



SoonerSelect Member Handbook
Aetna Better Health® of Oklahoma
Learn about your health care benefits

Sooner**Select** 

 **aetna**®

AetnaBetterHealth.com/Oklahoma

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Aetna Better Health® of Oklahoma

You can get this handbook and other plan information in large print for free. To get materials in large print, call Member Services at **1-844-365-4385 (TTY: 711)**.

If English is not your first language (or if you are reading this on behalf of someone who doesn't read English), we can help. Call **1-844-365-4385 (TTY: 711)**. You can ask us for the information in this handbook in your language. We have access to interpreter services and can help answer your questions in your language.

Si el inglés no es su lengua materna (o si está leyendo esto en representación de alguien que no lee inglés), podemos ayudarle. Comuníquese con **1-844-365-4385 (TTY: 711)**. Puede solicitar la información de este manual en su idioma. Tenemos acceso a servicios de interpretación y podemos ayudarle a responder a sus preguntas en su idioma.

Your Aetna Better Health of Oklahoma Quick Reference Guide

I WANT TO:	I CAN CONTACT:
Find a doctor, specialist or health care service	My primary care provider (PCP) is the primary doctor providing care to me. For help with choosing my PCP, I can call Member Services at 1-844-365-4385 (TTY: 711) .
Get the information in this handbook in another format or language	Member Services at 1-844-365-4385 (TTY: 711) .
Keep better track of my appointments and health services	My PCP or Member Services at 1-844-365-4385 (TTY: 711) .
Get help with getting to and from my doctor's appointments	Member Services at 1-844-365-4385 (TTY: 711) . I can also find more information on Transportation Services in this handbook on page 34.
Get help to deal with my stress or anxiety	Oklahoma Mental Health Lifeline at 988 , at any time, 24 hours a day, 7 days a week. If I am in danger or need immediate medical attention, I will call 911 .
Get answers to basic questions or concerns about my health, symptoms or medicines	Nurse Line at 1-844-365-4385 (TTY: 711) at any time, 24 hours a day, 7 days a week, or talk with your PCP.
<ul style="list-style-type: none"> • Understand a letter or notice I got in the mail from my health plan • File a complaint about my health plan • Get help with a recent change or denial of my health care services 	Member Services at 1-844-365-4385 (TTY: 711) .
Update my address or personal information	Call the SoonerCare Helpline at 1-800-987-7767 or visit www.MySoonerCare.org .
Find my plan's provider directory or other general information about my plan	Visit my plan's website at AetnaBetterHealth.com/Oklahoma or call Member Services at 1-844-365-4385 (TTY: 711) .

Key words used in this handbook

As you read this handbook, you may see some new words. Here is what we mean when we use them.

Abuse: Provider or member practices that result in an unnecessary cost to the Medicaid program or in reimbursement for services that are not medically necessary.

Advance Directive: A set of directions you give about the medical and behavioral health care you want if you ever lose the ability to make decisions for yourself. This may include a living will, the appointment of a health care proxy or both.

Adverse Benefit Determination: A decision your plan can make to reduce, stop or restrict your health care services.

American Indian/Alaska Native (AI/AN): An individual who is a member of a federally recognized American Indian tribe; an individual who resides in an urban center and qualifies as a member of an American Indian tribe, Alaska Native, or is considered to be an American Indian under federal regulations; an individual considered by the federal government to be an American Indian for any purpose. AI/AN may be used to refer to this population.

Appeal: A request to your health plan to review a decision the plan made about reducing, stopping or restricting your health care services.

Behavioral Health Emergency: A situation in which there is a high risk of behaving in a way that could result in serious harm or death to yourself or others.

Behavioral Health Services: Mental health (emotional, psychological and social well-being) and substance use (alcohol and drugs) disorder diagnostic, treatment, and rehabilitation services.

Benefits: Medical and behavioral health care services covered by your health plan.

Care Manager: A specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Copay: A fee you pay when you get certain health care services or a prescription.

Durable Medical Equipment: Certain items (such as a walker or a wheelchair) your doctor can order for you to use if you have an illness or an injury.

Emergency Medical Condition: A situation in which your life could be threatened or you could be hurt permanently if you don't get care right away (such as a heart attack or broken bones).

Emergency Medical Transportation: Ambulance transportation to the nearest hospital or medical facility for an emergency medical condition.

Emergency Room Care: Care you receive in a hospital if you are experiencing an emergency medical condition.

Emergency Services: Services you receive to evaluate, treat or stabilize your emergency medical condition.

Excluded Benefits: Services or benefits that are not covered by the health plan.

Expansion Adult: An individual who is aged 19-64, with income at or below 138% of the federal poverty level, and who is determined eligible for Medicaid.

Expedited (faster) Appeal: If your health plan made a decision about reducing, stopping or restricting your health care services and you think waiting 30 days for an appeal decision will harm your health, this is a request to review the decision within 72 hours.

Fraud: Intentional deception or misrepresentation made by a person resulting in some unauthorized benefit to themselves or another person.

Grievance: A complaint you can file if you have a problem with your health plan, provider, care or services.

Habilitation Services and Devices: Health care services that help you keep, learn or improve skills and functioning for daily living.

Health Insurance: A type of insurance coverage that pays for your health and medical costs. Your Medicaid coverage is a type of insurance.

Home Health Care: Certain services you receive outside a hospital or a nursing home to help with daily activities of life, such as home health aide services or skilled nursing.

Hospice Services: Special services for patients and their families during the final stages of illness. Hospice services include certain physical, psychological and social services that support terminally ill individuals and their families or caregivers.

Hospital Outpatient Care: Care you receive at a hospital or medical facility without being admitted or for a stay of less than 24 hours (even if this stay occurs overnight).

Hospitalization: Admission to a hospital for treatment that lasts more than 24 hours.

Indian Health Care Provider (IHCP): A health care program operated by Indian Health Services or by an American Indian tribe, tribal organization, or Urban Indian Organization. IHCP may be used to refer to this kind of provider. Any individual who is an American Indian or Alaska Native (AI/AN) may choose an IHCP as their primary care provider.

Medicaid: A health plan that helps some individuals pay for health care. For example, the SoonerSelect program is a Medicaid health program that pays for health coverage.

Medically Necessary: Medical services or treatments that you need to get and stay healthy. Services must follow standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability.

Member: A person enrolled in and covered by a health plan.

Network (or Provider Network): A group of doctors, hospitals, pharmacies and other health care professionals who have a contract with your health plan to provide health care services for its members.

Non-Emergency Medical Transportation: Transportation your plan can arrange to help you get to and from your appointments, including personal vehicles, taxis, vans, mini-buses and public transportation.

Non-Expansion Adult: An adult who qualifies for Oklahoma's Medicaid program and meets eligibility requirements such as pregnant women and parents/caretakers of dependents under age 19 who meet income limits.

Non-Participating Provider/Out-of-Network Provider: A physician or other provider who has not contracted with or is not employed by the health plan to deliver services under the SoonerSelect program.

Notice of Adverse Resolution: Written information the plan sends you if your appeal is denied.

Notice of Resolution: Written information the plan sends you when a decision has been made for your appeal or grievance.

Oklahoma Health Care Authority (OHCA): The state agency for Medicaid in Oklahoma, and the agency that oversees the SoonerSelect program.

Out-of-Network Referral: If your health plan does not have the specialist you need in its provider network, they may find one for you to visit who is outside your health plan.

Participating Provider: A physician or other provider, including a pharmacy, who is contracted with or employed by the health plan to deliver services under the SoonerSelect program.

Physician Services: The services provided by an individual licensed under state law to practice medicine or osteopathy, but not services offered by doctors while you are admitted in the hospital.

Plan (or Health Plan): The company providing you with health insurance coverage. Your health plan is Aetna Better Health.

Premium: A monthly payment made for health insurance coverage. You do not have a premium in SoonerSelect.

Prescription Drugs: A drug that, by law, requires a prescription by a doctor.

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

(general) **Primary care provider:** A medical doctor who is trained to prevent, diagnose and treat a broad array of illnesses and injuries in the general population.

(specific to you) **Primary Care Provider (PCP):** The medical provider who takes care of and coordinates all your health needs, including referrals and prior authorizations. Your PCP is often the first person you should contact if you need care. Your PCP can be a physician, including an OB/GYN, a nurse practitioner, a physician assistant, or a certified nurse midwife. If you are an individual who is American Indian or Alaska Native (AI/AN), you may choose an Indian Health Care Provider as your PCP.

Prior Authorization (PA) (or Preauthorization): The approval needed from your plan before you can get certain health care services or medicines.

Provider: A health care professional or a facility that delivers health care services, such as a doctor, hospital or pharmacy.

Rehabilitation Services and Devices: Health care services and equipment that help you regain skills, abilities or knowledge that may have been lost or compromised because of an illness, accident, injury or surgery. These services can include physical or speech therapy or behavioral rehabilitation services.

Skilled Nursing Care: Care that requires the skill of a licensed nurse.

Specialist: A doctor who is trained and practices in a specific area of medicine.

Specialty Care: Advanced medically necessary care that focuses on specific health conditions or are provided by a specialist.

Standard Appeal: A request to your health plan to review a decision the plan made about reducing, stopping or restricting your health care services. Your plan will make a decision on your appeal within 30 days.

State Fair Hearing: If you are unhappy with the final decision your health plan made on your appeal, you may request a hearing to make your case before an administrative law judge.

Substance Use: A condition that includes the misuse or addiction to alcohol and/or legal or illegal drugs.

Urgent Care: Care for a health condition that needs prompt medical attention but is not an emergency medical condition. You can get urgent care in a walk-in clinic for a non-life-threatening illness or injury (such as the flu or sprained ankle).

Waste: The overuse or misuse of health care services that increases Medicaid costs.

**Welcome to Aetna Better Health®
of Oklahoma**

Sooner**Select** 

Aetna Better Health[®] of Oklahoma

SoonerSelect Program

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Welcome to Aetna Better Health's SoonerSelect Program

This handbook will be your guide to the full range of Medicaid health care services available to you. If you have questions about the information in your welcome packet, this handbook, or your new health plan, call Member Services at **1-844-365-4385 (TTY: 711)** or visit our website at [AetnaBetterHealth.com/Oklahoma](https://www.aetna.com/betterhealth/oklahoma). We can also help you make an appointment with your doctor and tell you more about the services you can get with your new health plan.

How SoonerSelect Works

The Plan, Our Providers and You

- Many people get their health benefits through programs like SoonerSelect, which works like a central home for your health. SoonerSelect helps coordinate and manage all your health care needs.
- Aetna Better Health has a contract with the Oklahoma Health Care Authority (OHCA) to meet the health care needs of people with Oklahoma Medicaid. In turn, we partner with a group of health care providers to help us meet your needs. These providers (doctors, therapists, specialists, hospitals, home care providers and other health care facilities) make up our provider network. You will find a list of participating providers in our provider directory. The directory also includes the following details for network providers:
 - Name, address, telephone numbers
 - Professional qualifications
 - Specialty
 - Medical school attended
 - Residency completion
 - Board certification status
- You can visit our website at [AetnaBetterHealth.com/Oklahoma](https://www.aetna.com/betterhealth/oklahoma) to find the provider directory online. You can also call Member Services at **1-844-365-4385 (TTY: 711)** to get a free copy of the provider directory.
- When you join Aetna Better Health, our providers are here to support you. Most of the time, that person will be your primary care provider (PCP). The PCP is the medical provider who takes care of and coordinates all your health needs, including referrals and prior authorizations. If you need to

have a test, see a specialist or go into the hospital, your PCP can help arrange it.

- If you need to speak to your PCP after hours or weekends, call and leave a message with information on how you can be reached. Your PCP will get back to you as soon as possible. Even though your PCP is your main source for health care, in some cases, you can go to certain doctors for some services without checking with your PCP. See page 9 for details.

How to Use This Handbook

This handbook will tell you how Aetna Better Health will work. This handbook is your guide to health and wellness services. It tells you the steps to take to make the plan work for you.

The first several pages will tell you what you need to know right away. The rest of the handbook can wait until you need it. Use it for reference or check it out a bit at a time.

When you have a question, check this handbook, ask your PCP or call Member Services at **1-844-365-4385 (TTY: 711)**. You can also visit our website at AetnaBetterHealth.com/Oklahoma.

Help from Member Services

For help with non-emergency issues and questions, call Member Services 24 hours a day, 7 days a week to speak with a Member Services representative, except on the day after Thanksgiving and Martin Luther King Jr. Day where you can leave a voice mail message for a call back within 1 business day.

- In case of a medical emergency, call **911**.
- **You can call Member Services to get help when you have a question.** You may call us to choose or change your PCP, to ask about benefits and services, to get help with referrals, to replace a lost ID card, to report the birth of a new baby, or to ask about any change that might affect you or your family's benefit.
- If you are pregnant or become pregnant, your child will become part of Aetna Better Health on the day your child is born. If you become pregnant, call your plan to choose a doctor for both you and your baby before your baby is born.
- **If English is not your first language (or if you are reading this on behalf of someone who doesn't read English), we can help.** We want you to know how to use your health care plan, no matter what language you

speak. Just call us and we will find a way to talk with you in your own language. We have a group of people who can help.

Other Ways We Can Help

- If you have basic questions or concerns about your health, you can call our Nurse Line at **1-844-365-4385 (TTY: 711)** at any time, 24 hours a day, 7 days a week. You can get advice on when to go to your PCP or ask questions about symptoms or medications.
- If you are experiencing emotional or mental distress, call the Oklahoma Mental Health Lifeline at **988** at any time, 24 hours a day, 7 days a week, to speak with someone who will listen and help. We are here to help you with problems like stress, depression or anxiety. We can connect you to the support you need to feel better. **If you are in danger or need immediate medical attention, call 911.**
- **For people with disabilities:** If you use a wheelchair or have trouble hearing or understanding, call us if you need extra help. If you are reading this on behalf of someone who is blind, deaf-blind, or has difficulty seeing, we can also help. We can tell you if a doctor's office is wheelchair accessible or is equipped with special communications devices. Also, we have services like:
 - Our TTY phone number is **1-844-365-4385 (TTY: 711)**.
 - Information in large print.
 - Help in making or getting to appointments.
 - Names and addresses of providers who specialize in your condition.

Auxiliary Aids and Services

If you have a hearing, vision or speech impairment, you have the right to receive information about your health plan, care and services in a format that you can understand and access. Aetna Better Health provides free aids and services to help people communicate effectively with us, like:

- Use **711** to contact us at **1-844-365-4385**.
- Qualified American Sign Language interpreters.
- Closed captioning.
- Written information in other formats (like Braille, large print, audio, accessible electronic format, and other formats).

These services are available to members for free. To ask for aids or services, call Member Services at **1-844-365-4385 (TTY: 711)**.

Aetna Better Health complies with federal civil rights laws and does not leave out or treat people differently because of race, color, national origin, age, sex, sexual orientation, gender identity or disability. Aetna Better Health will not discriminate against anyone on the basis of frequent or high-cost care, health status, need for health care services, or due to an adverse change in enrollment, disenrollment, or re-enrollment with Aetna Better Health. If you believe that Aetna Better Health failed to provide these services, you can file a grievance or appeal. To file a grievance or appeal, or to learn more, call Member Services at **1-844-365-4385 (TTY: 711)**. You may also file a complaint about your plan with the Oklahoma Insurance Department.

How You Become a Member of the SoonerSelect Program

As an American Indian/Alaskan Native (AI/AN) individual, you may disenroll from the SoonerSelect program for any reason. As an AI/AN individual, if you choose not to enroll or later decide to disenroll from the SoonerSelect program, you will be able to opt in again during the next open enrollment period. Open enrollment periods happen about every 12 months.

All other individuals who are determined eligible for SoonerCare and the SoonerSelect program will be enrolled in the SoonerSelect program by SoonerCare. You may not disenroll from the SoonerSelect program, but you may change health plans as discussed below.

How You Become a Member of Aetna Better Health

As an AI/AN individual, if you choose to opt in to the SoonerSelect program, you will have the option to choose your health plan when first enrolled and during open enrollment periods. If you opt in to the SoonerSelect program and don't choose a health plan, SoonerCare will assign one to you. You can disenroll from your assigned health plan and choose a different health plan any time within the first 90 days after your health plan benefits begin. You can also change plans during the yearly open enrollment period.

All other individuals who are enrolled in the SoonerSelect program will have the option to choose a health plan when first enrolled and during the yearly open enrollment period. If you don't choose a health plan, SoonerCare will assign one to you. You can disenroll from your assigned health plan and choose a different health plan any time within the first 90 days after your health plan benefits begin or during an open enrollment period.

Your Health Plan ID Card

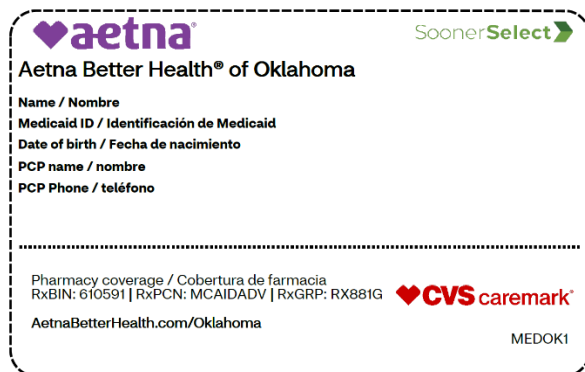
Your Aetna Better Health ID card is mailed to you within 7 days after you enroll in your health plan. We use the mailing address on file at Oklahoma Health Care Authority. It will have your Medicaid identification number and information on how you can contact us if you have any questions. Your ID card will have Aetna Better Health's claims information for providers to use. If anything is wrong on your Aetna Better Health ID card, call us right away. If you lose your card, call Member Services at **1-844-365-4385 (TTY: 711)**. Carry your ID card always and show it each time you go for care.

Your member ID card will also have your Primary Care Provider (PCP) name on it. If you did not select a PCP or if we could not assign you to the PCP that you wanted, a PCP was auto assigned for your primary care and sick visits.

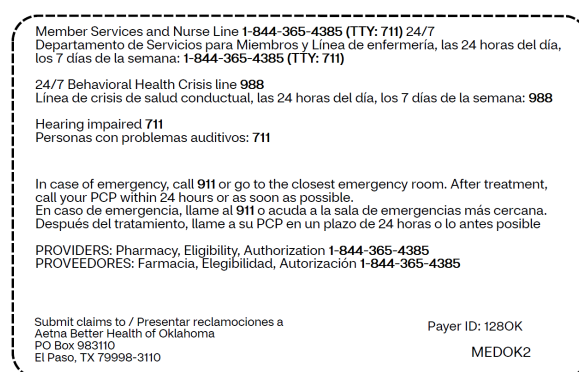
If you do not want to see the PCP that we have auto assigned, and you would like to select a new one, just call Member Services at **1-844-365-4385 (TTY: 711)**. If you need to see a doctor before you have received your ID card, you can download our mobile app. Register for the app using your ID number from your state Medicaid ID card. This number will be the same as your member ID for Aetna Better Health of Oklahoma. You can access your digital ID card within the mobile app.

Sample ID card:

Front



Back



Member Mobile app

With the Aetna Better Health mobile app, you can get on demand access to the tools you need to stay healthy. Find a doctor, request or view your Plan ID card or change your PCP at any time, from anywhere.

To get the mobile app, you can download it from Apple's App Store or Google's Play Store. Search for "Aetna Better Health" to locate the app. It is

free to download and free to use. This application is available on certain devices and operating systems (OS).

Mobile app features

- Find a provider
- View or request your Plan ID card
- Speak to a nurse
- Change your PCP
- View your claims and prescriptions
- Message Member Services for questions or support
- Update your phone number, address and other important member details

PART I: First Things You Should Know

How to Choose Your PCP

- Your primary care provider (PCP) is a doctor, nurse practitioner, physician assistant, or another type of provider who will care for your health, coordinate your needs, and help you get authorization for specialized services if you need them. There are lots of types of health care providers. Yours may be a general practitioner or family medicine, internal medicine, pediatrics, or Indian Health Care Provider. When you enroll in Aetna Better Health, you will have an opportunity to choose your own PCP. To choose your PCP, call Member Services at **1-844-365-4385 (TTY: 711)**. If you do not select a PCP or if we are not able to assign you to the PCP that you chose, we will choose one for you. If we choose a provider for you, we will try to choose a provider you have seen before. Any provider we choose for you will be close to your home. (See “How to Change Your PCP” to learn how you can change your PCP.)
- When deciding on a PCP, you may want to find a PCP who:
 - You have seen before
 - Understands your health needs
 - Is taking new patients
 - Can serve you in your language
 - Is easy to get to
- Each family member enrolled in Aetna Better Health can have a different PCP, or you can choose one PCP to take care of the whole family. A pediatrician treats children from birth through 18. Family practice doctors treat the whole family. Internal medicine doctors treat adults ages 19 and older. Call Member Services at **1-844-365-4385 (TTY: 711)** to get help with choosing a PCP who is right for you and your family. You can change your PCP at any time to another provider in our network.
- You can find the list of all the doctors, clinics, hospitals, labs and others who partner with Aetna Better Health in our provider directory. You can visit our website at [AetnaBetterHealth.com/Oklahoma](https://www.aetnabetterhealth.com/Oklahoma) to look at the provider directory online. You can also call Member Services at **1-844-365-4385 (TTY: 711)** to get a copy of the provider directory. The provider directory includes each provider’s:
 - Name, address, telephone number
 - Professional qualifications

- Specialty
- Medical schools attended and residency
- Women can choose an OB/GYN to serve as their PCP, but do not have to. Women do not need a PCP referral to see an OB/GYN doctor or another provider who offers women's health care services. Women can get routine check-ups, follow-up care if needed, and regular care during pregnancy.
- If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP. You can call Member Services for help with this. Member Services will gather details on your request for review by our care management team who will follow up with you to discuss your needs.

A specialist may be requested to serve as a PCP under the following conditions:

- Complex, chronic health condition that requires a specialist's care over a long period and exceeds the capacity of the non-specialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.)
- Health condition is life threatening or so degenerative and disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-member relationship would prevent access to proper care or services or would end a therapeutic relationship that has been developed over time.
- Aetna Better Health of Oklahoma's Chief Medical Officer (CMO) will review the request for a specialist to serve as PCP, and will have the authority to make the final decision.
- If your provider leaves Aetna Better Health, we will tell you within 15 days from when we know about this. If the provider who leaves Aetna Better Health is your PCP, we will contact you to help you choose another PCP. In some cases, you may be able to continue to see your provider for a period of time or until a new provider can be assigned to maintain your care. You can call Member Services at **1-844-365-4385 (TTY: 711)** for questions about this.
- If you are an American Indian/Alaska Native individual, you may choose an Indian Health Care Provider as your PCP, but you don't have to. Claims for non-American Indian/non-Alaskan Native members receiving covered services are submitted by the Tribal Facility/Tribal Provider directly to

Oklahoma Health Care Authority (OHCA). These claims for covered services will be reviewed and paid by OHCA to the Tribal Facility/Tribal Provider. If you are an Aetna Better Health member and a non-American Indian/non-Alaskan Native, work with your provider to submit your claim to OHCA. If you have questions, call Member Services at **1-844-365-4385**.

How to Change Your PCP

When you enroll in Aetna Better Health, if you do not choose a PCP for yourself, we will choose one for you.

Whether you choose a PCP for yourself or Aetna Better Health chooses a PCP for you, you can change your PCP any time and the change will become effective immediately. You do not have to give us a reason for the change. If you'd like to change your PCP, you can do so by calling Member Services at **1-844-365-4385 (TTY: 711)** and you can also change your PCP by logging into our secure member portal, AetnaBetterHealth.com/Oklahoma.

How to Get Regular Health Care

- Regular health care means exams, regular checkups, shots or other treatments to keep you well, advice when you need it, and referrals to the hospital or specialists when you need them. It means you and your primary care provider (PCP) work together to keep you well or to see that you get the care you need.
- Day or night, your PCP is only a phone call away. Be sure to call your PCP if you have a medical question or concern. If you call after hours or on weekends, leave a message and information on how you can be reached. Your PCP will call you back as quickly as possible. Remember, your PCP knows you and knows how your health plan works.
- Your PCP will take care of most of your health care needs, but you must have an appointment to see your PCP. If you cannot keep an appointment, it is important to call to let your PCP know as soon as you know.
- **Making your first regular health care appointment.** As soon as you choose or are assigned a PCP, call to make a first appointment. There are several things you can do to help your PCP get to know you and your health care needs. Your PCP will need to know as much about your medical history as possible. Make a list of your medical history, any problems you have now, and the questions you want to ask your PCP. Bring any medications and supplements that you are taking with you to the visit. In most cases, your first visit should be within 3 months of you joining Aetna Better Health.

If you need care before your first appointment, call your PCP's office to explain your concern. Your PCP will give you an earlier appointment. You should still keep the first appointment to talk about your medical history and ask questions.

It is important to Aetna Better Health that you can visit a doctor within a reasonable amount of time, depending on what the appointment is for. When you call for an appointment, use the appointment guide below to know how long you can expect to wait to be seen.

APPOINTMENT GUIDE	
IF YOU CALL FOR THIS TYPE OF SERVICE:	YOUR APPOINTMENT SHOULD TAKE PLACE:
PCP (services like routine health check-ups or immunizations)	<p>Within 30 days from date of request for a routine appointment.</p> <p>Within 72 hours for non-urgent sick visits.</p> <p>Within 24 hours for urgent care.</p>
OB/GYN	<p>Within 30 days from date of request for a routine appointment.</p>
OB/GYN	<p>Maternity care:</p> <p>First trimester – within 14 calendar days.</p> <p>Second trimester – within 7 calendar days.</p> <p>Third trimester – within 3 business days.</p>

Specialty	<p>Within 60 days from date of request for a routine appointment.</p> <p>Within 24 hours for urgent care.</p>
Mental Health	
Mental health	<p>Within 30 days from date of request for a routine appointment.</p> <p>Within 7 days of residential care and hospitalization.</p> <p>Within 24 hours for urgent care.</p> <p>For mental health emergencies, please call the Oklahoma Mental Health Lifeline at 988.</p>
Substance Use Disorders	
Substance use	<p>Within 30 days from date of request for a routine appointment.</p> <p>Within 7 days of residential care and hospitalization.</p> <p>Within 24 hours for urgent care.</p>

If you are having trouble getting the care you need within the time limits described above, call Member Services at **1-844-365-4385 (TTY: 711)**.

Telehealth

Telehealth is interactive audio, video. With Telehealth you can get access to providers in real time. Telehealth service is not an expansion of SoonerSelect but a different way to offer quality health care access to SoonerSelect members.

Your plan includes the convenience of telemedicine coverage. Virtually access participating in-network primary care providers (PCPs), physician specialty care, urgent care clinics, mental health support and more.

To participate, you:

- May receive telehealth services outside of Oklahoma when medically necessary
- Retains right to leave telehealth services at any time
- Should be aware that all telehealth activities must comply with the Health Insurance Portability and Accountability Act (HIPAA) Security Rule, OHCA policy and all other applicable state and federal laws and regulations

If you're a parent or legal guardian of a minor child, you must present your child for services unless exempted by state or federal law. You only need to attend if therapeutically appropriate.

How to Get Specialty Care – Referrals

- If you need specialized care that your primary care provider (PCP) cannot give, you can self-refer or your PCP can refer you to a specialist who can. A specialist is a doctor who is trained and practices in a specific area of medicine (like a cardiologist or a surgeon). It is important to let your PCP know about any care that you are receiving from another doctor, to make sure they can help you with any authorizations that may be needed. Talk with your PCP or call Member Services at **1-844-365-4385 (TTY: 711)** to be sure you know how referrals work.
- If you think a specialist does not meet your needs, talk with your PCP. Your PCP can help you if you need to see a different specialist.
- There are some treatments and services that your PCP must ask Aetna Better Health to approve before you can get them. Your PCP will be able to tell you what they are.
- If you have trouble getting a referral you think you need, contact Member Services at **1-844-365-4385 (TTY: 711)**.
- If Aetna Better Health does not have a specialist in our provider network who can give you the care you need, we will refer you to a specialist outside our plan. This is called an out-of-network referral. Your PCP or another network provider must ask Aetna Better Health for approval before you can get an out-of-network referral.

When a need for services is not able to be met through a contracted provider, Aetna Better Health of Oklahoma will authorize service through an out-of-network provider.

- Your PCP will contact our Provider Services Department and notify need of going out of network.
- Provider Service Department will negotiate an agreement for the necessary services.
- Provider Network will be notified to reach out to the out of network provider for interest in joining the Aetna Better Health of OK network.
- Transition to a network provider when the treatment or service has been completed or the member's condition is stable enough to allow a transfer of care.
- Transportation services to out-of-network appointments if needed is available through our vendor.
- It is important you get approval before seeing an out-of-network provider. If you do not, there may be a delay in services, and you may be responsible for paying for the services.
- Sometimes, we may not approve an out-of-network request because we have a provider in Aetna Better Health's network who can treat you. If you do not agree with our decision, you can appeal our decision. See page 47 to find out how.
- Sometimes, we may not approve an out-of-network request for a specific treatment because you asked for care that is not very different from what you can get from an Aetna Better Health provider. If you do not agree with our decision, you can appeal our decision. See page 48 to find out how.

If you have a complex health condition or a special health care need, you may be able to choose a specialist to act as your PCP.

A specialist may be requested to serve as a PCP under the following conditions:

- Complex, chronic health condition that requires a specialist's care over a long period and exceeds the capacity of the non-specialist PCP (i.e., members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology/oncology conditions, cystic fibrosis, etc.)
- Health condition is life threatening or so degenerative and disabling in nature to warrant a specialist serve in the PCP role.
- In unique situations where terminating the clinician-member relationship would prevent access to proper care or services or would end a therapeutic relationship that has been developed over time leaving.

- Aetna Better Health of Oklahoma’s Chief Medical Officer (CMO) will review the request for a specialist to serve as PCP, and will have the authority to make the final decision.

Second Medical Opinions

You have the right to receive a second opinion as an option for an illness, surgery, and/or confirming a treatment of care your provider has told you that you need. Contact your provider or Member Services for help to get a second opinion. If an appropriate provider for the second opinion is not available within the Aetna Better Health network, we will arrange for you to get the second opinion outside of our network. When approved by us, out-of-network second opinions are provided at no more cost than if the service was provided in-network.

Out-of-Network Providers

A participating provider is a physician or other provider who is contracted with Aetna Better Health to deliver services under the SoonerSelect program. A non-participating provider is a physician or other provider who has not contracted with Aetna Better Health to deliver services under the SoonerSelect program. If we do not have a specialist in our provider network who can give you the care you need, we will get you the care you need from a specialist outside our plan, or an out-of-network provider. For help and more information about getting services from an out-of-network provider, talk to your primary care provider (PCP) or call Member Services at **1-844-365-4385 (TTY: 711)**.

You can receive family planning services (birth control) from a doctor that is not an Aetna Better Health doctor. You do not have to get a referral from your PCP, but you must visit an Oklahoma Medicaid provider. If you are AI/AN, you may receive services from any Indian Health Care Provider (IHCP), even if the IHCP is out of network.

Get These Services from Aetna Better Health Without a Referral

You do not need a referral to get these services:

- Primary care
- Behavioral health services
- Substance use disorder treatment
- Vision services
- Emergency services

- Well-child checkups/EPSTD (Early Periodic Screening Diagnosis and Treatment)
- Family planning services and supplies
- Prenatal care
- Department of health providers, including mobile clinics
- Services provided by IHCPs to AI/AN health plan members

Emergencies

If you believe you have an emergency, call **911** or go to the nearest emergency room. If you believe you have a mental health emergency, call **988**.

You do not need approval from your plan or your PCP before getting emergency care, and you are not required to use our hospitals or doctors.

If you're not sure, call your PCP at any time, day or night. Tell the person you speak with what is happening. Your PCP's team will:

- Tell you what to do at home;
- Tell you to come to the PCP's office; or
- Tell you to go to the nearest urgent care clinic or emergency room.

If you are out of the area when you have an emergency:

Go to the nearest emergency room.

Remember: Use the emergency room only if you have an emergency. If you have questions, call your PCP or Aetna Better Health Member Services at **1-844-365-4385 (TTY: 711)**.

You are always covered for emergencies. An emergency medical condition is a situation in which your life could be threatened, or you could be hurt permanently if you don't get care right away. Some examples of an emergency are:

- A heart attack or severe chest pain
- Bleeding that won't stop
- A bad burn
- Broken bones
- Trouble breathing, convulsions or loss of consciousness
- When you feel you might hurt yourself or others

- If you are pregnant and have signs like pain, bleeding, fever or vomiting
- Drug overdose

Some examples of non-emergencies are colds, upset stomach or minor cuts and bruises. Non-emergencies may also be family issues or a break-up. These may feel like an emergency, but they are not a reason to go to the emergency room unless you are in immediate danger of harm.

Urgent Care

You may have an injury or an illness that is not an emergency but still needs prompt care and attention. This could be:

- A child with an earache who wakes up in the middle of the night and won't stop crying
- Flu symptoms
- If you need stitches
- A sprained ankle
- A bad splinter you cannot remove

You can walk into an urgent care clinic to get care the same day or make an appointment for the next day. Whether you are at home or away, call your PCP any time, day or night. If you cannot reach your PCP, call Member Services at **1-844-365-4385 (TTY: 711)**. Tell the person who answers what is happening. They will tell you what to do.

Care Outside Oklahoma

- In some cases, Aetna Better Health may pay for health care services you get from a provider located just beyond the Oklahoma border or in another state. Your PCP and Aetna Better Health can give you more information about which providers and services are covered outside of Oklahoma by your health plan, and how you can get them if needed. If you need medically necessary emergency care while traveling anywhere within the United States and its territories, Aetna Better Health will pay for your care.
- Your health plan will not pay for care received outside of the United States and its territories.

If you have any questions about getting care outside of Oklahoma or the United States, talk with your PCP or call Member Services at **1-844-365-4385 (TTY: 711)**.

PART II: Your Benefits

The rest of this handbook is for your information when you need it. It lists covered and non-covered services. If you are having problems with your health plan, the handbook tells you what to do. The handbook has other information you may find useful. Keep it handy for when you need it.

How You Know if You are an Expansion Adult or a Non-Expansion Adult

Non-expansion adults are individuals who qualify for Oklahoma's Medicaid program and meet eligibility requirements such as those who are eligible for Medicare, pregnant women, or needy caretakers of dependents under age 19 who meet the income requirements listed at

<https://oklahoma.gov/ohca/individuals/mysoonercares/apply-for-soonercares-online/eligibility/income-guidelines.html>.

Expansion adults are individuals who meet income requirements, are ages 19 to 64, and determined eligible for Medicaid; but do not meet requirements for aged, blind or disabled, breast and cervical cancer, or Medicare. Eligible income means someone earns at or below 138% of the federal poverty level. See the income guidelines at

<https://oklahoma.gov/ohca/individuals/mysoonercares/apply-for-soonercares-online/eligibility/income-guidelines.html>.

Benefits

SoonerSelect provides benefits or health care services covered by your plan.

Aetna Better Health will provide or arrange for most health services that you will need. Your health benefits can help you stay as healthy as possible if you:

- Are pregnant;
- Are sick or injured;
- Experience a substance use disorder or have other behavioral health care needs;
- Need help getting to the doctor's office; or
- Need medications.

The section below describes the specific services covered by Aetna Better Health. Ask your PCP or call Member Services at

1-844-365-4385 (TTY: 711) if you have any questions about your benefits.

You can get services without going through your PCP. These include primary care, emergency care, women’s health services, family planning services, children’s screening services, services provided at local health departments, school-based services, and some behavioral health services. You can find more information about these services on page 14.

You will receive all SoonerSelect dental benefits from a separate dental plan that you choose. Your choices are DentaQuest (**1-833-479-0687** and TTY/TDY **1-800-466-7566**, Monday – Friday 8 AM – 5 PM CT) and LIBERTY Dental (**1-888-700-1093** Monday – Friday 6 AM – 6 PM CT). Aetna Better Health will provide transportation to your dental appointments. See page 34 for more information on how to schedule transportation.

Services Covered by Aetna Better Health’s Network

In most situations, you must get the services below from the providers who are in Aetna Better Health’s network. Services must be medically necessary and provided, coordinated or requested by your PCP. Talk with your PCP or call Member Services at **1-844-365-4385 (TTY: 711)** if you have any questions or need help with any health services.

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Advanced Practice Registered Nurse (APRN)	Covered.	Covered: Four (4) outpatient visits per month.	Limit can be exceeded based on medical necessity.
Allergy testing	Covered.	Covered. Limited to 60 tests every three years. Some services may require prior authorization. Limit can be exceeded based on medical necessity.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Alternative Treatment for Pain Management	Covered.	Physical therapy when provided in a non-hospital-based setting: <ul style="list-style-type: none"> a. Initial evaluation covered without prior authorization (PA). b. 12 hours per year requires PA. Chiropractic services: <ul style="list-style-type: none"> a. Initial evaluation covered without PA. b. 12 visits per year requires PA. PA limits can be exceeded based on medical necessity.	
Ambulance or emergency transportation	Covered.		
Ambulatory surgical center	Covered.		
Bariatric surgery	Covered, upon meeting pre-surgical evaluation and weight-loss requirements. Prior authorization required.	Covered, upon meeting pre-surgical evaluation and weight-loss requirements. Not covered for treatment of obesity alone. Prior authorization (PA) required.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Certified registered nurse anesthetist and anesthesiologist assistants	Covered.		
Chemotherapy	Covered.		
Clinic services	Covered. Some services may require a prior authorization (PA).		
Diabetes education	Covered, 10 hours per first year; 2 hours per subsequent year. Limits can be exceeded based on medical necessity and under EPSDT.	Covered, 10 hours per first year; 2 hours per subsequent year.	Covered, 10 hours per first year; 2 hours per subsequent year. Limits can be exceeded based on medical necessity.
Diagnostic testing entities	Covered. Some services may require prior authorization.		
Donor Human Breast Milk	Covered during the first year of life. Prior authorization required.	Not covered.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Durable medical equipment supplies and appliances	<p>Covered.</p> <p>Requires a prescription by a medical provider.</p> <p>Some services may require prior authorization (PA).</p>		
Early and Periodic Screening, Diagnostic and Treatment (EPSDT) and early intervention services, including health and immunization history; physical exams, various health assessments and counseling; lab and screening tests; necessary follow-up care; and applied behavioral analysis (ABA) services	<p>Covered.</p> <p>Some services may require prior authorization.</p>	<p>Not covered.</p>	
Emergency room/department	<p>Covered.</p>		
Eye care to treat a medical or surgical condition	<p>Covered.</p>		
Family planning services	<p>Covered.</p>		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Federally Qualified Health Center (FQHC) and rural health clinic services	Covered.		
Genetic counseling and testing	Covered for pregnant members and members meeting medical necessity criteria. May require prior authorization (PA).		
Hearing services	Covered. May require prior authorization.	Not covered.	
Home health care services	Covered.		
Hospice (non-hospital based)	Covered for members with a life expectancy of 6 months or less.	Not covered.	Covered for members with a life expectancy of 6 months or less.
Immunizations	Covered.		
Infusion therapy	Covered.	Covered when medically necessary and not considered a compensable part of the procedure.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Inpatient hospital services	Covered.	Covered: a. Inpatient hospital services (inpatient stay): no limit. b. Inpatient physician services: covered. c. Inpatient surgical services: no limit. d. Inpatient rehabilitation hospital services: 90 days per individual per state fiscal year (SFY).	Covered: a. Inpatient hospital services (inpatient stay): no limit. b. Inpatient physician services: covered. c. Inpatient surgical services: no limit. d. Inpatient rehabilitation hospital services: 90 days per individual per SFY. Amount limits can be exceeded based on medical necessity.
Laboratory, X-ray, diagnostic imaging and imaging (CT/PET scans and MRIs)	Covered. Some services may require prior authorization (PA).		
Lactation consultant (help with breastfeeding)	Covered for pregnant and postpartum members.		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Lodging and meals for the health plan member and/or one approved medical escort	Covered. Services require prior authorization.		
Long-term care hospital for children	Covered.	Not covered.	
Mammograms	Covered.		
Maternal and infant licensed clinical social worker (LCSW) services	Covered for pregnant and postpartum members.		
Non-emergency medical transportation (NEMT)	Covered.		
Nurse midwives	Covered under EPSDT.	Covered.	
Nursing facility and ICF-IID services	Covered for up to 60 days pending the level of care determination.		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Nutrition services (dietician)	Covered (includes dietician and nutritional counseling).	Covered up to 6 hours per year. Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating or preventing, or minimizing effects of illness.	Covered up to 6 hours per year. Nutritional services for treatment of obesity are not covered. Services must be for diagnosing, treating or preventing, or minimizing effects of illness. Limits can be exceeded based on medical necessity.
Orthotics	Covered.	Not covered.	Covered without limitations when medically necessary.
Outpatient hospital and surgery services	Covered.		
Parenteral/ enteral nutrition (IV and tube-feeding)	Covered. Some services may require prior authorization (PA).		
Personal care	Covered.		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Physician and physician assistant services	Covered.	Covered. Limit 4 visits per month (hard limit).	Covered. Limit to 4 visits per month. Limit can be exceeded based on medical necessity.
Podiatry	Covered.	Covered. All outpatient visits are subject to the 4-visit per month limit.	
Post-stabilization care services	Covered.		
Pregnancy and maternity services including prenatal, delivery and postpartum	Covered.		
Preventive care and screening	Refer to EPSDT coverage.	Covered for outpatient hospital services, other laboratory and X-ray services, diagnosis and treatment of conditions found, clinic services, screening services, and rehabilitative services. There is not a stand-alone preventive services benefit package for adults providing coverage for all services.	

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Private duty nursing	Covered up to 16 hours per day. Additional hours available for 30 days following a stay in the hospital or when regular caregiver is not available.	Not covered.	This service is substituted with skilled nursing under the home health services benefit.
Prosthetic devices	Covered when prior authorized.	Limited coverage with required prior authorization (PA). Only breast prosthesis and support accessories and prosthetic devices are covered when part of surgery.	Covered without limitations when medically necessary.
Public health clinic services	Covered.	Covered: 4 visits per month.	Covered: 4 visits per month. Limit can be exceeded based on medical necessity.
Radiation	Covered.		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Reconstructive surgery	Covered. May require prior authorization.	Covered. Non-cosmetic breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is medically necessary. May require prior authorization (PA).	
Renal dialysis facility services	Covered.		
Routine patient cost in qualifying clinical trials	Covered to the extent that the provision of the service would otherwise be covered outside of the participation in the clinical trial.		
School-based health related services	Covered.	Not covered.	
Telehealth	Covered.		

Service	Children (under 21)	Non-Expansion Adults (21 and over)	Expansion Adults (21 and over)
Therapy services: physical therapy (PT), occupational therapy (OT), and speech therapy (ST)	OT and PT: a. Initial evaluation covered without prior authorization (PA). b. Treatment requires prior authorization (PA). ST: a. Evaluation and treatment require prior authorization (PA).	Rehabilitative services: a. 15 visits per year for each OT, PT and ST (cumulative total 45 visits).	Habilitative services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits). Rehabilitative Services: a. 15 visits per year for each OT, PT and ST (cumulative total: 45 visits).
Organ transplant services	Covered with a prior authorization (PA). Cornea and kidney transplants do not require PA.		
Urgent care centers or facilities	Covered.	Up to 4 outpatient visits per month.	Up to 4 outpatient visits per month. Limit can be exceeded based on medical necessity.
Vision services	Covered, with a limit of 2 eyeglass frames per year.	Coverage to treat a medical or surgical condition only. No coverage for routine eye exams.	

Pharmacy

Talk with your pharmacist or call Member Services at **1-844-365-4385 (TTY: 711)** if you have any questions or need help with your pharmacy services.

Service	Children (under 21)	Non-Expansion Adults	Expansion Adults
Prescription drugs	Covered.	Covered. 6 prescription per month (includes specialty drugs). 2 of 6 prescriptions can be brand name per month. Up to 3 total prescriptions can be brand name drugs with prior authorization (PA) (within the 6-prescription limit). All can be generic. Some may require prior authorization (PA).	
Medication-assisted treatment services	Includes: <ul style="list-style-type: none"> • Drugs/agents used for substance use disorder treatment. • Opioid treatment programs (OTPs). • OTP services require prior authorization (PA). 		

Service	Children (under 21)	Non-Expansion Adults	Expansion Adults
Tobacco cessation products (to help you quit using tobacco)	<p>Nicotine replacement therapy (NRT) products (including patches, gum, lozenges, inhalers and nasal spray) and Zyban®/Bupropion to include combination therapy of these products are covered.</p> <p>Chantix®/Varenicline is covered up to 180 days per 12 months. Tobacco cessation products are covered without duration limits, PA or co-payment and do not count against monthly prescription limits.</p> <p>8 tobacco cessation counseling sessions with contracted providers per year.</p>		
Diabetic supplies (insulin, syringes, test strips, lancets and pen needles)	Covered.		
Family planning supplies	Covered.		
Enteral nutrition	<p>Covered if administered via gravity, syringe or pump.</p> <p>May require prior authorization (PA).</p>		

Behavioral Health Services (Mental Health and Substance Use Disorder Services)

Behavioral health care includes mental health (your emotional, psychological, and social well-being) and substance use (alcohol and drugs) disorder treatment and rehabilitation services. All members have access to services to help with mental health issues like depression or anxiety, or to help with alcohol or other substance use disorders. These services can include:

- Medication-assisted therapy (MAT)
- Tobacco cessation (to help you quit using tobacco)
- Behavioral health crisis services

- If you believe you need access to more intensive behavioral health services that your plan does not provide, talk with your PCP or call Member Services **1-844-365-4385 (TTY: 711)**.

Service	Children (Under 21)	Non-Expansion Adults	Expansion Adults
Applied Behavioral Analysis	Covered. Requires prior authorization (PA).	Not covered.	
Certified Community Behavioral Health (CCBH) Services	Covered.		
Day treatment services	Covered when prior authorized for a minimum of 3 hours per day for 4 days per week.	Not covered.	
Inpatient hospital – freestanding psychiatric	Covered. Requires prior authorization (PA).	Ages 21-64: Covered when prior authorized. Maximum of 60 days per episode. Ages 65 and older: Covered when prior authorized.	
Inpatient hospital – general acute	Covered. Requires prior authorization (PA).		
Licensed behavioral health provider (who can bill independently)	Covered. Requires prior authorization (PA).	Not covered.	

Medication-assisted treatment services	Covered. Includes: <ul style="list-style-type: none">• Suboxone® (buprenorphine/ naloxone SL films)• Vivitrol• Methadone	
Opioid treatment programs	Covered. Requires prior authorization (PA).	
Outpatient behavioral health agency services	Covered. Requires prior authorization (PA).	
Partial hospitalization	Covered when prior authorized for a minimum of 3 hours per day for 5 days per week.	
Peer recovery support services	Covered for ages 16-21 when prior authorized.	Covered. Prior authorization (PA) required.
Program for Assertive Community Treatment (PACT) services	Covered for ages 18-21.	Covered.
Psychiatric residential treatment facility	Covered. Prior authorization (PA) required.	Covered for individuals under 21. Prior authorization (PA) required.
Psychiatrist	Covered.	
Psychologist (who can bill independently)	Covered. Prior authorization (PA) required.	
Substance abuse treatment (outpatient, inpatient, and residential)	Outpatient substance abuse treatment: Covered when prior authorized. Residential substance abuse treatment: Covered.	

Targeted case management	Covered for targeted populations when prior authorized.	
Therapeutic behavioral services, family support and training	Covered for children with SED in a systems of care wraparound team.	Not covered.
Therapeutic foster care	Covered. Prior authorization required (PA).	Not covered.

Transportation Services

- **Emergency:** If you need emergency transportation (an ambulance), call **911**.
- **Non-emergency:** Aetna Better Health can arrange and pay for your transportation to help you get to and from your appointments for Medicaid-covered care. This service is free to you. If you need an attendant to go with you to your doctor’s appointment, or if your child (18 years old or younger) is a member of the plan, the transportation is also covered for the attendant or parent or guardian. Non-emergency transportation includes personal vehicles, taxis, vans, ambulatory vehicles, and public transportation.
- **How to get non-emergency transportation.** If you need transportation to receive covered benefits such as medical, behavioral, vision and pharmacy services, call the Aetna Better Health transportation provider, ModivCare, at **1-877-718-4208**.
- You will need to call ModivCare at **1-877-718-4208**, Monday through Friday from 7 AM to 8 PM. Call up to 72 hours before your appointment, excluding weekends and state holidays, to arrange transportation to and from your appointment.
- If you have your own ride to your appointment, your driver may be paid back at a set rate per mile (limits apply). Members, family, friends and caregivers are eligible for mileage reimbursement through ModivCare. You need to call ModivCare before your appointment to obtain a Trip Number and be eligible for reimbursement. Visit www.mymodivcare.com/members/ok and go to Forms to review the Mileage Reimbursement Program Instructions, Mileage Reimbursement Trip Log Instructions and download a Mileage Reimbursement Trip Log.

- Call ModivCare at **1-877-718-4208** as soon as you know you need to cancel your appointment.
- If you have trouble getting to an appointment or have transportation questions, call Member Services **1-844-365-4385 (TTY: 711)**. If we deny you transportation services, you have the right to appeal our decision. See page 47 for more information on appeals.
- Emergency Medical Transportation
 - If you are experiencing an emergency medical condition and need transportation to the hospital, call **911** for an ambulance. Aetna Better Health will cover an ambulance if you need it.

Other Covered Services

- Post-stabilization care services (provided after you have had an emergency medical condition to keep you safe).
- School-based health related services.
- Public health clinic services.
- Federally Qualified Health Center (FQHC) services.
- Services provided at your local health department.

Extra benefits

As a member of Aetna Better Health you'll receive all the additional services and extra benefits below. If you have questions on any of these, just give us a call at **1-844-365-4385 (TTY: 711)**.

Diabetes Care Program – Kidney Screening	If eligible, you can receive \$15 for completing a kidney screening.
Diabetes Care Program – Diabetic Retinal Eye Exam	If eligible, you can receive \$15 for completing a diabetic retinal eye exam.
Diabetes Care Program – A1c Testing	If eligible you can receive \$15 for completing an A1c test.

Diabetes Care Program – Healthy Foods	If eligible, you can receive \$50 per month to use towards healthy foods.
Go/Get Outside	Receive \$40 annually to use toward the Oklahoma City Zoo, the Tulsa Zoo or to get an Oklahoma state park pass.
Enhanced Transportation	Access to up to 10 non-medical transportation round trips per year. You can get a ride to job interviews, grocery stores and community health and social services.
Over the counter (OTC)	If you are 18 and older, your household can order \$25 per month of certain OTC drugs and supplies from our Aetna Better Health of Oklahoma catalog. Monthly supplies can be ordered online or by phone and mailed to your home.
Substance Use Disorder Support	You'll have access to an app that connects you to recovery support and services.
Pyx Health	Through Pyx Health, you can download an application that helps you fight loneliness. You can connect with compassionate people for a friendly chat or help with resources.
Mental Health Coaching	If you are 13 years or older, you will have access to mental health coaching that assists in strengthening emotional health. The app provides access to tools and support for: <ul style="list-style-type: none"> • Depression • Substance abuse • Tobacco cessation • Early pregnancy
Career & Life Skills Training/GED Support	If you are age 16 and up, you can get your General Education Diploma (GED) and learn new job skills. Access GED prep courses, get assistance in scheduling exam, if you pass you can take the GED at no cost.
Ted E. Bear, M.D. Club	The Ted E Bear MD Kids Club provides rewards for children age 0-13 years old when they complete activities and meet goals.

After School Engagement	If you are ages 5 – 18, you can get up to \$50 per year for activities at YMCAs, Boys and Girls Clubs, Boy Scouts or Girl Scouts, and other sports and afterschool programs.
Diaper Club	If you are eligible, you can receive up to \$45 monthly for diapers for children ages 2.5 and under.
Healthy Living for Children	Children ages 8-16 years old who are diagnosed with obesity receive \$50 toward home exercise, sports supplies and after school programs. You can also receive two family nutritional counseling sessions. When family members attend the two nutritional counseling sessions, you can earn \$20 incentive for each session and will qualify for an annual allowance of \$100 for youth sports and fitness fees.
Well-Child	If your child is 3 – 20 years old, they can receive \$25 for completing their well-child exam.
Notification of Pregnancy	If you are pregnant and complete a Notice of Pregnancy in your first trimester, you'll receive a \$25 gift card.
Initial Prenatal	When you complete your initial prenatal visit, you'll receive a \$25 gift card.
Subsequent Prenatal	You can earn additional \$10 gift cards when you see your provider for subsequent prenatal visits, up to \$100 maximum.
Postpartum	After your baby is born, you can receive \$25 for your first visit before 21 days post-delivery. You can receive an additional \$25 for your second visit within 22-84 days post-delivery.
Maternal Dental Visits	If you are pregnant, you can receive \$10 for your first dental visit and another \$10 for your second dental visit.
Childcare Financial Support	If you have a high-risk pregnancy, you can receive up to \$150 per quarter for childcare.
Postpartum Doula Visits	If eligible and based on provider, you may have access to extra postpartum visits.
Asthma Home Care	If you have an asthma diagnosis, you can receive hypoallergenic bedding, deep carpet cleaning and pest control services each year. You may receive up

	to \$150 to use towards these services in addition to the bedding.
Alternatives to Opioids	If you are 21 years and older with a chronic-pain diagnosis, you can receive up to \$500 to use towards acupuncture, massage therapy, dry-needling and yoga.
Adult Vision	\$150 every two years to cover glasses or contacts and \$75 towards an annual exam.
Traditional Healing	If you are eligible, you can receive up to \$400 a year for non-traditional healing practices if you select these healing methods.
"Keeping Kids Safe" Opioid Lockbox Program	If you are prescribed an opioid and have children in the home, you have access to a lockbox to secure medications.
Behavioral Health Follow-up Visit	If you are 6 years and older, you are eligible for a \$20 incentive for a follow up visit completed with a mental health practitioner within 7 days following an acute behavioral health inpatient hospitalization.
Waived Copays	Copays waived for all medical and behavioral health services except IP Hospital (ICU/CC, other room and board, routine) and outpatient hospital non-ER.
Short-term Housing Support	Upon discharge from an inpatient treatment facility for substance use, a member may be eligible for funding for short-term housing.
Post-discharge Meals	Eligible members can receive medical appropriate meals post discharge.

Extra Support to Manage Your Health

Managing your health care alone can be hard, especially if you are dealing with many health problems at the same time. If you need extra support to get and stay healthy, we can help. As a member of Aetna Better Health, you may have a care manager on your health care team. A care manager is a specially trained health professional who works with you and your doctors to make sure you get the right care when and where you need it.

Your care manager can:

- Coordinate your appointments and help arrange for transportation to and from your doctor;
- Support you in reaching your goals to better manage your ongoing health conditions;

- Answer questions about what your medicines do and how to take them;
- Follow up with your doctors or specialists about your care;
- Connect you to helpful resources in your community; and
- Help you continue to receive the care you need if you switch health plans or doctors.

Aetna Better Health can also connect you to a care manager who specializes in supporting:

- Management of chronic conditions
- Pregnancy care
- Substance Use Disorders
- Behavioral Health needs

To learn more about how you can get extra support to manage your health, talk to your PCP or call Member Services at **1-844-365-4385 (TTY: 711)**, 24 hours a day, 7 days a week.

Help With Problems Beyond Medical Care

It can be hard to focus on your health if you have problems with your housing or worry about having enough food to feed your family. Aetna Better Health can connect you to resources in your community to help you manage issues beyond your medical care.

Call the Member REACH Team at **1-833-316-7010 (TTY: 711)** if you need:

- Financial assistance
- Food assistance
- Educational services
- Housing assistance
- Legal services
- Employment services
- Support groups
- Baby supplies
- Clothing

The Member REACH (Real Engagement And Community Help) team is dedicated to understanding and assisting with member's individual needs and can connect you to local community programs that may be able to offer the above services.

Call **1-833-316-7010**, Monday through Friday, 8 AM-5 PM CT to talk to a Member REACH Coordinator.

Aetna Better Health of Oklahoma Member Advocates

Aetna Better Health's Advocates are also here for you. They have lived similar experiences and were also health plan members. They provide plan overviews and help you understand and make the most of your benefits. If you have questions, just call us at **1-844-365-4385 (TTY: 711)** or email us at Memberadvocateok@aetna.com.

Other Programs to Help You Stay Healthy

Aetna Better Health wants to help you and your family get and stay healthy. If you want to quit smoking or are a new mom who wants to learn more about how to best feed your baby, we can help connect you with the right program for support.

Call Member Services at **1-844-365-4385 (TTY: 711)** to learn more about:

Tobacco cessation services (support to help you stop smoking or dipping).
Oklahoma Tobacco Helpline (**1-800-QUIT-NOW**)

- SoonerStart. Oklahoma's early intervention program is designed to meet the needs of families with infants or toddlers (ages birth to 3 years old) with developmental delays and/or disabilities in accordance with the Individuals with Disabilities Education Act (IDEA). The program builds upon and provides supports and resources to assist family members to enhance infants or toddler's learning and development through everyday learning opportunities.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Benefit

Plan members under age 21 can get any treatment or health service that is medically necessary to treat, prevent or improve a health problem. This special set of benefits are called Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Members who need EPSDT benefits:

- Can get EPSDT services through their health plan;
- Do not have to pay any copays for EPSDT services; and

- Can get help with scheduling appointments and arranging for free transportation to and from the appointments.

Some EPSDT services may require a prior authorization (PA). EPSDT includes services that can help treat, prevent or improve a member's health issue, including, but not limited to:

- Health and immunization history;
- Physical exams;
- Various health assessments and counseling;
- Lab and screening tests;
- Necessary follow-up care; and/or
- Applied behavioral analysis (ABA) services.

If you have questions about EPSDT services, talk with your child's primary care provider (PCP). You can also find more information on EPSDT services online by visiting our website at [AetnaBetterHealth.com/Oklahoma](https://www.aetna.com/betterhealth/oklahoma) or by visiting the SoonerCare EPSDT web page at

<https://oklahoma.gov/ohca/providers/types/child-health-epsdt.html>

Services Not Covered

These are examples of some of the services that are not available from Aetna Better Health. If you get any of these services, you may have to pay the bill:

- Acupuncture.
- Chiropractic care.
- Cosmetic surgery.
- Infertility treatment.
- Weight loss programs.
- Services from a provider who is not part of Aetna Better Health unless it is a provider you are allowed to see as described elsewhere in this handbook or Aetna Better Health, or your primary care provider (PCP) sent you to that provider.
- Services for which you need approval in advance, and you did not get it.
- Services for which you need prior authorization (PA) in advance, and you did not get it.

- Medical services provided out of the country.
- Tattoo removal.

This list does not include all the services that are not covered. To determine if a service is not covered, call Member Services at **1-844-365-4385 (TTY: 711)**.

You may have to pay for any service that your PCP or Aetna Better Health does not approve. This includes:

- Services not covered (including those listed above).
- Unauthorized services.
- Services provided by providers who are not part of Aetna Better Health.

If You Get a Bill

In most cases, you do not have to pay for SoonerSelect services and should not get a bill from a provider. You may have to pay if you agreed in writing to pay for services not paid for by Aetna Better Health. If you get a bill for a treatment or service you do not think you should pay for, do not ignore it. Call Member Services at **1-844-365-4385 (TTY: 711)** right away. We can help you understand why you may have gotten a bill. If you are not responsible for payment, Aetna Better Health will contact the provider and help fix the problem for you.

You have the right to file an appeal if you think you are being asked to pay for something Aetna Better Health should cover. See the grievance and appeals section on pages 47-52 in this handbook for more information. If you have any questions, call Member Services at **1-844-365-4385 (TTY: 711)**.

Plan Member Copays

Some members may be required to pay a copay, or a fee you pay when you get certain health care services from a provider or pick up a prescription from a pharmacy:

Your Copays Under the Plan

Service	Amount	Explanation
Inpatient hospital	\$10 per day.	Up to \$75 maximum.
Outpatient hospital services	\$4 per visit.	
Outpatient clinic services	\$0 per visit.	

Service	Amount	Explanation
Ambulatory surgery	\$4 per visit.	
Physician services	\$0 per visit.	
Physician assistant/anesthesiologist assistant	\$0 per visit.	
Advanced practice nurse services	\$0 per visit.	
Optometrist services	\$0 per visit.	
Durable medical equipment	\$0 per item.	Blood glucose testing supplies and insulin syringes have \$0 copay.
Home health agency services	\$0 per visit.	
Rural health clinic services	\$0 per visit.	
Behavioral health and substance abuse services – Inpatient	\$0 per day.	
Behavioral health and substance abuse services – outpatient	\$0 per visit.	
Laboratory and X-ray	\$0 per visit.	
Prescription drugs	\$4 per prescription.	<ul style="list-style-type: none"> • Tobacco cessation products \$0 copay. • Prenatal vitamins \$0 copay. • Birth control \$0 copay. • Naloxone \$0 copay. • Medication assisted treatments for opioid use \$0 copay.
ACIP-recommended Vaccines	\$0 copay.	
Federally Qualified Health Centers (FQHC)	\$0 per visit.	

Service	Amount	Explanation
State plan personal care services	\$0 per visit.	
Physical therapy, occupational therapy, speech and audiologist therapy (PT/OT/ST)	\$0 per visit.	
Alternative treatment for pain management	\$0 per visit.	
Prosthetics and orthotics	\$0 per visit.	

There are no copays for the following members or services:

- Members under age 21.
- Members who are pregnant (and in their postpartum period.)
- Members receiving hospice care.
- American Indians/Alaska Natives.
- Children in foster care.
- Emergency services.
- Family planning services.
- Preventive services delivered to expansion adults.
- Provider preventable services.

If you have cost share questions, please call the SoonerCare Helpline at **1-800-987-7767**.

PART III: Plan Procedures

Our utilization management (UM) program helps you get the right care in the right place at the right time. UM staff can help you and your doctors make decisions about your healthcare. Our UM program helps make sure you get the right services at the right place. When we make decisions it's important for you to remember:

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

If you have questions about UM, you can speak to someone by calling Member Services toll-free at **1-844-365-4385 (TTY: 711)**, 24 hours a day, 7 days a week. If you need Language translation or assistance, you can contact Member Services toll -free at **1-844-365-4385 (TTY: 711)**.

Pharmacy Lock-in Program

To protect the health of our members, Aetna Better Health has a pharmacy lock-in program. This is for members who abuse or misuse prescription drugs. Members are assigned to one pharmacy and one doctor. You may change your doctor or pharmacy one time a year unless you have a special situation like moving. If you are placed in the program, you may be enrolled for a minimum of two years. We will review your enrollment at least every year. You can appeal being placed in the lock-in program. See the grievance and appeals section on pages 47-53 in this handbook for more information.

Prior Authorization and Actions

Aetna Better Health will need to approve some treatments and services before you receive them. Aetna Better Health may also need to approve some treatments or services for you to continue receiving them. This is called prior authorization. For a list of services that require a prior authorization, please see the chart in the "Services Covered by Aetna Better Health's Network" section of this handbook, 19.

- Typically, your primary care provider (PCP) will submit the prior authorization to Aetna Better Health for you through the provider portal, by faxing a request form, or by calling the prior authorization team directly.

Asking for approval of a treatment or service is called a prior authorization request. To get approval for these treatments or services you or your doctor may call Member Services at **1-844-365-4385 (TTY: 711)**.

Prior Authorization Requests for Children Under Age 21

Special rules apply to decisions to approve medical services for children under age 21 receiving Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. To learn more about EPSDT services, see page 41 or visit our website at [AetnaBetterHealth.com/Oklahoma](https://www.aetna.com/betterhealth/oklahoma).

What Happens After We Get Your Prior Authorization Request?

The health plan has a review team to be sure you get the services we promise and that you need. Qualified healthcare professionals (such as doctors and nurses) are on the review team. Their job is to be sure that the treatment or service you asked for is covered by your plan and that it will help with your medical condition. They do this by checking your treatment plan against medically acceptable standards.

After we get your request, we will review it under either a standard or an expedited (faster) process. You or your doctor can ask for an expedited review if a delay will cause serious harm to your health. In all cases, we will review your request as fast as your medical condition requires us to do so but no later than described timeframes noted within the next section of this handbook.

We will tell you and your provider in writing if your request is approved or denied. We will also tell you the reason for the decision. We will explain what options you will have for an appeal when you don't agree with our decision.

Any decision to deny a prior authorization (PA) request or to approve it for an amount that is less than requested is called an adverse benefit determination. These decisions will be made by a health care professional. You can request the specific medical standards at no cost to you, called clinical review criteria, used to make the decision for adverse benefit determinations related to medical necessity.

Prior Authorization and Timeframes

We will review your request for a prior authorization (PA) within the following timeframes:

- **Standard review:** We will make a decision about your request within 72 hours after we receive it.
- **Expedited (faster) review:** We will decide about your request, and you will hear from us within 24 hours.
- **Inpatient Behavioral Health:** We will make a decision about your request within 24 hours.

If additional information is needed to make the decision, the review could take up to an additional 14 days. If this happens, Aetna Better Health will send you a written notice along with information on how to file an appeal on the extension.

- In most cases, if you are receiving a service and a new request is made to keep receiving a service, we must tell you at least 10 days before we change the service if we decide to reduce, stop or restrict the service. **If we approve a service and you have started to receive that service, we will not reduce, stop or restrict the service during the approval period unless we determine the approval was based on information that was known to be false or wrong.**
- If we deny payment for a service, we will send a notice to you and your provider the day the payment is denied. These notices are not bills.

How You Can Help with Plan Policies

We value your ideas. You can help us develop policies that best serve our members. Maybe you would like to work with one of the member committees in our health plan or with OHCA, like:

- Aetna Better Health Advisory Board; and /or
- Aetna Better Health Behavioral Health Advisory Board (BHAB).

Call Member Services at **1-844-365-4385 (TTY: 711)** to learn more about how you can help.

Appeals

If you are not satisfied with our decision about your care or received an adverse benefit determination, you have the right to file an appeal.

To file an appeal, write to:

PO Box 81139
5801 Postal Road
Cleveland, OH 44181

To file an appeal by phone, call Member Services at **1-844-365-4385 (TTY: 711)**.

- If you are not satisfied with an action we took or what we decided about your prior authorization (PA) request (see page 45 about prior authorizations and actions), you can file an appeal at any time. An appeal is a request for us to review the decision.
- You can do this yourself or, with your written consent, your authorized representative or your provider can call Member Services at **1-844-365-4385 (TTY: 711)** or visit our website at Aetna Better Health if you need help filing an appeal.
- The appeal can be made by phone or in writing. You don't have to use any specific or legal terms as long as you clearly state that you are dissatisfied with the decision we made. We can help you complete the appeal form. If needed, auxiliary aids and services will be provided to you upon request and free of charge.
- If your appeal review needs to be reviewed more quickly than the standard timeframe because you have an immediate need for health services, you may request an expedited (faster) appeal.
- **Standard appeals:** If we have all the information we need, we will tell you our decision in writing within 30 days after your appeal is received.
- **Expedited (faster) appeals:** If we have all the information we need, we will call you and send you a written notice of our decision within 72 hours from when we receive your appeal. We'll let you know we received your expedited appeal within 24 hours.
- You may file a grievance (see page 52 for more about grievances) if your request for an expedited (fast tracked) appeal is denied.
- We will not treat you any differently or act badly toward you because you file an appeal.
- Before and during the appeal, you or your representative can see your case file, including medical records and any other documents and records being used to decide your case.

- You can ask questions and give any information (including new medical documents from your providers) that you think will help us to approve your request. You may do that in person, in writing or by phone.
- If you need assistance with the appeals process, have questions, or want to check the status of your appeal, you can call Member Services at **1-844-365-4385 (TTY: 711)**.

More Information for Appeals

If we need more information to make either a standard or an expedited (faster) decision about your appeal, we may extend the time to resolve your appeal. If so, we will:

- Write you and tell you what information is needed. For expedited appeals, we will call you right away and send a written notice later.
- Explain why the delay is in your best interest.
- Make a decision no later than 14 days from the original decision date.

If you need more time to gather your documents and information, just ask. You, your provider, or someone you trust may ask us to delay your case until you are ready. We want to make the decision that supports your health best. You can request more time by calling Member Services at **1-844-365-4385 (TTY: 711)**, or writing to:

Aetna Better Health of Oklahoma
777 NW 63rd Street, Suite 100
Oklahoma City, OK 73116

Our Decision on Your Appeal

If we agree with you that we should not have reduced or stopped services you were already receiving, we will send you a notice of resolution of the appeal telling you that we granted your appeal. If we still disagree with you and believe we were right to have reduced or stopped services you were already receiving, we will send you a notice of adverse resolution of the appeal telling you that we denied your appeal. If you disagree with the adverse resolution of the appeal, you have the right to request a State Fair Hearing. See the next section on page 48 for important details about timing and filing your request.

Your Care While You Wait for a Decision on Your Appeal

- When the health plan's decision reduces or stops a service you were already receiving, you can ask to continue the services your provider had already ordered while we are making a decision on your appeal. You can

also ask an authorized representative to make that request for you. Providers are not allowed to ask for your services to continue for you.

- While you are waiting for us to make a decision on your appeal, if you want to continue services you were already receiving, be sure to ask us to continue those services at the time you file your appeal.
- If we continue the services that you were already receiving, we will pay for those services if your appeal is decided in your favor. **Your appeal might not change the decision the health plan made about your services.**
- When your appeal doesn't change the health plan's decision, the health plan may require you to pay for the services you received while waiting for a decision.

If you are unhappy with the result of your appeal, you can ask for a State Fair Hearing.

State Fair Hearings

After you receive a notice of adverse resolution to your appeal and you still don't agree with the decision that we made that reduced, stopped, or restricted your services, you can ask for a State Fair Hearing. A State Fair Hearing is your opportunity to give more information and ask questions about the decision in front of an administrative law judge. The judge in your State Fair Hearing is not a part of your health plan in any way.

If you want to continue benefits while you wait for the administrative law judge's decision about your State Fair Hearing, you should say so at the time you request a State Fair Hearing.

- **If you need help with understanding the State Fair Hearing process,** you can call Member Services at **1-844-365-4385 (TTY: 711)**. You don't have to use any special legal or formal language to request a State Fair Hearing as long as you clearly state that you are dissatisfied with the decision we made.

Your Care While You Wait for a Decision on your State Fair Hearing

- If you requested and received continued services during your appeal, we must continue providing those services until you do one of the following:
 - You withdraw your appeal or your request for State Fair Hearing, or
 - A State Fair Hearing officer issues a hearing decision that disagrees with you.

- You can also ask a trusted representative to make that request for you.
- If you ask your health plan to continue services you already receive during your State Fair Hearing case, the health plan will pay for those services if your case is decided in your favor. Your State Fair Hearing might not change the decision the health plan made about your services.

Requesting a State Fair Hearing

- You don't have to use any special legal or formal language to request a State Fair Hearing as long as you clearly state that you are dissatisfied with the decision we made.
- You must first file an appeal with Aetna Better Health and receive our decision before requesting a State Fair Hearing. If we don't decide your appeal within 30 days of your appeal request, you can also ask for a State Fair Hearing.
- You don't need an attorney for your State Fair Hearing, but you may use one.
- You may represent yourself or allow someone else to represent you.
- If you allow someone else to represent you, they will have to show proof in writing that you asked for their help.
- Without this written proof, your appeal will be rejected.
- You can ask for a State Fair Hearing at any time within 120 days from the day we send you notice of adverse resolution.
- You can use one of the following ways to request a fair hearing below:
 1. By phone – **405-522-7217**
 2. By internet www.okhca.org
 3. By mail 4345 N. Lincoln Blvd, Oklahoma City, OK 73105

If You Have Problems with Your Health Plan

We hope our health plan serves you well. If you have a problem, talk with your primary care provider (PCP) and call Member Services at **1-844-365-4385 (TTY: 711)** or write to:

Aetna Better Health of Oklahoma
 777 NW 63rd Street, Suite 100
 Oklahoma City, OK 73116

Most problems can be solved right away. If you have a problem with your health plan, care, provider, or services, you can file your complaint with Aetna Better Health. **This kind of complaint is called a grievance.** Problems that are not solved right away over the phone and any grievance that comes in the mail will be handled according to our grievance procedures described below.

You can ask someone you trust (your authorized representative) to file the grievance for you. If you need our help because of a hearing or vision impairment, if you need translation services, or if you need help filling out the forms, we can help you. We will not make things hard for you or take any action against you for filing a grievance.

You may also file a complaint with the Oklahoma Insurance Department by going to www.oid.ok.gov/consumers/file-an-online-complaint/.

If You Are Unhappy with Your Plan: How to File a Grievance

If you are unhappy with your health plan, provider, care or your health services, you can file a grievance (a formal complaint) with Aetna Better Health. You can file a grievance by phone or in writing at any time.

To file by phone, call Member Services at **1-844-365-4385 (TTY: 711)**, 24 hours a day, 7 days a week.

To file in writing, you can write us with your grievance to
Aetna Better Health of Oklahoma
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

What Happens Next?

- We will let you know in writing that we got your grievance within 10 days of receiving it.
- We will decide the resolution of a grievance within 30 days after receiving your grievance.
- We will tell you how we resolved it in writing within 3 days after we resolve the grievance.

Your Care When You Change Health Plans or Doctors

- If you choose to leave Aetna Better Health, we will share your health information with your new plan. You can finish receiving any services that have already been authorized by your previous health insurance or SoonerCare, even if the provider you are seeing is an out-of-network provider. Prior authorizations will be honored until the services are used or until 90 days after your new plan benefits begin, whichever comes first. After that, we will help you find a provider in our network to get any additional services if you need them.
- If you are pregnant when you join Aetna Better Health you can continue the care that you were receiving before you joined our plan. You can continue seeing your doctor even if he or she is an out-of-network provider.
- If you are receiving chemotherapy or radiation treatment, dialysis, major organ or tissue transplant services, bariatric surgery, Synagis treatment, medications for hepatitis C treatment or if you are terminally ill, when you change plans you can continue your current treatment plan.
- Children receiving private duty nursing services will continue to receive these services. These services will only change if we perform a new assessment and determine your child needs different services.
- We will continue to cover your out-of-state services and/or meals and lodging assistance if it is already being received from SoonerCare when you join our plan.
- If you are receiving services for hemophilia, those services will continue being provided by your current hemophilia providers for up to 120 days even if the provider is out-of-network. After 120 days, we can help you find a network provider.
- If you are on a current treatment plan and receiving behavioral health services, you may keep seeing your current behavioral health treatment provider(s) for up to 120 days, even if the provider is out-of-network. After 120 days, we can help you find a network provider.
- If you are waiting for durable medical equipment (DME) or supplies authorized and ordered prior to joining our plan, we will help you to receive these items on time.
- If your PCP leaves Aetna Better Health, we will tell you in writing within 15 days from when we know about this. We will tell you how you can choose a new PCP or choose one for you. If you do not want the PCP that we chose, you can call Member Services to change at any time.

- PCP's terminating their contracts with Aetna Better Health of Oklahoma are required to provide a notice before terminating with Aetna Better Health of Oklahoma. Providers must also continue to treat our members until the treatment course has been completed if in active treatment or care is transitioned. An authorization may be necessary for these services. Members who lose eligibility and continue to have medical needs must be referred to a facility or provider that can provide the needed care at no or low cost.

If you have any questions, call Member Services at **1-844-365-4385 (TTY: 711)**.

Member Rights and Responsibilities

Your Rights

As a member of Aetna Better Health, you have a right to:

- Receive information on the SoonerSelect program and Aetna Better Health.
- Be treated with respect and with due consideration for your dignity and privacy.
- Receive information on available treatment options and alternatives, in a way you understand.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records, and to request that they be amended or corrected.
- Obtain available and accessible health care services covered by Aetna Better Health.

Your Responsibilities

As a member of Aetna Better Health, you agree to the following responsibilities:

- Check Aetna Better Health information, correct inaccuracies and allow government agencies, employers and providers to release records to OHCA or Aetna Better Health.

- Notify OHCA or Aetna Better Health within 10 days if there are changes in income, the number of people living in the home, address or mailbox changes, or health insurance changes.
- Transfer, assign, and authorize to OHCA all claims you may have against health insurance, liability insurance companies or other third parties. This includes payments for medical services made by OHCA for any dependents.
- Work on requests for assistance from the Office of Child Support Services.
- Allow SoonerCare to collect payments from anyone who is required to pay for medical care.
- Share necessary medical information with any insurance company, person or entity who is responsible for paying the bill.
- Inspect any medical records to see if claims for services can be paid.
- Obtain permission for Oklahoma Human Services or Oklahoma Health Care Authority to make payment or overpayment decisions.
- Keep your identification card and know your Social Security number to receive health care services or prescriptions.
- Confirm that any care received is covered.
- Understand how and when to request non-emergency medical transportation (NEMT) services.
- Cost sharing.
- Ensure all information provided to OHCA or Aetna Better Health is complete and true upon penalty of fraud or perjury.

Disenrollment Options

If You Want to Leave the Plan

- You can try us out for 90 days. You may leave Aetna Better Health and join another healthplan at any time during the first 90 days after you begin to receive health plan benefits. You don't have to have a reason to switch plans.
- You can also switch health plans once every 12 months. This change happens through open enrollment.

- If you want to leave Aetna Better Health at any other time, you can do so **only** with a good reason (good cause). Some examples of good cause include:
 - You need related services to be performed at the same time, not all services are available within Aetna Better Health’s network, and getting the services separately would put your health at risk,
 - You have a complex medical condition and another health plan can better meet your needs,
 - You have filed and won a grievance about poor quality of care, lack of access to services we must provide, lack of access to providers experienced in dealing with your needs, or any other issue that would support disenrollment,
 - You were enrolled by mistake.
- If you have a good reason to disenroll from Aetna Better Health, you must submit your request using the grievance process on page 52. We will review the request within 10 days from when you filed the grievance. If you are unhappy with the disenrollment decision, we will refer the request to the Oklahoma Health Care Authority for the final decision.

You Could Become Ineligible for SoonerSelect

You may have to leave Aetna Better Health if you:

- Are no longer eligible for Medicaid. If you become ineligible for Medicaid, all your services may stop immediately.
- Begin receiving Medicare.
- Transition to an eligibility group that does not participate in SoonerSelect.
- Become a foster child under state custody.
- Become a juvenile in the justice system under state custody.
- Become an inmate of a public institution.
- Commit fraud or provide fraudulent information.
- Are ordered by a hearing officer or court.

We Can Ask You to Leave Aetna Better Health

You can also lose your Aetna Better Health membership if you:

- Abuse or harm to plan members, providers or staff.

- Were enrolled in error.
- Have a complex medical condition and another health plan can better meet your needs.
- Do not fill out forms honestly or do not give true information. This is considered fraud.

Advance Directives

There may come a time when you become unable to manage your own health care and a family member or other person close to you is making decisions on your behalf. By planning in advance, you can arrange now for your wishes to be carried out. An advance directive is a set of directions you give about the medical and mental health care you want if you ever lose the ability to make decisions for yourself. For example, some people do not want to be put on life-support machines if they go into a coma.

Making an advance directive is your choice. If you become unable to make your own decisions, and you have no advance directive, your doctor or behavioral health provider will consult with someone close to you about your care. Discussing your wishes for medical and behavioral health treatment with your family and friends now is strongly encouraged, as this will help to make sure that you get the level of treatment you want if you can no longer tell your doctor or other physical or behavioral health providers what you want. Your advance directives, no matter the type, should be given to your primary care provider (PCP) and your care manager at Aetna Better Health.

Oklahoma has three ways for you to make a formal advance directive. These include living wills, health care power of attorney, and advance instructions for mental health treatment. Aetna Better Health does not place any limitations on conscience objections to implementation of a member's advance directive.

Living Will

In Oklahoma, a living will is a legal document that tells others whether or not you want to die a natural death if you:

- Become incurably sick with an irreversible condition that will result in your death within a short period of time,
- Are unconscious and your doctor determines that it is highly unlikely that you will regain consciousness, or

- Have advanced dementia or a similar condition which results in a substantial cognitive loss, and it is highly unlikely the condition will be reversed.

In a living will, you can direct your doctor not to use certain life-prolonging treatments such as a breathing machine (called a “respirator” or “ventilator”), or to stop giving you food and water through a feeding tube.

A living will go into effect only when your doctor and one other doctor determine that you meet one of the conditions specified in the living will. Discussing your wishes with family, friends and your doctor now is strongly encouraged so that they can help make sure that you get the level of care you want at the end of your life.

Health Care Power of Attorney

A Health Care Power of Attorney is a legal document in which you can name one or more people as your health care agents to make medical and behavioral health decisions for you as you become unable to decide for yourself, for as long as you choose. You can always say what medical or behavioral health treatments you would want and would not want. You should choose an adult you trust to be your health care agent. Discuss your wishes with the people you want as your agents before you put them in writing. Your designated Power of Attorney will be able to have access to your medical information and medical records, for as long as that person is so designated, up to your death.

Again, it is always helpful to discuss your wishes with your family, friends and your doctor. A Health Care Power of Attorney will go into effect when a doctor states in writing that you are not able to make or to communicate your health care choices. If, due to moral or religious beliefs, you do not want a doctor to make this determination, the law provides a process for a non-physician to do it.

Advance Instruction for Mental Health Treatment

An Advance Instruction for Mental Health Treatment is a legal document that tells doctors and mental health providers what mental health treatments you would want and what treatments you would not want if you later became unable to decide for yourself. It can also be used to nominate a person to serve as guardian if guardianship proceedings are started. Your advance instruction for behavioral health treatment can be a separate document or combined with a Health Care Power of Attorney or a General Power of Attorney. An Advance Instruction for Behavioral Health may be

followed by a doctor or behavioral health provider when your doctor or an eligible psychologist determines in writing that you are no longer able to make or communicate behavioral health decisions.

You can change your mind and these documents at any time. We can help you understand or get these documents. They do not change your right to quality health care benefits. The only purpose is to let others know what you want if you can't speak for yourself. Talk to your primary care provider (PCP) or call Member Services at **1-844-365-4385 (TTY: 711)** if you have any questions about advance directives.

Fraud, Waste and Abuse

If you suspect that someone is committing Medicaid fraud, report it. Some examples of Medicaid fraud include (not limited to):

- An individual does not report all income or other health insurance when applying for Medicaid.
- An individual who does not get Medicaid uses a Medicaid member's card with or without the member's permission.
- A doctor or a clinic bills for services that were not provided or were not medically necessary.

You can report suspected fraud and abuse in any of the following ways:

- Call the Medicaid Fraud, Waste and Program Abuse Tip Line at **1-800-784-5887 OHCA Medicaid Unit**
- Call the U.S. Office of Inspector General's Fraud Line at **1-800-447-8477 HHS.GOV OIG**

Important Phone Numbers

- Member Services **1-844-365-4385 (TTY: 711)**, 24 hours a day, 7 days a week.
- Behavioral Health Crisis Line **988**, 24 hours a day, 7 days a week.
- Nurse Line **1-844-365-4385 (TTY: 711)**, 24 hours a day, 7 days a week.
- EyeMed **1-844-844-0908 (TTY: 711)**
- LIBERTY Dental **1-888-700-1093**
- DentaQuest **1-833-479-0687**
- ModivCare non-emergency transportation **1-877-718-4208**, Monday - Friday from 7 AM to 8 PM

- SoonerCare Helpline **1-800-987-7767**
- Advance Health Care Directive Registry phone number **405-426-8030**
- OK Medicaid Fraud, Waste and Abuse Tip Line **1-833-898-1441**
- State Auditor Waste Hotline **405-521-3495**
- U. S. Office of Inspector General Fraud Line **1-800-HHS-TIPS (1-800-447-8477)**

Keep Us Informed

Call Member Services at **1-844-365-4385 (TTY: 711)** whenever these changes happen in your life:

- You have a change in Medicaid eligibility.
- You become pregnant or give birth.
- There is a change in Medicaid coverage for you or your children.
- Someone in your household goes into state custody.
- You begin receiving Medicare.
- You move.

PART IV: Health & Wellness Information

Children's Health

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

Children need to get their child health checkups at the ages listed below:

3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months
18 months	24 months/2 years	3 years
4 years	5 years	6 years
7 years	8 years	9 years
10 years	11 years	12 years
13 years	14 years	15 years
16 years	17 years	18 years
19 years	20 years	

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

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

Preventive Health Care for Adults

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

Preventive health guidelines

Aetna Better Health of Oklahoma takes an active role in the health of its members. We have preventive health guidelines to assist you in staying healthy. Screening tests can find diseases early when they are easier to treat. Talk to your doctor about which ones apply to you and how often you should be tested or contact Member Services at **1-844-365-4385 (TTY: 711)**.

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

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression screening
- Prostate and colorectal screenings

You can also ask your doctor about:

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

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

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

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

Hospital Care

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

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

Routine Care

Routine care is for things like:

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

Mental Health and Substance Abuse Services

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

Signs and symptoms of substance abuse:

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

If you have questions about your mental health or substance abuse benefits call Member Services **1-844-365-4385 (TTY: 711)**. You can also call Behavioral Health Crisis Line **988** or your local Certified Community Behavioral Health Clinic (CCBHC).



Aetna Better Health® of Oklahoma

Nondiscrimination Notice

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

Aetna:

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

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

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

Address: Attn: Civil Rights Coordinator
PO Box 818001
Cleveland, OH 44181-8001
Telephone: **1-888-234-7358 (TTY 711)**
Email: **MedicaidCRCoordinator@aetna.com**

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

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

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

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