2026 CHIP Member Handbook Children's Health Insurance Program

Bexar and Tarrant service areas

Member Services 1-866-818-0959 (Bexar) and 1-800-245-5380 (Tarrant), TTY 1-800-735-2989
May 2026

TEXAS Health and Human Services | CHIP

AetnaBetterHealth.com/Texas

TX-24-09-11 (Rev 5/2026)

aetna®

Aetna Better Health® of Texas

Personal Information

My member ID number: _____

My PCP (primary care practitioner)/prenatal provider: _____

My PCP's/prenatal provider phone number: _____

Your child's primary care provider (PCP) phone number: _____

Your child's primary care provider address: _____

Your child's primary care provider phone: _____

In case of an emergency, call 911 or your local emergency hotline.

Call us:
Aetna Better Health of Texas Member Services
Toll free: **1-866-818-0959** (Bexar service area), **1-800-245-5380** (Tarrant service area)
English/Spanish interpreter services available
Member Services hours: Monday - Friday 8 AM - 5 PM
TTY: For people that are deaf or hearing impaired, please call through the Relay of Texas TTY line at **1-800-735-2989** and ask them to call the Aetna Better Health of Texas Member Services line.

Write us:
Aetna Better Health of Texas
Attention: Member Services
PO Box 818042
Cleveland, OH 44181-8042

Visit our website:
AetnaBetterHealth.com/Texas

Aetna Better Health® of Texas

CHIP Member Handbook
Children's Health Insurance Program

May 2026

Bexar and Tarrant service areas
Aetna Better Health covers CHIP members in the following counties:
Bexar service area: Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina and Wilson
Tarrant service area: Tarrant, Denton, Hood, Johnson, Parker and Wise

Member Services:
1-866-818-0959 (Bexar)
1-800-245-5380 (Tarrant)

AetnaBetterHealth.com/Texas

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In case of an emergency, call 911 or your local emergency hotline.

Call us

Aetna Better Health Member Services
Toll free: **1-866-818-0959** (Bexar service area), **1-800-245-5380** (Tarrant service area)

English/Spanish interpreter services available.

Member Services hours: Monday - Friday 8 AM - 5 PM excluding state-approved holidays
After hours and weekends: you can contact our 24-Hour Nurse Line, or you can leave a voice message, your call will be returned on the next business day.

TTY: For people that are deaf or hearing impaired, please call through the Relay of Texas TTY line at **1-800-735-2989** or **7-1-1** and ask them to call the Aetna Better Health Member Services line.

Write us

Aetna Better Health
Attention: Member Services
PO Box 818042
Cleveland, OH 44181-8042

Visit the website
AetnaBetterHealth.com/Texas

Quick Tips and Member Safety for CHIP/CHIP Perinate Members

We think it is important to teach our members about health safety. Here are some important tips:

- Be involved in every decision about your health care. You can know what you and your doctor can do to improve and/or stay healthy if you are involved.
- Ask questions. You have a right to question anyone who is involved with your care.
- Make sure your doctor knows about all medications you are taking. Medications can include those given to you by your doctor or bought in a store. Ask that these be written down in your medical file.
- Make sure your doctor knows if you have any allergies or reactions to medications. This helps your physician avoid prescribing medications that could potentially harm you.
- Ask for information about your health care in a language you can understand. Be sure you are clear on the amounts of medicine you should take. You should ask your doctor how you will react if taking one or more kinds of medicines at the same time.

Should you go to the ER, Urgent Care, or call my Primary Care Provider?

See your Primary Care Provider

- When you are out of medicine
- If you have questions about your medicine
- When you have an earache, cough, cold, fever, sore throat
- When you have a minor injury, burn or cut
- Routine asthma care
- When you need vaccines

Go to Urgent Care (if your doctor's office is closed)

- When you have an earache, cough, cold, fever, sore throat
- When you have a minor injury, burn or cut

Go to the Emergency Room

- Having a hard time breathing
- Bleeding does not stop
- Poisoning
- Broken bones
- Asthma attack
- Passing out (fainting)
- Deep cuts or burns

Dental checkups

Dental checkups should start at 6 months of age. Dental checkups should be done every six months unless the dentist needs to see your child more often. Your child's Medicaid dental plan includes services that prevent tooth decay and fix dental problems. You do not need a referral from your doctor.

My child has a fever

Fever can be a sign of infection. Fever can be a reason to call the doctor, especially for babies under three months old. Call your provider if your child is not taking fluids, is very fussy, your child won't wake up, is vomiting or looks very ill.

Age	Temperature	What to do
1 to 2 months old	100	Call your Primary Care Provider right away
3 to 4 months old	100	Call your Primary Care Provider if the fever last more than 24 hours
over 4 months old	103	Call your Primary Care Provider if the fever last more than 2 days after giving medicine

Introduction

Your CHIP/CHIP Perinate/CHIP Perinate Newborn member handbook
Through Aetna Better Health, we are pleased to offer you or your child all the benefits offered in the State of Texas's Children's Health Insurance Program ("CHIP") plus expanded and value-added benefits. Information on eligibility and benefits are included in this member handbook. You picked your/your child's doctor or clinic when you joined Aetna Better Health. The doctor or clinic you picked is your/your child's Primary Care Provider and will act as the gateway to care for all your/your child's healthcare needs.

This handbook is a guide to help you know your/your child's Aetna Better Health plan. If you have questions about your/your child's benefits or what is covered, please refer to the benefits section of this handbook. If you cannot find the answer to your question(s) in this handbook, use our website, **AetnaBetterHealth.com/Texas**, or call us at the toll-free number on your/your child's Aetna Better Health Member ID card. We will be happy to help you.

Tips for members

- Check the Aetna Better Health Member ID card to make sure the information is correct. Your Primary Care Provider's name will appear on your Aetna Better Health card.
- Keep this handbook for future use.
- Write your ID number(s) in the front of this book or other safe place.
- Always carry your Aetna Better Health Member ID card with you.
- Keep your Primary Care Provider's name and number near the phone.
- Call your/your children's Primary Care Provider for appointments and tell them you or your child is an Aetna Better Health member.
- Call the Primary Care Provider when you or your child needs care.
- Follow the Primary Care Provider's advice.
- Use the hospital emergency room (ER) only for emergencies.

Questions or need help understanding/reading member handbook
We are staffed with individuals who speak English and Spanish who can help you understand this handbook. We also have services for people who have a hard time reading, hearing, seeing, or speaking a language other than English or Spanish. You can ask for the member handbook in audio, other languages, braille or larger print. If you need an audiocassette or CD, we will mail it to you. To get help, go to our website at **AetnaBetterHealth.com/Texas** or call us at the toll-free number on your or your child's Aetna Better Health Member ID card.

You can get a printed copy of your member handbook in English or Spanish at no charge. We'll send it to you within five days of your request.

Plan information and resources online

Get information 24 hours a day, 7 days a week on our website at **AetnaBetterHealth.com/Texas**. You may find information and answers to your questions without calling us.

This website allows you to:

- See member newsletters.
- See questions and answers about Medicaid.
- Search our provider directory to find Aetna doctors and hospitals in your area.
- Get information on different health topics.

Provider directory resource

Our provider directory has a list of all types of network providers and their names, addresses, phone numbers, specialty, education, board certification, languages spoken, ages served and more. The latest directory is always at https://www.aetnabetterhealth.com/texas/find-provider. Call Member Services if you need help locating an in-network provider or if you'd like us to send you a printed copy.

You can also search our providers on the **HealthGrades.com website** to get more information, such as medical school attended and residency completion.

Certificate of credible coverage

If you need proof of your child's CHIP coverage to help you enroll your child with another insurance plan, please call us at **1-866-818-0959** (Bexar service area) or **1-800-245-5380** (Tarrant service area). You can also write to:

Aetna Better Health
Attention: Member Services
PO Box 818042
Cleveland, OH 44181-8042

We will be happy to give you with a certificate of credible coverage upon request.

Important Phone Numbers

Member Services

We are available to assist you by phone Monday through Friday from 8 AM to 5 PM excluding state-approved holidays. Call us at the toll-free number on your Medicaid Aetna Better Health Member ID card.

- Ask questions about your benefits and coverage.
- Change your address or phone number.
- Change your Primary Care Provider.
- Find out more about how to file a complaint.

In case of an emergency or crisis, please call 911 or your local emergency hotline.
For assistance after hours and weekends you can contact our 24-Hour Nurse Line, or you can leave a voice message and your call will be returned on the next business day. Call your Primary Care Provider with questions about appointments, hours of service or getting care after hours.

All information is available in both English and Spanish. Interpreter services are available upon request.

TTY: For people that are deaf or hearing impaired, please call the Relay of Texas TTY line at **711** and ask them to call the Aetna Better Health Member Services line.

Behavioral Health (*this applies to CHIP/CHIP Perinate Newborn members only*)
Behavioral health services (includes mental health and substance use disorder) are available 24 hours a day, 7 days a week at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). We have staff members who are available to speak both English and Spanish. Interpretation services are available upon request.

If your child has a medical or behavioral health emergency and needs care, please go to the nearest emergency room. You or someone on your behalf will need to call us at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) and tell us your child had an emergency.

Other Important Numbers

24-Hour Nurse Line (Health information from a registered nurse) 24 hours a day, 7 days a week	**1-866-818-0959** (Bexar service area) **1-800-245-5380** (Tarrant service area)
CHIP/CHIP Perinate/CHIP Perinate Newborn Help Line	**1-800-647-6558**
The following benefits apply to CHIP/CHIP Perinate Newborn only	
Superior Vision Services	**1-800-879-6901**
CHIP Dental Managed Care Organizations • DentaQuest • MCNA Dental • United Healthcare Dental	 **1-800-508-6775** **1-800-494-6262** **1-877-901-7321**
Texas Early Childhood Intervention Program	**1-800-628-5115**
Prescription Information	**1-866-818-0959** (Bexar service area) **1-800-245-5380** (Tarrant service area)
Ombudsman Managed Care Assistance Team	**1-866-566-8989** TTY: **1-866-222-4306**

Aetna Better Health Notice of Privacy Practices

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

This notice took effect on September 1, 2025.

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
- Your date of birth
- Health care you received
- Amounts paid for your care

How we use and share your health information

Help take care of you: We may use your health information to help with your health care. We also use it to decide what services your benefits cover. We may tell you about services you can get. This could be checkups or medical tests. We may also remind you of appointments. We may share your health information with other people who give you care This could be doctors or drug stores.

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. 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.

Once health information is shared for any of the reasons above it may potentially be reshared or used for purposes not in this document.

Some state and federal laws may require additional limits on how we use and disclose sensitive health information like mental health or communicable diseases. We will follow the most strict law that applies to your health information.

Substance Use Disorder (SUD) Information

We are not a SUD treatment program. We may receive or keep information about you that comes from a SUD program. If a SUD program gives us this information with a legal consent, we will use or share the information as allowed if we have the legal consent. We must have the consent and okay per federal privacy law. This includes a consent for future uses and disclosures for:

- treatment,
- payment, and
- health care operations

In some situations, we may share this information without your consent. It would be for things like a medical emergency or government audits. We will follow the more protective law. We will not use or share this information in any legal case against you unless:

- You give us written consent, or
- A court orders us with a subpoena or other legal requirement.

You or Aetna must also receive notice and a chance to be heard.

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 medical 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 at the toll-free number on your member ID card 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 PrivacyAetna@AETNA.com or:

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

You also can file a complaint with the Department of Health and Human Services, Office for Civil Rights. Call us to get the address.

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

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. We will mail you the notice if a material change is made. You can get a copy of the most recent notice on our web site at **https://www.aetnabetterhealth.com.**

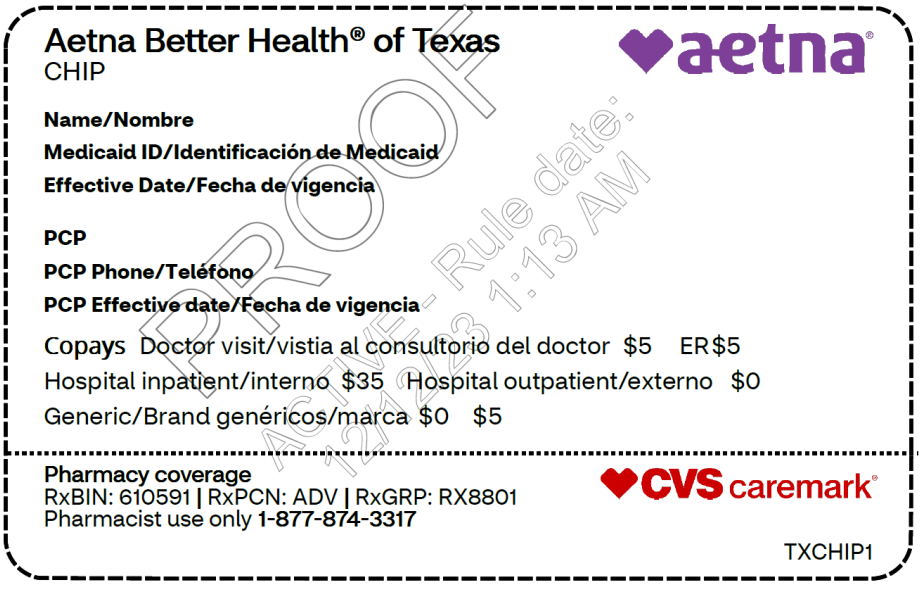
Member Identification (ID) Cards

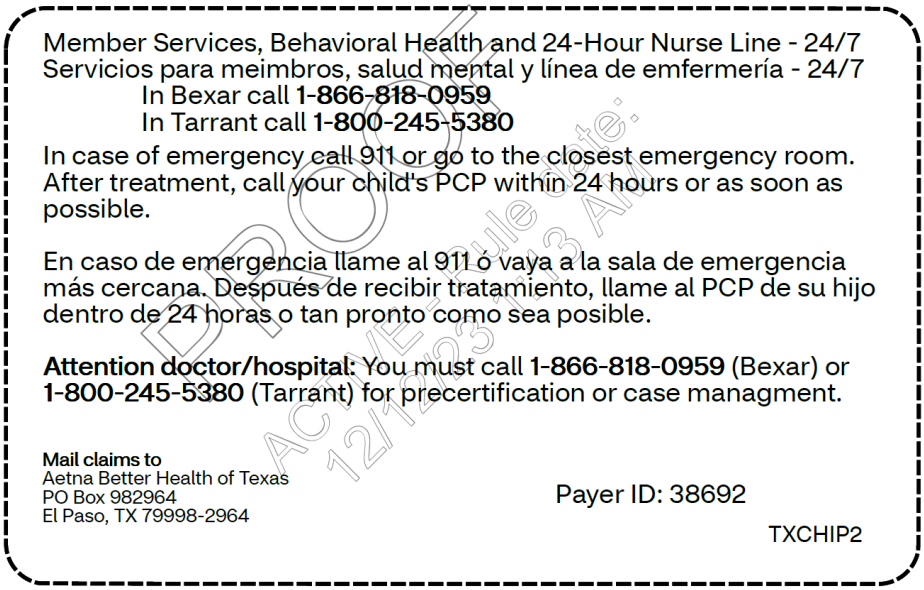
When you or your child is enrolled with Aetna Better Health, you or your child will get an Aetna Better Health member Aetna Better Health Member ID card from us. You or your child will not get a new Aetna Better Health Member ID card every month. If you call us to change your/your child's Primary Care Provider or if you/your child's copay changes, you or your child will get a new Aetna Better Health Member ID card.

How to read your card: The Aetna Better Health Member Aetna Better Health Member ID card lists the name and phone number(s) of your/your child's Primary Care Provider. It will show copayment information, if you have to pay for services. The back of the Aetna Better Health Member ID card has important phone numbers for you to call if you need help. Please make sure your/your child's information on his/her Aetna Better Health Member ID card is correct.

- Medicaid ID: Member identification number
- Eff date: Effective date of coverage with the health plan
- PRIMARY CARE PROVIDER: Name and phone number of Primary Care Provider
- PRIMARY CARE PROVIDER Effective date: Effective date of coverage with the provider
- RxBIN: Bank identification number pharmacy uses to submit claims
- RxGrp: Prescription group number pharmacy uses to identify the health plan
- RxPCN: Processor control number pharmacy uses to submit claims
- can send you another Aetna Better Health Member ID card.

CHIP Aetna Better Health Member ID card





How to use your card: Always carry your/your child's Aetna Better Health Member ID card with you when going to see the doctor. You will need it to get health care for you or your child. You must show it each time you or your child gets services.

How to replace your/your child's card if lost or stolen: Please call Member Services at 1-800-248-7767 (Bexar) or 1-800- 306-8612 (Tarrant) right away at so we can send you another Aetna Better Health Member ID card.

Primary Care Provider Information – CHIP/ CHIP Perinate Newborn

References to "you," "my," or "I" apply if you are a CHIP member. References to "my child" apply if your child is a CHIP member or a CHIP Perinate Newborn member.

Role of the Primary Care Provider

What is a Primary Care Provider?

A Primary Care Provider is your/your child's main doctor, nurse, or clinic that gives you most of your health care. This is called your "medical home". It will help you with all the medical care you or your child needs. Your/your child's Primary Care Provider can take care of routine medical problems. Sometimes you or your child might have a problem that needs to be handled by a specialist. The Primary Care Provider will help coordinate and tell you how to make an appointment with a specialist. If you or your child needs to be admitted to a hospital, your Primary Care Provider can arrange that for you or your child.

Our goal is your/your child's good health. We urge you or your child to see the Primary Care Provider to get preventive care services within the next sixty (60) days or as soon as possible. This will help your doctor learn about you or your child so he or she can help you plan for you or your child's future health care needs. Getting started with your doctor can also help prevent delays in care when you or your child is sick.

Remember, you and the Primary Care Provider are the most important members of your/your child's health care team.

What do I need to bring with me to my/my child's doctor's appointment?
You should take the following items with you when you go to your/your child's doctor's appointment:

- Aetna Better Health Member ID card
- Immunization (shot) records, and
- Paper to take notes on information you get from the doctor.

Visiting your/your child's Primary Care Provider
Regular visits to your Primary Care Provider and dentist are important, even if your children are healthy. Well-child checkups are available at no cost to our members. Babies, children, and teens all need well-child checkups. Follow this schedule:

Age Range	Number of Checkups	Target Ages
Birth to 1 year	6	2 weeks, 2 months, 4 months 6 months, 9 months
1 year to 4 years	7	12 months, 15 months 18 months, 24 months 30 months, 36 months, 4 years
5 years to 20 years	16	Annually within 30 days of birthday

Vaccines help protect your child from many infections that can cause serious health problems. Your child can receive vaccines during their well-child exams if needed. Be sure to bring your child's vaccine record to every visit.

NOTE: Day care centers and schools require all children to be up to date on vaccines.

Choosing your Primary Care Provider

Can a clinic be my/my child's Primary Care Provider? (Rural Health Clinic/Federally Qualified Health Center)

Your/your child's Primary Care Provider can be a clinic. Some of the doctors that you can also pick from to be your/your child's Primary Care Providers are: Family doctors; pediatricians (for children); OB/GYNS (woman's doctor); general practitioners (GPs); advanced nurse practitioners (ANPs); Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

Please look at our provider directory to get more information on Primary Care Providers. You must pick a Primary Care Provider for you or your child who is in our network. You can get a copy of the directory on **https://www.aetnabetterhealth.com/texas/find-provider** or by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card.

How can I change my/my child's Primary Care Provider?

You can change your/your child's Primary Care Provider by calling us at the toll-free number on your/your child's Aetna Better Health Member ID card. Or you can change your PRIMARY CARE PROVIDER through the secure member portal. The doctor or clinic needs to be listed in our provider directory. For a list of doctors and clinics, see our provider directory at **AetnaBetterHealth.com/Texas**.

When will a Primary Care Provider change become effective?

If you change your/your child's Primary Care Provider, you or your child will receive a new Aetna Better Health Member ID card. The new Aetna Better Health Member ID card will tell you the new Primary Care Provider's name, address, phone number and date your/your child's new Primary Care Provider will be effective. The Primary Care Provider change will become effective the same day that you call us to change your/your child's Primary Care Provider.

How many times can I change my/my child's Primary Care Provider?

There is no limit on how many times you can change your or your child's Primary Care Provider. You can change Primary Care Providers by calling us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) or writing to:

Aetna Better Health
Attention: Member Services
PO Box 818042
Cleveland, OH 44181-8042

You can also go online to our secure member portal at **AetnaBetterHealth.com/Texas/login** to request a Primary Care Provider change.

What if I choose to go to another doctor who is not my/my child's Primary Care Provider?

You can see any doctor or clinic in our network to get services for routine medical care that we cover or approve. This includes well-child exams. You do not need a referral from your Primary Care Provider. The doctor or clinic needs to be listed in our provider directory.

Are there any reasons why a request to change a Primary Care Provider may be denied?

In some cases, your request to change your/your child's Primary Care Provider can be denied. Your request can be denied if:

- The Primary Care Provider you picked for you or your child is not accepting new patients.
- The Primary Care Provider you picked for you or your child is no longer a part of Aetna Better Health.

Can a Primary Care Provider move me or my child to another Primary Care Provider for non-compliance?

A Primary Care Provider can request that you or your child pick a new Primary Care Provider for the following reasons:

- You or your child often misses appointments and you have not called to let the Primary Care Provider know.
- You do not follow advice from your/your child's Primary Care Provider.

What if my/my child's Primary Care Provider leaves the Aetna Better Health network?

If your/your child's doctor leaves the Aetna Better Health network, we will send you a letter telling you the new Primary Care Provider we have chosen for you or your child. If you are not happy with the new Primary Care Provider, call us at the toll-free number on your/your child's Aetna Better Health Member ID card and tell us the Primary Care Provider you want. If you or your child is getting medically necessary treatments, you or your child will be able to stay with that doctor if he or she is willing to see you or your child. When we find a new Primary Care Provider on our list who can give you or your child the same type of care, we will change your/your child's Primary Care Provider.

After Hours Care

How do I get medical care after my/my child's Primary Care Provider is office is closed?

If you or your child gets sick at night or on a weekend and cannot wait to get medical care, call your/your child's primary care or perinatal provider for advice. Your/your child's primary care or perinatal provider or another doctor is ready to help by phone 24 hours a day, 7 days a week.

How do I get after hours care?
If you are not able to reach your/your child's Primary Care Provider, you may also call the 24-Hour Nurse Line at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) to speak with a registered nurse to help you decide what to do.

Physician Incentive Plans

The MCO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members. Right now, Aetna Better Health does not have a physician incentive plan.

Health Plan Information

What if I want to change health plans?
You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP;
- for cause at any time;
- if you move to a different service delivery area; and
- during your annual CHIP re-enrollment period.

Who do I call?
For more information, call CHIP toll-free at **1-800-964-2777**.

How many times can I change health plans?
There is no limit on how many times you can change health plans.

When will my health plan change become effective?
If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can Aetna Better Health ask that I get dropped from their health plan for non-compliance, etc.?
You or your child can be disenrolled from our plan if:

- You or your child turns 19
- You do not re-enroll yourself or your child at the end of the 12-month eligibility period
- You or your child permanently moves out of the service area

- You or your child becomes enrolled in another health plan or has a change in health insurance status (i.e. coverage by employer insurance)
- You keep taking yourself or your child to the ER when you or your child does not have an emergency
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition
- You or your child misses many visits without letting your/ your child's doctor know in advance
- You let someone else use your/your child's Aetna Better Health Member ID card
- You often do not follow your/your child's doctor's advice

Concurrent Enrollment in CHIP, CHIP Perinatal and Medicaid for Certain Newborns

If you have children enrolled in the CHIP program, they will remain in the CHIP program, but will be moved to Aetna Better Health's CHIP Perinatal coverage. Copayments, cost-sharing, and enrollment fees still apply for those children enrolled in the CHIP program.

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous **Medicaid** coverage, beginning on the date of birth, if the child lives in a family with an income ***at or below*** the Medicaid eligibility threshold.

An unborn child will continue to receive coverage through the CHIP program as a "**CHIP Perinate Newborn**" after birth if the child is born to a family with an income ***above*** the Medicaid eligibility threshold.

Benefit Information- CHIP and CHIP Perinate Newborns

References to "you," "my," or "I" apply if you are a CHIP member. References to "my child" apply if your child is a CHIP member or a CHIP Perinate Newborn member.

What are my CHIP benefits?

For a list of medical services you can get from Aetna Better Health, please refer to the table on pages **74-86**. Some of your benefits do have limits, which are listed in the table also. You can call Member Services toll free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for more benefit information.

Certificate of credible coverage

If you need proof of your child's CHIP coverage to help you enroll your child with another insurance plan, please call us at **1-800-245-5380** (Tarrant) or **1-866-818-0959** (Bexar). You can also write to:

Aetna Better Health
Attention: Member Advocate
PO Box 818042
Cleveland, OH 44181-8042

We will be happy to give you with a certificate of credible coverage upon request.

How do I get these services? How do I get these services for my child?
You should see your/your child's Primary Care Provider to ask about medical services. To learn more about how to obtain these or other services, please use the website **AetnaBetterHealth.com/Texas** or call us at the toll-free number on your/your child's Aetna Better Health Member ID card.

Are there any limits to covered services?
There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the table on pages **74-86**.

What are the CHIP Perinate Newborn benefits? What benefits does my baby receive at birth?
Your child will receive the same benefits as all other CHIP members. There are ***no copays*** while on CHIP Perinatal. Please refer to the table on pages **93-99** for a full list of some of the medical services you can get from Aetna Better Health.

What are my prescription drug benefits?
CHIP covers most of the medicine your/your child's doctor says you need.

What services are not covered?
Services that are not covered by CHIP are called **Exclusions**. For a full list of exclusions, please refer to the table on pages **87-88**.

What health education classes does Aetna Better Health offer?
We work with our community partners to provide free and/or low-cost classes for parents and children. Some health topics include:

Car seat safety	Poison safety	Drug & alcohol awareness	Prenatal care
Immunizations	Sexually transmitted diseases	Infant mortality	Smoking cessation
Nutrition	Teen pregnancy prevention	Oral health	Vision awareness
Physical fitness	Weight management	Mental Health	

What extra benefits does a member of Aetna Better Health get? How can I get these benefits/how can I get these benefits for my child?
Aetna Better Health members get several value-added services. For a list of these benefits, please refer to the table on pages **89-92**. If you have any questions, please call us at the toll-free number on the back of your Aetna Better Health Member ID card.

Your Out-of-Pocket Costs

What are copayments? How much are they, and when do I have to pay them?
. The table below lists the CHIP copayment schedule according to family income. No copayments are paid for preventive care, such as vaccinations, well-child, or well-baby checkup.

Copayments do not apply to CHIP Perinate Newborn members, Native Americans or Alaska Natives.

Copays do not apply on benefits for well-baby and well-child services, preventive services or pregnancy related assistance.

Your/your child's Aetna Better Health Member ID card lists the copayments that apply to you/your child. Present your/your child's ID card whenever you/your child gets healthcare services.

Need access 24/7? You can access all the information that you need by using our website **AetnaBetterHealth.com/Texas** or by logging on to our member portal at **AetnaBetterHealth.com/Texas/login**. Need help accessing the website or portal? Give us a call and we can get you registered.

Note: CHIP members who are Native American or Alaskan Native do not have any cost-sharing. This includes enrollment fees and copays. If you are Native American or Alaskan Native and your member Aetna Better Health Member ID card shows that a copay is required, please call Aetna Better Health to have your card corrected.

Copayment table for CHIP members

Federal Poverty Levels (FPLs)	Enrollment fee **	Office visits	Non-Emergency ER	Inpatient hospital copay	Rx drug (generic)	Rx drug (brand name)	Cost sharing cap
At or below 151%	$0	$5	$5	$35	$0	$5	5% of family net income**
Above 151% - including 186%	$35	$20	$75	$75	$10	$35	5% of family net income**
Above 186%- including 201%	$50	$25	$75	$125	$10	$35	5% of family net income**

*The federal poverty level (FPL) refers to income guidelines established annually by the federal government.
**Per 12-month term of coverage.

Health Care and Other Services – CHIP / CHIP Perinate Newborns

References to “you,” “my,” or “I” apply if you are a CHIP member. References to “my child” or “my daughter” apply if your child is a CHIP member or a CHIP Perinate Newborn member.

What does medically necessary mean?
Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of "Medically Necessary." A CHIP Perinate Member is an unborn child.

Medically Necessary means:

1. Health Care Services that are:
    a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
    b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
    c. Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
    d. Consistent with the member's diagnoses;
    e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
    f. Not experimental or investigative; and
    g. Not primarily for the convenience of the member or provider; and
2. Behavioral Health Services that:
    a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
    b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
    c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
    d. Are the most appropriate level or supply of service that can safely be provided;
    e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
    f. Are not experimental or investigative; and
    g. Are not primarily for the convenience of the member or provider.

What is routine medical care? How soon can I/my child expect to be seen?

Routine Medical Care is the non-emergency or non-urgent care that you or your child receives from their Primary Care Provider, perinatal provider or other healthcare provider.

The Primary Care Provider you picked for yourself or your child is called your "medical home" and will help you with all of your/your child's medical care. Your Primary Care Provider will provide you or your child with regular checkups and treatment when needed. Your Primary Care Provider will order prescription drugs and medical supplies. Your Primary Care Provider will also send you or your child to a specialist if needed. A specialist can be your/your child's Primary Care Provider if decided by your/your child's Primary

Care Provider and us. It is important that you follow your/your child's Primary Care Provider's advice and take part in decisions about your/your child's healthcare.

When you or your child needs care, call his/her Primary Care Provider's phone number on your/your child's Aetna Better Health Member ID card. The doctor's office or clinic will make an appointment for you or your child. It is very important that you keep your /your child's appointments. If you cannot keep an appointment, please call your/your child's doctor to let him/her know. Your/your child's Primary Care Provider should be able to see you or your child within two (2) weeks after you ask for a routine care appointment or within eight (8) weeks after you ask for an appointment for a physical or a wellness checkup.

What is urgent medical care? How soon can I expect to be seen/how soon can I expect my child to be seen?

Urgent care is when you or your child has a medical problem that is not an emergency, including a cold, cough, small cuts, minor burns or bruises.

You must first call your/your child's Primary Care Provider or your perinatal provider at the number shown on your/your child's Aetna Better Health Member ID card. If you would like to speak to a nurse you can call the 24-Hour Nurse Line at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). The nurse can help decide if you or your child needs to go to the emergency room. Many illnesses do not need to be treated in the ER. A cold, cough, rash, small cuts, minor burns or bruises are not good reasons to go to the ER. If you or your child needs urgent care, the primary care or perinatal provider should see you or your child within 24 hours after you ask for care.

What is emergency medical care? What is an Emergency, an Emergency Medical Condition, and an Emergency Behavioral Health Condition?

Emergency care is a covered service. Emergency care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

"**Emergency Medical Condition**" is a medical condition characterized by sudden acute symptoms, severe enough (including severe pain), that would lead an individual with average knowledge of health and medicine, to expect that the absence of immediate medical care could result in:

- Placing the member's health in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant CHIP member, serious jeopardy to the health of the CHIP member or her unborn child.

"**Emergency Behavioral Health Condition**" means any condition, without regard to the nature or cause of the condition, which in the opinion of an individual, possessing average knowledge of health and medicine:

- Requires immediate intervention or medical attention without which the member would present an immediate danger to himself/herself or others; or
- Renders the member incapable of controlling, knowing, or understanding the consequences of his/her actions.

What is Emergency Services or Emergency Care?

"**Emergency Services**" and "**emergency care**" mean health care services provided in an in-network or out-of-network hospital emergency department, free-standing emergency medical facility, or other comparable facility by in-network or out-of-network physicians, providers, or facility staff to evaluate and stabilize Emergency Medical Conditions or Emergency Behavioral Health Conditions. Emergency services also include any medical screening examination or other evaluation required by state or federal law that is necessary to determine whether an Emergency Medical Condition or an Emergency Behavioral Health Condition exists.

How soon can I/my child expect to be seen?

Regardless of which CHIP plan you are enrolled in, you should be seen right away if you or your child needs emergency care. Whether you are in or out of one of our service areas, we ask that you follow the guidelines below when you believe you or your child needs emergency care.

- Call **911** or the local emergency hotline or go to the nearest emergency facility. If a delay would not be harmful to your/your child's health, call your/your child's Primary Care Provider. Tell your/your child's Primary Care Provider as soon as possible after getting treatment.
- As soon as your/your child's health condition is stabilized, the emergency facility should call your/your child's Primary Care Provider for information on your/your child's medical history.
- If you or your child is admitted to an inpatient facility, you, a relative or friend on your behalf should tell your/your child's Primary Care Provider as soon as possible.

Some good reasons to go to the ER are:

- Danger of losing life or limb
- Very bad chest pains
- Poisoning or overdose of medicine
- Choking or problems breathing
- Possible broken bones
- Uncontrolled diarrhea or vomiting

- Heavy bleeding
- Serious injuries or burns
- Fainting
- Suddenly not being able to move (paralysis)
- Victim of violent attack (rape, mugging, stab, or gunshot wound)
- You or your child has thoughts of causing harm to self or others
- About to deliver a baby

What do I do if I need/my child needs Emergency Dental Care?
During normal business hours, call your child's Main Dentist to find out how to get emergency services. If your child needs emergency dental services after the Main Dentist's office has closed, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

What is post-stabilization?
Post-stabilization care services are services covered by CHIP that keep the Member's condition stable following emergency medical care.

After-Hours Care

How do I get medical care after my Primary Care Provider's office is closed?
If your primary care office is closed and you get sick at night or on a weekend and cannot wait to get medical care, call your Primary Care Provider for advice. Your primary care or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-Hour Nurse Line at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) to help you decide what to do.

What if I get sick when I am out of town or traveling/what if my child gets sick when he or she is out of town or traveling?
If you/your child needs medical care when traveling, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) and we will help you find a doctor.

If you/your child needs **emergency** services while traveling go to a nearby hospital, then call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

What if I am out of state?
If you/your child has an emergency out of state, please go to the nearest emergency room for care. If you/your child gets sick and need medical care while you are out-of-state, call your Aetna Better Health doctor or clinic. Your doctor can tell you what you need to do if you are not feeling well. Please show your Aetna Better Health Aetna Better Health Member ID card before you are seen. Have the doctor call us for an authorization number.

The phone number for the doctor to call is on the back of your Aetna Better Health Aetna Better Health Member ID card.

What if I am out of the country?
Medical services performed out of the country are not covered by CHIP.

What if I need/my child needs to see a special doctor (specialist)?
Your/your child's Primary Care Provider can send you to another doctor if you or your child needs a special type of care your Primary Care Provider cannot give. Your/your child's Primary Care Provider will tell you if you or your child needs to see a specialist. Some specialist services require a referral or a prior authorization.

What is a referral? Will I need a referral?
A **referral** is a recommendation from the doctor for you/ your child to see a specialist other than your primary care physician (Primary Care Provider). The doctor will talk to you about your/your child's needs and will help make plans for you to see the specialist, if needed, that can provide the best care for you.

A referral is not required with CHIP/CHIP Perinate members.

What services do not need a referral?
The CHIP/CHIP Perinate plan of benefits does not require referrals for any services; however, there are services that may need prior authorization.

What is a prior authorization?
It is not a referral or a pre-authorization. **Prior authorization** is an approval that Aetna Better Health requires for certain services and medications. Some services need approval before they are given. The provider who is treating you/your child should get this approval. You can ask your doctor or us if an approval is needed for a service or treatment.

How soon can I expect to be seen by a specialist/how soon can I expect my child to be seen by a specialist?
You should be able to go or take your child to see a specialist within 3 weeks for a routine appointment; within 24 hours for urgent care appointments.

How can I ask for a second opinion?
You/your child can get a second opinion about the use of any health care service from a network provider. If a network provider is not available, you/your child can see an out-of-network provider. There is no cost to you for getting a second opinion. To learn more on how to ask for a second opinion call us at the toll-free number on your Aetna Better Health Member ID card.

Behavioral Health

How do I get help if I have/my child has behavioral (mental) health, alcohol, or drug problems?

Aetna Better Health of Texas covers health for you/your child as a whole person. You also can get help if you/your child are drinking or using drugs.

For crisis intervention and community referrals for urgent mental health and substance use concerns, call our hotline 24 hours a day, 7 days a week:

- (Bexar): **1-866-818-0959** press 1
- (Tarrant): **1-800-245-5380** press 1

Do I need a referral for this?

You/your child may go to any mental health provider in our network. You do not need to ask your doctor to refer you to someone. You do not need to ask your doctor for a referral; however, some services may require prior authorization. Emergency care is covered anywhere in the United States.

Pharmacy and Medications

How do I get my/my child's medications?

CHIP covers most of the medicine your/your child's doctor says you need. Your/your child's doctor will write a prescription so you can take it to the drug store, or may be able to send the prescription to the drug store for you.

Exclusions include contraceptive medications prescribed only for the purpose to prevent pregnancy and medications for weight loss or gain.

You may have to pay a copayment for each prescription filled depending on your income. You can call Member Services toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380**. (Tarrant) if you have questions about whether a medication is covered. There are no copayments required for CHIP Perinate Newborn Members.

How do I find a network drug store?

- You can find a network pharmacy in one of two ways.
- Visit our website at **AetnaBetterHealth.com/Texas** and then search for a pharmacy in your area.
- Call Member Services toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380**. (Tarrant). Ask the representative to help you find a network pharmacy in your area.

What if I go to a drug store not in the network?
Prescriptions filled at other pharmacies that are not in the Aetna Better Health network will not be covered. All prescriptions must be filled at a network pharmacy.

What do I bring with me to the drug store?
You will need to bring the prescription your doctor wrote for you/your child. You will also need to show your/your child's Aetna Better Health Aetna Better Health Member ID card.

What if I need my/my child's medications delivered to me?
If you take medication for an ongoing health condition, you can have your medications mailed to your home. CVS Caremark is your mail service pharmacy. If you choose this option, your medication comes right to your door. You can schedule your refills and reach pharmacists if you have 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 medication that you take on an ongoing basis:

- Call the FastStart® toll-free number at **1-800-875-0867**, Monday through Friday, 7 AM to 7 PM (CT). A representative will let you know which of your prescriptions can be filled through CVS Caremark Mail Service Pharmacy. CVS Caremark will then contact your doctor for a prescription and mail the medication to you.
  - When you call, be sure to have:
    - Your Aetna Better Health member Aetna Better Health Member ID card
    - Your doctor's first and last name and phone number
    - Your payment information and mailing address

- Log on to **www.caremark.com/faststart**. Going online is a quick and easy way to start using mail service. Once you provide the requested information, CVS Caremark will contact your doctor for a new prescription. If you haven't registered yet on **www.caremark.com**, be sure to have your member Aetna Better Health 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 print on online or you can request one by calling toll-free **1-855-271-6603**.
  - Please have the following information with you when you complete the form:
    - Your Aetna Better Health member Aetna Better Health 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

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medication:

- One for a short-term supply (30 days or less) that can be filled at a participating network pharmacy AND
- One for the maximum day's supply allowed by your plan, with refills as needed. Enclose this prescription along with the mail service order form.

Who do I call if I have problems getting my/my child's medications?
If you have a problem getting your medications, please call us at the toll-free number on your Aetna Better Health Member ID card.

What if I can't get the medication my/my child's doctor ordered approved?
If your/your child's doctor cannot be reached to approve a prescription, you/your child may be able to get a **three-day emergency supply** of your medication.

Call Aetna Better Health at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for help with your medications and refills.

What is Step-Therapy?
Some drugs are not approved unless another drug has been tried first. Step-Therapy (ST) coverage requires that a trial of another drug be used before a requested drug is covered.

When you get a new prescription, ask your provider if we need to approve the medicine before you can get it. If we do, ask if there is another medicine you can use that does not need approval. When we need to approve your medicine, your provider must call Aetna Better Health for you. We will review the request to approve your medicine. If the pharmacist cannot reach Aetna Better Health to make sure it is approved, your pharmacist can give you a three (3) day temporary supply of the new prescription.

We will tell you in writing if we do not approve the request. We will also tell you how to start the appeal process.

What if I lose my/my child's medication(s)?
If you lose your medications, please call us at the toll-free number on your Aetna Better Health Member ID card. We will be able to help you replace your lost medications.

What if I need/my child needs an over-the-counter medication?
The pharmacy cannot give you an over-the-counter medication as part of your/your child's CHIP benefit. If you need/your child needs an over-the-counter medication, you will have to pay for it.

What if I need/my child needs birth control pills?
The pharmacy cannot give you/your child birth control pills to prevent pregnancy. You/your child can only get birth control pills if they are needed to treat a medical condition.

Vision services

How do I get eye care services for myself/my child?
To get eye checkups or eyewear, call Superior Vision at 1-800-520-3711. Customer Service Representatives are ready to help you pick a doctor near you. They will also tell you what to do to get your/your child's eyeglasses. One eye exam is covered every 12 months. You do not need a referral from your/your child's primary care provider to get an eye checkup.

Early Childhood Intervention (ECI)

What is Early Childhood Intervention (ECI)?
ECI gives services to children ages 0 to 3 years whose development is delayed. Some of the services for children are screenings, physical, occupational, speech and language therapy, and activities to help children learn better.

Does my child need a referral for this?
You **do not** have to go to your child's doctor to get these services. If you have questions or need help, call us at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Where do I find an ECI provider?
If you have additional questions or need help with these services, please call us at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Dental Services

How do I get dental services for my child?

Aetna Better Health will pay for some emergency dental services in a hospital or ambulatory surgical center. We will pay for the following:

- Treatment of a dislocated jaw
- Treatment of traumatic damage to teeth and supporting structures
- Removal of cysts
- Treatment of oral abscess of tooth or gum origin
- Treatment and devices for craniofacial anomalies

Aetna Better Health covers hospital, physician and related medical services for the above conditions. This includes services from the doctor and other services your child might need, like anesthesia or other drugs.

The CHIP medical benefit provides limited emergency dental coverage for dislocated jaw, traumatic damage to teeth, and removal of cysts; treatment of oral abscess of tooth or gum origin; treatment and devices for craniofacial anomalies; and drugs.

Your child's CHIP dental plan provides all other dental services, including services that help prevent tooth decay and services that fix dental problems. Call your child's CHIP dental plan to learn more about the dental services they offer.

Interpreter Services

Can someone interpret for me when I talk with my/my child's doctor? Who do I call for an interpreter?

Our Member Services staff speaks both English and Spanish. We also have a language line if you do not speak English or Spanish. If you need an interpreter, call us at the toll-free number on your/your child's Aetna Better Health Member ID card. At the time of your call, we will get a language interpreter that speaks your language on the line. People that are deaf or hearing impaired can call the TTY line toll-free at **1-800-735-2989** or **7-1-1**.

How can I get a face-to-face interpreter in the provider's office? How far in advance do I need to call?

We can help you if you need an interpreter to go with you to your/your child's doctor's office. As soon as you know the date of your/your child's appointment, please call us at the toll-free number on your/your child's Aetna Better Health Member ID card. We ask for 72 hours advance notice of a need for an interpreter.

Women's Health

What if I need/my daughter needs OB/GYN care? Do I have the right to choose an OB/GYN?

You have the right to pick an OB/GYN for yourself/your daughter without a referral from your/your daughter's Primary Care Provider. An OB/GYN can give you:

- One well-woman checkup each year
- Care related to pregnancy
- Care for any female medical condition
- Referral to special doctor (specialist) within the network

Aetna Better Health allows you/your daughter to pick an OB/GYN for you/your daughter, but this doctor must be in the same network as your/your daughter's Primary Care Provider.

***How do I choose an OB/GYN provider*?**
Check our provider directory to find an OB/GYN provider for you or your child. You can get a copy of the provider directory online at **AetnaBetterHealth.com/Texas** or call us at the toll-free number on your/your child's Aetna Better Health Member Aetna Better Health Member ID card for help in finding an OB/GYN.

If I don't choose an OB/GYN, do I have direct access?
You have the right to pick an OB/GYN from our network for yourself/your child without a referral from your Primary Care Provider.

Will I need a referral?
You have the right to pick an OB/GYN/perinatal provider from our network for yourself/your child without a referral from your Primary Care Provider.

How soon can I/my daughter be seen after contacting my OB/GYN provider for an appointment?
If you or your child is pregnant, you /she should be seen within 2 weeks of enrollment/request or by the 12th week of your/her pregnancy. If you or your child is not pregnant, she should be seen within 3 weeks of asking for an appointment.

Can I/my daughter stay with an OB/GYN provider who is not with Aetna Better Health?
If you or your daughter is past the 24th week of pregnancy when you/she joins she will be able to stay under the care of your/her current OB/GYN/perinatal provider. If you/she chooses, you/she can pick an OB/GYN/perinatal provider who is in our network as long as the doctor agrees to treat you/her. If you need help with changes between doctors, please call us toll-free at 1-866-818-0959 (Bexar) or 1-800-245-5380 (Tarrant)

What if I or my daughter is pregnant? Who do I need to call? (** CHIP only **)
Call us at the toll-free number on your/your child's Aetna Better Health Member Aetna Better Health Member ID card as soon as you know you or your daughter is pregnant. You/she needs to apply right away for Medicaid services. Your/your daughter's baby will be enrolled in Medicaid from birth up to a year old if you/she enrolls in Medicaid while you/she is pregnant.

Note: If you or your daughter do not enroll in Medicaid while pregnant, you/she will have to apply for coverage for your/her newborn after the baby is born. Please note that there could be a gap in coverage for your/her baby.

What other services/activities/education does Aetna Better Health offer pregnant women?

Aetna Better Health offers the following services/activities/education to our pregnant members:

- **Case Coordination :** Case Coordination is given to members who are pregnant. Our Case managers help members get the services that they might need. We can also help you get referrals when needed.
- **Prenatal education:** We will mail a prenatal packet to all pregnant women. The packet has information about how to stay healthy during pregnancy and a list of child birth classes and much more.

Special Health Care Needs Members

Who do I call if I have/my child has special health care needs and I need someone to help me?

Our case managers are ready to help coordinate services for children with special health care needs. You or your child can also have his/her health care given by a specialist if you or your child has special health care needs.

If you or your child has special health care needs and you need someone to help you, please call us at the toll-free number on your/your child's to learn more.

Provider Billing

What if I get a bill from my doctor? Who do I call? What information will they need?

As a parent or guardian, you must pay for the copayments for your child's care. If you feel that you should not have gotten a bill or you need help to understand the bill, call us at the toll-free number listed on your child's Aetna Better Health Member ID card.

We will help explain the bill to you. We can talk to the doctor's office for you to explain your child's benefits. We can also help you arrange for the bill to be paid. When you call us, please have your child's Aetna Better Health Member ID card and the doctor's bill with you. We will need this information so we can help you quickly.

Member Services Notification

What do I have to do if I move/my child moves?

As soon as you have your new address, give it to HHSC by calling **2-1-1** or updating your account on **YourTexasBenefits.com** and call the Aetna Better Health Member Services Department at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Before you get CHIP services in your new area, you must call Aetna Better Health, unless you need emergency services. You will continue to get care through Aetna Better Health until HHSC changes your address.

Member Rights and Responsibilities – CHIP/CHIP Perinate Newborn

What are my rights and responsibilities?

Member Rights

1. You have the right to get accurate, easy-to-understand information to help you make good choices about your child's health plan, doctors, hospitals, and other providers.
2. Your health plan must tell you if they use a "limited provider network." This is a group of doctors and other providers who only refer patients to other doctors who are in the same group. “Limited provider network” means you cannot see all the doctors who are in your health plan. If your health plan uses "limited networks," you should check to see that your child's Primary Care Provider and any specialist doctor you might like to see are part of the same "limited network."
3. You have a right to know how your doctors are paid. Some get a fixed payment no matter how often you visit. Others get paid based on the services they give to your child. You have a right to know about what those payments are and how they work.
4. You have a right to know how the health plan decides whether a service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
5. You have a right to know the names of the hospitals and other providers in your health plan and their addresses.
6. You have a right to pick from a list of health care providers that is large enough so that your child can get the right kind of care when your child needs it.
7. If a doctor says your child has special health care needs or a disability, you may be able to use a specialist as your child's Primary Care Provider. Ask your health plan about this.
8. Children who are diagnosed with special health care needs or a disability have the right to special care.
9. If your child has special medical problems, and the doctor your child is seeing leaves your health plan, your child may be able to continue seeing that doctor for three months, and the health plan must continue paying for those services. Ask your plan about how this works.
10. Your daughter has the right to see a participating obstetrician/gynecologist (OB/GYN) without a referral from her Primary Care Provider and without first checking with your health plan. Ask your plan how this works. Some plans may make you pick an OB/GYN before seeing that doctor without a referral.
11. Your child has the right to emergency services if you reasonably believe your child's life is in danger, or that your child would be seriously hurt without getting treated right away. Coverage of emergencies is available without first checking with your health plan. You may have to pay a copayment depending on your income. Copayments do not apply to CHIP Perinatal Members.
12. You have the right and responsibility to take part in all the choices about your child's health care.

13. You have the right to speak for your child in all treatment choices.
14. You have the right to get a second opinion from another doctor in your health plan about what kind of treatment your child needs.
15. You have the right to be treated fairly by your health plan, doctors, hospitals, and other providers.
16. You have the right to talk to your child's doctors and other providers in private, and to have your child's medical records kept private. You have the right to look over and copy your child's medical records and to ask for changes to those records.
17. You have the right to a fair and quick process for solving problems with your health plan and the plan's doctors, hospitals and others who provide services to your child. If your health plan says it will not pay for a covered service or benefit that your child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
18. You have a right to know that doctors, hospitals, and others who care for your child can advise you about your child's health status, medical care, and treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.
19. You have a right to know that you are only responsible for paying allowable copayments for covered services. Doctors, hospitals, and others cannot require you to pay any other amounts for covered services.
20. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or to punish you.
21. You have the right to get care from a doctor even if you choose not to get vaccines. If a doctor has refused you care because of your vaccine status, you should report it to MCCO Research and Resolution Team by sending an email to HPM_Complaints@hhsc.state.tx.us or online at https://texashhs.org/ManagedCareProviderComplaint or by Fax to 512-491-1958 or writing to:

    Health and Human Services Commission/CHIP
    Managed Care Compliance and Operations
    P.O. Box 149030 MC-0210
    Austin, Texas 78714-9030

Member Responsibilities

You and your health plan both have an interest in seeing your child's health improve. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Encourage your child to stay away from tobacco and to eat a healthy diet.

2. You must become involved in the doctor's decisions about your child's treatments.
3. You must work together with your health plan's doctors and other providers to pick treatments for your child that you have all agreed upon.
4. If you have a disagreement with your health plan, you must try first to resolve it using the health plan's complaint process.
5. You must learn about what your health plan does and does not cover. Read your Member Handbook to understand how the rules work.
6. If you make an appointment for your child, you must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
7. If your child has CHIP, you are responsible for paying your doctor and other providers copayments that you owe them. If your child is getting CHIP Perinatal services, you will not have any copayments for that child.
8. You must report misuse of CHIP or CHIP Perinatal services by health care providers, other members, or health plans.
9. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **www.hhs.gov/ocr**.

Coverage Renewal

How does renewal work?

It's important to renew your/your child's CHIP/Children's Medicaid coverage on time, if not, the coverage could end. In your tenth month of coverage HHSC will mail a renewal packet to you that contain an application with some of your information already filled in.

- Update information as needed.
- Fill in all the questions that have been left blank
- Make sure to send in copies of at least one paycheck stub or documents showing each family member's income and expenses.
- You will need to complete, sign, and return the renewal packet using the postage-paid return address envelope by the due date.
- You can also renew online or fax in the information.

Call **1-877-KIDS-NOW** (**1-877-543-7669**), dial 211 or visit, **www.yourtexasbenefits.com** to get help renewing your coverage.

Complaint Process

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) to tell us about your problem. An Aetna Better Health

Member Services Advocate can help you file a complaint. Just call **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). Most of the time, we can help you right away or at the most within a few days. Aetna Better Health cannot take any action against you as a result of your filing a complaint.

Can someone from Aetna Better Health help me file a complaint?

The Member Advocate can help you file a complaint. The Member Advocate will write down your concern. You can also send a written complaint to the Member Advocate at:

Aetna Better Health
Attention: Member Advocate
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

Or call **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Can someone else help me file a complaint?

At any time during the complaint process, you can have someone you know help you or act on your behalf. The person can be anyone you know, a family member, friend, guardian, doctor or an attorney. This person will be "your representative." If you decide to have someone represent you or act for you, tell us in writing, the name of that person and how we can reach him or her. You or your representative may ask to see any information about your complaint.

How long will it take to process my complaint? What are the requirements and timeframes for filing a complaint?

When we get the complaint from you, we will send you a letter within five (5) days to let you know that we got it. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results. This letter will explain the complete complaint and appeal process. It will also tell you about your appeal rights. If the complaint is for an emergency for inpatient hospital or on-going care, Aetna Better Health will resolve your complaint within one (1) business day.

What if more time is needed?

If you need more time to send information about your complaint, you can request an extension. If we need more time, we will send you a letter within 30 days from when we got your complaint telling you that we need more time and why it is best for you that we take the extension. When a complaint is extended, we will extend the timeframe to resolve your complaint by another 14 days. That means we will send you the complaint results letter within 44 days from the date we got your complaint.

Do I have the right to meet with a complaint appeal panel?
Within five (5) days of getting your request for an appeal, the Member Advocate will send you a letter to let you know that your appeal came to us. The Appeal Panel will look over the information you submitted and discuss your/your child's case. It is not a court of law. You have the right to appear in front of the Appeal Panel at a specified place to talk about the written appeal you sent us. When we make the decision on your appeal, we will send you a response in writing within thirty (30) days after we get the appeal.

If I am not satisfied with the outcome, who else can I contact?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to **1-800-252-3439**. If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
P.O Box 149091
Austin, Texas 78714-9091

If you can get on the Internet, you can submit your complaint online at ***www.tdi.texas.gov/consumer/complaint-health.html***.

Process to Appeal a CHIP Adverse Determination

Does my request have to be in writing?
Your request for an appeal can be verbal or in writing. You can call us and ask for an appeal by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card and ask for the Member Advocate. If the appeal is received verbally, the Member Advocate will write down the information and send it to you for review. You will need to return the form to the Member Advocate. A written request can be sent to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

What can I do if my doctor asks for a service or medicine for me/my child that's covered but Aetna Better Health denies or limits it?
If we deny or limit your doctor's request for a covered service for your/your child, you have the right to ask for an appeal. You can file your appeal verbally or in writing within 60 days of the notice we sent you saying the service or medicine was denied. You or your child's doctor can send us more information to show why you do not agree with the decision. You can call us and ask for an appeal. The Member Advocate will write down the information and send it to you to look over. A written appeal can be sent to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

How will I find out if services are denied?
If your child's services are denied, you and your child's doctor will get a letter that tells you the reason for denial. The letter will also tell you how to file an appeal and how to ask for a review by an Independent Review Organization (IRO).

What are the timeframes for the appeal process?
The timeframe for the resolution of the appeal will depend on what services have been denied. For a standard appeal, the Member Advocate will send you a letter within five (5) days of getting your request for an appeal to let you know that we got it. We will send all available information to a doctor who was not involved in making the first decision. You will get a written response on your appeal within thirty (30) days after we get the appeal.

If you are in the hospital or are already receiving services that are being limited or denied, you can call and ask for an expedited appeal. The expedited appeal process is explained below.

What if more time is needed?
If you need more time to send information about your appeal, you can request an extension. If we need more time, we will send you a letter within 30 days from when we got your appeal telling you that we need more time and why it is best for you that we take the extension. When an appeal is extended, we will extend the timeframe to resolve your appeal by another 14 days. That means we will send you the appeal results letter within 44 days from the date we got your appeal. The letter will also tell you if you don't like that we extended the timeframe you may file a complaint.

When do I have the right to ask for an appeal?
If you don't agree with the decision made by Aetna Better Health about a benefit or service, including denial for payment of services in whole or in part, you can ask Aetna Better Health you can ask us for an appeal. You do not have a right to an appeal if the services you asked for are not covered under the CHIP program or if a change is made to the state or federal law, which affects CHIP members. You do not have a right to an appeal if a change is made to the state or federal law, which affects some or all of Medicaid recipients.

Can someone from Aetna Better Health help me file an appeal?
You can get help in filing an appeal by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card and asking to speak with a Member Advocate or writing us at:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

The Member Advocate will listen to your appeal and tell you about the rules. They will also answer your questions and see that you are treated fairly.

Can someone else help me file an appeal?
At any time during the appeal process, you can have someone you know help you or act on your behalf. The person can be anyone you know, a family member, friend, guardian, doctor or an attorney. This person will be "your representative." If you decide to have someone represent you or act for you, tell us in writing, the name of that person and how we can reach him or her. You or your representative may ask to see any information about your appeal.

Expedited Appeal Process

What is an Expedited Appeal?
An **Expedited Appeal** is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an expedited appeal?
You can ask for an expedited appeal by calling us toll-free **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). A written expedited appeal can be sent to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

Does my request have to be in writing?
Like an appeal, your request for an expedited appeal can be verbal or in writing. You can call us and ask for an appeal by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card and ask for the Member Advocate.

What are the timeframes for an expedited appeal?
The timeframe for resolution of your request of an expedited appeal will be based on your medical emergency condition, procedure, or treatment, but will not take more than (24) hours from the date of your appeal request seventy-two (72) hours from your appeal. Aetna Better Health will let you know the final decision of the expedited appeal in writing within seventy-two (72) hours.

What happens if Aetna Better Health denies the request for an expedited appeal?
If you ask for an expedited appeal that does not involve an emergency, a hospital stay or services that are already being given, you will be told that the appeal review cannot be rushed. We will keep working the appeal and transfer it to the regular appeal timeframe and respond to you within thirty (30) days from the time we got your appeal.

Who can help me in filing an expedited appeal?

You can ask for an appeal by calling us at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) and asking for the Member Advocate or writing to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

If we change our decision after reviewing your appeal or expedited appeal, we will approve your request within 72 hours of the decision.

If you do not agree with this decision, you can ask for an outside review by an Independent Review Organization (IRO). The procedure to ask for a review by an IRO is explained below.

Independent Review Organization (IRO)

What is an Independent Review Organization (IRO)?
An Independent Review Organization (IRO) is an organization that has no connection to us or the doctors that were previously involved in your treatment or decisions made by us about services that have not been given.

How do I ask for a review by an Independent Review Organization?
You can ask for an IRO review by filling out the "Request for a Review by an Independent Review Organization" form that is sent with the decision letter. You will have 15 days from the day you get our decision letter to send it back to us. Once we get the completed form, we will forward your request to the Independent Review Organization (IRO), Maximus, for

review. There is no cost to you for an independent review. If you need help filling out the IRO form, please call the toll-free number on your/your child's Aetna Better Health Member ID card. We will be happy to help you.

What are the timeframes for this process?

If it is ***not*** a life-threatening condition, no later than the earlier of the:

- 15th day after the date the IRO gets all the information they need to make their decision; or
- 20th day after the date the IRO gets the request for a review.

If it is a life-threatening condition, no later than the earlier of the:

- 5th day after the date the IRO gets all the information they need to make their decision; or
- 8th day after the date the IRO gets the request for a review.

Report CHIP Fraud, Waste, and Abuse

How do I report someone who is misusing/abusing the CHIP Program or services? Do you want to report CHIP Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider, or a person getting CHIP benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us/** and click the red "Report Fraud" box to complete the online form; or
- You can report directly to your health plan:

  Aetna Better Health
  Attention: SIU Coordinator
  PO Box 818042
  Cleveland, OH 44181-8042
  1-888-761-5440

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened

- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

Subrogation

What is subrogation?

We might ask for payment for medical expenses to treat an injury or illness that was caused by someone else. This is a "right of subrogation" provision. Under our right of subrogation, we reserve the right to get back the cost of medical benefits paid when another party is (or might be responsible) for causing the illness or injury to you. We can ask to get back the cost of medical expenses from you if you get expenses from the other party.

CHIP Perinate Member Handbook

The following section of this handbook applies to our CHIP Perinate members. A CHIP Perinate member is defined as an "unborn child".

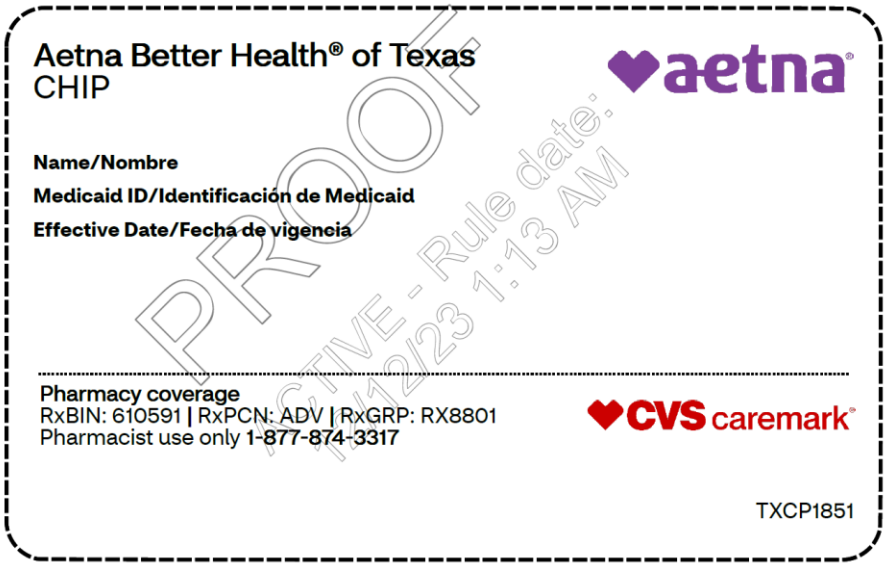
Member Identification (ID) Cards - CHIP Perinate

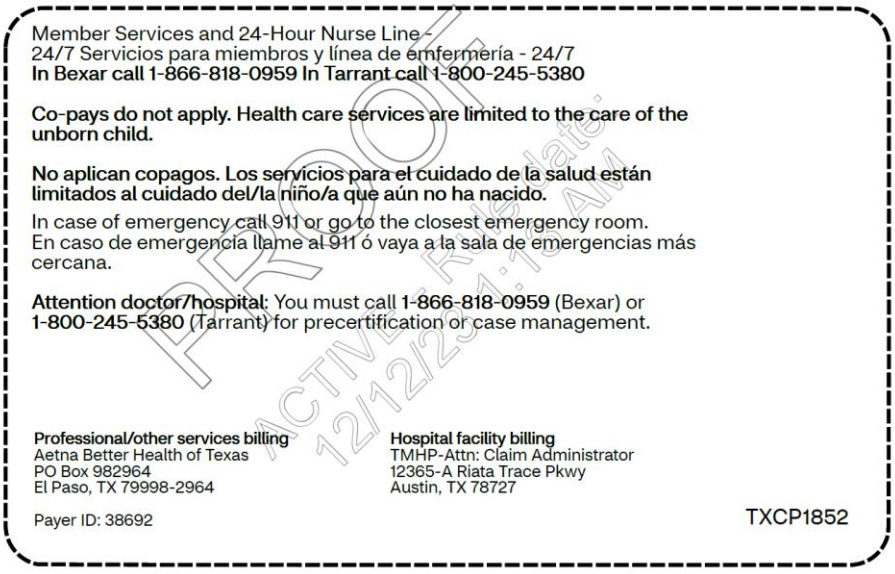
When you or your child is enrolled with us, you or your child will get an Aetna Better Health Member ID card from us. You or your child will not get a new Aetna Better Health Member ID card every month. If you call us to change your/your child's Primary Care Provider or if your/your child's copay changes, you or your child will get a new Aetna Better Health Member ID card.

How to read your card: The Aetna Better Health Member ID card lists the name and phone number(s) of your/your child's Primary Care Provider. It will show copayment information, if you have to pay for services. The back of the Aetna Better Health Member ID card has important phone numbers for you to call if you need help. Please make sure your/your child's information on his/her Aetna Better Health Member ID card is correct.

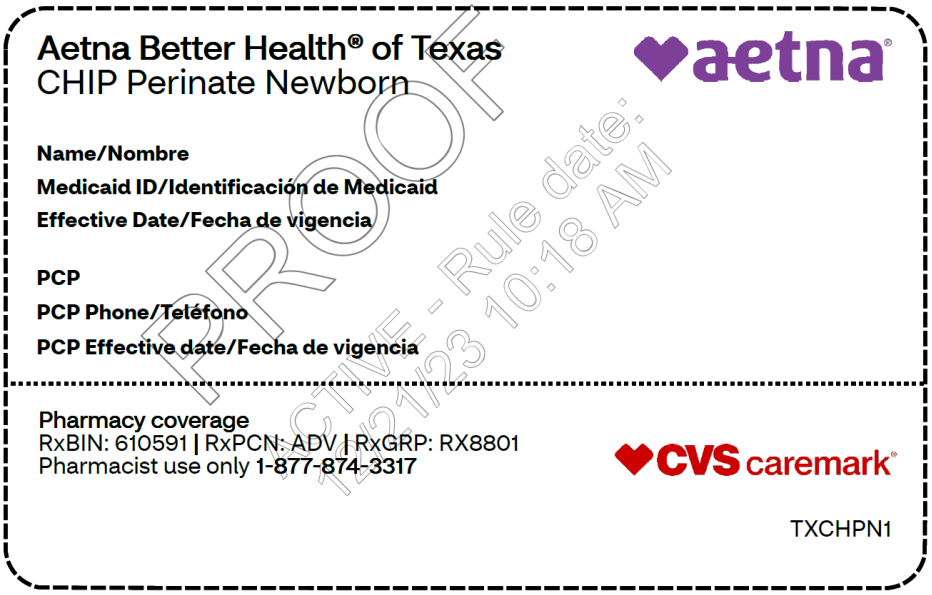
- Medicaid ID: Member identification number
- Eff date: Effective date of coverage with the health plan
- PRIMARY CARE PROVIDER: Name and phone number of Primary Care Provider
- PRIMARY CARE PROVIDER Effective date: Effective date of coverage with the provider
- RxBIN: Bank identification number pharmacy uses to submit claims
- RxGrp: Prescription group number pharmacy uses to identify the health plan
- RxPCN: Processor control number pharmacy uses to submit claims
- can send you another Aetna Better Health Member ID card.

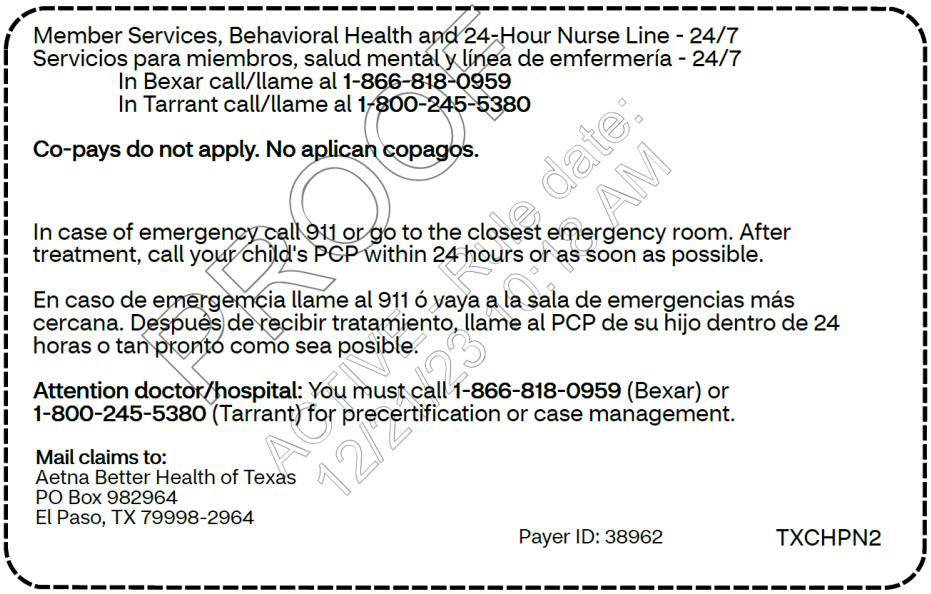
CHIP Perinatal Aetna Better Health Member ID card





CHIP Perinatal Newborn Aetna Better Health Member ID card





How to use your card: Always carry your/your child's Aetna Better Health Member ID card with you when going to see the doctor. You will need it to get health care for you or your child. You must show it each time you or your child gets services.

How to replace your/your child's card if lost or stolen: Please call Member Services right away so we can send you another Aetna Better Health Member ID card.

Providers for CHIP Perinate Members

What do I need to bring to a perinatal provider's appointment?
You should take the following items with you when you go to your doctor's appointment:

- Aetna Better Health Aetna Better Health Member ID card
- A list of all over-the-counter and prescription medications that you take
- Paper to take notes on information you get from the doctor

How do I choose a perinatal provider?
Please look at our provider directory to get more information on perinatal providers. You must pick a perinatal provider who is in our Aetna Better Health CHIP Perinate network. You can get a copy of the provider directory on **AetnaBetterHealth.com/Texas** or by calling us at the toll-free number listed on your Aetna Better Health Member ID card.

Can a clinic be a perinatal provider? (Rural Health Clinic, Federally Qualified Heath Center)
If you have been getting health care services at a clinic and you want to keep going there, please pick one of the doctors in the clinic as your perinatal provider. The perinatal provider you pick needs to be listed in our provider directory.

Some of the providers that you can also pick from to be your perinatal provider are: OB/GYNs (woman's doctor); Local Public Health Clinics; Federally Qualified Health Clinics (FQHCs); and Rural Health Clinics (RHCs).

How soon can I be seen after contacting a perinatal provider for an appointment?
You should be seen by a perinatal provider within 2 weeks of asking for an appointment. If you have problems getting an appointment, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Can I stay with a perinatal provider if they are not with Aetna Better Health CHIP Perinate?
If you are past the 24th week of pregnancy when you join you will be able to stay under the care of your current perinatal provider. If you choose, you can pick a perinatal provider who is in our network as long as the doctor agrees to treat you. We are available to help you with the changes between doctors.

How do I get medical care after my/my child's perinatal provider is office is closed?
If you or your child gets sick at night or on a weekend and cannot wait to get medical care, call your/your child's primary care or perinatal provider for advice. Your/your child's primary care or perinatal provider or another doctor is ready to help by phone 24 hours a day, 7 days a week.

How do I get after hours care?

If you are not able to reach your/your child's Primary Care Provider, you may also call the 24-hour Nurse Line at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) to speak with a registered nurse to help you decide what to do.

Health Plan Information – CHIP Perinate

Attention: If you meet certain income requirements, your baby will be moved to Medicaid and get 12 months of continuous Medicaid coverage from date of birth.

Your baby will continue to receive services through the CHIP program if you meet the CHIP Perinatal requirements. Your baby will get 12 months of continuous CHIP Perinatal coverage through his or her health plan, beginning with the month of enrollment as an unborn child.

What if I want to change health plans?

You are allowed to make health plan changes:

- For any reason within 90 days of enrollment in CHIP;
- For cause at any time;
- If you move to a different service delivery area; and
- During your annual CHIP re-enrollment period.

Who do I call?

For more information, call CHIP toll-free at **1-800-964-2777.**

How many times can I change health plans?

There is no limit on how many times you can change health plans.

When will my health plan change become effective?

If you call to change your health plan on or before the 15th of the month, the change will take place on the first day of the next month. If you call after the 15th of the month, the change will take place the first day of the second month after that. For example:

- If you call on or before April 15, your change will take place on May 1.
- If you call after April 15, your change will take place on June 1.

Can Aetna Better Health ask that I get dropped from their health plan for non-compliance, etc.?

You or your child can be disenrolled from our plan if:

- You or your child turns 19
- You do not re-enroll yourself or your child at the end of the 12-month eligibility period

- You or your child permanently moves out of the service area
- You or your child becomes enrolled in another health plan or has a change in health insurance status (i.e. coverage by employer insurance)
- You keep taking yourself or your child to the ER when you or your child does not have an emergency
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition
- You or your child misses many visits without letting your/ your child's doctor know in advance
- You let someone else use your/your child's Aetna Better Health Member ID card
- You often do not follow your/your child's doctor's advice

Concurrent enrollment of family members in CHIP, CHIP Perinatal and Medicaid coverage for certain newborns

If you have children enrolled in the CHIP program, they will remain in the CHIP program, but will be moved to Aetna Better Health' CHIP Perinatal coverage. Copayments, cost-sharing, and enrollment fees still apply for those children enrolled in the CHIP program.

An unborn child who is enrolled in CHIP Perinatal will be moved to Medicaid for 12 months of continuous **Medicaid** coverage, beginning on the date of birth, if the child lives in a family with an income **at or below** the Medicaid eligibility threshold.

An unborn child will continue to receive coverage through the CHIP program as a "**CHIP Perinate Newborn**" after birth if the child is born to a family with an income above the Medicaid eligibility threshold.

Benefit Information - CHIP Perinate

What are my unborn child's CHIP Perinatal benefits?

For a full list of some of the medical services you can get from Aetna Better Health, please refer to the table on pages **93-99**. Some of your benefits do have limits, which are listed in the table also. You can call Member Services toll free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for more benefit information.

Certificate of credible coverage

If you need proof of your child's CHIP coverage to help you enroll your child with another insurance plan, please call us at **1-866-818-0959** (Bexar service area) or **1-800-245-5380** (Tarrant service area). You can also write to:

Aetna Better Health
Attention: Member Services
PO Box 818042
Cleveland, OH 44181-8042

We will be happy to give you with a certificate of credible coverage upon request.

How do I get these services?

You should see your perinatal provider to ask about medical services. To learn more about how to obtain these or other services, please use the website, **AetnaBetterHealth.com/Texas**, or call us at the toll-free number on your Aetna Better Health Member ID card.

What is a referral? Will I need a referral?

A **referral** is a recommendation from the doctor for you/ your child to see a specialist other than your primary care physician (PRIMARY CARE PROVIDER). The doctor will talk to you about your/your child's needs and will help make plans for you to see the specialist, if needed, that can provide the best care for you.

A referral is not a requirement for your CHIP/CHIP Perinate plan of benefits.

What services do not need a referral?

The CHIP Perinate plan of benefits does not require referrals for any services; however, there are services that may need prior authorization.

What is a prior authorization?

It is not a referral or a pre-authorization. **Prior authorization** is an approval that Aetna Better Health requires for certain services and medications. Some services need approval before they are given. The provider who is treating you/your child should get this approval. You can ask your doctor or us if an approval is needed for a service or treatment.

What if I need services that are not covered by CHIP Perinatal?

Call your perinatal provider to ask about ways to get services not covered by CHIP Perinatal.

What services are not covered?

Services that are not covered by CHIP are called **Exclusions**. For a full list of exclusions, please refer to the table on pages **100-101.**

What are my unborn child's prescription drug benefits?

CHIP Perinate covers most of the medicine your unborn child needs. If you have questions what drugs are covered for your unborn child, call us at the toll-free number on your Aetna Better Health Member ID card.

How can I get these benefits for my unborn child?

You do not have to go to your Primary Care Provider to get these services. If you have questions or need help with these services, visit the website

AetnaBetterHealth.com/Texas or call us at the toll-free number on your Aetna Better Health Member ID card.

What health education classes does Aetna Better Health offer?
We work with our community partners to make available free and/or low-cost classes for parents and children. Some health topics include:

Car seat safety	Poison safety	Drug & alcohol awareness	Prenatal care
Immunizations	Sexually transmitted diseases	Infant mortality	Smoking cessation
Nutrition	Teen pregnancy prevention	Oral health	Vision awareness
Physical fitness	Weight management	Mental Health	

What extra benefits does a member of Aetna Better Health get? How can I get these benefits for my unborn child?
Aetna Better Health CHIP Perinate members get several value-added services and extra benefits. If you are needing additional assistance or resources, please call us at the toll-free number on your Aetna Better Health Member ID card and we can help you locate community resources in your area. The resources may be at a free or reduced cost to you.

Your Out-of-Pocket Costs – CHIP Perinate

How much do I have to pay for my unborn child's health care under CHIP perinatal?
No copayments or cost sharing is required for covered services listed in the benefits section of this handbook. If you have any questions, please call the Member Services toll free phone number on your Aetna Better Health Member ID card.

Copayments and cost-sharing do not apply to CHIP Perinate Mothers

Will I have to pay for services that are not a covered benefit?
If the service is not a covered benefit listed in the benefits table of this handbook, then you will have to pay for the service. If you have any questions, please call the Member Services toll free phone number on your Aetna Better Health Member ID card.

Health Care and Other Services – CHIP Perinate

What does medically necessary mean?
Covered services for CHIP Members, CHIP Perinate Newborn Members, and CHIP Perinate Members must meet the CHIP definition of "Medically Necessary." A CHIP Perinate Member is an unborn child.

Medically Necessary means:

1. Health Care Services that are:
    a. Reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;
    b. Provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
    c. Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
    d. Consistent with the member's diagnoses;
    e. No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
    f. Not experimental or investigative; and
    g. Not primarily for the convenience of the member or provider; and

2. Behavioral Health Services that:
    a. Are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
    b. Are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
    c. Are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
    d. Are the most appropriate level or supply of service that can safely be provided;
    e. Could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
    f. Are not experimental or investigative; and
    g. Are not primarily for the convenience of the member or provider.

What is routine medical care? How soon can I expect to be seen?
Routine Medical Care is the non-emergency or non-urgent care that you or your child receives from their Primary Care Provider, perinatal provider or other healthcare provider.

The perinatal provider you choose will help you with all your prenatal medical care. Your perinatal provider will get to know you and do regular check-ups on you and your unborn child. This type of care is known as routine medical care. Your perinatal provider will give you prescriptions for medicines and medical supplies and send you to a specialist if needed during your pregnancy. It is important that you follow your perinatal provider's advice and take part in decisions about your pregnancy.

When you need care, call your perinatal provider. Someone in the doctor's office or clinic will make an appointment for you. It is very important that you keep your appointments. Your perinatal provider should be able to see you within two (2) weeks after you ask for the routine care appointment. Call early to make appointments. If you cannot keep your appointment, call back to let the perinatal provider know.

What is urgent medical care? How soon can I expect to be seen?
Urgent care is when you or your child has a medical problem that is not an emergency, including a cold, cough, small cuts, minor burns or bruises.

You must first call your/your child's Primary Care Provider or your perinatal provider at the number shown on your/your child's Aetna Better Health Member ID card. If you would like to speak to a nurse, you can call the 24-Hour Nurse Line at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). The nurse can help decide if you or your child needs to go to the emergency room.

Many illnesses do not need to be treated in the ER. A cold, cough, rash, small cuts, minor burns or bruises are not good reasons to go to the ER. If you or your child needs urgent care, the primary care or perinatal provider should see you or your child within 24 hours after you ask for care.

What is an Emergency and an Emergency Medical Condition?
A CHIP Perinate Member is defined as an unborn child. Emergency care is a covered service if it directly relates to the delivery of the unborn child until birth. Emergency care is provided for the following Emergency Medical Conditions:

- Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child;
- Stabilization services related to the labor with delivery of the covered unborn child;

- Emergency ground, air and water transportation for labor and threatened labor is a covered benefit;
- Emergency ground, air, and water transportation for an emergency associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) is a covered benefit.

Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.

What is Emergency Services or Emergency Care?
"**Emergency Services**" or "**Emergency Care**" are covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services and that are needed to evaluate or stabilize an Emergency Medical Condition, including post-stabilization care services related to labor and delivery of the unborn child.

How soon can I expect to be seen?
Regardless of which CHIP plan you are enrolled in. You should be seen right away if you or your child needs emergency care. Whether you are in or out of one of our service areas, we ask that you follow the guidelines below when you believe you or your child needs emergency care.

- Call **911** or the local emergency hotline or go to the nearest emergency facility. If a delay would not be harmful to your/your child's health, call your/your child's Primary Care Provider. Tell your/your child's Primary Care Provider as soon as possible after getting treatment.
- As soon as your/your child's health condition is stabilized, the emergency facility should call your/your child's Primary Care Provider for information on your/your child's medical history.
- If you or your child is admitted to an inpatient facility, you, a relative or friend on your behalf should tell your/your child's Primary Care Provider as soon as possible.

Some good reasons to go to the ER are:

- Danger of losing life or limb
- Very bad chest pains
- Poisoning or overdose of medicine
- Choking or problems breathing
- Possible broken bones
- Uncontrolled diarrhea or vomiting
- Heavy bleeding
- Serious injuries or burns
- Fainting
- Suddenly not being able to move (paralysis)

- Victim of violent attack (rape, mugging, stab, or gunshot wound)
- You or your child has thoughts of causing harm to self or others
- About to deliver a baby

After-Hours Care – CHIP Perinate

How do I get medical care after my Primary Care Provider's office is closed?
If your primary care office is closed and you get sick at night or on a weekend and cannot wait to get medical care, call your Primary Care Provider for advice. Your primary care or another doctor is ready to help by phone 24 hours a day, 7 days a week. You may also call the 24-Hour Nurse Line at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) to help you decide what to do.

What if I get sick when I am out of town or traveling?
If you/your child needs medical care when traveling, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) and we will help you find a doctor.

If you/your child need **emergency** services while traveling go to a nearby hospital, then call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

What if I am out of state?
If you/your child has an emergency out of state, please go to the nearest emergency room for care. If you/your child gets sick and need medical care while you are out-of-state, call your Aetna Better Health doctor or clinic. Your doctor can tell you what you need to do if you are not feeling well. Please show your Aetna Better Health Aetna Better Health Member ID card before you are seen. Have the doctor call us for an authorization number. The phone number for the doctor to call is on the back of your Aetna Better Health Aetna Better Health Member ID card.

What if I am out of the country?
Medical services performed out of the country are not covered by CHIP Perinate

What is a referral?
A **referral** is a recommendation from the doctor for you/ your child to see a specialist other than your primary care physician (Primary Care Provider). The doctor will talk to you about your/your child's needs and will help make plans for you to see the specialist, if needed, that can provide the best care for you.

A referral is not a requirement for your CHIP Perinate plan of benefits.

What services do not need a referral?

CHIP Perinate members do not need referrals for any services; however, there are services that may need prior authorization.

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What is a prior authorization?

It is not a referral or a pre-authorization. **Prior authorization** is an approval that Aetna Better Health requires for certain services and medications. Some services need approval before they are given. The provider who is treating you/your child should get this approval. You can ask your doctor or us if an approval is needed for a service or treatment.

What if I need services that are not covered by CHIP Perinatal?

Call your perinatal provider to ask about ways to get services not covered by CHIP Perinatal.

Pharmacy and Medications – CHIP Perinate

How do I get my medications?

CHIP Perinatal covers most of the medicine your doctor says you need for your pregnancy. Your doctor will write a prescription so you can take it to the drug store or may be able to send the prescription to the drug store for you.

There are **no** copayments required for CHIP Perinate Members.

How do I find a network drug store?

You can find a network pharmacy in one of two ways:

- Visit our website at **AetnaBetterHealth.com/Texas** and then search for a pharmacy in your area.
- Call Member Services toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). Ask the representative to help you find a network pharmacy in your area.

What if I go to a drug store not in the network?

Prescriptions filled at other pharmacies that are not in the Aetna Better Health network will not be covered. All prescriptions must be filled at a network pharmacy.

What do I bring with me to the drug store?

You will need to bring the prescription your doctor wrote for you/your child. You will also need to show your Aetna Better Health Aetna Better Health Member ID card.

What if I need my medications delivered to me?

If you take medication for an ongoing health condition, you can have your medications mailed to your home. CVS Caremark is your mail service pharmacy. If you choose this option, your medication comes right to your door. You can schedule your refills and reach pharmacists if you have 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 medication that you take on an ongoing basis:

- Call the FastStart® toll-free number at **1-800-875-0867**, Monday through Friday, 7 AM to 7 PM (CT). A representative will let you know which of your prescriptions can be filled through CVS Caremark Mail Service Pharmacy. CVS Caremark will then contact your doctor for a prescription and mail the medication to you.
  - When you call, be sure to have:
    - Your Aetna Better Health member Aetna Better Health Member ID card
    - Your doctor's first and last name and phone number
    - Your payment information and mailing address
- Log on to **www.caremark.com/faststart**. Going online is a quick and easy way to start using mail service. Once you provide the requested information, CVS Caremark will contact your doctor for a new prescription. If you haven't registered yet on **www.caremark.com**, be sure to have your member Aetna Better Health 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 print on online or you can request one by calling toll-free **1-855-271-6603**.
  - Please have the following information with you when you complete the form:
    - Your Aetna Better Health member Aetna Better Health 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

If you need your prescription filled right away, ask your doctor to write two prescriptions for your long-term medication:

- One for a short-term supply (30 days or less) that can be filled at a participating network pharmacy AND
- One for the maximum day's supply allowed by your plan, with refills as needed. Enclose this prescription along with the mail service order form.

Who do I call if I have problems getting my medications?
If you have a problem getting your medications, please call us at the toll-free number on your Aetna Better Health Member ID card.

What if I can't get the medication my/my child's doctor ordered approved?
If your/your child's doctor cannot be reached to approve a prescription, your child may be able to get a **three-day emergency supply** of your medication.

Call Aetna Better Health at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for help with your medications and refills.

What is Step-Therapy?
Some drugs are not approved unless another drug has been tried first. Step-Therapy (ST) coverage requires that a trial of another drug be used before a requested drug is covered.

When you get a new prescription, ask your provider if we need to approve the medicine before you can get it. If we do, ask if there is another medicine you can use that does not need approval. When we need to approve your medicine, your provider must call Aetna Better Health for you. We will review the request to approve your medicine. If the pharmacist cannot reach Aetna Better Health to make sure it is approved, your pharmacist can give you a three (3) day temporary supply of the new prescription.

We will tell you in writing if we do not approve the request. We will also tell you how to start the appeal process.

What if I lose my medication(s)?
If you lose your medications, please call us at the toll-free number on your Aetna Better Health Member ID card. We will be able to help you replace your lost medications.

What if I need/my child needs an over-the-counter medication?
The pharmacy cannot give you an over-the-counter medication as part of your/your child's CHIP benefit. If you need/your child needs an over-the-counter medication, you will have to pay for it.

Interpreter Services – CHIP Perinate

Can someone interpret for me when I talk with my perinatal provider? Who do I call for an interpreter?
Our Member Services staff speaks both English and Spanish. We have a language line if you do not speak English or Spanish. If you need an interpreter, call us at the toll-free number. At the time of your call, we will get a language interpreter that speaks your

language on the line. People that are deaf or hearing impaired can call the TTY line toll-free at **1-800-735-2989** or **7-1-1.**

How can I get a face-to-face interpreter in the provider's office? How far in advance do I need to call?
We can help you if you need an interpreter to go with you to your/your child's doctor's office. As soon as you know the date of your/your child's appointment, please call us at the toll-free number on your/your child's Aetna Better Health Member ID card. We ask for 72 hours advance notice of a need for an interpreter.

Choosing a Provider - CHIP Perinate

How do I choose a perinatal provider?
Please look at our provider directory to get more information on perinatal providers. You must pick a perinatal provider who is in our Aetna Better Health CHIP Perinate network. You can get a copy of the provider directory on **AetnaBetterHealth.com/Texas** or by calling us at the toll-free number listed on your Aetna Better Health Member ID card.

What is a referral? Will I need a referral?
A **referral** is a recommendation from the doctor for you/ your child to see a specialist other than your primary care physician (PRIMARY CARE PROVIDER). The doctor will talk to you about your/your child's needs and will help make plans for you to see the specialist, if needed, that can provide the best care for you.

A referral is not a requirement for your CHIP/CHIP Perinate plan of benefits.

How soon can I be seen after contacting a perinatal provider for an appointment?
You should be seen by a perinatal provider within 2 weeks of asking for an appointment. If you have problems getting an appointment, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Can I stay with a perinatal provider if they are not with Aetna Better Health CHIP Perinate?
If you are past the 24th week of pregnancy when you join you will be able to stay under the care of your current perinatal provider. If you choose, you can pick a perinatal provider who is in our network as long as the doctor agrees to treat you. We are available to help you with the changes between doctors.

Can I choose my baby's Primary Care Provider before the baby is born? Who do I call? What information do they need?
Yes, you can select a Primary Care Provider before your child is born. You can do this by calling our Member Services Department at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) and request an Aetna Better Health provider directory.

Remember: the Primary Care Provider will be the one you call when your child needs care. Your child's Aetna Better Health CHIP or Aetna Better Health CHIP Texas Perinate Newborn Primary Care Provider is also part of a "network." When you choose this Primary Care Provider, you also choose this Primary Care Provider's network. This means that you should not take your child to any other provider who is not in the Primary Care Provider's network, even if this provider is listed in the Aetna Better Health provider directory.

Look in your Aetna Better Health provider directory for the names, addresses and telephone numbers of Aetna Better Health Primary Care Providers or pediatricians or call Member Services toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for help. You can also see or print a copy of the provider directory at **AetnaBetterHealth.com/Texas**.

Provider Billing – CHIP Perinate

What if I get a bill from my doctor? Who do I call? What information will they need?
As a parent or guardian, you must pay for the copayments for your child's care. If you feel that you should not have gotten a bill or you need help to understand the bill, call us at the toll-free number listed on your child's Aetna Better Health Member ID card.

We will help explain the bill to you. We can talk to the doctor's office for you to explain your child's benefits. We can also help you arrange for the bill to be paid. When you call us, please have your child's Aetna Better Health Member ID card and the doctor's bill with you. We will need this information so we can help you quickly.

Member Services Notification – CHIP Perinate

What do I have to do if I move?
As soon as you have your new address, give it to HHSC by calling **2-1-1** or updating your account on **YourTexasBenefits.com** and call the Aetna Better Health Member Services Department at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant).

Before you get CHIP services in your new area, you must call Aetna Better Health, unless you need emergency services. You will continue to get care through Aetna Better Health until HHSC changes your address.

Member Rights and Responsibilities – CHIP Perinate

What are my rights and responsibilities?

Member Rights

1. You have a right to get accurate, easy-to-understand information to help you make good choices about your unborn child's health plan, doctors, hospitals, and other providers.
2. You have a right to know how the Perinatal providers are paid. Some may get a fixed payment no matter how often you visit. Others get paid based on the services they provide for your unborn child. You have a right to know about what those payments are and how they work.
3. You have a right to know how the health plan decides whether a Perinatal service is covered or medically necessary. You have the right to know about the people in the health plan who decide those things.
4. You have a right to know the names of the hospitals and other Perinatal providers in the health plan and their addresses.
5. You have a right to pick from a list of health care providers that is large enough so that your unborn child can get the right kind of care when it is needed.
6. You have a right to emergency Perinatal services if you reasonably believe your unborn child's life is in danger, or that your unborn child would be seriously hurt without getting treated right away. Coverage of such emergencies is available without first checking with the health plan.
7. You have the right and responsibility to take part in all the choices about your unborn child's health care.
8. You have the right to speak for your unborn child in all treatment choices.
9. You have the right to be treated fairly by the health plan, doctors, hospitals, and other providers.
10. You have the right to talk to your Perinatal provider in private, and to have your medical records kept private. You have the right to look over and copy your medical records and to ask for changes to those records.
11. You have the right to a fair and quick process for solving problems with the health plan and the plan's doctors, hospitals and others who provide Perinatal services for your unborn child. If the health plan says it will not pay for a covered Perinatal service or benefit that your unborn child's doctor thinks is medically necessary, you have a right to have another group, outside the health plan, tell you if they think your doctor or the health plan was right.
12. You have a right to know that doctors, hospitals, and other Perinatal providers can give you information about your or your unborn child's health status, medical care, or treatment. Your health plan cannot prevent them from giving you this information, even if the care or treatment is not a covered service.

13. You have the right to not be restrained or secluded when it is for someone else's convenience or is meant to force you to do something you do not want to do or is to punish you.

14. You have the right to get care from a doctor even if you choose not to get vaccines. If a doctor has refused you care because of your vaccine status, you should report it to MCCO Research and Resolution Team by sending an email to HPM_Complaints@hhsc.state.tx.us or online at https://texashhs.org/ManagedCareProviderComplaint or by Fax to 512-491-1958 or writing to:

Health and Human Services Commission/CHIP
Managed Care Compliance and Operations
P.O. Box 149030 MC-0210
Austin, Texas 78714-9030

Member Responsibilities

You and your health plan both have an interest in having your baby born healthy. You can help by assuming these responsibilities.

1. You must try to follow healthy habits. Stay away from tobacco and eat a healthy diet.
2. You must become involved in the decisions about your unborn child's care.
3. If you have a disagreement with the health plan, you must try first to resolve it using the health plan's complaint process.
4. You must learn about what your health plan does and does not cover. Read your CHIP Perinatal Program Handbook to understand how the rules work.
5. You must try to get to the doctor's office on time. If you cannot keep the appointment, be sure to call and cancel it.
6. You must report misuse of CHIP Perinatal services by health care providers, other members, or health plans.
7. You must talk to your provider about your medications that are prescribed.

If you think you have been treated unfairly or discriminated against, call the U.S. Department of Health and Human Services (HHS) toll-free at **1-800-368-1019**. You also can view information concerning the HHS Office of Civil Rights online at **www.hhs.gov/ocr.**

Coverage Renewal – CHIP Perinate

When does CHIP perinatal coverage end? Will the state send me anything when my CHIP Perinatal coverage ends?

CHIP perinatal coverage ends the last day of the baby's birth month. Yes, the State will send you a letter stating when your coverage ends.

How does renewal work?

It's important to renew your/your child's CHIP/Children's Medicaid coverage on time, if not, the coverage could end. In your tenth month of coverage HHSC will mail a renewal packet to you that contain an application with some of your information already filled in.

- Update information as needed.
- Fill in all the questions that have been left blank
- Make sure to send in copies of at least one paycheck stub or other document showing each family member's income and expenses.
- Sign and date the application then send it in using the postage-paid return address envelope. Missing information or documents can cause a delay in working on your application.
- You can also renew online or fax in the information.

Call **1-877-KIDS-NOW** (**1-877-543-7669**), dial 211 or visit **www.yourtexasbenefits.com** to get help renewing your coverage.

Complaint Process

What should I do if I have a complaint?

We want to help. If you have a complaint, please call us toll-free at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) to tell us about your problem. An Aetna Better Health Member Services Advocate can help you file a complaint. Just call **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). Most of the time, we can help you right away or at the most within a few days. Aetna Better Health cannot take any action against you as a result of your filing a complaint.

Can someone from Aetna Better Health help me file a complaint?

The Member Advocate can help you file a complaint. The Member Advocate will write down your concern. You can also send a written complaint to the Member Advocate at:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181
Or call **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant)

Can someone else help me file a complaint?
At any time during the complaint process, you can have someone you know help you or act on your behalf. The person can be anyone you know, a family member, friend, guardian, doctor or an attorney. This person will be "your representative." If you decide to have someone represent you or act for you, tell us in writing, the name of that person and how we can reach him or her. You or your representative may ask to see any information about your complaint.

How long will it take to process my complaint? What are the requirements and timeframes for filing a complaint?
When we get the complaint from you, we will send you a letter within five (5) days to let you know that we got it. We will send you another letter within thirty (30) days from the date we got your complaint that will give you the results. This letter will explain the complete complaint and appeal process. It will also tell you about your appeal rights. If the complaint is for an emergency for inpatient hospital or on-going care, Aetna Better Health will resolve your complaint within one (1) business day.

What if more time is needed?
If you need more time to send information about your complaint, you can request an extension. If we need more time, we will send you a letter within 30 days from when we got your complaint telling you that we need more time and why it is best for you that we take the extension. When a complaint is extended, we will extend the timeframe to resolve your complaint by another 14 days. That means we will send you the complaint results letter within 44 days from the date we got your complaint.

Do I have the right to meet with a complaint appeal panel?
Within five (5) days of getting your request for an appeal, the Member Advocate will send you a letter to let you know that your appeal came to us. The Appeal Panel will look over the information you submitted and discuss your/your child's case. It is not a court of law. You have the right to appear in front of the Appeal Panel at a specified place to talk about the written appeal you sent us. When we make the decision on your appeal, we will send you a response in writing within thirty (30) days after we get the appeal.

If I am not satisfied with the outcome, who else can I contact?
If you are not satisfied with the answer to your complaint, you can also complain to the Texas Department of Insurance by calling toll-free to **1-800-252-3439**. If you would like to make your request in writing send it to:

Texas Department of Insurance
Consumer Protection
P.O Box 149091

Austin, Texas 78714-9091

If you can get on the Internet, you can submit your complaint online at **www.tdi.texas.gov/consumer/complaint-health.html**.

Process to Appeal a CHIP Adverse Determination

Does my request have to be in writing?

Your request for an appeal can be verbal or in writing. You can call us and ask for an appeal by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card and ask for the Member Advocate. If the appeal is received verbally, the Member Advocate will write down the information and send it to you for review. You will need to return the form to the Member Advocate.

What can I do if my doctor asks for a service or medicine for me/my child that's covered but Aetna Better Health denies or limits it?

If we deny or limit your doctor's request for a covered service for your/your child, you have the right to ask for an appeal. You can file your appeal verbally or in writing within 60 days of the notice we sent you saying the service or medicine was denied. You or your child's doctor can send us more information to show why you do not agree with the decision. You can call us and ask for an appeal. The Member Advocate will write down the information and send it to you to look over. A written appeal can be sent to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

How will I find out if services are denied?

If your child's services are denied, you and your child's doctor will get a letter that tells you the reason for denial. The letter will also tell you how to file an appeal and how to ask for a review by an Independent Review Organization (IRO).

What are the timeframes for the appeal process?

The timeframe for the resolution of the appeal will depend on what services have been denied. For a standard appeal, the Member Advocate will send you a letter within five (5) days of getting your request for an appeal to let you know that we got it. We will send all available information to a doctor who was not involved in making the first decision. You will get a written response on your appeal within thirty (30) days after we get the appeal.

If you are in the hospital or are already receiving services that are being limited or denied, you can call and ask for an expedited appeal. The expedited appeal process is explained below.

What if more time is needed?

If you need more time to send information about your appeal, you can request an extension. If we need more time, we will send you a letter within 30 days from when we got your appeal telling you that we need more time and why it is best for you that we take the extension. When an appeal is extended, we will extend the timeframe to resolve your appeal by another 14 days. That means we will send you the appeal results letter within 44 days from the date we got your appeal. The letter will also tell you if you don't like that we extended the timeframe you may file a complaint.

When do I have the right to ask for an appeal?

If you don't agree with the decision made by Aetna Better Health about a benefit or service, including denial for payment of services in whole or in part, you can ask us for an appeal. You do not have a right to an appeal if the services you asked for are not covered under the CHIP program or if a change is made to the state or federal law, which affects CHIP members. You do not have a right to an appeal if a change is made to the state or federal law, which affects some or all of Medicaid recipients.

Can someone from Aetna Better Health help me file an appeal?

You can get help in filing an appeal by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card and asking to speak with a Member Advocate or writing us at:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

The Member Advocate will listen to your appeal and tell you about the rules. They will also answer your questions and see that you are treated fairly.

Can someone else help me file an appeal?

At any time during the appeal process, you can have someone you know help you or act on your behalf. The person can be anyone you know, a family member, friend, guardian, doctor or an attorney. This person will be "your representative." If you decide to have someone represent you or act for you, tell us in writing, the name of that person and how

we can reach him or her. You or your representative may ask to see any information about your appeal.

Expedited Appeal Process

What is an Expedited Appeal?

An **Expedited Appeal** is when the health plan has to make a decision quickly based on the condition of your health and taking the time for a standard appeal could jeopardize your life or health.

How do I ask for an expedited appeal?

You can ask for an expedited appeal by calling us toll-free **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant). A written expedited appeal can be sent to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

Does my request have to be in writing?

Like an appeal, your request for an expedited appeal can be verbal or in writing. You can call us and ask for an appeal by calling us at the toll-free number listed on your/your child's Aetna Better Health Member ID card and ask for the Member Advocate.

What are the timeframes for an expedited appeal?

The timeframe for resolution of your request of an expedited appeal will be based on your medical emergency condition, procedure, or treatment. It will not take more than (24) hours from the date of your appeal request or seventy-two (72) hours from your appeal. Aetna Better Health will let you know the final decision of the expedited appeal in writing within seventy-two (72) hours.

What happens if Aetna Better Health denies the request for an expedited appeal?

If you ask for an expedited appeal that does not involve an emergency, a hospital stay or services that are already being given, you will be told that the appeal review cannot be rushed. We will keep working the appeal and transfer it to the regular appeal timeframe and respond to you within thirty (30) days from the time we got your appeal.

Who can help me in filing an appeal?

You can ask for an appeal by calling us at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) and asking for the Member Advocate or writing to:

Aetna Better Health
Attention: Member Advocate
P.O. Box 81139
5801 Postal RD
Cleveland, OH 44181

If we change our decision after reviewing your appeal or expedited appeal, we will approve your request within 72 hours of the decision.

If you do not agree with this decision, you can ask for an outside review by an Independent Review Organization (IRO). The procedure to ask for a review by an IRO is explained below.

Independent Review Organization (IRO)

What is an Independent Review Organization (IRO)?

An Independent Review Organization (IRO) is an organization that has no connection to us or the doctors that were previously involved in your treatment or decisions made by us about services that have not been given.

How do I ask for a review by an Independent Review Organization?

You can ask for an IRO review by filling out the "Request for a Review by an Independent Review Organization" form that is sent with the decision letter. You will have 15 days from the day you get our decision letter to send it back to us. Once we get the completed form, we will forward your request to the Independent Review Organization (IRO), Maximus, for review. There is no cost to you for an independent review. If you need help filling out the IRO form, please call the toll-free number on your/your child's Aetna Better Health Member ID card. We will be happy to help you.

What are the timeframes for this process?

If it is ***not*** a life-threatening condition, no later than the earlier of the:

- 15th day after the date the IRO gets all the information they need to make their decision; or
- 20th day after the date the IRO gets the request for a review.

If it is a life-threatening condition, no later than the earlier of the:

- 5th day after the date the IRO gets all the information they need to make their decision; or
- 8th day after the date the IRO gets the request for a review.

Report CHIP Fraud, Waste, and Abuse

How do I report someone who is misusing/abusing the CHIP Program or services? Do you want to report CHIP Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health-care provider, or a person getting CHIP benefits is doing something wrong. Doing something wrong could be waste, abuse, or fraud, which is against the law. For example, tell us if you think someone is:

- Getting paid for CHIP services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use a CHIP ID.
- Using someone else's CHIP ID.
- Not telling the truth about the amount of money or resources he or she has to get benefits.

To report waste, abuse, or fraud, choose one of the following:

- Call the OIG Hotline at **1-800-436-6184**;
- Visit **https://oig.hhsc.state.tx.us/** and click the red "Report Fraud" box to complete the online form; or
- You can report directly to your health plan:

  Aetna Better Health
  Attention: SIU Coordinator
  PO Box 818042
  Cleveland, OH 44181-8042
  1-888-761-5440

To report waste, abuse, or fraud, gather as much information as possible.

- When reporting about a provider (a doctor, dentist, counselor, etc.) include:
  - Name, address, and phone number of provider
  - Name and address of the facility (hospital, nursing home, home health agency, etc.)
  - Medicaid number of the provider and facility, if you have it
  - Type of provider (doctor, dentist, therapist, pharmacist, etc.)
  - Names and phone numbers of other witnesses who can help in the investigation
  - Dates of events
  - Summary of what happened
- When reporting about someone who gets benefits, include:
  - The person's name
  - The person's date of birth, Social Security Number, or case number if you have it
  - The city where the person lives
  - Specific details about the waste, abuse, or fraud

Subrogation

What is subrogation?

We might ask for payment for medical expenses to treat an injury or illness that was caused by someone else. This is a "right of subrogation" provision. Under our right of subrogation, we reserve the right to get back the cost of medical benefits paid when another party is (or might be responsible) for causing the illness or injury to you. We can ask to get back the cost of medical expenses from you if you get expenses from the other party.

Join our Member Advisory Group

We meet once every three months in your community. There will be an advisory group for Medicaid Star and CHIP. You can tell us how we're doing and offer suggestions. We would love to hear from you. Go to **AetnaBetterHealth.com/Texas/members/** to sign up.

CHIP/CHIP Perinate Newborn Covered Benefits and Limitations

Benefit Type	Benefit Description	Limitation
Inpatient general acute and inpatient rehabilita-tion hospital services	• Hospital-provided physician or provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or hospitals meeting equivalent levels of care • In-network or out-of-network facility and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care.	Requires authorization for non-emergency care and care following stabilization of an emergency condition. Requires authorization for in-network or out-of-network facility and physician services for a mother and her newborn(s) after 48 hours following an uncomplicated vaginal delivery and after 96 hours following an uncomplicated delivery by caesarian section.

Benefit Type	Benefit Description	Limitation

Inpatient general acute and inpatient rehabilita-tion hospital services (continued)	• Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: – Dilation and curettage (D&C) – Procedures – Appropriate provider-administered medications – Ultrasounds – Histological examination of tissue samples • Pre-surgical or post-surgical orthodontic • Services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – Cleft lip and/or palate – Severe traumatic, skeletal and/or congenital craniofacial deviations – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: – All stages of reconstruction on the affected breast – Surgery and reconstruction on the other breast to produce symmetrical appearance – Treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit

Benefit Type	Benefit Description	Limitation
Skilled nursing	Services include, but are not limited to, the following: • Semi-private room and board	Requires authorization

facilities (includes rehabilitation hospitals)	• Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility	and physician prescription. 60 days per 12-month period limit
Outpatient hospital, compre-hensive outpatient rehabilitation hospital, clinic (including health center) and ambulatory health care center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility	May require prior authorization and physician prescription.

Benefit Type	Benefit Description	Limitation
Outpatient hospital, compre-	• Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).	Requires authorization

hensive outpatient rehabilitation hospital, clinic (including health center) and ambulatory health care center (Continued)	Outpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: – Dilation and curettage (D&C) – Procedures – Appropriate provider -administered medications – Appropriate provider -administered medications – Ultrasounds – Histological examination of tissue samples • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: – Cleft lip and/or palate – Severe traumatic, skeletal and/or congenital craniofacial deviations – Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment • Surgical implants • Other artificial aids including surgical implants • Inpatient services for a mastectomy and breast reconstruction include: – All stages of reconstruction on the affected breast – Surgery and reconstruction on the other breast to produce symmetrical appearance – Treatment of physical complications from the mastectomy and treatment of lymphedemas • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit	and physician prescription. 60 days per 12-month period limit

Benefit Type	Benefit Description	Limitation
Physician and physician extender	Services include, but are not limited to the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including but not limited to vision and hearing screening and immunizations)	Requires authorization for all out-of-network

professional services	• Physician office visits, in-patient and outpatient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in Physician's office • Allergy testing, serum and injections • Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care – Administration of anesthesia by physician (other than surgeon) or CRNA – Second surgical opinions – Same-day surgery performed in a hospital without an over-night stay – Invasive diagnostic procedures such as endoscopic examinations • Hospital-based physician services (including Physician-performed technical and interpretive components) • Physician and professional services for a mastectomy and breast reconstruction include: – All stages of reconstruction on the affected breast – Surgery and reconstruction on the other breast to produce symmetrical appearance – Treatment of physical complications from the mastectomy and treatment of lymphedemas • Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Physician services associated with miscarriage or non-viable pregnancy include, but are not limited to: – Dilation and curettage (D&C) – Procedures – Appropriate provider - administered medications – Ultrasounds – Histological examination of tissue samples • Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial	specialty referrals.

anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat:
  - Cleft lip and/or palate
  - Severe traumatic, skeletal and/or congenital craniofacial deviations
  - Severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment
- Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.
- In-network and out-of-network physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section.

Benefit Type	Benefit Description	Limitation
Birthing center services	• Covers birthing services provided by a licensed birthing center	Limited to facility services (e.g., labor and delivery) **** CHIP only ****
Services rendered by a certified nurse midwife or physician in a licensed birthing center	• Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center	**** CHIP only ****
Durable medical equipment (DME), prosthetic devices and disposable medical supplies	Covered services include DME (equipment that can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness, injury, or disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including but not limited to: • Orthotic braces and orthotics • Dental devices • Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Other artificial aids including surgical implants • Hearing aids • Implantable devices are covered under inpatient and outpatient services and do not count towards the DME 12-month period limit • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements	May require prior authorization and physician prescription. $20,000 per 12-month period limit for DME, prosthetics, devices and disposable medical supplies (implantable devices, diabetic supplies and equipment are not counted against this cap).

Benefit Type	Benefit Description	Limitation
Home and community health services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.) • Home health aide when included as part of a plan of care during a period that skilled visits have been approved • Speech, physical and occupational therapies	Requires prior authorization and physician prescription. Services are not intended to replace the child's caretaker or to provide relief for the caretaker. Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services. Services are not intended to replace 24-hour inpatient or skilled nursing facility services.
Inpatient mental health services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state operated facilities, including but not limited to: • Neuropsychological and psychological testing **NOTE**: When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	Requires prior authorization for non-emergency services. Does not require Primary Care Provider referral.

Benefit Type	Benefit Description	Limitation
Outpatient mental health services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development)	May require prior authorization. Does not require Primary Care Provider referral.
	NOTE: When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility.
	A ***Qualified Mental Health provider - Community Services*** (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1), §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (that can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.	These requirements are not applicable when the Member is considered incarcerated as defined by UMCM Section 16.1.15.2.

Benefit Type	Benefit Description	Limitation
Inpatient substance use disorder treatment services	Inpatient substance use disorder treatment services include, but are not limited to: • Inpatient and residential substance use disorder treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs.	Requires prior authorization for non-emergency services. Does not require Primary Care Provider referral
Outpatient substance use disorder treatment services	Outpatient substance use disorder treatment services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders • Partial hospitalization • Intensive outpatient services- defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training that consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day. • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training **NOTE:** When outpatient substance use disorder treatment services are required as a court order, consistent with Chapter 462, Subchapter D of the Texas Health and Safety Code, or as a condition of probation, the court order serves as a binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.	May require prior authorization Does not require Primary Care Provider referral

Benefit Type	Benefit Description	Limitation
Rehabilitation services	Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational and speech therapy • Developmental assessment	Requires prior authorization and physician prescription
Hospice care services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment services, including treatment related to the terminal illness, are unaffected by electing hospice care services	Requires prior authorization and physician prescription Services apply to hospice diagnosis Up to a maximum of 120 days with a 6-month life expectancy Patients electing hospice services may cancel this election at anytime
Transplants	Covered services include: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses	Requires prior authorization

Benefit Type	Benefit Description	Limitation
Emergency services, including emergency hospitals, physicians, and ambulance services	Health plan cannot require authorization as a condition for payment for Emergency Conditions or labor and delivery. Covered services include: • Emergency services based on prudent layperson definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts	Does not require prior authorization for post-stabilization services
Vision benefit	Covered services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	The health plan may reasonably limit the cost of the frames/lenses. Does not require authorization for protective and polycarbonate lenses when medically necessary as part of a treatment plan for covered diseases of the eye.
Chiropractic services	Covered services do not require physician prescription and are limited to spinal subluxation	Does not require authorization for 12 visits per 12-month period limit (regardless of number of

		services or modalities provided in one visit)
Benefit Type	**Benefit Description**	**Limitation**
Drug benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider - administered outpatient drugs and biologicals; and • Drugs and biologicals provided in an inpatient setting.	Services must be medically necessary for the unborn child. Some drug benefits require prior authorization.
Tobacco cessation program	Covered up to $100 for a 12-month period limit plan-approved program	Does not require authorization. Health plan defines plan-approved program. May be subject to formulary requirements.

CHIP/CHIP Perinate Newborn Exclusions

Services that are not covered by CHIP are called "Exclusions."

Benefits Exclusions
Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
Contraceptive medications prescribed only for the purpose of primary and preventive reproductive health care (i.e. cannot be prescribed for family planning)
Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles that are not required for the specific treatment of sickness or injury
Experimental and/or investigational medical, surgical or other health care procedures or services that are not generally employed or recognized within the medical community. *This exclusion is an adverse determination and is eligible for review by an Independent Review Organization*
Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court.
Dental devices solely for cosmetic purposes
Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
Mechanical organ replacement devices including, but not limited to artificial heart.
Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise preauthorized by the health plan
Prostate and mammography screening
Elective surgery to correct vision
Gastric procedures for weight loss
Cosmetic surgery/services solely for cosmetic purposes
Out-of-network services not authorized by the health plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the health plan

Benefits Exclusions (continued)
Medications prescribed for weight loss or gain
Acupuncture services, naturopathy and hypnotherapy
Immunizations solely for foreign travel
Routine foot care such as hygienic care
Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails).
Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the member or the vendor
Corrective orthopedic shoes
Convenience items
Over-the-counter medications
Orthotics primarily used for athletic or recreational purposes
Custodial care (Care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) **NOTE: This exclusion does not apply to hospice**
Housekeeping
Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
Services or supplies received from a nurse that does not require the skill and training of a nurse.
Vision training and vision therapy
Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/Primary Care Provider.
Donor non-medical expenses
Charges incurred as a donor of an organ when the recipient is not covered under this health plan
Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP/CHIP Perinate Newborn Value-Added Benefits

Benefit Type	Benefit Description
24-Hour Nurse Line	This 24-hours-a-day, 7-days-a-week service enables all members to have telephonic access to clinical support from experienced registered nurses. Members can call the nurse line directly at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for assistance.
Over-the-Counter Benefits/Discount Pharmacy	The OTC Health Solutions program offers members a $25 quarterly allowance ($100 annually). OTC medications and products can be ordered by phone, online, fax or mail and are then delivered directly to members' homes. Limited to $25 per quarter ($100 annually) per member. Discount drug store services. These products include*: • Baby care • Cold remedies • Digestive health • Ear & eye care • Feminine care • First aid supplies • Foot care • Home diagnostics • Incontinence • Oral care • Pain relievers • Personal care • Vitamins/minerals • Groceries *Excludes prescriptions, alcohol, lottery, postage stamps, gift cards, money orders, Aetna Better Health Member ID cards and photo finishing and is not valid on any items reimbursed by the federal government. This benefit covers Over-the Counter (OTC) medications and other products items that do not need a prescription and are not otherwise covered benefits.
Extra help for pregnant women	Aetna Better Health offers our pregnant members: • $25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of enrollment

	• $25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of pregnancy diagnosis if already a member • $50 worth of diapers, baby wipes and/or similar items for completion of 3 prenatal visits • $50 worth of diapers, baby wipes and/or similar items for completion of 3 additional prenatal visits (6 in total) and 1 postpartum care visit • Members will call the health plan when they have completed all their prenatal and postpartum visits to claim their gift of baby items • Pregnancy handbook for pregnant members in case management • $200 gift card to existing members who become pregnant while enrolled, for enrolling in the Aetna pregnancy case management program and notifying HHSC of pregnancy within 30 days of pregnancy diagnosis
Extra help getting a ride	Need help getting a ride? We can provide daily bus pass/token, cab fare or ride share for members and their legally authorized representative (LAR) as well as siblings if the LAR cannot make other arrangements; when needed to visit for WIC offices, plan sponsored community events/classes or attend Member Advisory Groups meetings.
Extra Vision Services	Aetna Better Health members will receive financial assistance in obtaining vision services and products. • 18 years and younger – Aetna will cover up to $175 once a year for eye wear including eyeglass frames, lenses and contact lenses that are not covered by CHIP.
Behavioral Health Inpatient Follow-up Incentive	Receive a $25 gift card for members who complete a follow-up visit with their behavioral health provider within 7 days of leaving the behavioral health hospitalization.
Online Behavioral Health Resources	Members can access online mental health resources on our website at **AetnaBetterHealth.com/Texas/members/behavior**.
Help for Members with Asthma	Members with an asthma diagnosis and enrolled in the asthma disease management program will receive the following, up to $100 per year: • One peak flow meter and holding chamber or spacer each year • Pest control • Hypoallergenic bedding

	• Deep carpet cleaning
Sports Physicals	Medically necessary sports physicals to any member 18 years and younger.
Well-Child Exams Gift Program	Members can receive: • $50 gift card at no cost to members for completing well-child checkups/visits at 2 weeks and 2, 4, 6, months of age. Upon completion of these checkups, Members will call Member Services to redeem and request one $50 gift card. • $25 gift card at no cost to you for completing a well-child checkup/visit at 9 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one $25 gift card. • $25 gift card at no cost to you for completing a well-child checkup/visit at 12 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one $25 gift card. • $25 gift card at no cost to you for completing a well-child checkup/visit at 15 months of age. Upon completion of this checkup, Members will call Member Services to redeem and request one $25 gift card. • $25 gift card at no cost to you for completing a well-child checkups/visits at 18 and 30 months of age. Upon completion of each of these checkups, the Members will call Member Services to redeem and request one $25 gift card. A total of two $25 gift cards are available for completing both checkups. • $25 gift card at no cost to you each time an annual well-child checkups/visits is received for members 3-18 years of age. Upon completion of each of these checkups/visits, the Members will call Member Services to redeem and request one $25 gift card. Limit one card per member per year.
Home visits	Virtual home visit for lactation consultant for all new moms.
Smoking Cessation Program	A smoking cessation program including assessment and counseling is offered to members 12 years of age and older. This program will provide members with the tools and support to assist them to stop smoking and lead healthier lives.
Disease Management	Two $25 gift cards for diabetic members 18 years of age for completing a diabetic eye exam and a A1c or kidney screening.

Health and Wellness Services	Weight loss program including counseling with a nutritionist / dietician for non-pregnant Members ages 3 to 18; Body Mass Index (BMI) greater than 85th percentile
Healthy Play and Exercise Programs	Aetna Activate Kids Health Club members earn two $50 retail gift cards annually upon enrollment in plan specified extracurricular programs and swimming programs.
Housing Deposit Gift Program	$125 gift card towards housing deposit fee for house, apartment or hotel for members who complete the Health Risk Questionnaire (HRQ)

***** Restrictions and limitations may apply*****

CHIP Perinate Covered Benefits and Limitations

Benefit Type	Benefit Description	Limitation
Inpatient general acute	Services include: • Covered medically necessary hospital-provided services. • Operating, recovery and other treatment rooms. • Anesthesia and administration (facility technical component). • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: • Dilation and curettage (d&c) procedures, • Appropriate provider - administered medications, • Ultrasounds, and • Histological examination of tissue samples	For CHIP Perinate in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinate in families with incomes above 185% up to and including 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth.

Benefit Type	Benefit Description	Limitation
Comprehensive outpatient hospital, clinic (including health center) and ambulatory health care center	Services include the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs • Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) • Outpatient services associated with miscarriage or non-viable pregnancy includes, but are not limited to: – Dilation and Curettage (d&c) procedures, – Appropriate provider-administered medications, ultrasounds, and – Histological examination of tissue samples **Note:** Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth Ultrasound of the pregnant uterus is a covered benefit of the CHIP Perinatal Program when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, gestational age conformation, or miscarriage or non-viable pregnancy. Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits of the	May require prior authorization and physician prescription

	CHIP Perinatal Program with an appropriate diagnosis. **Laboratory tests** for the CHIP Perinatal Program are limited to: nonstress testing, contraction stress testing, hemoglobin or hematocrit repeated one a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client. Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy or a fetus that expired in utero) are a covered benefit.	
Comprehensive outpatient hospital, clinic (including health center) and ambulatory health care center (Continued)	Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. Physician office visits, in-patient and out-patient services	May require authorization for specialty referral from a Primary Care Provider to an in-network specialist.

Benefit Type	Benefit Description	Limitation
Physician / physician extender professional services Physician / physician extender professional services (continued)	Services include, but are not limited to the following: • Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth. • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging and pathology services, including technical component or professional interpretation Medically necessary medications, biologicals and materials administered in Physician's office • Professional component (in/outpatient) of surgical services, including: – Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth. – Administration of anesthesia by physician (other than surgeon) or CRNA – Invasive diagnostic procedures directly related to the labor with delivery of the unborn child – Surgical services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). • Hospital-based physician services (including Physician-performed technical and interpretive components) • Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero.) Professional services associated	Requires authorization for all out-of-network specialty referrals. Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age conformation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentesis, and FIUT.

	with miscarriage or non-viable pregnancy include but are not limited to: dilation and curettage (D&C) procedures, appropriate provider-administered medications, ultrasounds, and histological examination of tissue samples.	
Birthing center services	Covers birthing services provided by a licensed birthing center. Limited to facility services (e.g., labor and delivery)	Applies only to CHIP Perinate members (unborn child) with incomes at 186% FPL to 200% FPL.
Services rendered by a certified nurse midwife or physician in a licensed birthing center Services rendered by a certified nurse midwife or physician in a licensed birthing center (continued)	Covers prenatal, birthing, and postpartum services rendered in a licensed birthing center. Prenatal services subject to limitations: Visits after the initial visit must include: • Interim history (problems, marital status, fetal status) • Physical examination (weight, blood pressure, fundal height, fetal position and size, fetal heart rate, extremities) • Laboratory tests (urinalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for rh negative women at 28 weeks followed by rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client). More frequent visits are allowed as medically necessary. Benefits are limited to: • Limit of 20 prenatal visits and two (2)	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: – One (1) visit every four (4) weeks for the first 28 weeks or pregnancy; one (1) visit every two (2) to three (3) weeks from 28 to 36 weeks of pregnancy; and one (1) visit per week from 36 weeks to delivery. More frequent visits may be necessary for high-risk pregnancies. High-risk

	postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy.	prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained and is subject to retrospective review.
Prenatal care and pre-pregnancy family services and supplies	Covered services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: • One visit every four weeks for the first 28 weeks of pregnancy; • One visit every two to three weeks from 28 to 36 weeks of pregnancy; and • One visit per week from 36 weeks to delivery. More frequent visits are allowed as medically necessary.	Does not require prior authorization.

Benefit Type	Benefit Description	Limitation
Emergency services, including emergency hospitals, physicians, and ambulance services	Health plan cannot require authorization as a condition for payment for emergency conditions related to labor and delivery. Covered services are limited to those emergency services that are directly related to the delivery of the covered unborn child until birth. • Emergency services based on prudent layperson definition of emergency health condition. Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor and delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit. Emergency services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).	Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Case management services	Case management services are a covered benefit for the unborn child	These covered services include outreach informing, case management, care coordination and community referral
Care coordination services	Care coordination services are a covered benefit for the unborn child	
Drug benefits	Services include, but are not limited to, the following: • Outpatient drugs and biologicals; including pharmacy-dispensed and provider - administered outpatient drugs and biologicals • Drugs and biologicals provided in an inpatient setting	Services must be medically necessary for the unborn child.

CHIP Perinate Exclusions

Services that are not covered by CHIP are called "Exclusions."

Benefits Exclusions
Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth. Services related to preterm, false or other labor not resulting in delivery are excluded services
Inpatient mental health services
Outpatient mental health services
Durable medical equipment or other medically related remedial devices
Disposable medical supplies
Home and community-based health care services
Nursing care services
Dental services
Inpatient substance use disorder treatment services and residential substance use disorder treatment services
Outpatient substance use disorder treatment services
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
Hospice care
Skilled nursing facility and rehabilitation hospital services
Emergency services other than those directly related to the delivery of the covered unborn child
Transplant services
Tobacco cessation programs
Chiropractic services
Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor and delivery or postpartum care.
Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community. *This exclusion is an adverse determination and is eligible for review by an Independent Review Organization*.
Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, right clearance, camps, insurance or court
Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility

Mechanical organ replacement devices including, but not limited to artificial heart
Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor and delivery
Prostate and mammography screening
Elective surgery to correct vision
Gastric procedures for weight loss
Cosmetic surgery/services solely for cosmetic purposes
Medications prescribed for weight loss or gain
Out-of-network services not authorized by the health plan except for emergency care related to the labor and delivery of the covered unborn child.
Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
Acupuncture services, naturopathy and hypnotherapy
Immunizations solely for foreign travel
Routine foot care such as hygienic care
Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
Corrective orthopedic shoes
Convenience items
Over-the-counter medications
Orthotics primarily used for athletic or recreational purposes
Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel)
Housekeeping
Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
Services or supplies received from a nurse, which do not require the skill and training of a nurse
Vision training, vision therapy, or vision services
Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
Donor non-medical expenses
Charges incurred as a donor of an organ
Coverage while traveling outside the United States and U.S. Territories (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).

CHIP Perinate (Pregnant Women) Value-Added Benefits

Benefit Type	Benefit Description
24-Hour Nurse Line	This 24-hours-a-day, 7-days-a-week service enables all members to have telephonic access to clinical support from experienced registered nurses. Members can call the nurse line directly at **1-866-818-0959** (Bexar) or **1-800-245-5380** (Tarrant) for assistance.
Over-the-Counter Benefits/Discount Pharmacy	The OTC Health Solutions program offers members a $25 quarterly allowance ($100 annually). OTC medications and products can be ordered by phone, online, fax or mail and are then delivered directly to members' homes. Limited to $25 per quarter ($100 annually) per member. Discount drug store services. These products include*: • Baby care • Cold remedies • Digestive health • Ear & eye care • Feminine care • First aid supplies • Foot care • Home diagnostics • Incontinence • Oral care • Pain relievers • Personal care • Vitamins/minerals • Groceries *Excludes prescriptions, alcohol, lottery, postage stamps, gift cards, money orders, Aetna Better Health Member ID cards and photo finishing and is not valid on any items reimbursed by the federal government. This benefit covers Over-the Counter (OTC) medications and other products items that do not need a prescription and are not otherwise covered benefits.
Extra help for pregnant women	Aetna Better Health offers our pregnant members: • $25 gift card and a special pregnancy handbook for enrolling in case management within 30 days of enrollment or pregnancy diagnosis, if already a member

	• $50 worth of diapers, baby wipes and/or similar items for completion of 3 prenatal visits • $50 worth of diapers, baby wipes and/or similar items for completion of 3 additional prenatal visits (6 in total) and 1 postpartum care visit • Members will call the health plan when they have completed all their prenatal and postpartum visits to claim their gift of baby items • Pregnancy handbook for pregnant members in case management • $200 gift card to existing members who become pregnant while enrolled, for enrolling in the Aetna pregnancy case management program and notifying HHSC of pregnancy within 30 days of pregnancy diagnosis
Extra help getting a ride	Demand response transportation for CHIP Perinate members for nonemergency health care
Online Behavioral Health Resources	Members can access online mental health resources on our website at **AetnaBetterHealth.com/Texas/members/behavior**.
Help for Members with Asthma	Members with an asthma diagnosis and enrolled in the asthma disease management program will receive the following, up to $100 per year: • One peak flow meter and holding chamber or spacer each year • Pest control • Hypoallergenic bedding • Deep carpet cleaning
Sports Physicals	Medically necessary sports physicals to any member 18 years and younger.
Home visits	Virtual home visit for lactation consultant for all new moms.
Dental Services	CHIP Perinate Members are eligible for annual Dental Benefits: Biannual teeth cleaning, annual x-rays, simple extractions, limited fillings and fluoride treatments.
Smoking Cessation Program	A smoking cessation program including assessment and counseling is offered to members 12 years of age and older. This program will provide members with the tools and support to assist them to stop smoking and lead healthier lives.
Housing Deposit Gift Program	$125 gift card towards housing deposit fee for house, apartment or hotel for members who complete the Health Risk Questionnaire (HRQ)

Notice of Non-Discrimination

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, sex, health status or need for health care services.

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
PO Box 818001
Cleveland, OH 44181-8001
Telephone: **1-888-234-7358 (TTY 711)**

Email: **MedicaidCRCoordinator@aetna.com**

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at the Aetna Better Health website: **AetnaBetterHealth.com/Texas**.

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

TTY:711

ENGLISH: To access language services at no cost to you, call **1-800-385-4104**.

SPANISH: Para acceder a los servicios de idiomas sin costo, llame al **1-800-385-4104**.

VIETNAMESE: Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số **1-800-385-4104**.

CHINESE: 如欲使用免費語言服務，請致電 **1-800-385-4104**.

KOREAN: 무료로 언어 서비스를 이용하려면 **1-800-385-4104** 번으로 전화하세요

ARABIC: للحصول على خدمات اللغة مجانًا، اتصل على **1-800-385-4104**.

URDU: بلاقیمت زبان سے متعلقہ خدمات حاصل کرنے کے لیے ، **1-800-385-4101** پر بات کریں۔

TAGALOG: Upang ma-access ang mga serbisyo sa wika nang wala kang babayaran, tumawag sa **1-800-385-4104**.

FRENCH: Afin d'accéder aux services langagiers sans frais, composez le **1-800-385-4104**.

HINDI: आपके लए बना कसी कमत के भाषा सेवाआ का उपयोग करने के लए, **1-800-385-4104** पर कॉल करे।

PERSIAN: برای دسترسی به خدمات زبان به طور رایگان، با شماره **1-800-385-4104** تماس بگیرید.

GERMAN: Um kostenlos auf Sprachdienste zuzugreifen, rufen Sie **1-800-385-4104** an.

GUJARTI: તમારે કોઇ તના ખર્ચ વના ભાષાની સેવાઓની પહચ માટે, કોલ કરો **1-800-385-4104**.

RUSSIAN: Чтобы получить бесплатные языковые услуги, позвоните по номеру **1-800-385-4104**.

JAPANESE: 無料の言語サービスをご利用いただくには、 **1-800-385-4104** にお電話ください。

LAOTIAN: ເພື່ອເຂົ້າເຖິງການບໍລິການພາສາໂດຍບເສຍຄ່າໃຊ້ຈ່າຍໃດໆແກ່ທ່ານ, ໃຫ້ໂທຫາ **1-800-385-4104**.

Glossary

Appeal - A request for your managed care organization to review a denial or a grievance again.

Complaint - A grievance that you communicate to your health insurer or plan.

Copayment - A fixed amount (for example $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Durable Medical Equipment (DME) - Equipment ordered by a health care provider for everyday or extended use. Coverage for DME may include but is not limited to oxygen equipment, wheelchairs, crutches, or diabetic supplies.

Emergency Medical Condition - An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid harm.

Emergency Medical Transportation - Ground or air ambulance services for an emergency medical condition.

Emergency Room Care - Emergency services you get in an emergency room.

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

Excluded Services - Health care services that your health insurance or plan doesn't pay for or cover.

Grievance - A complaint to your health insurer or plan.

Habilitation Services and Devices - Health care services such as physical or occupational therapy that help a person keep, learn, or improve skills and functioning for daily living.

Health Insurance - A contract that requires your health insurer to pay your covered health care costs in exchange for a premium.

Home Health Care - Health care services a person receives in a home.

Hospice Services - Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization - Care in a hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care - Care in a hospital that usually doesn't require an overnight stay.

Medically Necessary - Health care services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network - The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-participating Provider - A provider who doesn't have a contract with your health insurer or plan to provide covered services to you. It may be more difficult to obtain authorization from your health insurer or plan to obtain services from a non-participating provider instead of a participating provider. In limited cases, such as when there are no other providers, your health insurer can contract to pay a non-participating provider.

Participating Provider - A provider who has a contract with your health insurer or plan to provide covered services to you.

Physician Services - Health-care services a licensed medical physician (M.D. -Medical Doctor or D.O. -Doctor of Osteopathic Medicine) provides or coordinates.

Plan - A benefit, like Medicaid, which provides and pays for your health-care services.

Pre-authorization - A decision by your health insurer or plan that a health-care service, treatment plan, prescription drug, or durable medical equipment that you or your provider has requested, is medically necessary. This decision or approval, sometimes called prior authorization, prior approval, or pre-certification, must be obtained prior to receiving the requested service. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

Premium - The amount that must be paid for your health insurance or plan.

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

Prescription Drugs - Drugs and medications that by law require a prescription.

Primary Care Physician - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health-care services for a patient.

Primary Care Provider- A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed

under state law, who provides, coordinates, or helps a patient access a range of health-care services.

Provider - A physician (M.D. - Medical Doctor or D.O. - Doctor of Osteopathic Medicine), health-care professional, or health-care facility licensed, certified, or accredited as required by state law.

Rehabilitation Services and Devices - Healthcare services such as physical or occupational therapy that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled.

Skilled Nursing Care - Services from licensed nurses in your own home or in a nursing home.

Specialist - A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Urgent Care - Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

AetnaBetterHealth.com/Texas • 1-866-818-0959 (Bexar) **or 1-800-245-5380** (Tarrant)

AetnaBetterHealth.com/Texas

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