2022 STAR (Medicaid) Member Handbook

Bexar and Tarrant service areas

Member Services 1-800-248-7767 (Bexar) and 1-800-306-8612 (Tarrant), TTY 1-800-735-2989
September 2022

TEXAS Health and Human Services | TEXAS STAR Your Health Plan ★ Your Choice

AetnaBetterHealth.com/Texas

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aetna
Aetna Better Health® of Texas

Personal Information

My STAR (Medicaid) member ID number: _____

My primary care provider (PCP) name: _____

My primary care provider (PCP) address: _____

My primary care provider (PCP) phone number: _____

Aetna Better Health of Texas Member Services
Toll free: **1-800-248-7767** (Bexar service area), **1-800-306-8612** (Tarrant service area)
English/Spanish interpreter services available

Member Services hours: Monday - Friday 8 AM - 5 PM excluding state-approved holidays
After hours: Leave a voice mail message

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 569150
Dallas, TX 75356-9150

Visit our website:
AetnaBetterHealth.com/Texas

Aetna Better Health® of Texas

STAR (Medicaid) Member Handbook

September 1, 2022

Bexar and Tarrant service areas
Aetna Better Health of Texas covers Medicaid 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
1-800-248-7767 (Bexar)
1-800-306-8612 (Tarrant)

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

Call us 

Aetna Better Health of Texas Member Services
Toll free: **1-800-248-7767** (Bexar service area), **1-800-306-8612** (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 of Texas Member Services line.

Write us 

Aetna Better Health of Texas
Attention: Member Services
PO Box 569150
Dallas, TX 75356-9150

Visit the website 

AetnaBetterHealth.com/Texas

Introduction

Your STAR (Medicaid) member handbook
Through Aetna Better Health of Texas, we are pleased to offer you all the benefits offered in the State of Texas STAR Medicaid Program plus expanded and value-added benefits. Information on eligibility and benefits are included in this member handbook. You picked your child's doctor or clinic when you join Aetna Better Health of Texas. This doctor or clinic you picked is your primary care provider and will act as the gateway to care for all your healthcare needs.

This handbook is a guide to help you understand your Aetna Better Health of Texas plan. If you have questions about your benefits, or what is covered, 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 ID card. We will be happy to help you.

Tips for members

- Check the ID card to make sure the information is correct. Your primary care provider's name will appear on your Aetna Better Health of Texas 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 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 of Texas member.
- Call your primary care provider when you or your child needs care.
- Follow your primary care provider's advice.
- Use the hospital emergency room (ER) only for emergencies.

Questions or need help understanding/reading member handbook?
We have staff who speaks English or Spanish that can help you understand this handbook. We also have special services for people who have trouble 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, visit our website at **AetnaBetterHealth.com/Texas** or call us at the toll-free number on your ID card.

Plan information and resources online
Get information 24 hours a day, 7 days a week on our website at **AetnaBetterHealth.com/Texas**. You can 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 **AetnaBetterHealth.com/Texas.** Call Member Services if you need help locating an in-network provider or if you'd like us to send you a printed copy.

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 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 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 of Texas Member Services line.

Behavioral Health
Behavioral health services (includes mental health and substance use) are available 24 hours a day, 7 days a week at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant).

In case of an emergency or crisis, please call 911, your local emergency hotline, or go to the nearest emergency room.

We have staff members available who speak both English and Spanish. Interpretation services are also available upon request. All information is available in English and Spanish.

Other Important Numbers

24-Hour Nurse Line (Health information from a registered nurse) 24 hours a day, 7 days a week	**1-800-556-1555**
Vision services: Superior Vision	**1-800-879-6901**
STAR Program Help Line	**1-800-964-2777**
Dental Contractors • DentaQuest • MCNA Dental • United Healthcare Dental	 **1-800-516-0165** **1-855-691-6262** **1-877-901-7321**
Non-emergency medical transportation (NEMT) provided by Access2Care	**1-866-411-8920 (TTY: 711)**, two business days before your appointment to schedule your ride . Available 24 hours a day, 7 days a week. Or use the Access2Care (**A2C**) app on your smartphone. Where's my ride? Hotline: **1-866-411-8920 (TTY: 711)**
Prescription Information	**1-800-248-7767** (Bexar) **1-800-306-8612** (Tarrant)
Ombudsman Managed Care Assistance Team	**1-866-566-8989** TTY: **1-866-222-4306**

Aetna Better Health of Texas Privacy Notice

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

This notice takes effect on September 16, 2013.

What do we mean when we use the words "health information?"[1]
We use the words "health information" when we mean information that identifies you. Examples include your:

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

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

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

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

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

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

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

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

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

Race/Ethnicity, Language, Sexual Orientation and Gender Identity Data
We may get information related to your race, ethnicity, language, sexual orientation and gender identity. We protect this information as described in this notice. We use this information to:

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

We do not use this information to:

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

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

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

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

Reasons that we will need your written okay

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

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

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

What are your rights

You have the right to look at your health information.

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

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

- You can ask us to change your health information if you think it is notright.
- 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 no cost to you:
STAR Medicaid **1-800-248-7767** (Bexar), **1-800-306-8612** (Tarrant)
For hearing impaired **TTY 1-800-735-2689** or **TTY: 711**

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

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

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

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address at **1-800-248-7767 (Bexar); 1-800-306-8612 (Tarrant); TTY: 1-800-735-2689**.

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. For example, we protect entry to our computers and buildings. This helps us to block unauthorized entry. We follow all state and federal laws for the protection of your health information.

Will we change this notice

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

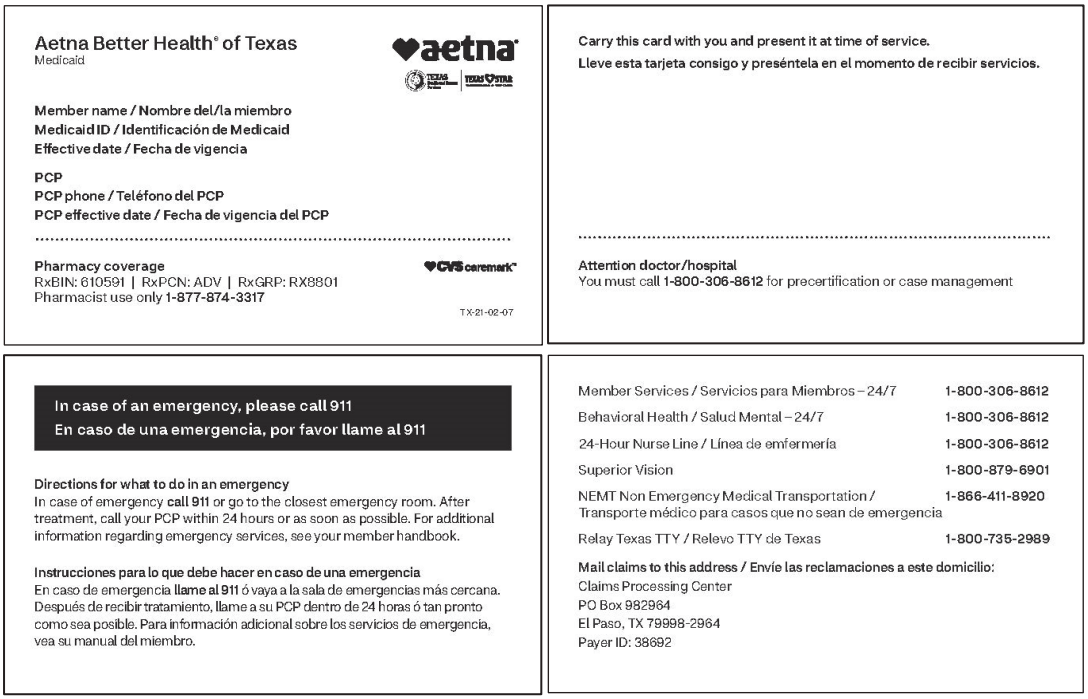
Member Identification (ID) Cards

When you sign-up with Aetna Better Health of Texas, you will get an ID card from us. You will not get a new Aetna ID card every month. If you call us to change your primary care provider, you will get a new card.

How to read your card: The ID card lists the name and phone number(s) of your primary care provider. The back of the ID card has important phone numbers for you to call if you need help. Please make sure your information on your ID card is correct.

- Medicaid ID: Member identification number
- Eff date: Effective date of coverage with the health plan
- PCP: Name and phone number of primary care provider
- PCP 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

Aetna Better Health of Texas STAR (Medicaid) ID card



How to use your card: Always carry your ID card with you when going to see the doctor. You will need it to get health care. You must show it each time you get services.

How to replace your card if lost or stolen: Please call us right away so we can send you another ID card.

Your Texas Benefits Medicaid Card

When you are approved for Medicaid, you will get a Your Texas Benefits Medicaid Card. This plastic card will be your everyday Medicaid card. You should carry and protect it just like your driver's license or a credit card. Your doctor can use the card to find out if you have Medicaid benefits when you go for a visit.

You will be issued only one card and will receive a new card only if your card is lost or stolen. If your Medicaid card is lost or stolen, you can get a new one by calling toll-free **1-800-252-8263** or by going online to order or print a temporary card at **www.YourTexasBenefits.com.**

If you are not sure if you are covered by Medicaid, you can find out by calling toll-free at **1-800-252-8263**. You can also call **2-1-1**. First pick a language and then pick option 2. Your health history is a list of medical services and drugs that you have gotten through Medicaid. We share it with Medicaid doctors to help them decide what health care you need. If you don't want your doctors to see your health history through the secure online network, call toll-free at **1-800-252-8263** or opt out of sharing your health information at **www.YourTexasBenefits.com**.

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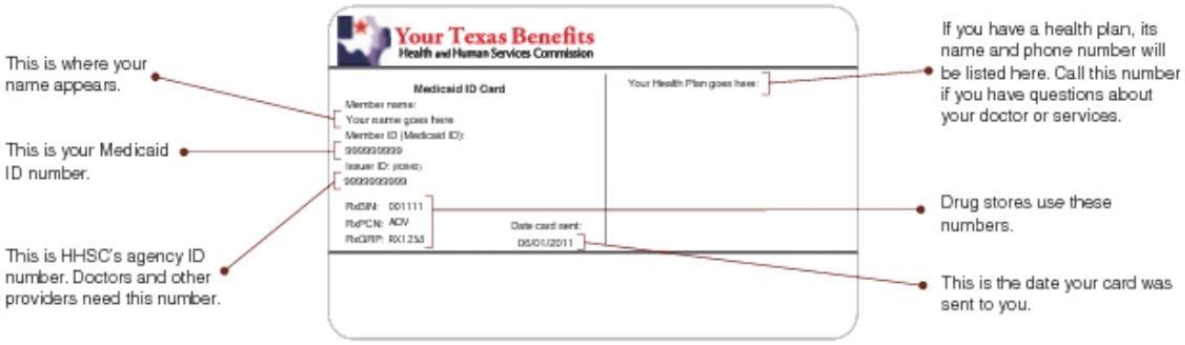

The Your Texas Benefits Medicaid card has these facts printed on the front:

- Your name and Medicaid ID number.
- The date the card was sent to you.
- The name of the Medicaid program you're in if you get:
  - Medicare (QMB, MQMB)
  - Healthy Texas Women Program (HTW)
  - Hospice
  - STAR Health
  - Emergency Medicaid
  - Presumptive Eligibility for Pregnant Women (PE)
- Facts your drug store will need to bill Medicaid.
- The name of your doctor and drug store if you're in the Medicaid Lock-in program.

The back of the Your Texas Benefits Medicaid card has a website you can visit **www.YourTexasBenefits.com** and a phone number you can call toll-free (**1-800-252-8263**) if you have questions about the new card. If you forget your card, your doctor, dentist, or drug store can use the phone or the Internet to make sure you get Medicaid benefits.

The YourTexasBenefits.com Medicaid Client Portal

You can use the Medicaid Client Portal to do all of the following for yourself or anyone whose medical or dental information you are allowed to access:

- View, print, and order a YTB Medicaid card
- See your medical and dental plans
- See your benefit information
- See STAR and STAR Kids Texas Health Steps alerts
- See broadcast alerts
- See diagnoses and treatments
- See vaccines
- See prescription medicines
- Choose whether to let Medicaid doctors and staff see your available medical and dental information

To access the portal, go to **www.YourTexasBenefits.com**.

- Click **Log In**.
- Enter your User name and Password. If you don't have an account, click **Create a new account**.
- Click **Manage**.
- Go to the "Quick links" section.
- Click **Medicaid & CHIP Services**.
- Click **View services and available health information**.

Note: The **YourTexasBenefits.com** Medicaid Client Portal displays information for active clients only. A legally authorized representative may view the information of anyone who is a part of their case.

Information about the temporary ID card (Form 1027- A)
Medicaid also has a temporary ID card called a Form 1027-A. You will get this card in the mail when Your Texas Benefits Medicaid Card has been lost or stolen. The Medicaid temporary ID card tells providers about you and the services that you can get for the time period listed on the Form 1027-A. Be sure to read the back of the Form 1027-A. The back of the card tells you how and when to use the card. There is a box that has specific information for providers.

You must take your Form 1027-A and your Health Plan ID card with you when you get any health care services. You will need to show these cards every time you need services. You can use the temporary ID card until you get Your Texas Benefits Medicaid Card.

Primary Care Provider Information

Role of the primary care provider

What is a primary care provider?
A primary care provider is your main doctor, nurse or clinic that gives you most of your health care. This is called your "medical home". It will help with all the medical care you need. Your primary care provider can take care of routine medical problems. Sometimes you may have a problem that needs to be handled by a specialist. The primary care provider will help coordinate this care and tell you how to make an appointment with a specialist. If you need to be admitted to a hospital, your primary care provider can arrange that for you.

Our goal is your good health. We urge you to see your 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 so he or she can help you plan for your future health care needs. Getting started with your doctor can also help prevent delays in care when you are sick.

Remember that you and your primary care provider are the most important members of your healthcare team.

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

- Your Texas Benefits Medicaid Card and/or your Form 1027-A
- Aetna Better Health of Texas ID card
- Immunization (shot) records
- Paper to take notes on information you get from the doctor

Choosing your primary care provider

Can a clinic be my primary care provider? (Rural Health Clinic/Federally Qualified Health 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 primary care provider. The primary care provider you pick needs to be listed in our provider directory.

Some of the providers that you can also pick from to be your primary care provider 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).

Look at our provider directory to get more information on primary care providers. You must pick a primary care provider who is in our Aetna Better Health of Texas network. You can get a copy of the provider directory on **AetnaBetterHealth.com/Texas** or by calling us at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant).

Can a specialist ever be considered a primary care provider?

You can keep seeing your current primary care provider if the primary care provider is listed in our provider directory. There might be times when we can let a specialist be your primary care provider.

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.

Regular visits to your Primary Care Provider and dentist are important, even if your children are healthy. The Texas Health Steps/well-child checkups are available at no cost to our members, Babies children, and teens all need 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, 3 years, 4 years
5 years to 20 years	16	Annually within 30 days of birthday

Vaccines help protect your child from many infections. Infections can cause serious health problems. Your provider will give vaccines during your child's Texas Health Steps/well child exam, 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.

What if I choose to go to another doctor who is not my 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 Texas Health Steps and 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.

What type of care does not require me to first be seen by primary care provider?
For the following types of care, you do not have to go to your primary care provider first:

- Emergency
- OB/GYN
- Family planning
- Routine eye care
- Behavioral health
- Texas Health Step medical and dental checkups

To learn more, use our website, **AetnaBetterHealth.com/Texas**, or call us at the toll-free number on your ID card.

How can I change my primary care provider?
You can change your primary care provider by calling us at the toll-free number on your ID card. Or you can change your PCP 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**.

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 **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) or writing to:

Aetna Better Health of Texas
Attention: Member Services
P.O. Box 569150
Dallas, TX 75356-9150

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

When will my primary care provider change become effective?
If you change your primary care provider, you will get a new ID card. The new ID card will tell you the new primary care provider's name, address, phone number and date the new primary care provider will be effective. The primary care provider change will become effective the same day that you call Member Services to make the change.

Are there reasons why a request to change a primary care provider may be denied?
In some cases, your request to change your primary care provider can be denied. Your request can be denied if:

- The primary care provider you picked is not accepting new patients
- The primary care provider you picked is no longer a part of Aetna Better Health of Texas

Can my primary care provider move me to another primary care provider for non-compliance?
Your primary care provider can request that you pick a new primary care provider for the following reasons:

- You often miss your appointments and do not call to let the primary care provider know
- You do not follow advice from your primary care provider

What if my primary care provider leaves the Aetna Better Health of Texas network?
If your primary care provider leaves the Aetna Better Health of Texas network, we will send you a letter telling you the new primary care provider we have chosen for you. If you are not happy with the new primary care provider, call us at the toll-free number on your ID card and tell us the primary care provider you want. If you are getting medically necessary treatments, you might be able to stay with that doctor if he or she is willing to see you.

When we find a new primary care provider on our list who can give you the same type of care, we will change your primary care provider.

After-Hours Care

How do I get medical care after my primary care provider's office is closed?

If you get sick at night or on a weekend and cannot wait to get medical care, call your primary care provider. Your primary care provider 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 **1-800-556-1555** to speak with a registered nurse to help you decide what to do.

Medicaid Lock-in Program

What is the Medicaid Lock-in Program?

You may be put in the Lock-In Program if you do not follow Medicaid rules. It checks how you use Medicaid pharmacy services. Your Medicaid benefits remain the same. Changing to a different MCO will not change the Lock-In status.

To avoid being put in the Medicaid Lock-in Program:

- Pick one drug store at one location to use all the time.
- Be sure your main doctor, main dentist, or the specialists they refer you to are the only doctors that give you prescriptions.
- Do not get the same type of medicine from different doctors.

To learn more, call Aetna Better Health of Texas Member Services.

Physician Incentive Plan

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 of Texas does not have a physician incentive plan.

Health Plan Information

Changing your health plan

What if I want to change my health plan? Who do I call?

You can change your health plan by calling the Texas STAR, STAR Kids, or STAR+PLUS Program Helpline at **1-800-964-2777**.

How many times can I change health plans?
You can change health plans as often as you want.

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 of Texas ask that I get dropped from their health plan (for non-compliance, etc.)?
You can be disenrolled from our plan if:

- You move out of the service area
- You keep going to the ER when you do not have an emergency
- You or your children show a pattern of disruptive or abusive behavior not related to a medical condition
- You miss many appointments without letting your doctor know
- You let someone else use your ID card
- You often do not follow your doctor's advice

Benefit Information

What are my health care benefits?
For a full list of the medical services you can get from Aetna Better Health of Texas, refer to the table on page **63**. Please follow your primary care provider's advice. Your primary care provider is responsible for coordinating all of your care.

How do I get these services?
You should see your primary care provider to ask about medical services. To learn how to get these or other services, please use the website, **AetnaBetterHealth.com/Texas,** or call us at the toll-free number on your ID card.

Are there any limits to any covered services?
There can be limits on some services. Call us at the toll-free number on your ID card to learn more.

What services are not covered?
Services that are not covered by STAR are called **Exclusions**. For a full list of exclusions, please refer to the table on page **64**.

If you agree to get services that we do not cover or approve, you might have to pay for them.

What are my prescription drug benefits?
Aetna Better Health of Texas covers all prescription drugs approved by the State Medicaid program. For a listing of covered drugs, please go to our website **AetnaBetterHealth.com/Texas** or call us at the toll-free number on your ID card

Value-Added Services

What extra benefits do I get as member of Aetna Better Health of Texas?
Aetna Better Health of Texas members get several value-added services and extra benefits. For a list of these benefits, please refer to the table on pages **65-69**. If you have any questions, please call us at the toll-free number on the back of your ID card.

How can I get these benefits?
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, go to our website, **AetnaBetterHealth.com/Texas,** or call us at the toll-free number on your ID card.

What health education classes does Aetna Better Health of Texas offer?
We work with our community partners to make available at no cost to you and/or low-cost classes for parents and children. For a list of these health topics refer to page **64**. If you have any questions, you can call us at the toll-free number on the back of your ID card. Call us to learn more. Also check with your provider before you begin any new health or wellness program.

What other services can Aetna Better Health of Texas help me get (non-capitated services)?
In addition to the services listed in the benefits section, you may be able to get some of the following services or programs:

Department of State Health Services (DSHS) Targeted Mental Health Case Management	DSHS Mental Health Services	DSHS Case Management for Children and Pregnant Women	Department of Assistive and Rehabilitative Services (DARS) Case Management for the Blind
Tuberculosis (TB) services offered by DSHS-Approved providers	Department of Aging and Disability (DADS) Hospice Services	Medical Transportation Program	Supplemental Nutrition Program for Women, Infants, and Children (WIC)

Additional services available for member's birth through 20 years of age include:

- **Texas Health Steps Dental** - including braces (These services are available when medically necessary and do not include dental services that are mainly for cosmetic purposes.)
- **Early Childhood Intervention (ECI) Program** - 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.
- **Texas School Health and Related Services (SHARS) -** Services covered by SHARS include:
  - Audiology services
  - Counseling
  - Nursing services
  - Occupational therapy
  - Personal care services
  - Physical therapy
  - Physician services
  - Psychological services, including assessments
  - Speech therapy
  - Transportation in a school setting

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, call us at the toll-free number on your ID card.

What does medically necessary mean?

Medically Necessary means:

(1) For Members birth through age 20, the following Texas Health Steps services:
  (a) Screening, vision, and hearing services; and
  (b) Other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
    (i) Must comply with the requirements of the *Alberto N., et al. v. Traylor, et al*. partial settlement agreements; and
    (ii) May include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3)(b-g) of this definition.

(2) For Members over age 20, non-behavioral health related 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 handicap, 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 diagnoses of the conditions;
  (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

(3) For Members over age 20, 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.

Routine, Urgent, and Emergency Medical Care

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

Routine care is when you go to your primary care provider and/or other health care providers for a checkup, without being sick. This care is important to keep you in good health.

Your primary care provider should be able to see you 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?

Another type of care is **urgent care**. There are some injuries and illnesses that are probably not emergencies but can turn into emergencies if they are not treated within 24 hours. Some examples are:

- Minor burns or cuts
- Earaches
- Sore throat
- Muscle sprains/strains

What should I do if my child or I need urgent medical care?

For urgent care, you should call your doctor's office even on nights and weekends. Your doctor will tell you what to do. In some cases, your doctor may tell you to go to an urgent care clinic. If your doctor tells you to go to an urgent care clinic, you don't need to call the clinic before going. You need to go to a clinic that takes Aetna Better Health of Texas Medicaid. For help, call us toll-free at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant). You also can call our 24-Hour Nurse Help Line at **1-800-556-1555** for help with getting the care you need.

How soon can I expect to be seen?

You should be able to see your doctor within 24 hours for an urgent care appointment. If your doctor tells you to go to an urgent care clinic, you do not need to call the clinic before going. The urgent care clinic must take Aetna Better Health of Texas Medicaid.

What is emergency medical care? How soon can I expect to be seen?
Emergency medical care is provided for Emergency Medical Conditions and Emergency Behavioral Health Conditions.

You should be seen the same day if you need emergency care. We ask that you follow the guidelines below when you believe you need 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 health, call your primary care provider. Tell your primary care provider as soon as possible after getting treatment.
- As soon as your health condition is stabilized, the emergency facility should call your primary care provider for information on your medical history.
- If you are admitted to an inpatient facility, you, a relative, or friend on your behalf should tell your primary care provider as soon as possible.

"Emergency medical condition" means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case of a pregnant woman, serious jeopardy to the health of a woman 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 a prudent layperson, possessing average knowledge of medicine and health:

1. Requires immediate intervention or medical attention without which the Member would present an immediate danger to themselves or others; or
2. Which renders the Member incapable of controlling, knowing or understanding the consequences of their actions.

"Emergency services" and "emergency care" means 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 or Emergency Behavioral Health Condition, including post-stabilization care services.

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 have thoughts of causing harm to yourself or others
- About to deliver a baby

Emergency Dental Care

Are emergency dental services covered by the health plan?

Aetna Better Health of Texas covers limited emergency dental services in a hospital or ambulatory surgical center, including payment for the following:

- Treatment for dislocated jaw
- Treatment for 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
- Hospital, physician and related medical services such as drugs for any of the above conditions

What do I do if 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, call us toll-free at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) or call **911**.

What is post stabilization?

Post-stabilization care services are services covered by Medicaid that keep your condition stable following emergency medical care.

Follow-up care after emergency

You might need follow-up care after you go to the emergency room. If so, make an appointment with your primary care provider. Do not go back to the emergency room (unless it is an emergency). Do not go back to the doctor that treated you at the hospital unless told to by your primary care provider.

How do I get medical care after my primary care Provider's office is closed?
If your primary care provider's 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 to help by phone 24 hours a day, 7 days a week. You may also call the 24-Hour Nurse Line at **1-800-556-1555** to help you decide what to do.

What if I get sick when I am out of town or traveling?
If you need medical care when traveling, call us toll-free at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) and we will help you find a doctor.

If you need emergency services while traveling, go to a nearby hospital, then call us toll-free at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant).

What if I am out of state?
If you need medical care while out of state, call us toll-free at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) and we will help you find a doctor.

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

Specialty Care

Specialty care means advanced medically necessary care and treatment of specific physical, mental or behavioral health condition(s), that are provided by a special doctor (specialist).

What if I need to see a special doctor (specialist)?
Your primary care provider can send you to another doctor if a special type of care your primary care provider cannot offer. Your primary care provider will tell you if you need to see a specialist. Some specialist services require a prior authorization.

How soon can I expect to be seen by the specialist?
You should be able to see a specialist within 3 weeks for a routine appointment; within 24 hours for urgent care appointments.

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

What is a referral?
A referral is an approval from your primary care provider for you to get covered specialty care and follow-up treatment.

What services do not need a referral?
The STAR (Medicaid) plan of benefits does not require referrals for any services; however, there are services that may need prior authorization.

How can I ask for a second opinion?
You 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 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, please call us at the toll-free number on your ID card.

What if I need to receive services in my home?
In certain cases, your doctor may recommend home nursing care. You may also need equipment or supplies that can be delivered to your home. These services require prior authorization. Your provider will need to send documentation about the medical need before these services can be approved.

- HHSC has settled a lawsuit that affects Private Duty Nursing, Home Health Skilled Nursing, Durable Medical Equipment and Supplies, and Personal Care Services for Medicaid beneficiaries under the age of 21. A copy of the Settlement Agreement is at: **www.hhsc.state.tx.us** and **www.advocacyinc.org**. If you have any questions, call Advocacy, Inc. at **1-800-252-9108**.

What if my PCP wants me to see a provider that is not in the Aetna Better Health of Texas network?
If your PCP wants you to see a provider who is not in Aetna Better Health of Texas provider network, he/she must request prior authorization from Aetna Better Health of Texas. You may go to a non-participating provider only if:

- The care is needed AND
- There are no Aetna Better Health of Texas providers to give the care AND
- Aetna Better Health of Texas has approved the care

Aetna Better Health of Texas has the right to decide where you can get services when there is not an Aetna Better Health of Texas provider available to give the care. The non-participating provider who plans to give you care should assure prior authorization is obtained by your PCP to provide services. Call us at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) with any questions.

You may see any provider at any time in the case of an emergency or for family planning services.

What about coverage of new technology?
We are always looking at new medical procedures and services to make sure you get safe, up to date and high-quality medical care. A team of doctor's reviews new health care methods and decides if they should become covered services. Researched and studied investigational services and treatments are not covered services.

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

Behavioral Health

How do I get help if I have mental health, alcohol or drug problems?
Aetna Better Health of Texas covers health for you as a whole person. That includes help for mental health problems like depression. You also can get help when you or someone else thinks you are drinking too much or using drugs.

If you need help right away, call our hotline. 24 hours a day, 7 days a week:
- STAR Medicaid (Bexar): **1-800-248-7767**
- STAR Medicaid (Tarrant): **1-800-306-8612**

Do I need a referral for this?
You may go to any mental health provider in our network. You do not need to ask your doctor to refer you to someone. You may need to get plan approval (prior authorization) first before you get some services. Emergency care is covered anywhere in the United States.

What are mental health rehabilitation services and mental health targeted case management?
These benefits help you know more about your mental health, provide peer support and more.

How do I get these services?
To access these services, call us. We will help you find a provider to determine your eligibility.

- **1-800-248-7767** Medicaid Bexar
- **1-800-306-8612** Medicaid Tarrant

Pharmacy and Medications

How do I get my medications?

Medicaid pays for most medicine your doctor says you need. Your doctor will write a prescription, so you can take it to the drug store, or may be able to send the prescription for you.

How do I find a network drug store?

- You can find a network pharmacy by visiting our website at **AetnaBetterHealth.com/Texas**, and then search for a pharmacy in your area.
- Call Member Services toll-free at **1-800-248-7767** (Bexar), **1-800-306-8612** (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 of Texas 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. You will also need to show Your Texas Benefits Medicaid Card and your Aetna Better Health of Texas Plan 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 **1-855-271-6603**, 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 of Texas 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**. 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 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 one 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 of Texas 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
  - One for the maximum days' supply allowed by your plan, with refills as needed. Enclose this prescription along with the mail service order form.

Do some medicines need to be prior approved - prior authorization?

Aetna Better Health of Texas must approve some medicines on our drug list before we cover them. We do this through prior authorization or Step Therapy. Prior authorization is an approval that Aetna Better Health of Texas requires for certain services and medications.

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 of Texas for you. We will review the request to approve your medicine. If the pharmacist cannot reach Aetna Better Health of Texas 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/grievance process.

What if I can't get the medication my doctor ordered approved?
If your doctor cannot be reached to approve a prescription, you may be able to get a three-day emergency supply of your medication. Call Aetna Better Health of Texas at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) for help with your medications and refills.

What if I can't get the medication my doctor prescribed?
If the medicine your doctor feels you need isn't on our formulary and you cannot take any other medication except the one prescribed, your doctor may request an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception. Your doctor will need to fill out the request form and send us medical records to support the request for an exception.

Who do I call if I have problems getting my medications?
If you have a problem getting your medications, you can call us at the toll-free number on your ID card and we can assist you.

What if I lose my medication(s)?
If you lose your medications, you should call your doctor or clinic for help. If your doctor or clinic is closed, the drug store where you got your medication should be able to help you. You can also call or Member Services at the toll-free number on your ID card.

What if I need durable medical equipment (DME) or other products normally found in a drug store?
Some durable medical equipment (DME) and products normally found in a drug store are covered by Medicaid. For all members, Aetna Better Health pays for nebulizers, ostomy supplies, and other

covered supplies and equipment if they are medically necessary. For children (birth through age 20), we also pay for medically necessary prescribed over-the-counter drugs, diapers, formula, and some vitamins and minerals.

Call **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) for more information about these benefits.

How do I obtain or review a list of pharmaceuticals?
Aetna Better Health of Texas covers the medicines included on the Vendor Drug Preferred Drug List. This is the list of drugs that we cover when they are medically necessary. This list was included in your welcome packet. Aetna Better Health of Texas does not pay for drugs that have not been approved by the Federal Drug Administration (FDA).

You can find a list of your medication by going to either of the following websites **AetnaBetterHealth.com/Texas** or **www.txvendordrug.com**. There you will find the drugs on the Preferred Drug List and those that are non-preferred with the reasons for not being able to obtain the non-preferred agents.

Family Planning Services

How do I get family planning services?
Family planning services help you plan or control pregnancy. You do not need a referral from your primary care provider to receive family planning services or supplies. If you are under age 21, you do not have to get permission from your parent to get family planning services or supplies. You can get family planning services from your primary care provider, or you can go to any family planning provider who is in our provider directory.
The services you can get include:

A yearly checkup	Laboratory test	Pregnancy testing
An office or clinic visit for a problem, counseling, or advice	Prescriptions and contraceptive supplies like birth control pills, diaphragms, and condoms	Sterilization services (Only if you are 21 years of age or older; Federal Sterilization Consent Form needed)

Do I need a referral for this?
You do not need a referral from your primary care provider to get family planning services or supplies.

Where do I find a family planning services provider?
You can find the location of family planning providers near you online at **www.dshs.state.tx.us/famplan/** or you can call Aetna Better Health of Texas at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) for help in finding a family planning provider.

Case Management for Children and Pregnant Women (CPW)

Need help finding and getting services? You might be able to get a case manager to help you.

Who can get a case manager?
Children, teens, young adults (birth through age 20) and pregnant women who get Medicaid and:

- Have health problems
- Are at a high risk for getting health problems

What do case managers do?
A case manager will visit with you and then:

- Find out what services you need.
- Find services near where you live.
- Teach you how to find and get other services.
- Make sure you are getting the services you need.

What kind of help can you get?
Case managers can help you:

- Get medical and dental services.
- Get medical supplies or equipment.
- Work on school or education issues.
- Work on other problems.

How can you get a case manager?
Call the Texas Health Steps at **1-877-847-8377** (toll-free), Monday to Friday, 8 a.m. to 8 p.m.

If you have any questions about this program or our care management program, call at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) or visit our website at **AetnaBetterHealth.com/Texas.**

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.

Early Childhood Intervention (ECI)

What is Early Childhood Intervention (ECI)?
Early Childhood Intervention (ECI) is a statewide program within the Texas Health and Human Services Commission for families with children birth up to age 3, with developmental delays, disabilities or certain medical conditions that may impact development. ECI services support families as they learn how to help their children grow and learn.

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 with these services, call us at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant).

Where do I find an ECI provider?
If you have additional questions or need help with these services, call us at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant).

Service Management

What is STAR Service Management?
Service management, also known as case management, is a service that we offer to help you/your child and your/your child's doctors develop a plan to make sure that you/your child have access to and utilize medically necessary covered services, non-capitated services, and other services and supports, especially if you/your child have special health care needs.

Aetna Better Health of Texas has experienced nurses who can help you understand health conditions that you/ your child may have, like:

- Asthma
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Transplants

- Using the emergency room frequently
- Being in the hospital often
- Wounds that won't heal
- Multiple diseases or conditions

Our nurses will help you/your child stay healthy and get you the care you need. We help you find care close to you. We will work with your doctor to improve your health. The goal of our program is to learn what information or services you need. We want you to become more independent with your health.

How can I get Service Management?

If you/your child have special health-care needs, like a serious ongoing illness, disability, or chronic or complex conditions and would like more information, contact the toll-free number on the back of your ID card. We can help you make an appointment with one of our doctors that cares for patients with special health care needs. We will also refer you to one of our case managers who will:

- Help you get the care and services you need.
- Develop a plan of care with the help of you and your/your child's doctor.
- Will follow your/your child's progress and make sure you are getting the care you need.
- Answer your healthcare questions.

Although our nurses can help you, we know you may not want this. If you don't want to be in the program, you can quit at any time by calling your/ your child's nurse.

Texas Health Steps Checkups

What is Texas Health Steps?

Texas Health Steps is healthcare for children birth through age 20 who have Medicaid. Texas Health Steps gives your child free medical checkups starting at birth, and free dental checkups starting at 6 months of age. Checkups can help find health problems before they get worse and harder to treat.

What services are offered by Texas Health Steps?

Texas Health Steps is the Medicaid healthcare program for STAR and STAR Kids children, teens, and young adults, birth through age 20.
Texas Health Steps gives your child:

- Free regular medical checkups starting at birth.
- Free dental checkups starting at 6 months of age.

- A case manager who can find out what services your child needs and where to get these services.

Texas Health Steps checkups:

- Find health problems before they get worse and are harder to treat.
- Prevent health problems that make it hard for children to learn and grow like others their age.
- Help your child have a healthy smile.

When to set up a checkup:

- You will get a letter from Texas Health Steps telling you when it's time for a checkup. Call your child's doctor or dentist to set up the checkup.
- Set up the checkup at a time that works best for your family.

How and when do I get Texas Health Steps medical checkups for my child?

Regular medical checkups help make sure that your child grows up healthy. You should take them to their doctor or another Superior Texas Health Steps provider for medical checkups at the following ages:

THSteps- Medical Checkups		
	Babies and Toddlers	
Up to 5 days after discharge	2 weeks	2 months
4 months	6 months	9 months
12 months	15 months	18 months
24 months	30 months	
	Older Children	
3 years	4 years	5 years
6 years	7 years	8 years
9 years	10 years	
	Pre-Teen, Teen, Young Adult	
11 years	12 years	13 years
14 years	15 years	16 years

17 years	18 years	19 years
20 years		

THSteps Dental Checkup
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. You do not need a referral from your primary care provider. Children under 6 months of age can get dental services in an emergency.

If the doctor or dentist finds a health problem during a checkup, your child can get the care he or she needs, such as:

- Eye tests and eyeglasses
- Hearing tests and hearing aids
- Dental care
- Other health care
- Treatment for other medical conditions

Call us at **1-800-248-7767** (Bexar), **1-800-306-8612** (Tarrant) or Texas Health Steps **1-877-847-8377 (1-877-THSTEPS)** (toll-free) if you:

- Need help finding a doctor or dentist.
- Need help setting up a checkup.
- Have questions about checkups or Texas Health Steps.
- Need help finding and getting other services.

If you can't get your child to the checkup, Medicaid may be able to help. Children with Medicaid and their parent can get free rides to and from the doctor, dentist, hospital, or drug store.

- Dallas/Ft. Worth area: **1-855-687-3255**.
- All other areas: **1-877-633-8747 (1-877-MED-TRIP)**

Why is it important to get Texas Health Steps checkup for my child within 90 days?
As a new member to Aetna Better Health of Texas, it is important for your child to see a provider within the first 90 days you are enrolled with us for a Texas Health Steps checkup. To avoid health problems for your children, teens, and young adults, make sure they get their Texas Health Steps medical and dental checkups.

Does my doctor have to be part of the Aetna Better Health of Texas network?
Yes. Your PCP must be in network with Aetna Better Health of Texas. Members can go to any Texas Health Steps Provider and the Texas Health Steps Provider does not have to be a part of the Aetna Better Health of Texas Network. If you go to a Texas Health Steps provider who is not your primary care provider, ask the Texas Health Step provider to send a copy of your checkup results to your primary care provider.

Do I have to have a referral?
You do not need a referral from your primary care provider to get Texas Health Steps medical or dental checkups.

What if I need to cancel an appointment?
If you need to cancel or change your appointment for a Texas Health Steps checkup, please call your Texas Health Steps provider as soon as possible.

What if I am out of town and my child is due for a Texas Health Steps checkup?
It is important to schedule your child's checkup before you leave town. If you are out of town when the Texas Health Steps checkup is due, make an appointment with a Texas Health Steps provider as soon as you get home. If you have moved, call Aetna Better Health of Texas Services at the toll-free number on your ID card to get the name of a Texas Health Steps provider close to where you live.

What if I am a migrant farmworker?
You can get your checkup sooner if you are leaving the area.

Vision Services

How do I get eye care services?
Superior Vision will offer vision services like exams and glasses. Superior Vision will help you get the care you need while coordinating with Aetna Better Health of Texas. If you need vision services, please call Superior Vision at **1-800-879-6901**.

For routine eye exams you can visit an eye care doctor without a referral from your primary care provider. You can pick an eye doctor that is close to you. Vision services are different for adults and children.

- **Children, teens, and young adults, birth through age 20***,* you can get an eye exam and prescription eyeglasses once during a 12-month period. You may be able to get more services if there is a change in your vision. You may be able to get more services if they are requested in writing by the child's primary care provider, teacher or school nurse.
- **If you are age 21 or over***,* you can get an eye exam once every 24 months.

Dental Services

What dental services does Aetna Better Health of Texas cover for children?

Aetna Better Health of Texas covers emergency dental services in a hospital or ambulatory surgical center, including, but not limited to, payment for the following:

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

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

Aetna Better Health of Texas is also responsible for paying for treatment and devices for craniofacial anomalies.

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

Non-Emergency Medical Transportation (NEMT) Services

What are NEMT services?

NEMT services provide transportation to nonemergency health care appointments for Members who have no other transportation options. These trips include rides to the doctor, dentist, hospital, pharmacy, and other places you get Medicaid services. These trips do NOT include ambulance trips.

What NEMT services are available to me?

- Passes or tickets for transportation such as mass transit within and between cities or states, including by rail or bus.
- Commercial airline transportation services.
- Demand response transportation services, which is curb-to-curb transportation in private buses, vans, or sedans, including wheelchair-accessible vehicles, if necessary.
- Mileage reimbursement for an individual transportation participant (ITP) for a verified completed trip to a covered healthcare service. The ITP can be you, a responsible party, a family member, a friend, or a neighbor.

- If you are 20 years old or younger, you may be able to receive the cost of meals associated with a long-distance trip to obtain health care services. The daily rate for meals is $25 per day for the member and $25 per day for an approved attendant.
- If you are 20 years old or younger, you may be able to receive the cost of lodging associated with a long-distance trip to obtain health care services. Lodging services are limited to the overnight stay and do not include any amenities used during your stay, such as phone calls, room service, or laundry service.
- If you are 20 years old or younger, you may be able to receive funds in advance of a trip to cover authorized NEMT services.

If you need an attendant to travel to your appointment with you, NEMT services will cover the transportation costs of your attendant.

Children 14 years old and younger must be accompanied by a parent, guardian, or other authorized adult. Children 15-17 years old must be accompanied by a parent, guardian, or other authorized adult or have consent from a parent, guardian, or other authorized adults on file to travel alone. Parental consent is not required if the health care service is confidential in nature.

How to get a ride?
We will provide you with information on how to request NEMT services. You should request NEMT Services as early as possible, and at least two business days before you need the NEMT service. In certain circumstances you may request the NEMT service with less notice. These circumstances include being picked up after being discharged from a hospital; trips to the pharmacy to pick up medication or approved medical supplies; and trips for urgent conditions. An urgent condition is a health condition that is not an emergency but is severe or painful enough to require treatment within 24 hours.

You must notify us prior to the approved and scheduled trip if your medical appointment is cancelled.

Before you schedule your ride, have your information ready
- Your Medicaid or member ID number
- Your first and last name
- Your date of birth
- Your home address including ZIP code for the pick-up
- The name, address, and ZIP code for the health care provider, medical facility or the pharmacy you'll visit
- The date and time of your health care appointment

- If anyone is traveling with you (one additional person allowed)
- If you need special transportation requirements – wheelchair accessible for example

To request a ride

- Call Access2Care at **1-866-411-8920 (TTY: 711)**, two business days before your appointment to schedule your ride. They are open 24 hours a day, 7 days a week
- Download the Access2Care (**A2C**) app on your smartphone from the app store. You can schedule your rides through your phone and get reminder texts if you want them.

Don't forget to mark your calendar for time and date for your appointment. On the day of your appointment, be ready 30 minutes before your driver is due to arrive.

Long distance trips

You can schedule a ride to any medically necessary appointments with an in-network provider beyond 75 miles from your home. This will require prior authorization. Contact your case manager. You need to schedule this trip at least five business days in ahead. Meals and lodging cost may be reimbursed. If you are scheduling a ride for an appointment outside of the service area with an out-of-network provider, your doctor will need to first get approval (prior authorization) for that visit before transportation can be arranged.

Need help

Just call Aetna Better Health of Texas Member Services at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant). We are always glad to help our members with scheduling a ride.

Interpreter Services

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

Our staff speaks both English and Spanish. We have a language line if your first language is not English or Spanish. If you need an interpreter, call us at the toll-free number on your 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 at **1-800-735-2989**.

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

Women's Health

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

Attention Female Members

Aetna Better Health of Texas allows you to pick an OB/GYN but this doctor must be in the same network as your primary care provider.

You have the right to pick an OB/GYN without a referral from your 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 within the network

How do I choose an OB/GYN?

Check our provider directory to find an in-network OB/GYN. You can also get a copy of the provider directory online at **AetnaBetterHealth.com/Texas** or call us at the toll-free number on your ID card for help in finding an OB/GYN.

If I do not choose an OB/GYN, do I have direct access?

You can contact any OB/GYN in the Aetna Better Health of Texas network directly to receive services.

Will I need a referral?

You have the right to pick an OB/GYN from our network without a referral from your primary care provider.

How soon can I be seen after contacting my OB/GYN for an appointment?

If you are pregnant, you should be seen within 2 weeks of enrollment or by the 12th week of your pregnancy. If you are not pregnant, you should be seen within 3 weeks of asking for an appointment.

Can I stay with my OB/GYN if they are not with Aetna Better Health of Texas?

If you are pregnant and are past the 24th week of your pregnancy when you join, you will be able to stay under the care of your current OB/GYN. If you want, you can pick an OB/GYN who is in our network as long as the provider agrees to treat you. We can help with the changes between doctors.

What if I am pregnant? Who do I need to call?

Call us at the toll-free number on your ID card, as soon as you know you are pregnant. You

will need to call your Medicaid caseworker as soon as your baby is born to enroll your baby in Medicaid. Your baby can be eligible for Medicaid from birth up to a year old.

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

- **Case management -** Case management services are offered by Aetna Better Health of Texas to help you if you are pregnant to get the services you need. We can also help you get referrals when needed.
- **Prenatal education -** We will mail a prenatal packet to all pregnant women. This packet has information about how to stay healthy during pregnancy and other topics. Call us for information regarding prenatal classes. We can help you locate prenatal classes in the community (fees might apply-usually discounted fee for Medicaid eligible).

Where can I find a list of birthing centers?
Contact Member Services at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) or you can search our provider directory online at **AetnaBetterHealth.com/Texas** to find out which birthing centers are in our network.

Can I pick a primary care provider for my baby before the baby is born?
You should call us before your baby is born or as soon as possible to pick a pediatrician (baby doctor). You will be able to pick your baby's doctor from a list of doctors in the Aetna Better Health of Texas provider directory.

How and when can I switch my baby's primary care provider?
To change your baby's primary care provider, call us at the toll-free number on your ID card. We can change your baby's primary care provider on the same day you ask for the change. The change will be effective immediately.

Can I switch my baby's health plan?
For at least 90 days from the date of birth, your baby will be covered by the same health plan that you are enrolled in. You can ask for a health plan change before the 90 days is up by calling the Enrollment Broker at **1-800-964-2777**. You cannot change health plans while your baby is in the hospital.

How do I sign up my newborn baby? How and when do I tell my health plan?
It is important that you call us at the toll-free number on your ID card; as soon as possible so we can make sure you know about the health services for your baby.

How can I receive healthcare after my baby is born (and I am no longer covered by Medicaid)?

After your baby is born you may lose Medicaid coverage. You may be able to get some health care services through the Healthy Texas Women's Program and the Department of State Health Services (DSHS). These services are for women who apply for the services and are approved.

Healthy Texas Women Program

The Healthy Texas Women Program provides family planning exams, related health screenings and birth control to women ages 18 to 44 whose household income is at or below the program's income limits (185 percent of the federal poverty level). You must submit an application to find out if you can get services through this program.
To learn more about services available through the Healthy Texas Women Program, write, call, or visit the program's website:

Healthy Texas Women Program
P.O. Box 14000
Midland, TX 79711-9902
Phone: **1-800-335-8957**
Website: **www.texaswomenshealth.org/**
Fax: (toll-free) **1-866-993-9971**

DSHS Primary Health Care Program

The DSHS Primary Health Care Program serves women, children, and men who are unable to access the same care through insurance or other programs. To get services through this program, a person's income must be at or below the program's income limits (200 percent of the federal poverty level). A person approved for services may have to pay a co-payment, but no one is turned down for services because of a lack of money.
Primary Health Care focuses on prevention of disease, early detection and early intervention of health problems. The main services provided are:

- Diagnosis and treatment
- Emergency services
- Family planning
- Preventive health services, including vaccines (shots) and health education, as well as laboratory, x-ray, nuclear medicine or other appropriate diagnostic services.

Secondary services that may be provided are nutrition services, health screening, home health care, dental care, rides to medical visits, medicines your doctor orders (prescription drugs), durable medical supplies, environmental health services, treatment of damaged feet (podiatry services), and social services.

You will be able to apply for Primary Health Care services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.com/.**

To learn more about services you can get through the Primary Health Care program, email, call, or visit the program's website:

Website: **www.dshs.state.tx.us/phc/**
Phone: **512-776-7796**
Email: **PPCU@dshs.state.tx.us**

DSHS Expanded Primary Health Care Program
The Expanded Primary Health Care program provides primary, preventive, and screening services to women age 18 and above whose income is at or below the program's income limits (200 percent of the federal poverty level). Outreach and direct services are provided through community clinics under contract with DSHS. Community health workers will help make sure women get the preventive and screening services they need. Some clinics may offer help with breast feeding.

You can apply for these services at certain clinics in your area. To find a clinic where you can apply, visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.com/.** To learn more about services you can get through the DSHS Expanded Primary Health Care program, visit the program's website, call, or email:

Website: **www.dshs.state.tx.us/ephc/Expanded-Primary-Health-Care.aspx**
Phone: **512-776-7796**
Fax: **512-776-7203**
Email: **PPCU@dshs.state.tx.us**

DSHS Family Planning Program
The Family Planning Program has clinic sites across the state that provide quality, low-cost, and easy-to-use birth control for women and men.
To find a clinic in your area visit the DSHS Family and Community Health Services Clinic Locator at **http://txclinics.com/**. To learn more about services you can get through the Family Planning program, visit the program's website, call, or email:

Website: **www.dshs.state.tx.us/famplan/**
Phone: **512-776-7796**
Fax: **512-776-7203**
Email: **PPCU@dshs.state.tx.us**

How and when do I tell my caseworker?
You will need to contact your Medicaid caseworker as soon as your baby is born to enroll your baby in Medicaid.

Other Member Services

Who do I call if I have special health care needs and need someone to help me?
Case managers are ready to help you if you have special health care needs. You can also have your health care provided by a specialist if you have special health care needs. If you have special health care needs and you need someone to help you, please call us at the toll-free number on your ID card to learn more.

Medical Care Decisions

What if I am too sick to make a decision about my medical care? What are advance directives? How do I get an advance directive?
An advance directive is a written statement that you complete before a serious illness. This statement tells how you want medical decisions made. If you can't make treatment decisions, your doctor will ask your closest relative or friend to help you decide what is best for you. Sometimes everyone doesn't agree about what to do. That's why it is helpful if you tell us in advance what you want to happen if you can't speak for yourself.
If you do not have an advance directive and you would like more information on how to get one, call us at the toll-free number on your ID card. We will be glad to help you.

Coverage Renewal

What do I have to do if I need help with completing my child's renewal application?
Families must renew their child's Medicaid coverage every year. In the months before a child's coverage is due to end, HHSC will send the family a renewal packet in the mail. The renewal packet contains an application. It also includes a letter asking for an update on the family's income and cost deductions. Instructions and additional information can be located at **http://chipmedicaid.org/CommunityOutreach/How-to-Renew.**

What happens if I lose my Medicaid coverage?
If you lose Medicaid coverage but get it back again within six (6) months you will get your Medicaid services from the same health plan you had before losing your Medicaid coverage. You will also have the same Primary Care Provider you had before.

Provider Billing

What if I get a bill from my doctor? Who do I call? What information will they need?
If you have Medicaid, you should not be billed for any services covered by Medicaid. Please remember to always show your Medicaid ID card and Aetna Better Health of Texas ID card before you see the doctor. If you get a bill from a Medicaid provider, call Member Services at the number on the back of your card.

When you call, give the Member Services staff:

- Date of service
- Your patient account number
- Name of provider
- Phone number on the bill
- Total amount of bill

***** Note **:*** If you go to a provider who is not enrolled in Texas Medicaid, and/or is not signed up as an Aetna Better Health of Texas provider, we may not pay that provider and you may get billed for the services. You will need to pay for services not covered by Medicaid. It is your responsibility to determine which services are covered and which are not. If you have other insurance that is primary, please ensure you provide both your primary insurance and your Aetna Better Health of Texas Medicaid coverage to all of your providers. The provider should submit bills to your primary group insurance first, then Aetna Better Health of Texas Medicaid. Medicaid is the payer of last resort and should not be the only insurance presented to your providers.

Member Services Notification

What do I have to do if I move?
As soon as you have your new address, give it to the local HHSC benefits office and Aetna Better Health of Texas' Member Services Department at **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant). Before you get Medicaid services in your new area, you must call Aetna Better Health of Texas unless you need emergency services. You will continue to get care through Aetna Better Health of Texas until HHSC changes your address.

What if I have other health insurance in addition to Medicaid?
Medicaid and private insurance
You are required to tell Medicaid staff about any private health insurance you have. You should call the Medicaid Third Party Resources hotline and update your Medicaid case files if:

- Your private health insurance is cancelled

- You get new insurance coverage
- You have general questions about third party insurance

You can call the hotline toll-free at **1-800-846-7307**.

If you have other insurance, you may still qualify for Medicaid. When you tell Medicaid staff about your other health insurance, you help make sure that Medicaid only pays for what your other health insurance does not cover.

IMPORTANT: Medicaid providers cannot turn you down for services because you have private health insurance, as well as Medicaid. If providers accept you as a Medicaid patient, they must also file with your private health insurance company.

Member Rights and Responsibilities

Member Rights:

1. You have the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
   a. Be treated fairly and with respect.
   b. Know that your medical records and discussions with your providers will be kept private and confidential.
2. You have the right to a reasonable opportunity to choose a health care plan and Primary Care Provider. This is the doctor or health care provider you will see most of the time and who will coordinate your care. You have the right to change to another plan or provider in a reasonably easy manner. That includes the right to:
   a. Be told how to choose and change your health plan and your Primary Care Provider.
   b. Choose any health plan you want that is available in your area and choose your Primary Care Provider from that plan.
   c. Change your Primary Care Provider.
   d. Change your health plan without penalty.
   e. Be told how to change your health plan or your Primary Care Provider.
3. You have the right to ask questions and get answers about anything you do not understand. That includes the right to:
   a. Have your provider explain your health care needs to you and talk to you about the different ways your health care problems can be treated.

b. Be told why care or services were denied and not given.

4. You have the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
   a. Work as part of a team with your provider in deciding what health care is best for you.
   b. Say yes or no to the care recommended by your provider.
5. You have the right to use each Complaint and appeal process available through the Managed Care Organization and through Medicaid, and get a timely response to Complaints, appeals and fair hearings. That includes the right to:
   a. Make a Complaint to your health plan or to the state Medicaid program about your health care, your provider, or your health plan.
   b. Get a timely answer to your Complaint.
   c. Use the plan's appeal process and be told how to use it.
   d. Ask for an External Medical Review and State Fair Hearing from the state Medicaid program and get information about how that process works
   e. Ask for a State Fair Hearing without an External Medical Review from the state Medicaid program and receive information about how that process works
6. You have the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
   a. Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care you need.
   b. Get medical care in a timely manner.
   c. Be able to get in and out of a health care provider's office. This includes barrier free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
   d. Have interpreters, if needed, during appointments with your providers and when talking to your health plan. Interpreters include people who can speak in your native language, help someone with a disability, or help you understand the information.
   e. Be given information you can understand about your health plan rules, including the health care services you can get and how to get them.
7. 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.

8. You have a right to know that doctors, hospitals, and others who care for you can advise you about your 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.
9. You have a right to know that you are not responsible for paying for Covered Services. Doctors, hospitals, and others cannot require you to pay copayments or any other amounts for Covered Services.
10. You have a right to make recommendations to your health plan's member rights and responsibilities.

Member Responsibilities:

1. You must learn and understand each right you have under the Medicaid program. That includes the responsibility to:
   a. Learn and understand your rights under the Medicaid program.
   b. Ask questions if you do not understand your rights.
   c. Learn what choices of health plans are available in your area.
2. You must abide by the health plan's and Medicaid's policies and procedures. That includes the responsibility to:
   a. Learn and follow your health plan's rules and Medicaid rules.
   b. Choose your health plan and a Primary Care Provider quickly.
   c. Make any changes in your health plan and Primary Care Provider in the ways established by Medicaid and by the health plan.
   d. Keep your scheduled appointments.
   e. Cancel appointments in advance when you cannot keep them.
   f. Always contact your Primary Care Provider first for your non-emergency medical needs.
   g. Be sure you have approval from your Primary Care Provider before going to a specialist.
   h. Understand when you should and should not go to the emergency room.
3. You must share information about your health with your Primary Care Provider and learn about service and treatment options. That includes the responsibility to:
   a. Tell your Primary Care Provider about your health.

b. Talk to your providers about your health care needs and ask questions about the different ways your health care problems can be treated.

c. Help your providers get your medical records.

4. You must be involved in decisions relating to service and treatment options, make personal choices, and take action to keep yourself healthy. That includes the responsibility to:

   a. Work as a team with your provider in deciding what health care is best for you.

   b. Understand how the things you do can affect your health.

   c. Do the best you can to stay healthy.

   d. Treat providers and staff with respect.

   e. Talk to your provider about all of your medications.

Additional Member Responsibilities while using our NEMT services with Access2Care.

1. When requesting NEMT Services, you must provide the information requested by the person arranging or verifying your transportation.
2. You must follow all rules and regulations affecting your NEMT services.
3. You must return unused advanced funds. You must provide proof that you kept your medical appointment prior to receiving future advanced funds.
4. You must not verbally, sexually, or physically abuse or harass anyone while requesting or receiving NEMT services.
5. You must not lose bus tickets or tokens and must return any bus tickets or tokens that you do not use. You must use the bus tickets or tokens only to go to your medical appointment.
6. You must only use NEMT Services to travel to and from your medical appointments.
7. If you have arranged for an NEMT Service but something changes, and you no longer need the service, you must contact the person who helped you arrange your transportation as soon as possible.

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**.

Quick Tips and Member Safety

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 medicines 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 bad reactions to medicines. This can help you avoid getting medicines that could 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.

When 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

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	100.5	Call your PCP right away
3 to 4 months old	100.5	Call your PCP if the fever last more than 24 hours
over 4 months old	103	Call your PCP if the fever last more than 2 days after giving medicine

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 **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant) to tell us about your problem. An Aetna Better Health of Texas Member Services advocate can help you file a complaint. Just call **1-800-248-7767** (Bexar) or **1-800-306-8612** (Tarrant). Most of the time, we can help you right away or at the most within a few days.

Once you have gone through the Aetna Better Health of Texas complaint process, you can complain to the Health and Human Services Commission (HHSC) by calling toll-free **1-866-566-8989**. If you would like to make your complaint in writing, please send it to the following address:

Texas Health and Human Services Commission
Ombudsman Managed Care Assistance Team
P.O. Box 13247
Austin, Texas 78711-3247

If you can get on the Internet, you can submit your complaint at **hhs.texas.gov/managed-care-help.**

Can someone from Aetna Better Health of Texas help me file a complaint?
Our 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 of Texas
Attention: Member Advocate
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181

An Aetna Better Health of Texas Member Advocate cannot take any action against you as a result of your filing a complaint.

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 your complaint came to us. 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 of Texas 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 a right to meet with a complaint appeal panel?
Within five (5) days of getting your request for an appeal of a complaint, the Member Advocate will send you a letter to let you know that your complaint appeal came to us. The Complaint Appeal Panel will look over the information you sent us and discuss your case. It is not a court of law. You have the right to appear in front of the Complaint Appeal Panel at a specific place to talk about the written complaint appeal you sent to us. When we make

the decision on your appeal, we will send you a response in writing within thirty (30) after we receive your appeal.

Appeal Process

If I am not satisfied with the outcome, who else can I contact?
If you are not happy, you can call us at the toll-free number on your ID card and ask for an appeal. You can ask for an appeal of a complaint resolution by writing to:

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

What can I do if my doctor asks for a service or medicine for me that's covered but Aetna Better Health of Texas denies it or limits it?
There may be times when we say we won't pay for all or part of the care that has been recommended. If this happens, Aetna Better Health of Texas will send you a letter about an action on a covered service that your doctor requests. An **action** means the denial or limited authorization of a requested service. It includes:

- The denial in whole or part of payment for a service
- The denial of a type or level of service
- The reduction, suspension, or termination of a previously authorized service

If we deny or limit your doctor's request for a covered service, you have the right to ask for an appeal. An **appeal** is when you or your designated representative asks Aetna Better Health of Texas to look again at the request your doctor asked for and we said we won't pay for. 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 can appeal our decision 2 ways:

1. You can call Member Services
   a. The Member Advocate will write down the information and send it to you to look over
2. You can request an appeal in writing by sending a letter to:

   Aetna Better Health of Texas
   Attention: Member Advocate
   PO Box 81139
   5801 Postal Rd

Cleveland, OH 44181

Along with your written request, you or your doctor can also fax more information to show why you do not agree with the decision at **1-877-223-4580**, Attention: Member Advocate.

How will I find out if services are denied?
If your services are denied, you and your doctor will get a letter that tells you the reason for denial. The letter will also tell you how to file an appeal or how to ask for an External Medical Review (EMR) and/or a State Fair Hearing.

How can I continue getting services that were approved?
If you are receiving services now and you want to continue getting those services, you or your doctor must request an appeal within 10 days of the denial or the intended effective date of the proposed action. If the appeal decision is the same as our first decision, you may have to pay for the services you had during the appeal. If you have questions about what can be continued, please call or write to the Member Advocate:

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

What are the timeframes for the appeal process?
Your request for an appeal must be filed within sixty (60) days from the date of the notice of adverse benefit determination. To ensure currently authorized services, you must file the appeal on or before the later of 10 days following Aetna Better Health of Texas mailing of the notice of the action or the intended start date of the proposed action.

The timeframe for the resolution of the appeal will depend on what services have been denied. If you are in the hospital or are already receiving services that are being limited or denied, you can call and ask for an emergency appeal. The emergency appeal process is explained below.

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 receipt of the initial written or oral request for Appeal, including the option to extend up to 14 Days if you ask for an extension; or Aetna Better Health shows that there is a need for more information and how

the delay is in your interest. If Aetna Better Health needs to extend, you will receive written notice of the reason for delay.

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 calendar days. That means we will send you the appeal results letter within forty-four (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 of Texas about a benefit or service, including denial for payment of services in whole or in part, you can ask Aetna Better Health of Texas for an appeal.

You do not have a right to an appeal when:
- The services you requested are not covered under Medicaid.
- A change is made to the state or federal law, which affects some or all of Medicaid recipients.

Does my request have to be in writing?
Your request does not have to be in writing. You can call us to file your appeal. You can ask for an appeal by calling us and asking for the Member Advocate. We will write down what you tell us and send it to you to review. If you need help filing an appeal, see the section below.

Can someone from Aetna Better Health of Texas help me file an appeal?
You can get help in filing an appeal by calling us at the toll-free number on your ID card or writing to:

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

The Member Advocate will listen to your appeal and tell you about the rules. The Member Advocate will 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.

Emergency Appeal Process

What is an emergency appeal?
An Emergency 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 emergency appeal?
You can ask for an emergency appeal by calling us at the toll-free number on your ID card or by writing to:

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

Does my request have to be in writing?
Your request does not have to be in writing. You can ask for an emergency appeal by calling our Member Services Department.

What are the timeframes for an emergency appeal?
The timeframe for resolution will be based on your medical emergency condition, procedure, or treatment. Aetna Better Health will let you know the final decision of the emergency appeal within seventy-two (72) hours from when we receive your appeal request. If your appeal is about the denial of emergency care or a life threatening condition or continued hospitalization, Aetna Better Health will let you know the final decision of the emergency appeal within one (1) business day or seventy-two (72) hours which ever time happens first.

What happens if Aetna Better Health of Texas denies the request for an emergency appeal?
If you ask for an emergency appeal that does not involve an emergency, an ongoing hospitalization, or services that are already being provided, you will be told that the appeal cannot be rushed. We will continue to work on the appeal and transfer it to the regular appeal timeframe and respond to you within thirty (30) days from the time the appeal was received.

Who can help me in filing an emergency appeal?
You can ask for an appeal by calling us at the toll-free number on your ID card and asking for the Member Advocate or writing to:

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

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

If we change our decision after reviewing your appeal or emergency appeal, we will approve your request within 72 hours of the decision. If you do not agree with this decision, you can ask for a State Fair Hearing. The procedure for asking for a State Fair Hearing is explained below.

A Member must complete the appeal process before requesting a State Fair Hearing.

State Fair Hearing Process

Can I ask for a State Fair Hearing?
If you, as a Member of the health plan, disagree with the health plan's appeal decision, you have the right to ask for a State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling them the name of the person you want to represent you. A provider may be your representative.

If you want to challenge a decision made by your health plan, you or your representative must ask for the State Fair Hearing within one-hundred-twenty (120) days of the date on

the health plan's letter with the appeal decision. If you do not ask for the State Fair Hearing within one-hundred-twenty (120) days, you may lose your right to a State Fair Hearing.

To ask for a State Fair Hearing, you or your representative should either send a letter to the health plan at:

Aetna Better Health of Texas
Attention: Member Advocate
PO Box 81139
5801 Postal Rd
Cleveland, OH 44181
Or call **1-800-248-7767** (Bexar) **1-800-306-8612** (Tarrant)

If you ask for a State Fair Hearing within 10 days from the time you get the hearing notice from the health plan, you have the right to keep getting any service the health plan denied, at least until the final hearing decision is made. If you do not request a State Fair Hearing within 10 days from the time you get the hearing notice, the service the health plan denied will be stopped.

If you ask for a State Fair Hearing, you will get a packet of information letting you know the date, time and location of the hearing. Most State Fair Hearings are held by telephone. At that time, you or your representative can tell why you need the service the health plan denied.

HHSC will give you a final decision within ninety (90) days from the date you asked for the hearing. If the State Fair Hearing agrees with your request we will approve the services within seventy-two (72) hours of receiving the State Fair Hearing response.

Can I ask for an emergency State Fair Hearing?
If you believe that waiting for a State Fair Hearing will seriously jeopardize your life or health, or your ability to attain, maintain, or regain maximum function, you or your representative may ask for an emergency State Fair Hearing by writing or calling Aetna Better Health of Texas. To qualify for an emergency State Fair Hearing through HHSC, you must first complete Aetna Better Health of Texas's internal appeals process.

External Medical Review Information

Can a member ask for an External Medical Review?
If you, as a member of the health plan, disagrees with the health plan's internal appeal decision, you have the right to ask for an External Medical Review. An External Medical Review is an optional, extra step you can take to get the case reviewed for free before the State Fair Hearing. You may name someone to represent you by writing a letter to the health plan telling Aetna Better Health the name of the person you want to represent you. A provider may be your representative. You or your representative must ask for the External Medical Review within 120 days of the date the health plan mails the letter with the internal appeal decision. If you do not ask for the External Medical Review within 120 days, you may lose your right to an External Medical Review. To ask for an External Medical Review, you or your representative should either:

- Fill out the 'State Fair Hearing and External Medical Review Request Form' provided as an attachment to the Member Notice of MCO Internal Appeal Decision letter and mail or fax it to Aetna Better Health by using the address or fax number at the top of the form.
- Call Aetna Better Health at **1-800-248-7767** (Bexar) **1-800-306-8612** (Tarrant).
- Email the MCO at **TXMemberAdvocate@aetna.com**.

If you ask for an External Medical Review within 10 days from the time you get the appeal decision from the health plan, you have the right to keep getting any service the health plan denied, at least until the final State Fair Hearing decision is made. If you do not request an External Medical Review within 10 days from the time you get the appeal decision from the health plan, the service the health plan denied will be stopped.

You may withdraw your request for an External Medical Review before it is assigned to an Independent Review Organization or while the Independent Review Organization is reviewing your External Medical Review request. An Independent Review Organization is a third-party organization contracted by HHSC that conducts an External Medical Review during Member appeal processes related to Adverse Benefit Determinations based on functional necessity or medical necessity. An External Medical Review cannot be withdrawn if an Independent Review Organization has already completed the review and made a decision.

Once the External Medical Review decision is received, you have the right to withdraw the State Fair Hearing request. If you continue with the State Fair Hearing, you can also request

the Independent Review Organization be present at the State Fair Hearing. You can make both of these requests by contacting the Aetna Better Health at **1-800-248-7767** (Bexar) **1-800-306-8612** (Tarrant) information) or the HHSC Intake Team at **EMR_Intake_Team@hhsc.state.tx.us**.

Report Fraud, Waste, and Abuse

Do you want to report Waste, Abuse, or Fraud?

Let us know if you think a doctor, dentist, pharmacist at a drug store, other health care providers, or a person getting 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 services that weren't given or necessary.
- Not telling the truth about a medical condition to get medical treatment.
- Letting someone else use their Medicaid ID.
- Using someone else's Medicaid 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/** Under the box labeled "**I WANT TO**" click "Report Waste, Abuse, and Fraud" to complete the online form; or
- You can report directly to your health plan:
  - MCO's name
  - MCO's office/director address
  - MCO's toll free phone number

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 the 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

Annual Notification

The following information must be made available to Members on an annual basis (Balanced Budget Act requirement). This should be stated as below:

- As a Member of Aetna Better Health of Texas, you can ask for and get the following information each year:
- Information about Network Providers – at a minimum primary care doctors, specialists, and hospitals in our service area. This information will include names, addresses, telephone numbers, and languages spoken (other than English) for each Network Provider, plus identification of Providers that are not accepting new patients.
- Any limits on your freedom of choice among Network Providers.
- Your rights and responsibilities.
- Information on Complaint, Appeal External Medical Review and State Fair Hearing procedures.
- Information about benefits available under the Medicaid program, including amount, duration, and scope of benefits. This is designed to make sure you understand the benefits to which you are entitled.
- How you get benefits including authorization requirements.
- How you get benefits, including family planning services, from Out-of-Network providers and limits to those benefits.
- How you get after hours and emergency coverage and limits to those kinds of benefits, including:
  - What makes up Emergency Medical Conditions, Emergency Services, and Post-Stabilization Services.
  - The fact that you do not need prior authorization from your Primary Care Provider for emergency care services.
  - How to get Emergency Services, including instructions on how to use the 911 telephone system or its local equivalent.
  - The addresses of any places where providers and hospitals furnish Emergency Services covered by Medicaid.
  - A statement saying you have a right to use any hospital or other settings for emergency care.
  - Post-stabilization rules.

- Policy on referrals for specialty care and for other benefits you cannot get through your Primary Care Provider
- Aetna Better Health of Texas's practice guidelines.

Subrogation

What is subrogation?

We can ask for reimbursement 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 can be responsible) for causing the illness or injury to you. We can also ask to get back the cost of medical expenses from you if you get expenses from the other party.

STAR Covered Benefits

Benefit Description
Needed medical care for adults and children
Vaccines to prevent illness (Immunizations)
Chiropractic services
Podiatrists (Foot doctor)
Laboratory and x-ray services
Surgery as an outpatient (no hospital stays)
Hospital care and Outpatient care
Maternity care and newborn care
24-hour nurse line
24-hour emergency care from an emergency room
Eye doctor services (includes eyeglasses and contact lenses, if medically necessary)
Hearing services and hearing aids
Home health agency services
Ambulance services
Dialysis for kidney problems
Major organ transplants
Texas Health Steps medical and dental checkups
Physical exam for adults (once per year)
Physical, occupational, and speech therapy
Family planning services and supplies
HIV and sexually transmitted disease treatment
Behavioral health services (such as counseling and treatment)
Substance use disorder assistance (such as alcohol and drug assistance)
Diabetic supplies
Health education classes
Non-Emergency Medical Transportation (NEMT)

Services covered for member's birth through 20 years of age can be different than services covered for members 21 years of age or older.

STAR Benefit Exclusions

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

Benefits Exclusions
Faith Healing
Acupuncture
Cosmetic Surgery
Any service that is *not* medically necessary

Health Education Classes offered by Aetna Better Health of Texas

Health Education Topics
Car Seat Safety
Poison safety
Drug and Alcohol Awareness
Prenatal Care
Immunizations
Sexually Transmitted Diseases
Infant Mortality
Smoking Cessation
Nutrition
Teen Pregnancy Prevention
Oral Health
Vision Awareness
Physical Fitness
Weight Management

STAR 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 **1-800-556-1555** for assistance.
Over-the-Counter Benefits / Discount Pharmacy	The OTC Health Solutions program offers members a $25 monthly allowance ($300 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 month ($300 annually) per household. 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 *Excludes prescriptions, alcohol, lottery, postage stamps, gift cards, money orders, prepaid 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
PROMISE Program	Our pregnant members can earn diapers, baby wipes or similar baby items. • If you complete 3 prenatal visits you can earn up to $50 worth of baby items. • If you complete 3 more prenatal visits (6 total) and 1 postpartum visit after the baby is born you can earn another $50 worth.
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.

Benefit Type	Benefit Description
Extra Vision Services	Aetna Better Health of Texas members will receive financial assistance in obtaining vision services and products. • 21 years and older – Aetna will cover the cost of eye exams once every other year. • 21 years and older – Aetna will cover up to $175 once every other year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid. • Under 21 years old – Aetna will cover up to $175 once a year for eye wear not limited to eyeglass frames, lenses and contact lenses that are not covered by Medicaid.
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 • Vent cleaning • Deep carpet cleaning
Sports Physicals	Medically necessary sports physicals to any member 19 years and younger who have completed a well-child visit.
Cell Phone Assistance	Members that qualify for the Federal Lifeline Program are provided with choice of a smartphone, feature phone or use of their personal cell phone to include the following plan options depending on coverage area. (1) Assurance Wireless: Android smartphone with 500 MB of data, 350 talk minutes and unlimited text;

	(2) EnTouch Wireless: use of personal cell phone, 500 MB of data, and 500 units of voice/text where 1 unit = 1 text or 1 minute; (3) EnTouch Wireless: Feature phone, 10 MB of data, 500 talk minutes, 100 texts; (4) Life Wireless: use of personal cell phone, 10 MB of data, 500 talk minutes and unlimited text. Member calls to and from the Health Plan and health-related texts received from the Health Plan will not apply to minute or text limits.
Well-Child Exams	Members can receive: • $50 gift card at no cost to members for completing Texas Health Steps/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 Texas Health Steps/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 Texas Health Steps/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 Texas Health Steps/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 Texas Health Steps/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 Texas Health Steps/well-child checkups/visits is received for members 3-20 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.
Extra Foot Doctor (Podiatry) Services	Members have access to foot care products available through the OTC Health Solutions Program.
Dental Services	Members are eligible for the following annual dental benefits: • Cleaning every 6 months • X-Rays once a year • Simple extractions • Limited fillings • Fluoride treatments

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

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 and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

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-Emergency Medical Transportation (NEMT) – Non-emergency transportation to health care appointments for eligible Medicaid members who have no other transportation options available.

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 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, to pay for your health care services.

Pre-authorization - A decision by your health insurer or plan before you receive it that a health care service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or pre-certification. Preauthorization 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 - Health care 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.

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