you or your provider can file an appeal.

Please see page 61 for more information on appeals.

Understanding your service approval or denial
We use certain guidelines to approve or deny services. We call these “clinical practice” guidelines. These guidelines are used by other health plans across the country. They help us make the best decision we can about your care. You or your provider can get a copy of the guidelines we use to approve or deny services.

If you want a copy of the guidelines or do not agree with the denial of your services, please call Member Services at 1-866-815-3732 TTY 711.

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

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

Behavioral health services
Aetna Better Health of Nevada will cover specialized behavioral health services. Different members may be covered for different services. Below is a list of services that may be covered. For more information, talk to your case manager if you have one. You can also call Member Services at 1-866-815-3732 TTY 711.

Behavioral Health Crisis
If you are thinking about hurting yourself or someone else, or if you have an urgent behavioral health emergency, call 911 or go to the closest hospital. You can use any hospital for emergency care even if it is not in our network. Show your Aetna Better Health of Nevada ID card. We also have a behavioral health crisis line that is available 24 hours a day, 7 days a week. You can call us at 1-866-815-3732, TTY 711 and pick the option for a behavioral health crisis. We will connect you to our licensed mental health professionals.
## Behavioral Health Covered Services

<table>
<thead>
<tr>
<th>Service/Benefit</th>
<th>Covered Service/Benefit</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Free-Standing Psychiatric Hospitals</td>
<td>Care at a psychiatric hospital or a Distinct Part Psychiatric (DPP) Unit.</td>
<td>For members age 21 and under and members 65 and older. Prior authorization is required.</td>
</tr>
<tr>
<td>Licensed Mental Health Professionals (LMHP)</td>
<td>Mental health and substance use services including assessment and treatment.</td>
<td>For members under age 21. Prior authorization is not required.</td>
</tr>
<tr>
<td>- Licensed Psychologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Medical Psychologists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Professional Counselors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Clinical Social Workers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Addiction Counselors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Marriage and Family Therapists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Advanced Practice Registered Nurses (psychiatric specialists)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Methadone</td>
<td>Methadone and clinical treatment services</td>
<td>For members under age 21. Prior authorization may be required.</td>
</tr>
<tr>
<td>Psychiatric Residential Treatment Facilities</td>
<td>Allows youth to live in a treatment facility to get the behavioral health care needed.</td>
<td>For members under age 21. Prior authorization is required.</td>
</tr>
<tr>
<td>Psychiatrist visits</td>
<td>Visits with a licensed psychiatrist. A psychiatric nurse practitioner is also able to provide this service.</td>
<td>Prior authorization is not required.</td>
</tr>
<tr>
<td>Rehabilitation Substance Use</td>
<td>Outpatient and residential counseling and treatment for substance use conditions.</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>Service/Benefit</td>
<td>Covered Service/Benefit</td>
<td>Limits</td>
</tr>
<tr>
<td>-----------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td>Eligible adults can have a team of professionals help them with mental health and substance use services, housing and other social needs for community living.</td>
<td>For members 21 and older who are eligible for home and community based services. Prior authorization is required.</td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment (CPST)</td>
<td>Counseling and support provided at home, school, or work. Additional services may be available for members with special mental health care needs.</td>
<td>For members under age 21. For adults 21 and older who are eligible for home and community based services. Prior authorization may be required.</td>
</tr>
<tr>
<td>Crisis Intervention</td>
<td>You can get help right away if you have a mental health emergency or crisis.</td>
<td>For members under age 21. For adults 21 and older who are eligible for home and community based services. Prior authorization is not required.</td>
</tr>
<tr>
<td>Crisis Stabilization</td>
<td>Short-term, out-of-home care for a crisis situation</td>
<td>For members under age 21. Prior authorization is not required.</td>
</tr>
<tr>
<td>Psychosocial Rehabilitation (PSR)</td>
<td>Services to help you feel healthy and more comfortable with other people. This counseling can include family members and other helpers.</td>
<td>For members under age 21. For adults 21 and older who are eligible for home and community based services. Prior authorization may be required.</td>
</tr>
</tbody>
</table>
**Service/Benefit** | **Covered Service/Benefit** | **Limits** |
---|---|---|
*Therapeutic Group Homes* | Allows youth to live in a home-like setting with a small group of other youth to get the services needed. | For members under age 21. Prior authorization is required. |

**Extra Behavioral Health Benefits for our Members**
We offer additional behavioral health services that you may be eligible for. These services are only covered if you meet eligibility requirements and with prior approval. If you have questions please talk to your case manager or call Member Services at **1-866-815-3732 TTY 711**.

<table>
<thead>
<tr>
<th>Service/Benefit</th>
<th>Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-Hour Observation Bed Services</td>
<td>For members 21 and older</td>
</tr>
<tr>
<td>Community Psychiatric Support and Treatment, Psychosocial Rehabilitation, and Crisis Intervention</td>
<td>For members 21 and older enrolled in the Aetna Better Health Waiver for children/Youth with Severe Emotional Disturbances (SED)</td>
</tr>
<tr>
<td>Crisis Intervention (CI) Services</td>
<td>For adults 21 and older who are eligible for Aetna Better Health services</td>
</tr>
<tr>
<td>Crisis Stabilization Units</td>
<td>For adults 21 and older</td>
</tr>
<tr>
<td>Peer Support Services for adults</td>
<td>For members 21 and older</td>
</tr>
<tr>
<td>Residential Substance Use Treatment Facilities for Adults</td>
<td>For members 21 and older</td>
</tr>
</tbody>
</table>

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

Sometimes your provider will want to give you a drug that is not on our list or that is a brand name drug. Your provider may feel you need a medicine that is not on our list because you can’t take any other drugs except the one prescribed. Your provider can request approval from us. Your provider knows how to do this.
All of your prescriptions will need to be taken to one of our pharmacies. They are listed online at [www.aetnabetterhealth.com/nevada](http://www.aetnabetterhealth.com/nevada). You can also call Member Services or use our secure member portal to find a pharmacy in your area.

The Plan may pay for certain over-the-counter drugs when your provider writes a prescription for them.

**Prescriptions**

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

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

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

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

**Prescription refills**

The label on your medicine bottle tells you how many refills your provider has ordered for you. If your provider has ordered refills, you may only get one refill at a time. If your provider has not ordered refills, you must call them at least ten (10) days before your medication runs out. Talk to them about getting a refill. Your provider may want to see you before giving you a refill.

**Mail order prescriptions**

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

If you choose this option, your medicine comes right to your home. You can set up your refills. You can ask pharmacists questions. Here are some other features of home delivery:

- Pharmacists check each order for safety.
- You can order refills by mail, by phone, online, or you can sign up for automatic refills.
- You can talk with pharmacists by phone.
It’s easy to start using mail service
Choose ONE of the following three ways to use mail service for a medicine that you take on an ongoing basis:

• Call the CVS toll-free number at 1-800-552-8159 TTY 711 (24 hours a day, 7 days a week). They will let you know which of your medicines can be filled through CVS mail service pharmacy. CVS will then contact your doctor for a prescription and mail the medicine to you.
  
  When you call, be sure to have:
  – Your Plan member ID card
  – Your doctor’s first and last name and phone number
  – Your payment information and mailing address.

• Go online to [Pharmacy website address]. Once you enter the needed information, CVS Caremark will contact your doctor for a new prescription. If you haven’t registered yet on [Pharmacy website address], be sure to have your member ID card handy when you register for the first time.

• Fill out and send a mail service order form. If you already have a prescription, you can send it to CVS Caremark with a completed mail service order form. If you don’t have an order form, you can download it from the website. You can also request one by calling Member Services at 1-866-815-3732, TTY 711.
  
  Have the following information with you when you complete the form:
  – Your Plan member ID card
  – Your complete mailing address, including ZIP code
  – Your doctor’s first and last name and phone number
  – A list of your allergies and other health conditions
  – Your original prescription from your doctor.

Quick tips about pharmacy services

• Ask if your prescription is covered by the Plan before leaving your provider’s office.
• Take your prescription to a Plan pharmacy.
• If your provider has not ordered refills, call them at least ten (10) days before you need a refill.

You can get a list of covered drugs by calling Member Services 1-866-815-3732 TTY 711 or online at www.aetnabetterhealth.com/nevada.

Pharmacy Lock-In Program

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

In the Pharmacy Lock-in Program, you would be able to choose one in-network pharmacy to get your prescriptions. If you do not pick a pharmacy, one will be selected for you. By using one pharmacy, the staff will get to know your health status. The staff will also be better prepared to help you with your health care needs. The pharmacist can also look at past prescription history. They will work with your doctor if problems with medication occur.
Members in the Pharmacy Lock-in Program will only be able to get a 72-hour supply of medicine on or off our formulary from a different pharmacy if their chosen pharmacy does not have that medicine on hand. They can also do this in an emergency.

You will get a letter letting you know you are put in the lock-in program. If you do not agree with our decision to assign you to just one pharmacy, you can appeal it over the phone or in writing. We recommend that you follow your phone call by putting your appeal in writing to us. You also have the right to ask for a fast decision. A fast decision is called an expedited appeal. If your request meets expedited appeal requirements and you ask for it over the phone, you do not need to follow up in writing. Written appeals must be received by us within sixty (60) days of the date when you get this letter. See page 61 for more on member appeals. Send written appeals to:

Aetna Better Health of Nevada  
Attn: Grievance and Appeals Dept.  
475 E. Capovilla Ave, Suite 100  
Las Vegas, NV 89119  
Fax: 1-866-605-9157

Dental care services

Some routine preventative dental services are available at your local FQHC. Please contact them directly for services they offer. Other dental services are provided by the State. Please contact them at 1-XXX-XXX-XXXX.

At times you may need dental care that includes medical services such as repairing a broken jaw. If this happens services performed by a dentist will be dental. Services that are most often performed by a medical doctor will be medical.

There may be times when the type of dental care you need is severe or life threatening. Examples of this are the treatment of jaw fractures or the removal of tumors. You could have a condition that may require you receive dental care in a hospital setting. If so, Aetna Better Health of Nevada will decide which services are medical.

Vision care services

Aetna Better Health of Nevada uses Avesis to give you vision services. You can call Avesis at 1-844-557-2647, TTY: 711 (hours TBD).

You do not need a referral to see a network vision provider. You can find a vision provider in the provider directory online at www.aetnabetterhealth.com/nevada. You can also call us for help at 1-866-815-3732, TTY 711.

Your covered services include:
• Free eye exam every year
• $80 toward glasses or contacts

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

If you need help finding a provider call Avesis at 1-844-557-2647, TTY 711.
Family planning services

Any member of childbearing age can receive family planning services from any qualified provider. You do not need a referral to get family planning services. You can go to any family planning provider or clinic whether it is in our network or not. You must show your Plan ID cards when you go to your appointments.

Aetna Better Health of Nevada covers the following family planning services:

- Annual exams and pap smears
- Pregnancy and other lab tests
- Prescription and over the counter birth control medication and devices
- Birth control medical visits
- Education and counseling
- Treatment of problems related to the use of birth control including emergency services

For more information or to pick a network provider or clinic, call Member Services at 1-866-815-3732, TTY 711.

Pregnancy care

Pregnant women need special care. Call Member Services if you are pregnant. We can help you with the following:

- Choosing a PCP or OB/GYN for your pregnancy (prenatal) care
- Getting you into special programs for pregnant members, such as childbirth classes, or help getting healthy food through the Women Infants and Children (WIC) program
- If you are not sure you are pregnant, make an appointment with your provider for a pregnancy test

Here are some important reminders about pregnancy care:

- If you are pregnant and have chosen your pregnancy provider, make an appointment to see him or her
- If you need help finding a provider, call Member Services at 1-866-815-3732 TTY 711
- Your provider must set up a visit for you within 2 calendar days of your call
- Your provider will tell you about the schedule for pregnancy visits. Keep all of these appointments
- If you had a baby in the last two months and need a post-delivery checkup, call your provider’s office
- Early and regular care is very important for your health and your baby’s health

Your PCP or OB/GYN will tell you about the following:

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

**Prenatal appointments**
Regular visits with your doctor will help keep your pregnancy on track. Along with the care you’ll receive, your doctor can also help you learn more about your pregnancy. You can get counseling and support as needed. So be sure to follow your doctor’s advice about how often you should be seen. A common schedule is:

<table>
<thead>
<tr>
<th>Length of Pregnancy</th>
<th>Common visit schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weeks 4-28</td>
<td>1 visit at least every 4 weeks</td>
</tr>
<tr>
<td>Weeks 29-36</td>
<td>1 visit at least every 2 weeks</td>
</tr>
<tr>
<td>Weeks 37-40</td>
<td>1 visit at least every week</td>
</tr>
</tbody>
</table>

**Healthy pregnancy tips**
• During your pregnancy, your provider will tell you when you need to come back for a visit. It is important for your health and your baby’s health to keep all your appointments with your provider while you are pregnant.
• Childbirth classes can help with your pregnancy and delivery. These classes are available at no cost to you. Ask your provider about the classes and how you can sign up for them.
• Pregnancy duration of 40 weeks is optimal for your baby’s well being.
• Please discuss any history of early labor with your provider as soon as possible in your pregnancy. There are covered medications available to avoid early labor and delivery.
• High lead levels in a pregnant woman can harm her unborn child. If you are pregnant, talk to your provider to see if you may have been exposed to lead.
• If you are pregnant, it is important that you do not smoke, drink alcohol or take illegal drugs because they will harm you and your baby.

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

**Women, Infants and Children**
Here are some of the services the Women, Infants, and Children (WIC) program gives you at no cost to you:
• Help with breastfeeding questions
• Referrals to agencies
• Healthy food
• Healthy eating tips
• Fresh fruits and vegetables
If you need information about WIC, you can call Member Services. To see if you and your child are eligible for WIC visit [http://nevadawic.org/for-families/do-i-qualify/](http://nevadawic.org/for-families/do-i-qualify/). You can also call Nevada WIC directly at **1-775-684-5942**.

### Getting care for your newborn

It is important to make sure your baby has coverage. As long as you are actively enrolled or retro-actively enrolled with Aetna Better Health of Nevada at the date of birth, your newborn is automatically an Aetna Better Health of Nevada member. If you have other health insurance coverage that provides for 30 days of coverage for your newborn, coverage will start the first day of the next administrative month. If the coverage extends beyond that 30 day period the child will not be eligible for Nevada Check Up until after the insurance expires and eligibility is determined under Nevada Check Up eligibility rules. You should choose a PCP for your baby from our provider directory before your baby is born.

If you have questions or need help, call Member Services at **1-866-815-3732- TTY 711**.

### Well baby and well child (EPSDT)

Children should have regular check-ups even when they seem healthy. It is important to find problems early so your child can get the care needed to prevent serious illness and stay healthy. Your child’s PCP will give the care they need to stay healthy and treat serious illnesses early. These services are called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and available to most Medicaid recipients under age 21. In Nevada, the Medicaid EPSDT program is known as Healthy Kids. The program is designed to identify medical conditions and to provide medically necessary care to correct such conditions. Healthy Kids offers the opportunity for the best health status for children through regular, preventive health services and the early finding and treatment of disease. The actual EPSDT screening exam is designed to evaluate the general physical and mental health, growth, development and nutritional status of infants, children and adolescents. Below is more information on these services. You’ll also find schedules for check-ups and shots. For more details, visit our website [www.aetnabetterhealth.com/nevada](http://www.aetnabetterhealth.com/nevada). EPSDT services may include:

- Vaccines (shots) to help protect your child from serious illnesses, such as measles and mumps
- Complete check-ups
- Information about your child’s health and development
- Growth measurements
- Lab tests
- Screening for lead poisoning
- A check of the foods your child needs and advice about the right kind of diet for your child
- Checking for behavioral health and substance abuse problems
- Physical, occupational and speech therapy, if needed
- Eye tests and glasses, if needed
- Hearing tests and hearing aids, if needed
We have PCPs who are specially trained to care for members under age 21. Call us at 1-866-815-3732- TTY 711 if you need help picking the right PCP for your child. These services are available at no cost to you.

**Checkup Schedule**

<table>
<thead>
<tr>
<th>Under 1 year</th>
<th>1-2 years</th>
<th>3-5 years</th>
<th>6-9 years</th>
<th>10-14 years</th>
<th>15-18 years</th>
<th>19-20 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>Screening at: 2-3 days after initial hospital discharge</td>
<td>Screening at: 12 months of age</td>
<td>Screening at: 30 months of age</td>
<td>Screening at: 6 years of age</td>
<td>Screening at: 10 years of age</td>
<td>Screening before: 20 years of age</td>
</tr>
<tr>
<td>Screening at: 1 month of age</td>
<td>Screening at: 15 months of age</td>
<td>Screening at: 3 years of age</td>
<td>Screening at: 7 years of age</td>
<td>Screening at: 12 years of age</td>
<td>Screening at: 18 years of age</td>
<td></td>
</tr>
<tr>
<td>Screening at: 2 months of age</td>
<td>Screening at: 18 months of age</td>
<td>Screening at: 4 years of age</td>
<td>Screening at: 8 years of age</td>
<td>Screening at: 14 years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening at: 4 months of age</td>
<td>Screening at: 24 months of age</td>
<td>Screening at: 5 years of age</td>
<td>Screening at: 9 years of age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening at: 6 months of age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Screening at: 9 months of age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL Number of Screenings By Age Range of the Child / AAP Recommended</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

**Immunization (shot) schedule**

The chart below summarizes the Centers for Disease Control and Prevention’s (CDC) recommended Immunizations. You can get this information on their website at [www.cdc.gov/vaccines/schedules/easy-to-read/index.html](http://www.cdc.gov/vaccines/schedules/easy-to-read/index.html)
### Immunization (shot) schedule

<table>
<thead>
<tr>
<th>Age</th>
<th>Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>HepB (hepatitis B)</td>
</tr>
<tr>
<td>1-2 months</td>
<td>HepB</td>
</tr>
<tr>
<td>2 months</td>
<td>RV (Rotavirus) DTaP (diphtheria, tetanus, and pertussis), IPV (polio), Hib (Haemophilus influenza type b), PCV (pneumococcal)</td>
</tr>
<tr>
<td>4 months</td>
<td>RV, DTaP, IPV, Hib, PCV</td>
</tr>
<tr>
<td>6 months</td>
<td>RV, DTaP, Hib, PCV</td>
</tr>
<tr>
<td>6-18 months</td>
<td>HepB, IPV, influenza (every year)</td>
</tr>
<tr>
<td>12-15 months</td>
<td>Hib, MMR (measles, mumps and rubella), PCV, Varicella (chicken pox)</td>
</tr>
<tr>
<td>12-23 months</td>
<td>HepA (Hepatitis A)</td>
</tr>
<tr>
<td>15-18 months</td>
<td>DTaP</td>
</tr>
<tr>
<td>4-6 years</td>
<td>MMR, DTaP, IPV, Varicella</td>
</tr>
<tr>
<td>11-12 years</td>
<td>Tdap (Tetanus, Diphtheria, Pertussis) HPV (Human Papillomavirus) MCV4 (Meningococcal Conjugate)</td>
</tr>
<tr>
<td>13-18 years</td>
<td>If your child is catching-up on missed vaccines he/she may need:</td>
</tr>
<tr>
<td></td>
<td>• MMR</td>
</tr>
<tr>
<td></td>
<td>• Varicella</td>
</tr>
<tr>
<td></td>
<td>• HepB</td>
</tr>
<tr>
<td></td>
<td>• IPV</td>
</tr>
<tr>
<td>16 years</td>
<td>Booster</td>
</tr>
<tr>
<td>Every year starting at 6 months of age</td>
<td>Influenza</td>
</tr>
</tbody>
</table>

### Nevada Vaccines for Children (VFC) Program

Aetna Better Health trains their providers on the Nevada VFC program and the importance of participating in the program to better coordinate the care and services of our members. This program helps ensure that every
VFC eligible child does not contract a vaccine preventable disease. Talk to your child's doctor about this program or call Member Services at 1-866-815-3732, TTY 711.

**Case Management**

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

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

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

If you need this kind of help from the Case Management Unit, please call Member Services.

Every Plan member is contacted soon after they enroll. When we talk to you we complete a Health Risk Questionnaire (HRQ). The HRQ lets us learn more about your health care needs. We also get information about your past health care. Together the HRQ and your health history let us know if you have special health care needs. If so, we will then contact you to do an Outreach Risk Questionnaire (ORQ). We will attempt to contact you within forty-five (45) days of enrollment to complete the ORQ. If needed or requested, a Care Plan (CP) will be made to meet your specific health care needs. CPs help providers and our case managers make sure you get all the care you need. We will set up a mutually agreeable time to develop your plan.

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

Members with special health care needs may need to see specialists on a long term basis. Sometimes this is called a “standing referral”. The specialists must contact us for approval to make this happen. If it is in your best interest, you may have a specialist as your PCP. If you want a specialist to be your PCP, talk to the specialist about it. If one of our case managers has already talked with you about your special needs, he or she can help you make this change if the specialist agrees. If you have special needs and you have not talked with one of our case managers yet, call Member Services at 1-866-815-3732, TTY 711 and ask to be transferred to a case manager.

You may have special needs and have an existing relationship with an out-of-network provider. Sometimes you can continue to see that provider if it is in your best interest. The provider must first get approval from us.
If you have questions about case management, call your case manager or Member Services at 1-866-815-3732, TTY 711.

**Disease management**

We have a disease management program to help if you have certain conditions. We have programs for:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Diabetes
- Major Depression
- Coronary Artery Disease (CAD)
- Hypertension (HTN)
- HIV
- Severe Mental Illness (SMI)
- Substance Abuse
- Severe Cognitive and/or Developmental limitations

Call us at 1-866-815-3732, TTY 711 for help in managing your disease. We can help you or your child learn to manage these chronic conditions and lead a healthier life. You can learn about these programs in your member handbook or online at [www.aetnabetterhealth.com/nevada](http://www.aetnabetterhealth.com/nevada).

**As a member you are eligible to participate**

If you are diagnosed with any of these chronic conditions, or at risk for them, you may be enrolled in our disease management program. You can also ask your provider to request a referral. If you want to know more about our disease management programs, call us at 1-866-815-3732, TTY 711.

**I do not want to participate**

You have the right to make decisions about your health care. If we contact you to join in one of our programs, you may refuse. If you are already in one of our programs, you may choose to stop at any time by contacting us at 1-866-815-3732, TTY 711.

**Treatment of minors**

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

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

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

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

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

New medical treatments

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

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

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

Types of care

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

Emergency care
An emergency is the sudden onset of a medical condition with severe symptoms including severe pain. These symptoms are so serious that an average person with an average knowledge of health and medicine could reasonably expect that not getting immediate medical attention will result in:

• Placing the member’s health or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy
• Serious impairment to bodily functions
• Serious dysfunction of any body organ or part
Emergency conditions include:

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

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

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

- Call 911 for help
- Go to the nearest emergency room
- Call an ambulance to take you to the emergency room

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

Dental emergencies
Dental services are not covered by Aetna Better Health. Some services are covered by FQHCs. If you need emergency dental care call your dentist.

Dental emergencies include:
- A broken tooth
- A permanent tooth falls out
- Very bad pain in the gum around a tooth, and you are running a fever

Urgent care
Urgent care is treatment for serious medical conditions that are not emergencies. The conditions in the list below are not usually emergencies. They may need urgent care. Go to an urgent care center or call your PCP if you have any of these:
- Bruise
- Cold
- Diarrhea
- Ear ache
- Rash
- Sore throat
- Sprain
- Stomach ache (may need urgent care; not usually emergencies)
- Vomiting

How to get urgent care
Your provider must give you an appointment within 24 hours if you need urgent care. Do not use an emergency room for urgent care. Call the PCP’s telephone number that is on your ID card or visit one of the Plan urgent care centers.

Day or night, your PCP or on-call provider will tell you what to do. If the PCP is not in the office, leave a message with the answering service or the answering machine and the PCP will return your call.

24-hour nurse line
Aetna Better Health of Nevada has a nurse line available to help answer your medical questions. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. Please call us at 1-866-815-3732, TTY 711 and listen for the option for the nurse line.
**Routine care**

Routine care is health care that you need to keep you healthy or prevent illness. This includes dental care, shots and well-checks. It’s very important to see your doctor often for routine care. To schedule routine care please call your PCP’s telephone number that is on your ID card.

If you need help scheduling an appointment with the PCP, please call Member Services at 1-866-815-3732, TTY 711.

The chart below gives you examples of each type of care and tells you what to do. Always check with your PCP if you have questions about your care. If you have an emergency, call 911 or go to the nearest emergency room.

<table>
<thead>
<tr>
<th>Type of care</th>
<th>What to do</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preventive and Routine Care</strong> – This is</td>
<td>Call your provider to make an appointment for preventive care. You can expect to be seen within two (2) weeks.</td>
</tr>
<tr>
<td>regular care to keep your child healthy.</td>
<td></td>
</tr>
<tr>
<td>For example:</td>
<td></td>
</tr>
<tr>
<td>• Checkups</td>
<td></td>
</tr>
<tr>
<td>• Yearly exams</td>
<td></td>
</tr>
<tr>
<td>• Shots/immunizations</td>
<td></td>
</tr>
<tr>
<td>• Physicals</td>
<td></td>
</tr>
<tr>
<td><strong>Urgent/sick visit</strong> – This is when you</td>
<td>Call your PCP. Even if it is late at night or on the weekends, the PCP has an answering service that will take your message. Your PCP will call you back and tell you what to do.</td>
</tr>
<tr>
<td>need care right away, but are not in danger</td>
<td>You can also go to an urgent care center if you have an urgent problem and your provider cannot see you right away. Find an urgent care center in the provider directory on our website at <a href="http://www.aetnabetterhealth.com/nevada">www.aetnabetterhealth.com/nevada</a> or call Member Services toll free at 1-866-815-3732, TTY 711.</td>
</tr>
<tr>
<td>of lasting harm or of losing life. For</td>
<td>For urgent/sick visits, you can expect to be seen by a PCP:</td>
</tr>
<tr>
<td>example:</td>
<td>• Same day when you need immediate attention but your symptoms are not life-threatening</td>
</tr>
<tr>
<td>• Sore throat</td>
<td>• Within 2 calendar days when you have medical symptoms but do not need immediate attention</td>
</tr>
<tr>
<td>• Flu</td>
<td></td>
</tr>
<tr>
<td>• Migraines</td>
<td></td>
</tr>
<tr>
<td>You should NOT go to the emergency room</td>
<td></td>
</tr>
<tr>
<td>for urgent/sick care.</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency</strong> – This is when one or more of</td>
<td>Call 911 or go to the nearest emergency room. You can go to any hospital or facility that provides emergency services and post-stabilization services.</td>
</tr>
<tr>
<td>the following is happening:</td>
<td>The provider directory at <a href="http://www.aetnabetterhealth.com/nevada">www.aetnabetterhealth.com/nevada</a> contains a list of facilities that provide emergency services and post-stabilization services. You can also call Member Services</td>
</tr>
<tr>
<td>• In danger of lasting harm or the loss of</td>
<td></td>
</tr>
<tr>
<td>Type of care</td>
<td>What to do</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>life if you do not get help right away.</td>
<td>toll free at <strong>1-866-815-3732</strong>, TTY <strong>711</strong> and ask for the name and location of a facility that provides emergency services and post-stabilization services.</td>
</tr>
<tr>
<td>• For a pregnant woman, she or her unborn child is in danger of lasting harm or losing their life.</td>
<td>But you <strong>DO NOT</strong> have to call anyone at the health plan or call your provider before you go to an emergency room. You can go to <strong>ANY</strong> emergency room during an emergency – or for post-stabilization services.</td>
</tr>
<tr>
<td>• Bodily functions are seriously impaired.</td>
<td>If you can, show the facility your Aetna Better Health of Nevada ID and ask the staff to call your provider.</td>
</tr>
<tr>
<td>• Have a serious problem with any bodily organ or body part.</td>
<td>You must be allowed to remain at the hospital, even if the hospital is not part of our provider network (in other words, not an Aetna Better Health of Nevada hospital), until the hospital physician says your condition is stable and you can safely be transferred to a hospital within our network.</td>
</tr>
<tr>
<td><strong>For example:</strong></td>
<td></td>
</tr>
<tr>
<td>• Poisoning</td>
<td></td>
</tr>
<tr>
<td>• Sudden chest pains - heart attack</td>
<td></td>
</tr>
<tr>
<td>• Other types of severe pain</td>
<td></td>
</tr>
<tr>
<td>• Car accident</td>
<td></td>
</tr>
<tr>
<td>• Seizures</td>
<td></td>
</tr>
<tr>
<td>• Very bad bleeding, especially if for pregnant women</td>
<td></td>
</tr>
<tr>
<td>• Broken bones</td>
<td></td>
</tr>
<tr>
<td>• Serious burns</td>
<td></td>
</tr>
<tr>
<td>• Trouble breathing</td>
<td></td>
</tr>
<tr>
<td>• Overdose</td>
<td></td>
</tr>
<tr>
<td><strong>What is not an emergency?</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Some medical conditions that are NOT usually emergencies:</strong></td>
<td></td>
</tr>
<tr>
<td>• Flu, colds, sore throats, earaches</td>
<td></td>
</tr>
<tr>
<td>• Urinary tract infections</td>
<td></td>
</tr>
<tr>
<td>• Prescription refills or requests</td>
<td></td>
</tr>
<tr>
<td>• Health conditions that you have had for a long time</td>
<td></td>
</tr>
<tr>
<td>Type of care</td>
<td>What to do</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>• Back strain</td>
<td><strong>Post stabilization care</strong> - services means covered services, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition.</td>
</tr>
<tr>
<td>• Migraine headaches</td>
<td><strong>Always call your PCP for follow-up after an emergency.</strong>  Do not go back to the Emergency Room for follow-up care or treatment unless your PCP refers you.</td>
</tr>
<tr>
<td>What are post-stabilization services?</td>
<td></td>
</tr>
<tr>
<td>These are services related to an emergency medical condition. They are provided after the person’s immediate medical problems are stabilized. They may be used to improve or resolve the person’s condition.</td>
<td></td>
</tr>
</tbody>
</table>

| Pregnant women [A visit with an OB/GYN]          | • First Trimester – within seven (7) calendar days of first request  
|                                                 | • Second Trimester – within seven (7) calendar days of first request  
|                                                 | • Third Trimester – within three (3) calendar days of first request  
|                                                 | • High-risk pregnancies – within three (3) calendar days of identification of high risk by Aetna Better Health or maternity care provider, or immediately if an emergency exists |

| Specialist Referrals                             | • Same day, emergency appointments within twenty-four (24) hours of referral;  
| For specialty referrals to physicians, therapists, behavioral health services, vision services, and other diagnostic and treatment health care providers | • Urgent appointments within three calendar days of referral  
|                                                 | • Routine appointments within 30 calendar days of referral ; and  
|                                                 | • Aetna Better Health of Nevada will allow access to a child/adolescent specialist if requested by the parents |

| Lab and Radiology Services                        | • Routine appointments: three (3) weeks  
|                                                 | • Urgent care appointments: forty-eight (48) hours |

| Initial Pediatric Appointments                   | • Within ninety (90) days of enrollment |

| Mental Health/Substance Abuse Appointments       | • Emergency services immediately upon presentation at a service delivery site.  
<p>|                                                 | • Urgent care appointments within twenty four (24) hours of the |</p>
<table>
<thead>
<tr>
<th>Type of care</th>
<th>What to do</th>
</tr>
</thead>
<tbody>
<tr>
<td>request.</td>
<td></td>
</tr>
<tr>
<td>Routine care appointments within ten (10) days of the request</td>
<td></td>
</tr>
</tbody>
</table>

**After hours care**

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

You can even call the PCP in the middle of the night. You might have to leave a message with the answering service. It may take a while, but the PCP will call you back to tell you what to do.

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

We also have a nurse line available to help answer your medical questions. This number is available 24 hours a day, 7 days a week. It is staffed by medical professionals. Call 1-866-815-3732, TTY 711 and listen for the option for the nurse line.

**Self-referral**

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

- Emergency care
- Behavioral health
- Vision exams
- Routine care from an OB/GYN
- Routine family planning services
- Mammograms and prostate/colon cancer screenings

Apart from family planning and emergency services, you must go to a Plan provider for your service to be covered. To find a provider look in the provider directory online at [www.aetnabetterhealth.com/nevada](http://www.aetnabetterhealth.com/nevada). You can also call Member Services for help at 1-866-815-3732, TTY 711.

**Out-of-service area coverage**

There are times when you may be away from home and you or your child needs care. Aetna Better Health of Nevada provides services only in urban Washoe and Clark counties in Nevada. When you are out of our service area, you are only covered for emergency services or non-emergency situations when travel back to the service area is not possible, is impractical, or when medically necessary services could only be provided elsewhere. Full-time students are an exception. They are covered while they reside out of state to go to school.
Routine care out of the service area or out of the country is not covered. If you are out of the service area and you need health care services, call your PCP. They will tell you what to do. The PCP’s telephone number is on your ID card. If you need help with this, call Member Services at **1-866-815-3732**, TTY **711**.

If you are not in our service area and you are having an emergency, call 911 or go to the closest emergency room. Make sure you have your Plan ID card. If you get services in the emergency room and are admitted to the hospital while you are away from home, have the hospital call Member Services at **1-866-815-3732**, TTY **711**.

**Health tips**

**How you can stay healthy**

It is important to see your PCP and dentist for preventive care. Talk to your providers. You can improve your health by eating right, exercising and getting regular checkups. Regular well-visits may also help you stay healthy.

**Guidelines for good health**

Here are some ways you can work to keep healthy:

- Be sure to read the newsletters we will send you from time to time in the mail.
- Be sure to read the special mailings we will send you when we need to tell you something important about your health care.
- Talk to your providers and ask questions about your health care.
- If you have a case manager, talk to them and ask questions about your health care.
- Come to our community events.

**If you get a bill or statement**

Most members do not have to pay to get benefits. You should not get a bill for the services you receive.

You may get billed for services:

- If you received care from providers outside of our provider network and did not get prior approval from us
- If you did not get preapproval to receive certain services
- If the services are not covered

If you get a bill that you think you should not have gotten, call Member Services at **1-866-815-3732**, TTY **711**.

**Quality improvement programs**

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

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

We also want to make sure you are happy with your health care providers and with the health plan.

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

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

**Healthcare Effectiveness Data and Information Set (HEDIS)**

HEDIS is a tool used by more than 90 percent of America's health plans to measure performance on important parts of care and service. Included in HEDIS is the CAHPS survey, which measures members’ satisfaction with their care in areas such as customer service and getting needed care quickly. Aetna Better Health of Nevada uses HEDIS results to see where we need to focus our efforts for improvement. Visit [http://www.ncqa.org/hedis-quality-measurement/what-is-hedis#sthash.DhOrp6zA.dpuf](http://www.ncqa.org/hedis-quality-measurement/what-is-hedis#sthash.DhOrp6zA.dpuf) for more information or call Member Services at **1-866-815-3732**, TTY **711**.

**We want to hear from you**

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

We have a group that is made up of people who are our members and their caregivers, just like you. This group is called the Member Advisory Board (MAB). They meet during the year to review member materials, member feedback, changes and new programs. They tell us how we can improve our services and offer suggestions for changes in policies and procedures. If you want to know more about the MAB, call Member Services at **1-866-815-3732**, TTY **711**.
Other information for you
We will provide you information about our company structure and our operations. If you have any questions about us, our network providers and how we work with DHCFP, call Member Services at 1-866-815-3732, TTY 711.

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

Different providers in our network have agreed to be paid in different ways by us. Your provider may be paid each time he or she treats you (“fee for service”), or may be paid a set fee each month for each member whether or not the member actually receives services (“capitation”), or may receive a salary. These payment methods may include financial incentive agreements to pay some providers more (“bonuses”) or less (“withholds”) based on many factors: member satisfaction, quality of care, and control of costs and use of services among them. If you desire additional information about how our primary care physicians or any other provider in our network are compensated, please call us at 1-866-815-3732, TTY 711 or write to:

Aetna Better Health of Nevada
Attention: Member Services
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119

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

If you change your address, phone number or family size, call Member Services toll free at 1-866-815-3732, TTY 711. Also call your state caseworker to let them know about the change.

When you have other Nevada health insurance
Let us know if you have other insurance. The other insurance may be through Medicare, employment or a family member’s employment. We will work with the medical insurance companies to cover your expenses. Since Aetna Better Health of Nevada is always the “payor of last resort”, all claims should be billed to the other (primary) insurance company first. We will process your claims after the primary insurance makes their payment.

Remember to show all of your insurance ID cards when you go to the doctor, hospital or pharmacy.

Referrals with other insurance
Your PCP may refer you to another provider.

- If the service is covered by your other insurance, you do not need to contact us for a prior authorization.
- If the service is NOT covered by your other insurance, the provider has to contact us for prior authorization. See page 33 for details.
### When you have both Medicare and Medicaid

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

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1. A provider who has opted out of Medicare is one that does not accept Medicare beneficiaries for any services.
2. Generally, when a service is rendered by a provider who has opted out of Medicare, and is not in your Medicaid Health Plan network, the service will not be covered by Medicare or your Medicaid Health Plan.
3. Medicare Advantage is a Medicare Health Plan which includes benefits covered under Medicare Parts A and B, and may include Medicare Part D and additional benefits.
member by an unapproved, uncovered out-of-network provider providers who are in the Medicare Advantage Health Plan’s provider network.

| A prescription drug covered under Medicare Part D | Medicare is the primary payer. Member must pay a small prescription copay, if applicable. | Use a Medicare participating pharmacy to receive prescription drugs. |
| A prescription drug not covered under Medicare Part D or creditable drug coverage⁴ | Member is responsible for payment.⁵ Some exceptions apply. See footnote at the bottom of this page. | N/A |

**Picking providers**

If you have other insurance you still may want to make sure the providers you see are also in our network. This is helping ensure that you won’t be billed for Medicaid covered services. Call our Member Services at **1-866-815-3732**, TTY **711** if you have questions.

**Grievances and appeals**

At Aetna Better Health of Nevada, we try our best to deal with your concerns or issues quickly and to your satisfaction. You may use our grievance process or our appeal process. It depends on what kind of problem you have.

There will be no change to your service if you file a grievance or an appeal. Aetna Better Health of Nevada staff or a health care provider will not treat you differently. We will maintain your privacy. We can help you file a grievance or appeal. This includes providing you with interpreter services or help if you have vision and/or hearing problems. You may also choose someone like a relative, friend or provider to represent you.

To file a grievance or to appeal, call **1-866-815-3732**, TTY **711**, or write to:

Aetna Better Health of Nevada
Grievance System Manager
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119
Fax: 1-866-605-9157

⁴ Creditable drug coverage is coverage from an employer or union plan in place of Medicare Part D.
⁵ Exceptions: benzodiazepines, barbiturates, smoking cessation drugs, and certain vitamins are not covered by Medicare Part D but are covered by your Medicaid Health Plan. Copays do not apply.
You will need to give us your name, address, telephone number and the details of the problem

**Grievances**
A grievance is any message by you to us of being unhappy about the care and treatment you receive. It can be about our staff or providers including vision, transportation and adult dental services. For example, if someone was rude to you or you do not like the quality of care or services you have received, you can file a grievance with us.

Aetna Better Health takes member grievances very seriously. We want to know what is wrong so we can make our services better. If you have a grievance about a provider or the quality of care or services you have received, let us know right away. We have special procedures in place to help members file grievances. We will do our best to answer your questions. We want to take care of your concern. Filing a grievance will not affect your health care services or your benefits coverage.

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 the right 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.

**How to file a grievance**
If you have a grievance contact us at **1-866-815-3732**, TTY **711**, and, if you ask, we will help you with your grievance:

Fax us: 1-866-605-9157

Write to us:

Aetna Better Health of Nevada
Grievance System Manager
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119

**Tell us what happened**
You can write to us with your grievance. Give us as much information as you can. Include the date the incident happened. Include the names of the people involved. Tell us in detail what happened. Be sure to include your name and your member ID number. If asked, we will help you with your grievance. We may call you to get more information about your grievance.
Have someone represent you in a grievance
You can have someone represent you, such as a family member, friend or provider. You must agree to this in writing. Send us a letter telling us that you want someone else to represent you and file a grievance for you. Include your name, member ID number from your ID card, the name of the person you want to represent you and what your grievance is about.

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

The grievance process
You may file a grievance orally or in writing with us. The person who receives your grievance will record it. The appropriate plan staff will oversee the review of the grievance. We will send you a letter telling you that we received your grievance. The letter will give you a description of our review process. We will review your grievance and give you an answer. The time for us to answer is based on the following:

- If your grievance is the result of us denying your request for a fast decision on an authorization or an appeal, we will decide within 72 hours after receipt.
- If your grievance is the result of us taking an extension on the time to give you a decision on your request for an authorization or an appeal, we will decide within 72 hours after receipt.
- For all other types of grievances, we will decide within 30 days after the receipt. The review period can be increased up to 14 days. You can increase the review period if you need more time. We can increase the review period if we need more time. We can only request more time if it is in your best interest.
- Our decision letter will describe what we found when we reviewed your grievance. It will tell you our decision about your grievance.

Appeals
An action is when we do not approve a service your provider recommends. It can be when we say we will not pay for services. An action can also be when we do not provide you services in a timely manner. If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. An appeal is a way for you to ask for someone to review our actions. The list below includes examples of when you might want to file an appeal.

- Not approving a service your provider asks for
- Stopping a service that was approved before
- Not paying for a service your PCP or other provider asked for
- Not giving you the service in a timely manner
- Not answering your appeal in a timely manner
- Not approving a service for you because it was not in our network.

How to file an appeal
If you want to file an appeal contact us at 1-866-815-3732, TTY 711, and, if you ask, we will help you with your appeal:

Fax us: 1-866-605-9157
Write to us:

Aetna Better Health of Nevada
Grievance System Manager
475 E Capovilla Ave, Suite 100
Las Vegas, NV 89119

Tell us what happened
If you write to us, include your name, member ID number, the date of your Notice of Action letter, information about your case and why you are asking for the appeal.

Your timeframes for filing
You or your representative need to file an Appeal within sixty (60) calendar days from the date on our Notice of Action letter.

Have someone represent you in an appeal
You can have someone represent you, such as a family member, friend or provider. You must agree to this in writing. Send us a letter telling us that you want someone else to represent you and file an appeal for you. Include your name, member ID number from your ID card, the name of the person you want to represent you and what your appeal is about. When we get the letter from you, the person you picked can represent you. If someone else files an appeal for you, you cannot file one yourself about the same item.

For some actions, you may request to continue service during the appeal process
You may want your services to continue while your appeal is reviewed. Services that can be continued must be services that you are already receiving. They are services that are being reduced, put on hold, or ended. We will continue services if you request an appeal within 10 days from our notice of action letter. We will also continue services if you request an appeal before the date we told you they would be reduced, put on hold or ended, whichever is later. Our notice will tell you if we decided to reduce, suspend, or terminate your service. It will have the effective date of our action. It will state the original authorization period and when it ends.

Your services will continue until the original authorization period for your services has ended, or until 10 days after we mail the appeal decision, or if you withdraw your appeal. If the appeal was denied and you requested a Fair Hearing with continuation of services, your services will continue during State Fair Hearing. (See the State Fair Hearing section.)

You may request services while your appeal is under review. However, if we decide that we agree with our first decision to deny your service, we may require you to pay for these services. This is because you asked to continue to receive services while your appeal was being reviewed.

What happens next?
- We will send you a letter within 3 calendar days saying we got your appeal. We will tell you if we need more information.
- We will tell you how to give us more information in person or in writing, if needed.
- You provide more information about your appeal, if needed.
- You can see your appeal file.
• You can be there when the Appeals Committee reviews your appeal.

• The Appeals Committee will review your appeal. They will let you know if they need more information and will make a decision within 30 calendar days. If your appeal requires a fast decision we will call you to tell you the decision. For all appeals, we will send the results to you in writing. The decision letter will tell you what we will do and why.

• A provider with the same or like 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.

• The provider who reviews your appeal will not report to the provider who made the original decision about your case.

• We can extend the time for making a decision about your appeal by up to 14 days. We may extend the time to get more information. If we do this, we will send you a letter explaining the delay.

• You can also ask for an extension, if you need more time.

If the Appeals Committee’s decision agrees with the notice of action; you may have to pay for services you got during the review. If the Appeal’s Committee’s decision does not agree with the notice of action; we will let the services start right away.

**How long will it take Aetna Better Health to decide my appeal?**

Unless you ask for an expedited review, we will review your appeal as a standard appeal. We will send you a written decision as quickly as your health condition requires. It will be no later than 30 days from the day we receive an appeal. The review period can be increased up to 14 days if:

- You request an extension
- We need more information
- The delay is in your interest

During our review, you will have a chance to present your case in person or in writing. You will also have the chance to look at any of your records that are part of the appeal review. We will send a notice about the decision we made about your appeal. It will identify the decision and date that we reached that decision.

We will provide you with the disputed services as quickly as your health condition requires if:

- We reverse our decision to deny or limit requested services
- Or reduce, suspend, or terminate services
- Services were not furnished while your appeal was pending

In some cases you may request an “expedited” appeal. (See the Expedited Appeal Process Section.)

**Expedited appeal process**

You may ask for a fast appeal review if waiting the normal appeal time could harm your health. A fast appeal is also called an expedited appeal. We will respond to you with our decision within 72 hours. Then we will send a letter with our decision within 2 business days. The review period can be increased up to 14 days. You
can increase the review period if you need more time. We can increase the review period if we need more time. We can only request more time if it is in your best interest.

If we do not agree with your request for a fast appeal decision, we will make our best efforts to contact you. We will let you know that we have denied your request for an expedited appeal. If we deny your request for a fast decision we will give you a decision in the normal time. Also, we will send you a written notice of our decision to deny your request for an expedited appeal. We will send it within 2 days of receiving your request.

**If Aetna Better Health denies my appeal, what can I do?**

We will send an appeal decision letter. If our decision does not fully approve your appeal, the letter will explain additional appeal rights. You will have the right to ask for a State Fair Hearing from DHCFP. The letter will tell you who can appear at the Hearing on your behalf. It will also tell you if you can continue to receive services during the appeal process.

**State Fair Hearing**

You may ask for a State Fair Hearing from Division of Health Care Financing and Policy (DHCFP) within 90 days of the date we sent your appeal decision letter. At the State Fair Hearing, you may represent yourself, use a lawyer or have a relative or friend speak for you. You can ask for a State Fair Hearing by contacting DHCFP at the following:

Nevada Division of Health Care Financing and Policy (DHCFP)
1100 East William St., Suite 102
Carson City, NV 89701
Telephone: 1-877-638-3472

If your appeal involved reduced, on hold, or stopped services received, you may ask to continue to get these services while you wait for the State Fair Hearing decision. Your request to continue the services must be made within 10 days of the date of our appeal decision letter. If you do not request a State Fair Hearing within the 10 days, your services will be reduced, put on hold, or stopped by the effective date, whichever is later. Your services will continue until the original authorization period for your services has ended or you withdraw the appeal the State Fair Hearing Officer denies your request, whichever happens first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services right away. And as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be pay for the covered services ordered by the State Fair Hearing Officer.

You may ask to continue services while you are waiting for your State Fair Hearing decision. If your Hearing is not decided in your favor, you may be responsible for paying for services that were the subject of the Hearing.

**Fraud, waste and abuse**

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

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

Call our fraud, waste and abuse hotline to report these types of acts right away. You can do this confidentially. We do not need to know who you are. You can call us to report fraud, waste and abuse at **1-800-338-6361**, TTY **711**, email us at ReportFWA-Nevada@aetna.com or write to us at:

Aetna Better Health of Nevada
475 E Capovilla Ave, Suite 100
Las Vegas, Nevada 89119

You can also report suspected fraud, waste or abuse to the State of Nevada by calling **775-687-8405** to report a provider or contact the Medicaid Fraud Control Unit (MFCU) at: **775-684-1100** for all other reporting.

### Disenrollment

We hope that you are happy with Aetna Better Health of Nevada. If you are thinking about leaving, call us at **1-866-815-3732**, TTY **711** to see if we can help resolve any issues you are having. If you still wish to disenroll, you can change:

- During the DHCFP open enrollment period which occurs at least once every twelve (12) months
- If you are a new member to Medicaid and Nevada Check Up and not joining an existing case, you can change within the first ninety (90) days of enrollment.

You must submit your reason for the request in writing and include your name, Medicaid ID number and a good phone number to reach you to:

HPES
PO BOX 30042
Reno, Nevada 89520

After the first 90 days, you can also request disenrollment from Aetna Better Health of Nevada for good cause. Reasons for disenrollment due to good cause are:

- If you move out of the service area
- Aetna Better Health does not, due to moral or religious objections, cover the service that you seek (DHCFP will let you know where and how to obtain these services)
- You need related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the member’s primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk
- DHCFP determination
  - Other reasons including, but not limited to:
    - Poor quality of care
    - Lack of access to services covered under the contract
Lack of access to providers experienced in dealing with health care needs

If you want to disenroll from Aetna Better Health, call member Services at 1-866-815-3732, TTY 711 or submit your request in writing using our disenrollment form to:

Aetna Better Health of Nevada
ATTN: Member Services Department
Disenrollment Request
475 E. Capovilla Ave, Suite 100
Las Vegas, NV 89119

We will respond to your request in writing within fourteen (14) calendar days of when we receive it with a Notice of Decision letter.

Advance directives

If you are 18 years or older, your provider may ask if you have an advance directive. These are instructions about your medical care. They are used when you can’t say what you want or speak for yourself due to an accident or illness. You have the right to have and execute an advance directive. If your doctor cannot put your advance directive in place on the basis of conscience, the doctor must submit a statement of any limitations.

You will get medical care even if you don’t have an advance directive. You have the right to make your medical decisions concerning medical care. You can accept or refuse care. Advance directives help providers know what you want when you can’t tell them.

Written advance directives in Nevada fall into two main groups. It is up to you whether you want to have both or just one. If you decide to have an advance directive, you will be required to sign an “Acknowledgment of Patient Information on Advance Directives” form which will be included in your medical record. You should also make sure your doctor documents in your medical record that you have an advance directive.

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

Instruction directive (living will)
This is a document you use to tell your doctor and family about the kinds of situations you would want or not want to have life-sustaining treatment in the event you are unable to make your own health care decisions. You can also include a description of your beliefs, values, and general care and treatment preferences. This will guide your doctor and family when they have to make health care decisions for you in situations not specifically covered by your advance directive.
Advance directives are important for everyone to have, no matter what your age or health condition is. They let you say what type of end of life care you do and do not want for yourself.

If you have an advance directive:

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

The Plan can help you find a provider that will carry out your advance directive instructions. You can talk to your provider if you need help or have questions. Your doctor can not discriminate against you based on your choice to have or not have an advance directive. Your doctor can not base the decision of treatment on whether or not you choose to have an advance directive. Better Health of Nevada and your provider will follow State laws regarding advance directives. You can file a complaint with DHCFP if your advance directive is not followed. Send your complaint to:

Division of Health Care Financing and Policy  
1100 East William Street, Suite 101  
Carson City, NV 89701

Call Member Services at 1-866-815-3732, TTY 711 for help. You may also visit http://dhcfp.nv.gov/Resources/PI/AdvanceDirectives/ for more information on advanced directive. If the state law changes, we will tell you about it no later than ninety (90) days after the effective date of the change. The Plan will educate staff and providers on advance directives at least once a year.
COMMON QUESTIONS

Q. What should I do if I lose my Member ID card? Or if I don’t get one?
A. Call Member Services toll free at 1-866-815-3732, TTY 711 to get a new ID card.

Q. How will I know the name of my PCP?
A. Your ID card will list the name and phone number of your PCP. This will be on the front of your ID card. You can also log on to our secure web portal to view this information.

Q. Can I change my PCP if I need to?
A. Yes. You can log on to our secure web portal to submit your request or call Member Services toll free at 1-866-815-3732, TTY 711 for help. We will check if the new PCP is accepting new patients.

Q. How do I know which services are covered? Not covered?
A. List of covered services begins on page 25. These pages also list non-covered services. You can also ask your provider. You can call Member Services for help at 1-866-815-3732, TTY 711. You can also check online at www.aetnabetterhealth.com/nevada.

Q. What should I do if I get a bill?
A. If you get a bill, call the provider’s office. Give the staff your insurance information. If you keep getting a bill, please call Member Services for help at 1-866-815-3732, TTY 711.

Q. What hospitals can I use?
A. We use many contracted hospitals. Check the provider directory online at www.aetnabetterhealth.com/nevada. You can also call Member Services at 1-866-815-3732, TTY 711 to get a current list of our contracted hospitals.

Q. What is an emergency?
A. An emergency is when you have a serious medical problem. This means you are in danger of lasting harm or dying. If you have an emergency, go to the nearest hospital or call 911.

Q. Do you have urgent care?
A. Yes. If you have an urgent care need, call your PCP. At night or on weekends or holidays, your PCP’s answering service will take your call. Your PCP will call you back and tell you what to do. See page 50 for more information on urgent care.

Q. How do I get services that are not covered by Aetna Better Health of Nevada, but are covered by Medicaid-Fee-for-Service?
A. Call Member Services at 1-866-815-3732, TTY 711 and our staff will tell you how to get these services.
# Key health care terms

The list below includes definitions for health care terms.

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Adult</td>
<td>A member who is 21 or older.</td>
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<tr>
<td>Advance Directive</td>
<td>An Advance Directive refers to a written statement, completed in advance of a serious illness or condition, which allows the member to direct health care decisions when the member is unable to do so. The advance directive allows the member to make decisions regarding the use or refusal of life sustaining treatments. An Advance Directive consists of Declarations (Living Wills) and Durable Powers of Attorney for Health Care Decisions, recognized under Nevada State law, which relate to the provision of care when an individual 18 years of age and older has an incurable or irreversible condition, and is unable to communicate health care decisions verbally.</td>
</tr>
<tr>
<td>Aetna Better Health of Nevada</td>
<td>The agreement by the Department of Health and Human Services (DHHS), Division of Health Care Financing and Policy (DHCFP) and Aetna Better Health to provide services to TANF and CHIP members.</td>
</tr>
<tr>
<td>Appeal</td>
<td>A request for review of one of the following actions:</td>
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<tr>
<td></td>
<td>A denial or limited authorization of a requested service, including the type or level of service;</td>
</tr>
<tr>
<td></td>
<td>A reduction, suspension, or termination of a previously authorized service;</td>
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<td></td>
<td>A denial, in whole or in part, of payment for a service;</td>
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<td></td>
<td>Failure to provide services in a timely manner;</td>
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<tr>
<td></td>
<td>Failure to act within the timeframes provided in 42 CFR 438.408(b)</td>
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<tr>
<td>Basic Behavioral Health Services</td>
<td>Mental health and substance use services which are provided to members with emotional, psychological, substance use, psychiatric symptoms and/or disorders. These services are provided in the member’s PCP office by the member’s PCP as part of primary care service.</td>
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<tr>
<td>Child(ren)</td>
<td>A member who is under age 21.</td>
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<tr>
<td>Cosmetic Services and Surgery</td>
<td>Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.</td>
</tr>
<tr>
<td>Covered Services (Covered Care/Care)</td>
<td>The medical care, services and supplies that Aetna Better Health of Nevada will pay for. This care is described in this Guide.</td>
</tr>
<tr>
<td>Department of Health and Human Services (DHHS)</td>
<td>The federal agency responsible for management of the Medicaid program.</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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<tr>
<td>Division of Health Care Financing and Policy (DHCFP)</td>
<td>Division of Health Care Financing and Policy (DHCFP)</td>
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<tr>
<td>Early and Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>A program of preventive health care and well-child checkups with age-appropriate tests and shots.</td>
</tr>
<tr>
<td>Emergency</td>
<td>A sudden onset of a medical condition that shows itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention, one could reasonably expect: Serious jeopardy to the mental or physical health of the member Danger of serious impairment of the member’s bodily functions Serious dysfunction of one of the member’s bodily organs In the case of pregnant women, serious jeopardy to the health of the fetus Emergencies include active labor and psychiatric emergencies.</td>
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<tr>
<td>Family Planning Care</td>
<td>Family planning care helps you to plan your family size. It gives you information on birth control methods.</td>
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<tr>
<td>Grievance</td>
<td>Means any oral or written communications made by a member, or a provider acting on behalf of the member with the member’s written consent, to any Aetna Better Health employee or its providers expressing dissatisfaction with any aspect of the Medicaid managed care health plan or provider’s operations, activities or behavior, regardless of whether the communication requests any remedial actions.</td>
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<tr>
<td>HEDIS</td>
<td>Healthcare Effectiveness Data and Information Set - HEDIS is the performance measurement tool of choice for more than 90 percent of the nation’s managed care organizations. It is a set of standardized measures that specifies how health plans collect; audit and report on their performance in important areas ranging from breast cancer screening, to helping patients control their cholesterol to customer satisfaction. Purchasers and others use HEDIS data to compare plan performance.</td>
</tr>
<tr>
<td>Medically Necessary (Medically Needed/Needed)</td>
<td>Reasonable and necessary services to:  - protect life  - prevent significant illness or significant disability  - alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.</td>
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<tr>
<td>Member</td>
<td>A Medicaid or Nevada Check Up recipient who is enrolled in a managed care program. May also be referred to as enrollee, recipient, or beneficiary.</td>
</tr>
<tr>
<td>Member Handbook</td>
<td>This book as well as any amendment or related document sent together with this book, that tells you about your coverage and your rights.</td>
</tr>
<tr>
<td>Terms</td>
<td>Definitions</td>
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<tr>
<td>Member Representative</td>
<td>Any person that you tell us in writing that you want to act on your behalf to file an appeal or grievance.</td>
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<tr>
<td>Member Service Department</td>
<td>The Aetna Better Health staff that can answer questions about your benefits. The toll-free number is 1-866-815-3732, TTY 711.</td>
</tr>
<tr>
<td>Nevada Check Up</td>
<td>Children’s Health Insurance Program (CHIP) provided under Title XXI of the Social Security Act to children whose families exceed Medicaid limits, but is equal to or less than 200% of the federal poverty level.</td>
</tr>
<tr>
<td>Post-Stabilization Care</td>
<td>Covered Services that are provided after a Member is stabilized following an Emergency Medical Condition in order to maintain the stabilized condition or to improve or resolve the Member’s condition</td>
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<tr>
<td>Prior-authorization/Preauthorized</td>
<td>A formal process requiring a health care provider to obtain advance approval from Aetna Better Health to provide specific services or procedures.</td>
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<tr>
<td>Prescription Drug</td>
<td>A drug for which your provider writes an order so you can get it filled at a pharmacy.</td>
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<tr>
<td>Primary Care Physician (PCP)</td>
<td>A Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the Medical Home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN). For SPD beneficiaries, a PCP may also be a specialist or clinic.</td>
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<tr>
<td>Primary Care Provider</td>
<td>A person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician (PCP) or Non-Physician Medical Practitioner.</td>
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<tr>
<td>Primary Care Site</td>
<td>A location, usually a clinic, where a member chooses to access primary health care. The member’s medical record is maintained at this location, and a rotating staff of physicians manages and coordinates the recipient’s medical needs.</td>
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<tr>
<td>Provider/Participating Provider</td>
<td>A doctor, hospital, skilled nursing facility, drug store or other duly licensed institution or health professional, such as a nurse midwife that has directly or indirectly signed a contract with Aetna Better Health to be part of its network. These providers are also called participating providers. The provider directory will list these providers. Please be aware that the list changes.</td>
</tr>
<tr>
<td>Provider Directory/Provider Network</td>
<td>A list of providers that have contracted with Aetna Better Health to provide care to Aetna Better Health members. This list changes.</td>
</tr>
<tr>
<td>Service Area</td>
<td>The geographic area where you can get care under the Aetna Better Health program (Washoe and Clark counties)</td>
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<tr>
<td>Specialty Care Doctor/Specialist</td>
<td>A doctor who gives health care to members within his or her range of specialty. For the purposes of this Guide, a specialty care doctor does not mean an OB/GYN since an OB/GYN is PCP.</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>Medicaid eligibility category which became effective January 1, 1997 as a result of the Personal Responsibility and Work Opportunity Act of 1996. TANF eligibility allows for cash payments. In addition, States have the option of including Medicaid eligibility as a program benefit. Nevada has elected to include Medicaid coverage under this eligibility option.</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).</td>
</tr>
<tr>
<td>You, Your</td>
<td>Refers to a member.</td>
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</tbody>
</table>
AETNA BETTER HEALTH® OF NEVADA

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.

This notice takes effect on January 1, 2017.

Please review it carefully.

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

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

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

How we use and share your health information

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

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

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

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

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

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

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

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

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

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

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

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

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

What are your rights?
You have the right to look at your health information.

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

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

• You can ask us to change your health information if you think it is not right.
• If we don’t agree with the change you asked for. Ask us to file a written statement of disagreement.
You have the right to get a list of people or groups that we have shared your health information with.

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

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

You have the right to know if your health information was shared without your okay.
- We will tell you if we do this in a letter.

Call us toll free at **1-866-815-3732, TTY 711**, 24 hours a day, 7 days a week to:
- Ask us to do any of the things above.
- Ask us for a paper copy of this notice.
- Ask us any questions about the notice.

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

Aetna Better Health of Nevada  
Attn: Privacy Officer  
474 E Capovilla Ave, Suite 100  
Las Vegas, NV 89119

You also can file a complaint with regard to your privacy with the U.S. Department of Health and Human Services, Office for Civil Rights. Call us toll free at **1-866-815-3732, TTY 711** to get the address.

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

**Protecting your information**

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

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

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