2020-2021 Member Handbook

Learn about your health care benefits

AetnaBetterHealth.com/Maryland

aetna™

Aetna Better Health® of Maryland

92.07.305.0-MD A

Helpful Information

Member Services
1-866-827-2710 (toll-free)
24 hours a day, 7 days a week

Services for Hearing and Speech-Impaired (TTY)
Call **711**

24-Hour Nurse Line
1-866-827-2710 (toll-free)
24 hours a day, 7 days a week

Vision
1-866-827-2710 (toll-free)

Behavioral Health
1-800-888-1965 (toll-free)

Mailing address
Aetna Better Health of Maryland
509 Progress Drive, Suite 117
Linthicum, MD 21090

Interpreter service
You have the right for someone to help you with any communication issue you might have. There is no cost to you.
Call **1-866-827-2710** (toll-free).

Maryland Medicaid Enrollee Help Line
1-800-284-4510

Emergency (24 hours)
If you have a medical condition which could cause serious health problems or even death if not treated immediately, call **911**.

Website
AetnaBetterHealth.com/Maryland

Personal Information

_____
My PCP (Primary care physician)

_____
My member ID number

_____
My PCP's phone number

1. HealthChoice Overview

Dear Member,
Thank you for choosing Aetna Better Health® of Maryland as your Maryland HealthChoice Medicaid health plan. HealthChoice is a Program of the Maryland Department of Health. By choosing Aetna Better Health of Maryland, you have chosen a health plan that has been providing health care to families for over 150 years.

We have many providers ready to help keep you and your family well. We also have a caring member services staff ready to answer your health care coverage questions and assist with your needs and questions.

This member handbook tells you about our health plan. Most of what you need to know about getting care is covered in this handbook including:

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

You may have already received your Aetna Better Health of Maryland identification card (ID). Your ID card tells you when your membership starts and the name of your PCP. Please call us at **1-866-827-2710 (TTY: 711)** if:

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

If you have questions or problems getting services, we are here to help you. We are here to take your call 24 hours a day, 7 days a week. Our toll-free phone number is **1-866-827-2710 (TTY: 711)**. To view this handbook online, find information about our programs and services, or find a provider, go to our website at **AetnaBetterHealth.com/Maryland**. We look forward to providing your health care benefits!

Sincerely,

Angelo D. Edge
Chief Executive Officer

Nondiscrimination Statement

It is the policy of Aetna Better Health of Maryland not to discriminate on the basis of race, color, national origin, sex, age or disability. Aetna Better Health of Maryland has adopted an internal grievanceprocedure providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of Civil Rights Coordinator, 4500 East Cotton Center Boulevard, Phoenix, AZ 85040; Phone **1-888-234-7358 (TTY 711)**; Email **MedicaidCRCoordinator@aetna.com**; who has been designated to coordinate the efforts of Aetna Better Health to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for Aetna Better Health of Maryland to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinator will maintain the files and records of Aetna Better Health of Maryland relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including

a notice to the complainant of their right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is 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, DC 20201. 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html. Such complaints must be filed within 180 days of the date of the alleged discrimination.

Aetna Better Health of Maryland will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinator will be responsible for such arrangements

Table of Contents

1. HealthChoice Overview

1. HealthChoice Overview

A. What is Medicaid

Medicaid, also called Medical Assistance, is a health insurance (coverage of expenses incurred from health services) program that is administered by each state along with the federal government. Maryland Children's Health Program (MCHP), a branch of Medicaid, provides health insurance to children up to age 19. Medicaid provides coverage for:

- Low income families
- Low income pregnant women
- Low income children - Higher income families may have to pay a premium (monthly fee)
- Low income adults and
- Low income individuals with disabilities

B. What is HealthChoice

HealthChoice is Maryland's Medicaid Managed Care program. The HealthChoice Program provides health care to most Maryland Medicaid participants. HealthChoice members must enroll in a Managed Care Organization (MCO). Members get to choose their MCO (also referred to as a plan) as well as a primary care provider (PCP). A PCP can be a physician, physician's assistant or nurse practitioner. The PCP will oversee and coordinate your medical care. Some Medicaid recipients are not eligible for HealthChoice. They will receive their health care benefits through the Medicaid fee-for-service system.

MCOs are health care organizations that provide health care benefits to Medicaid recipients in Maryland. General health care benefits include (see pages 19-25) for a full listing of HealthChoice benefits):

- Physician Services - services provided by an individual licensed to provide inpatient/outpatient health care
- Hospital Services - services provided by licensed facilities to provide inpatient/outpatient benefits
- Pharmacy Services - services to provide prescription drugs and medical supplies

MCOs contract with a group of licensed/certified health care professionals (providers) to provide covered services to their enrollees, called a network. MCOs are responsible to provide or arrange for the full range of health care services covered by the HealthChoice

program. There are some benefits that your MCO is not required to cover but the State will cover.

HealthChoice benefits are limited to Maryland residents and generally limited to services provided in the State of Maryland. Benefits are not transferrable to other states. In some cases the MCO may allow you to get services in a nearby state if the provider is closer and in the MCO's network.

C. How to Renew Medicaid Coverage

To keep HealthChoice you must have Medicaid. Most people need to reapply yearly. You will receive a notice when it is time to renew. The State may automatically renew some individuals. You will receive a notice telling you what is required. If you lose Medicaid the State will automatically remove you from HealthChoice. There are several ways to renew Medicaid:

- **Maryland Health Connection**
  - Individuals eligible to apply/renew through Maryland Health Connection:
    - Adults under age of 65;
    - Parent/caretaker relatives;
    - Pregnant women; and
    - Children, and former foster care children.
  - Online**: www.marylandhealthconnection.gov**
  - Calling: **1-855-642-8572** (TTY: **1-855-642-8573**)
- **myDHR**
  - Individuals eligible to apply/renew through myDHR:
    - Aged, blind, or disabled (ABD);
    - Current foster care children or juvenile justice;
    - Receiving Supplemental Security Income (SSI); and
    - Qualified Medicare Beneficiaries (QMB) or Specified Low-income Medicare Beneficiaries (SLMB).
  - Online**: https://mydhrbenefits.dhr.state.md.us**
- **Department of Social Services (DSS) or Local Health Department (LHD)**
  - All individuals can apply
  - To get connected with DSS call **1-800-332-6347**
  - To get connected with a LHD see page 13

D. HealthChoice/MCO Enrollment

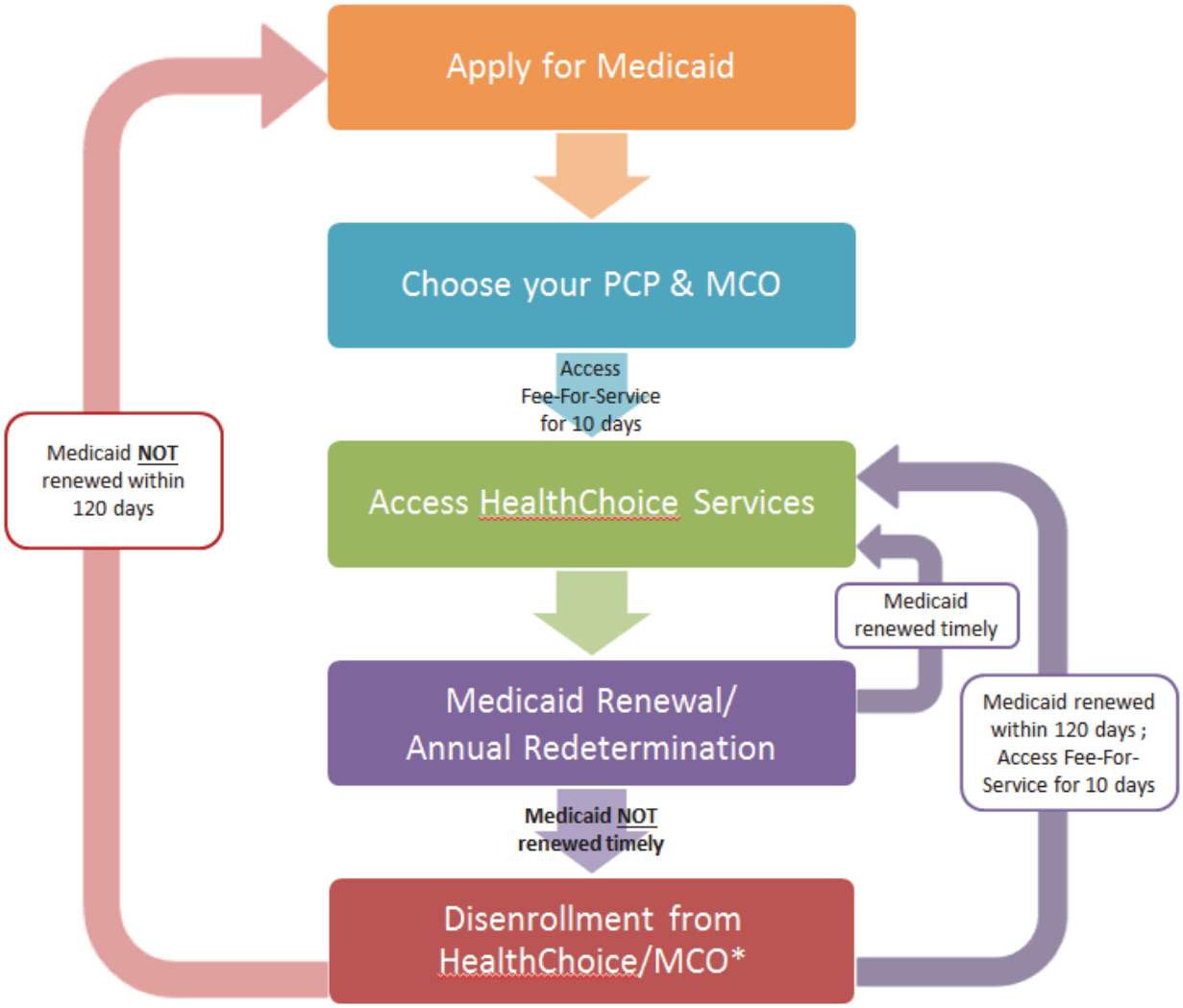
If you received this MCO Member Manual you have been successfully enrolled in HealthChoice. The State sent you an enrollment packet explaining how to select an MCO. If you did not choose an MCO the State automatically assigned you to an MCO in your area. It takes 10 -15 days after you chose or were automatically assigned until you are enrolled in HealthChoice. Until then you could use the red and white Medicaid card from the State.

You must now use your MCO ID card when you get services. If the MCO assigned you a different number your Medicaid ID will also be the MCO member ID card. The phone number for MCO Member Services and the HealthChoice Help Line (**1-800-284-4510**) are both on your card. If you have questions always call MCO Member Services first. If you did not receive your MCO member ID card or the card is misplaced, call the MCO Member Services (see Attachment A).

Communication is key in ensuring your health care needs are met. Help the MCO to better serve you. If you enrolled by phone or on-line you were asked to complete the Health Service Needs Information form. This information helps the MCO to determine what kinds of services you may need and how quickly you need services. If the form is not completed, we will make efforts to contact you so we know what your needs are.

The MCO will assist you in receiving needed care and services. If you kept your same PCP but it has been three months since your last appointment, call to see when you are due for a wellness visit. If you selected a new PCP make an appointment now. It is important that you get to know your PCP. The PCP will help to coordinate your care and services. The PCP will help to coordinate your care and services. The MCO will assist you in receiving the needed care and services.

E. HealthChoice Enrollment Process



*The State will disenroll you from HealthChoice and your MCO when Medicaid is NOT renewed timely.

F. HealthChoice Eligibility/Disenrollment

You will remain enrolled in the HealthChoice Program and in the MCO unless you fail to renew or are no longer eligible for Medicaid. If your Medicaid is cancelled the State will automatically cancel your enrollment in the MCO.

Even if you still qualify for Medicaid there are other situations that will cause the State to cancel your MCO coverage. This happens when:

- You turn age 65 – regardless of whether you enroll in Medicare
- You enroll in Medicare earlier than age 65 because of disability
- You are in a Nursing Facility longer than 90 days or lose Medicaid coverage while in the Nursing Facility
- You qualify for Long Term Care
- You are admitted to an intermediate care facility for individuals with intellectual disabilities
- You are incarcerated (a judge has sentenced you to jail or prison)
- You move to a different state.

If you lose Medicaid eligibility but regain coverage within 120 days, the State will re-enroll you with the same MCO. However your enrollment back into the MCO will take 10 days before it is effective. Until then you can use your red and white Medicaid card if your provider accepts it.

Always make sure the provider accepts your insurance otherwise you may be responsible for the bill. Also remember Medicaid and HealthChoice are State run programs. They are not like the federal Medicare program for the elderly and disabled. HealthChoice is only accepted in Maryland and by providers in nearby states when they are part of the MCO's network or your care is arranged by the MCO. Even when a nationwide insurance company operates a Maryland MCO the MCO is only required to cover emergency services when you are out of the State.

G. Updating Status and Personal Information

You must notify the State (where you applied for Medicaid, for example Maryland Health Connection, local Department of Social Services or myDHR, Local Health Department) of any change in your status or if corrections are needed. You must also keep your MCO informed about where you live and how to contact you. Notify the State when:

- Your mailing address changes**. If your mailing address is different from where you live we also need to know where you live.**
- You move**. Remember you must be a Maryland resident.**
- You need to change or correct your name, date of birth, or social security number
- Your income increases
- You get married or divorced
- You have a baby, adopt a child, or place a child for adoption or in foster care
- You gain or lose a tax dependent
- You gain or lose other health insurance
- Your disability status changes
- You are involved in an accident or are injured and another insurance or person may be liable

2. Important Information

A. HealthChoice and State Programs Contact Information

Help Information	Phone Number	Website
Enrollment into ***HealthChoice***	**855-642-8572** TDD (for hearing impaired) **1-800-977-7389**	**https://marylandhealthconnection.gov.org**
General Questions about ***HealthChoice***	**410-767-5800** (local) **1-800-492-5231** (rest of state) TDD (for hearing impaired) **1-800-735-2258**	**https://mmcp.dhmh.maryland.gov/healthchoice/pages/Home.aspx**
HealthChoice Help Line - for problems and complaints about access, enrollment process and quality of care.	**1-800-284-4510**	
Pregnant women and family planning	**1-800-456-8900**	**https://mmcp.dhmh.maryland.gov/chp/pages/Home.aspx**
Healthy Kids, EPSDT	**410-767-1903**	**http://mmcp.dhmh.maryland.gov/epsdt**
Healthy Smiles Dental Program	**1-855-934-9812**	**https://mmcp.dhmh.maryland.gov/Pages/maryland-healthy-smiles-dental-program.aspx**
Rare and Expensive Case Management Program (REM) - for questions about referrals, eligibility, grievances, services	**1-800-565-8190**	**https://mmcp.dhmh.maryland.gov/longtermcare/Pages/REM-Program.aspx**

Mental Health and substance use disorders- for referrals, provider information, grievances, preauthorization	**1-800-888-1965**	**http://bha.dhmh.maryland.gov/Pages/HELP.aspx**
Maryland Health Connection Consumer Support Center	**1-855-642-8572** TDD (for hearing impaired) **1-855-642-8573**	**www.marylandhealthconnection.gov**

B. Local Health Department Contact Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	www.aahealth.org/
Baltimore City	410-396-3835	410-396-6422	410-649-0521	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-4381	www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8023	http://dhmh.maryland.gov/carolinecounty

2. Important Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Carroll	410-876-2152	410-876-4813	410-876-4940	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5145	www.cecilcountyhealth.org/
Charles	301-609-6900	301-609-7917	301-609-6803	www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-228-3223	www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-1725	301-600-3341	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-9431	301-334-7695	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com
Howard	410-313-6300	1-877-312-6571	410-313-7567	www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org/
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1648	www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4481	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-6772	www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1766	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5654	http://talbothealth.org/
Washington	240-313-3200	240-313-3264	240-313-3290	http://dhmh.maryland.gov/washhealth
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-632-9230	www.worcesterhealth.org/

3. Rights and Responsibilities

A. As a HealthChoice member, you have the right to:

- Receive health care and services that are culturally competent and free from discrimination.
- Be treated with respect to your dignity and privacy.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Participate in decisions regarding your healthcare, 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 request that they be amended or corrected as allowed.
- Request copies of all documents, records, and other information free of charge, that was used in an adverse benefit determination.
- Exercise your rights, and that the exercise of those rights does not adversely affect the way the Managed Care Organizations (MCO), their providers, or the Maryland Department of Health treat you.
- File appeals and grievances with a Managed Care Organization.
- File appeals, grievances and State fair hearings with the State.
- Request that ongoing benefits be continued during an appeal or state fair hearing however, you may have to pay for the continued benefits if the decision is upheld in the appeal or hearing. Receive a second opinion from another doctor within the same MCO, or by an out of network provider if the provider is not available within the MCO, if you do not agree with your doctor's opinion about the services that you need. Contact your MCO for help with this.
- Receive other information about how your Managed Care Organization is managed including the structure and operation of the MCO as well as physician incentive plans. You may request this information by calling your Managed Care Organization**.**

3. Rights and Responsibilities

- Receive information about the organization, its services, its practitioners and providers and member rights and responsibilities.
- Make recommendations regarding the organization's member rights and responsibilities policy.

B. As a HealthChoice member, you have the responsibility to:

- **Inform your provider and MCO if you have any other health insurance coverage.**
- Treat HealthChoice staff, MCO staff, and health care providers and staff, with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if you need to cancel an appointment.
- Show your membership card when you check in for every appointment. Never allow anyone else to use your Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call your MCO if you have a problem or a complaint.
- Work with your Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Ask questions about your care and let your provider know if there is something you do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.
- Update the State if there has been a change in your status.
- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform your caregivers about any changes to your Advance Directive.

C. Nondiscrimination Statement

It is the policy of all HealthChoice MCOs not to discriminate on the basis of race, color, national origin, sex, age or disability. MCOs have adopted an internal grievance procedures providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its

implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of each MCO's nondiscrimination coordinator who has been designated to coordinate the efforts of each MCO in order to comply with Section 1557.

Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for an MCO to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

- Grievances must be submitted to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing, containing the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the remedy or relief sought.
- The Section 1557 Coordinator (or her/his designee) shall conduct an investigation of the complaint. This investigation may be informal, but it will be thorough, affording all interested persons an opportunity to submit evidence relevant to the complaint. The Section 1557 Coordinators will maintain the files and records relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinators will take appropriate steps to preserve the confidentiality of files and records relating to grievances and will share them only with those who have a need to know.
- The Section 1557 Coordinators will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is 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, DC 20201, toll-free: 800-368-1019, TDD: 800-537-7697.

Complaint forms are available at: **www.hhs.gov/ocr/office/file/index.html.** Such complaints must be filed within 180 days of the date of the alleged discrimination.

MCOs will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. The Section 1557 Coordinators will be responsible for such arrangements.

D. Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPAA) require MCOs and providers to report their privacy practices to their members. The Notice of Privacy Practices informs members of their rights to privacy as well as the access and disclosure of their protected health information (PHI). Examples of PHI include medical records, medical claims/billing, and health plan records. If you feel that your privacy rights have been violated, you can file a complaint with your provider, MCO, or the U.S. Department of Health and Human Services.

To file a complaint, see contact information below:

- Provider: call your provider's office
- MCO: call MCO Member Services
- U.S. Department of Health and Human Services
  - Online at: **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**
  - Email: **OCRComplaint@hhs.gov**
  - In Writing at:

    Centralized Case Management Operations
    U.S. Department of Health and Human Services
    200 Independence Avenue, S.W.
    Room 509F HHH Bldg.
    Washington, D.C. 20201

See Attachment B for the MCO's Notice of Privacy Practices.

1. Benefits and Services

A. HealthChoice Benefits

This table lists the basic benefits that all MCOs must offer to HealthChoice members. Review the table carefully as some benefits have limits, you may have to be a certain age, or have a certain kind of problem. Except for pharmacy co-payments (fee member pays for a health care service), you should never be charged for any of these health care services. Your PCP will assist you in coordinating these benefits to best suit your health care needs. You will receive most of these benefits from providers that participate in the MCO's network (participating provider) or you may need a referral to access them. There are some services and benefits you may receive from providers that do not participate with your MCO (non-participating provider) and do not require a referral. These services are known as self-referral services.

MCOs may waive pharmacy co-pays and offer additional benefits such as adult dental and more frequent eye exams (see Attachment C). Those are called optional benefits and can change from year to year. If you have questions call MCO Member Services.

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
Primary Care Services	These are all of the basic health services you need to take care of your general health needs, and are usually provided by your primary care provider (PCP). A PCP can be a doctor, advanced practice nurse, or physician assistant.	All members	
Early Periodic Screening Diagnosis Treatment (EPSDT)	Regular well-child checkups, immunizations (shots), developmental screens and wellness	Under age 21	

Services for Children http://mmcp.dhmh.maryland.gov/epsdt	advice. These services provide whatever is needed to take care of sick children and to keep healthy children well.		
Pregnancy-related Services	Medical care during and after pregnancy, including hospital stays and, when needed, home visits after delivery.	Women who are pregnant and for 2 months after the birth.	
Family Planning	Family planning office visits, lab tests, birth control pills and devices (includes latex condoms and emergency contraceptives from the pharmacy, without a doctor's order) and permanent sterilizations.	All members	
Primary Mental Health Services	Primary mental health services are basic mental health services provided by your PCP or another provider within the MCO. If more than just basic mental health services are needed, your PCP will refer you to or you can call the Public Behavioral Health System at **1-800-888-1965** for specialty mental health services.	All members	You do not get specialty mental health services from a MCO. For treatment of serious emotional problems your PCP or specialist will refer you or you can call the Public Behavioral Health System at: **1-800-888-1965**.

Specialist Services	Health care services provided by specialty trained doctors, advanced practice nurses or physician assistants. You may need a referral from your PCP before you can see a specialist	All Members	
Laboratory & Diagnostic Services	Lab test and X-rays to help find out the cause of an illness.	All Members	
Home Health Care	Health care services received in home that includes nursing and home health aide care.	Those who need skilled nursing care (care provided by or under the supervision of a registered nurse) in their home, usually after being in a hospital	No personal care services (help with daily living)

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU <u>DO NOT</u> GET WITH THIS BENEFIT
Case Management	A case manager may be assigned to help you plan for and receive health care services. The case manager also keeps track of what services are needed and what has been provided. You must communicate with case	(1) Children with special health care needs; (2) Pregnant and postpartum women; (3) Individuals with HIV/AIDS; (4) Individuals who	

	manager to receive effective case management.	are homeless; (5) Individuals with physical or developmental disabilities; (6) Children in State -supervised care (7) Case management provided for other members as needed	
Diabetes Care	Special services, medical equipment, and supplies for members with diabetes.	Members who have been diagnosed with diabetes.	
Diabetes Prevention Program	A program to prevent diabetes in members who are at risk.	Members 18-64 years old who are overweight and have elevated blood glucose level or a history of diabetes during pregnancy.	Not elible if previously diagnosed with diabetes or if pregnant.
BENEFIT	**WHAT IT IS**	**WHO CAN GET THIS BENEFIT**	**WHAT YOU <u>DO NOT</u> GET WITH THIS BENEFIT**
Podiatry	Foot care when medically needed.	All members	Routine foot care; unless you are under 21 years of age or have diabetes or vascular disease affecting the lower extremities

Vision Care	**Eye Exams** Under 21: one exam every year. 21 and Older: one exam every two years **Glasses** Under 21 only Contact lenses if there is a medical reason why glasses will not work	**Exams** – all members. **Glasses and contact lenses** – Members under age 21.	More than one pair of glasses per year unless lost, stolen, broken or new prescription needed.
Oxygen and Respiratory Equipment	Treatment to help breathing problems	All members	
Hospital Inpatient Care	Services and care received for scheduled and unscheduled admittance for inpatient hospital stays (hospitalization)	All members with authorization or as an emergency.	
Hospital Outpatient Care **Hospital Outpatient Care** *continued*	Services and care received from an outpatient hospital setting that does not require inpatient admittance to the hospital. Services would include diagnostic and laboratory services, physician visit, and authorized outpatient procedures.	All members	MCOs are not obligated to cover hospital observation services beyond 24 hours.

4. Benefits and Services

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
Emergency Care	Services and care received from a hospital emergency facility to treat and stabilize an emergent medical condition.	All members	
Urgent Care	Services and care received from an urgent care facility to treat and stabilize an urgent medical need.	All members	
Hospice Services	Home or inpatient services designed to meet the physical, psychological, spiritual, and social needs for people who are terminally ill.	All members	
Nursing Facility /Chronic Hospital	Skilled nursing care or rehab care up to 90 days	All members	
Rehabilitation Services/Devices	Outpatient services/devices that help a member function for daily living. Services include: Physical, Occupational, and Speech Therapy.	Members age 21 and older. Members under 21 are eligible under EPSDT (see section 6 E)	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
Habilitation Services/Devices	Services/devices that help a member function for daily living. Services include: Physical, Occupational, and Speech Therapy	Eligible members; benefits may be limited.	
Blood and Blood Products	Treatment for kidney disease	All members	
Dialysis	No prior authorization required	All members	
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	DME (can use repeatedly) are things like crutches, walkers, and wheelchairs) DMS (cannot use repeatedly) are equipment and supplies that have no practical use in the absence of illness, injury, disability or health condition. DMS are things like finger stick supplies, dressings for wounds, and incontinence supplies	All members	
Transplants	Medically necessary transplants.	All members	No experimental transplants.
Clinical Trials	Members costs for studies to test the effectiveness of new treatments or drugs	Members with little threatening conditions, when authorized.	
Plastic and Restorative Surgery	Surgery to correct a deformity from disease, trauma, congenital or development abnormalities or to restore body functions.	All members.	Cosmetic surgery to make you look better.

B. Self-referral Services

You will go to your PCP for most of your health care, or your PCP will send you to a specialist who works with the same MCO. For some types of services, you can choose a local provider who does not participate with your MCO. The MCO will still pay the non-participating provider for services as long as the provider agrees to see you and accept payment from the MCO. Services that work in this way are called "self-referral services". The MCO will also pay for any related lab work and medicine received at the same site that you receive the self-referral visit. The following services are self-referral services.

- Emergency Services
- Family Planning
- Pregnancy, under certain conditions, and birthing centers
- Doctor's check of newborn baby
- School-Based Health Centers
- Assessment for placement in Foster Care
- Certain Specialist for Children
- Diagnostic evaluation for people with HIV/AIDS
- Renal dialysis

Emergency Services

An emergency is considered a medical condition which is sudden, serious, and puts your health in jeopardy without immediate care. You do not need preauthorization or a referral from your doctor to receive emergency services. Emergency services are health care services provided in a hospital emergency facility from the result of an emergency medical condition. After you are treated or stabilized for an emergency medical condition you may need additional services to make sure the emergency medical condition does not return. These are called post-stabilization services.

Family Planning Services (Birth Control)

If you choose to do so, you can go to a provider who is not a part of your MCO for Family planning services. Family planning includes services such as contraceptive devices/supplies, laboratory testing, and medically necessary office visits. Voluntary sterilization is a family planning service but is NOT a self-referral service. If you need a voluntary sterilization you will need preauthorization from their PCP and must use a participating provider of the MCOs network.

Pregnancy Services

If you were pregnant when you joined the MCO, and had already seen a non-participating provider, for at least one complete prenatal check-up, then you can choose to keep seeing that non-participating provider all through your pregnancy, delivery, and for two months after the baby is born for follow-up, as long as the non-participating provider agrees to continue to see you.

Birthing Centers

Services performed at a birthing center, including an out-of-state center located in a contiguous (a state that borders Maryland) state.

Baby's first checkup before leaving hospital

It is best to select your baby's provider before you deliver. If the MCO provider you selected or another provider within the MCO network does not see your newborn baby for a checkup before the baby is ready to go home from the hospital, the MCO will pay for the on-call provider to do the checkup in the hospital.

School-Based Health Center Services

For children enrolled in schools that have a health center, there are a number of services that they can receive from the school health center. Your child will still be assigned to a PCP.

- Office visits and treatment for acute or urgent physical illness, including needed medicine
- Follow up to EPSDT visits when needed
- Self-referred family planning services

Checkup for children entering State custody

Children entering foster care or kinship care are required to have a checkup within 30 days. The foster parent can choose a convenient provider to self-refer to for this visit.

Certain providers for children with special health care needs

Children with special healthcare needs may self-refer to providers outside of the MCO network (non-participating provider) under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care, and assure that appropriate plans of care are in place. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in an MCO. Medical

services directly related to a special needs child's medical condition may be accessed out-of-network only if the following specific conditions are satisfied:

- New Member: A child who at the time of initial enrollment was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing non-participating provider submits the plan of care for review and approval within 30 days of the child's effective date of enrollment. The approved services must be medically necessary.

- Established Member: A child who is already enrolled in a MCO when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific non-participating provider. The MCO must grant the request unless the MCO has a local participating specialty provider with the same professional training and expertise who is reasonably available and provides the same services.

Diagnostic Evaluation Service (DES)
If you have HIV/AIDS, you are able to receive one annual diagnostic and evaluation service (DES) visit. The DES will consist of a medical and psychosocial assessment. You must select the DES provider from an approved list of sites but the provider does not have to participate with your MCO. The MCO is responsible to assist you with this service. The State and not Your MCO will pay for your HIV/AIDs related blood tests.

Renal Dialysis
If you have kidney disease that requires you to have your blood cleaned on a regular basis, then you can select your renal dialysis provider. You will have the option to choose either a renal dialysis provider who participates with your MCO or a provider who does not participate with your MCO. People needing this service may be eligible for the Rare and Expensive Case Management Program (REM).

If the MCO denies, reduces, or terminates the services, you can file an appeal.

C. Benefits Not Offered by MCOs but Offered by the State

Benefits in the table below are not covered by the MCO. If you need these services you can get them through the State using your red and white Medicaid or dental card. If you have questions on how to access these benefits, call the HealthChoice Help Line (**1-800-284-4510**).

4. Benefits and Services

BENEFIT	DESCRIPTION
Dental Services for Children Under 21, former foster care youth up to age 26, and Pregnant Women	General dentistry including regular and emergency treatment is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program administered by Scion. If you are eligible for the Dental Services Program, you will receive information and a dental card from Scion. If you have not received your dental ID card or have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at **1-855-934-9812**.
Occupational, Physical, Speech Therapies & Audiology for Children under the Age of 21	The State pays for these services if medically needed. For help in finding a provider, you can call the State's Hotline at **1-800-492-5231**.
Speech Augmenting Devices	Equipment that helps people with speech impairments to communicate.
Behavioral Health	Substance use disorder and specialty mental health services are provided through the Public Behavioral Health System. You can reach them by calling **1-800-888-1965**.
Intermediate Care Facility(ICF)-Mental Retardation (MR) Services	This is treatment in a care facility for people who have an intellectual disability and need this level of care.
Skilled Personal Care Services	This is skilled help with daily living activities.
Medical Day Care Services	This is help to improve daily living skills in a center licensed by the state or local health department, which includes medical and social services.
Nursing Facility & Long Term Care Services	The MCO does not cover care in a nursing home, chronic rehabilitation hospital, or chronic hospital after the first 90 days If you lose Medicaid coverage while you are in a nursing facility you will not be re-enrolled in the MCO. If this happens you will need to apply for Medicaid under long term care coverage rules. If you still meet the State's requirements after you are disenrolled from the MCO or after the MCO has paid the first 90 days, the State would be responsible.

BENEFIT	DESCRIPTION
HIV/AIDS	Certain diagnostic services for HIV/AIDS are paid for by the State (Viral load testing, genotypic, phenotypic, or other HIV/AIDS resistance testing).
Abortion Services	This medical procedure to end certain kinds of pregnancies is covered by the State only if: • The patient will probably have serious physical or mental health problems, or could die, if she has the baby; • She is pregnant because of rape or incest, and reported the crime; or • The baby will have very serious health problems. Women eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.
Transportation Services	**Emergency Medical Transportation:** Medical services while transporting the member to a health care facility in response to a 911 call. This service is provided by local fire companies. If you are having an emergency medical condition, call 911. **Non-Emergency Medical Transportation:** MCOs are not required to provide transportation for non-emergency medical visits. The exception is when you are sent to a far-away county to get treatment that you could get in a closer county. Certain MCOs may provide some transportation services such as bus tokens, van services, and taxis to medical appointments. Call your MCO to see if they provide any transportation services. Local health departments (LHD) provide non-emergency medical transportation to qualified individuals. The transports provided are only to Medicaid covered services. Transportation through the LHD is meant for individuals who have no other means of getting to their appointments. If you select a MCO that is not offered within your service area, both the LHD and MCO are not required to provide non-emergency medical transportation services. For assistance with transportation from your local health department, call the local health department's transportation program.

D. Additional Services Offered by MCOs and NOT by the State

At the beginning of each year MCOs must tell the State if they will offer additional services. Additional services are also called optional benefits. This means the MCO is not required to provide those services and the State does not cover them. If there is ever a change to the MCO's additional service(s), you will be notified in writing. However, if the MCO changes or stops offering additional services this is not an approved reason to change MCOs. Optional services and limitations of each service can vary between each MCO. Transportation to optional services may or may not be provided by the MCO. To find out the optional services and limitations provided by your MCO, see Attachment C or call MCO Member Services.

E. Excluded Benefits and Services Not Covered by the MCO or the State

Below are the benefits and services that MCOs and the State are not required to cover (excluded services). The State requires MCOs to exclude most of these services. A few of these services such as adult dental may be covered by a MCO. See Attachment C or call MCO Member Services to find out their additional benefits and services.

Benefits and Services NOT covered:

- Dental services for adults. (Except for pregnant women and former foster care youth up to age 26)
- Orthodontist services for people 21 years and older or children who do not have a serious problem that makes it difficult for them to speak or eat
- Hearing aids for people 21 years and older.
- Non-prescription drugs. (Except coated aspirin for arthritis, insulin, iron pills, and chewable vitamins for children younger than age 12.)
- Routine foot care for adults 21 years and older who do not have diabetes or vascular problems.
- Special (orthopedic) shoes and supports for people who do not have diabetes or vascular problems.
- Shots for travel outside the continental United States or medical care outside the United States.
- Diet and exercise programs, to help you lose weight.
- Cosmetic surgery to make you look better, but you do not need for any medical reason.
- Fertility treatment services, including services to reverse a voluntary sterilization.

- Private hospital room for people without a medical reason such as having a contagious disease.
- Private duty nursing for people 21 years and older.
- Autopsies.
- Anything experimental unless part of an approved clinical trial.
- Anything that you do not have a medical need for.

F. Change of Benefits and Service Locations

Change of Benefits

There may be times when HealthChoice benefits and services are denied, reduced or terminated because they are not or are no longer medically necessary. This is called an adverse benefit determination. If this situation occurs, you will receive a letter in the mail prior to any change of benefits or services. If you do not agree with this decision, you will be given the opportunity to file a complaint.

Loss of Benefits

Loss of HealthChoice benefits will depend on your Medicaid eligibility. Failure to submit necessary Medicaid redetermination paperwork or not meeting Medicaid eligibility criteria are causes for disenrollment from HealthChoice. If you become ineligible for Medicaid, the State will disenroll you from the MCO and you will lose your HealthChoice benefits. If you regain eligibility within 120 days, you will automatically be re-enrolled with the same MCO.

Change of Health Care Locations

When there is a change in a health care provider's location you will be notified in writing. If the provider is a PCP, and the location change is too far from your home, you can call MCO Member Services to switch to a PCP in your area.

5. Information on Providers

A. What is a Primary Care Provider (PCP), Specialist, and Specialty Care

Your PCP is the main coordinator of your care and assists you in managing your health care needs and services. Go to your PCP for routine checkups, medical advice, immunizations, and referrals for specialists when needed. A PCP can be a doctor, nurse practitioner, or physician assistant and will typically work in the field of General Medicine, Family Medicine, Internal Medicine or Pediatrics.

When you need a service not provided by your PCP, you will be referred to a Specialist. A Specialist is a doctor, nurse practitioner, or physician assistant that has additional training to focus on providing services in a specific area of care. The care you receive from a Specialist is called Specialty Care. To receive specialty care, you may need a referral from your PCP. There are some specialty care services that do not need a referral; these are known as self-referral services. For female members, if your PCP is not a women's health specialist, you have the right to see a women's health specialist within your MCO network without a referral.

Your providers will not be penalized for advising or advocating on your behalf.

B. Selecting or Changing Providers

When you first enroll in a MCO, you need to select a PCP that is a part of the MCOs network. If you do not have a PCP or need assistance choosing a PCP, call MCO Member Services. If you do not choose a PCP, the MCO will choose one for you. If you are not satisfied with your PCP, you can change your PCP at any time by calling the MCO member services. They will assist you in changing your PCP and inform you of when you can begin seeing your new PCP.

If there are other members of your household that are HealthChoice members, they will need to choose a PCP too. HealthChoice members of a household can all choose the same PCP or each member can choose a different PCP. It is recommended for HealthChoice members, who are under 21 years of age, select an Early Periodic Screening Diagnosis and Treatment (EPSDT) provider. EPSDT providers are trained and certified to identify and treat health problems before they become complex and costly. MCO Member Services will be able to tell you which providers are EPSDT certified.

5. Information on Providers

To view a list of participating providers within a MCO, provider directories are available on the MCOs website. If you would like a paper copy of the provider directory mailed to you, contact MCO Member Services.

C. Termination of a Provider

There may be times when a PCP or provider no longer contracts or works with a MCO. You will be notified in writing and or you will receive a phone call from the MCO.

- If the MCO terminates your PCP, you will be asked to select a new PCP and may be given the opportunity to switch MCOs if that PCP participates with a different MCO.
- If your PCP terminates the contract with your MCO, you will be asked to select a new PCP within your MCO.
- If you do not choose a new PCP, your current MCO will choose a PCP for you. After a PCP is selected, you will receive a new MCO ID card in the mail with the updated PCP information.

6. Getting into Care

A. Making or Canceling an Appointment

To make an appointment with your PCP or another provider, call the provider's office. Your PCPs name and number will be located on the front of the ID card the MCO provided you. You can also call MCO Member Services and they will provide you with your PCPs or other provider's name and number. To ensure the provider's office staff can have your records ready and there is availability in the provider's schedule, make an appointment prior going to the provider's office. When making an appointment:

- Inform the staff who you are;
- Inform staff why you are calling; and
- Inform staff if you think you need immediate attention.

Giving this information can help determine how quickly you need to be seen.

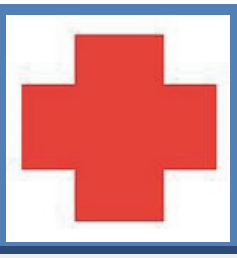
The day of the appointment, arrive on time. Arriving on time allows for the provider to spend the most amount of time with you and prevents long waiting times. For all appointments, bring your:

- Medicaid card
- MCO ID card
- A photo ID

To cancel an appointment with your PCP or another provider, call the provider's office as soon as you know you cannot make the appointment. Canceling appointments allows for provider's to see other patients. Reschedule the appointment as soon as you can to stay up to date with your health care needs.

B. Referral to a Specialist or Specialty Care

Your PCP is in charge of coordinating your care. If your PCP feels that you need specialty care, they will refer you to a specialist. Depending on your MCO, a referral may be needed from your PCP prior to making an appointment with a specialist. Call MCO Member Services for their referral requirements.

		
Doctor's Office	**Urgent Care Center**	**Emergency Room**
• Checkups • Health screenings • If something causes you concern • Cough/cold • Fever • Lingering pain • Unexplained weight loss	• Minor illness/injury • Flu/fever • Vomiting/diarrhea • Sore throats, earaches, or eye infection • Sprains/strains • Possible broken bones • Sports injuries	• Unconsciousness • Difficulty breathing • Serious head, neck, or back injury • Chest pain/pressure • Severe bleeding • Poisons • Severe Burns • Convulsions/seizures • Severely broken bone • Sexual Assault

C. After Hours, Urgent Care, and Emergency Room Care

Know Where to Go: Depending on your health needs, it is important to choose the right place at the right time. Above is a guide to help choose the right place based on your health needs.

After Hours

If you need non-emergency care after normal business hours, call your PCP's office or the MCO 24 hour Nurse Advice Line. Both numbers are on your MCO member ID card. Your doctor or their answering service will be able to answer your questions, provide you instructions, and can arrange any necessary services. The Nurse Advice Line is always open to answer your questions.They will help guide you to the right place so you get the

best care and so you don't get billed unnecessarily. The nurse can help you decide if you can wait to see the doctor or if you need an urgent care or emergency room (ER) visit.

Urgent Care
If you have an illness or injury that could turn into an emergency within 48hrs if it is not treated go to an Urgent Care Center. Be sure to go to an in-network Urgent Care Center. Preauthorization is not required but make sure they participate with the MCO or you may be billed. If you are unsure if you should go to an Urgent Care Center, call your PCP or the MCO 24 hour Nurse Advice Line. Both numbers are on your MCO card.

Emergency Room Care
An emergency medical condition is when one requires immediate medical attention to avoid serious impairment or dysfunction to one's health. If you have an emergency medical condition and need emergency room care (services provided by a hospital emergency facility), call 911 or go to the closest hospital emergency department. You will be able to self-refer to any emergency department, preauthorization is not required.

If you are unsure if you should go to the emergency department, call your PCP or the MCO 24 hour Nurse Advice Line.

After you are treated for an emergency medical condition you may need additional services to make sure the emergency medical condition does not return. These are called post-stabilization services. The MCO will work with the hospital staff to decide if you need these services. If you would like additional information about how this is decided, contact your MCO.

If your PCP and MCO are unaware of your emergency room care visit, call them as soon as you can after you receive emergency services so they can arrange for any follow-up care you may need.

D. Out of Service Area Coverage

Not all MCOs operate in all areas of the State. If you need non-emergency care while out of the MCOs service area call your PCP or MCO Member Services. Both numbers are on your MCO card. If you move and your new residence is in a different Maryland county that your MCO does not service, you can change MCOs by calling HealthChoice Enrollment

(**1-800-977-7388**). If you decide to stay with your MCO you may need to provide your own transportation to an in-network provider in another county.

HealthChoice is only accepted in Maryland and by providers in nearby states when they are part of the MCO's network or your care has been arranged by the MCO. Remember that when you travel out of the State of Maryland the MCO is only required to cover emergency services and post-stabilization services.

E. Wellness Care for Children: Healthy Kids-Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

It is important for infants, children and adolescents up to age 21 to receive regular checkups. The Healthy Kids/EPSDT program helps to identify, treat, and prevent health problems before they become complex and costly. EPSDT is a comprehensive benefit that covers medically necessary medical, dental, vision, and hearing services. Many of the EPSDT services will be covered by the MCO, but services such as dental, behavioral health, and therapies will be covered through Fee-For-Service Medicaid (see page 28).

Healthy Kids is the preventative well-child component of EPSDT. The State will certify your child's PCPs to ensure that he/she knows the Healthy Kids/EPSDT requirements, is prepared to perform the required screenings and has the required vaccines so your child receives immunizations at the appropriate times. We highly recommend that you select a PCP for your child who is EPSDT certified. If you choose a provider that is not EPSDT certified, the MCO will notify you. You can switch your child's PCP at any time. Contact the MCO Member Services if you have any questions or need assistance switching your child's PCP.

The table below shows the ages that children need well child visits. If your child's PCP recommends more visits they will also be covered. During well child visits the PCP will check your child's health and all aspects of development. They will also check for problems through screening. Some screenings for health problems are done through blood work while others are done by asking questions. Additional screens may be required based on age and risk. The PCP will also offer advice and tell you what to expect. Make sure you keep appointments for well-child exams. Do not miss immunizations and make sure children get their blood tested for lead. Lead in the blood causes serious problems so testing is required for all children regardless of risk. This applies even if your child has both Medicaid and other insurance.

6. Getting into Care

Age	Well Child Exam Assess Development Health Education	Childhood Immunizations (*influenza recommended every year starting at 6 months of age)	Blood Lead test (*additional if at risk)
Birth	**X**	**X**	
3-5 days	**X**		
1 month	**X**		
2 months	**X**	**X**	
4 months	**X**	**X**	
6 months	**X**	**X**	
9 months	**X**		
12 months (1 year)	**X**	**X**	**X**
15 months	**X**	**X**	
18 months (1.5 years)	**X**	**X**	
24 months (2 years)	**X**		**X**
30 months (2.5 years)	**X**		
36 months (3 years)	**X**		
4-20 years	**X** (yearly)	**X** (ages 4-6, 9-12 and 16)	

F. Wellness Care for Adults

Wellness visits with your doctor are important. Your PCP will examine you, provide or recommend screenings based on your age and needs, review your health history and current medications. Your PCP will coordinate the services you need to keep you healthy. During your visit, let your PCP know if anything has changed since your last visit, if you have any questions, and how you are doing with your plan of care. When speaking with your PCP, always give the most honest and up to date information about your physical, social, and mental health so that you can get the care that best meets your needs.

Adult Preventive Care Recommendations

Service	Frequency – Population
Blood pressure check	Yearly
Cholesterol	Every 5 years starting at age 35 for men and 45 for women, starting at age 20 if at increased risk
Diabetes	Adults aged 40 to 70 years who are overweight or obese
Colon Cancer Screening	Age 50-75, frequency depends on test used: stool based – yearly to every 3 years, flexsigmoid every 5 years, CT colonography every 5 years, or colonoscopy every 10 years
Sexually Transmitted Disease Screening	**HIV** - Once for all adults regardless of risk, additionally based on risk. **Hepatitis C (HCV)** – Once for anyone born between 1945 and 1965, others based on risk **Hepatitis B** – adults at increased risk **Chlamydia/Gonorrhea** – Yearly for women age 16 to 24 if sexually active, based on risk for age 25+ **Syphilis** – Adults at increased risk
Influenza Vaccine	Yearly
TdaP (tetanus, diphtheria, acellular Pertussis) Vaccine	Once as an adult (if didn't receive at age 11-12) During every pregnancy
Td (tetanus) Vaccine	Every 10 years, additional doses if dictated by risk.
Shingles (zoster) Vaccine	Once for all adults age 60 and older.
Pneumococcal vaccine (PPSV23)	Once for everyone (age 2-64) with diabetes, lung disease, heart disease, smokers, alcoholism, or other risk factors (talk to your doctor to determine your risk)
Breast Cancer Screening (Mammogram)	Every 2 years age 50-75, risk based 40-50
Lung Cancer Screening	Yearly for adults age 55-80 with 30 pack-year smoking history who are actively smoking or quit smoking less than 15 years ago, screening done using Low Dose CT (LDCT) scan
Cervical Cancer Screening	Every 3 years for women ages 21-29, every 5 years for women ages 30-65

Substance Use/ Misuse: Alcohol, Tobacco, Other	Adult 18 and older. Yearly or more frequently depending on risk.

*All recommendations are based on US Preventive Services Task Force (USPSTF). Excludes recommendations for patients 65 and older since not eligible for HealthChoice.

G. Case Management

If there is a time when you have a chronic health care need or an episode of care that affects your health status, the MCOs will assign a case manager to assist in coordinating your care. Case managers are nurses or licensed social workers trained to work with your providers to ensure your health care needs are being met. Communication with your case manager is important in order for them to help develop and implement a person centered plan of care. Case managers will work with you over the phone or may provide case management in person.

H. Care for Women During Pregnancy and Two months After Delivery

When you are pregnant or suspect you are pregnant it is very important that you call the MCO. They will help you get prenatal care (care women receive during pregnancy). Prenatal care consists of regular check-ups with an obstetrician (OB doctor) or certified nurse midwife to monitor your health and the health of your unborn baby.

If you are pregnant the MCO will assist you in scheduling an appointment for prenatal care within 10 days of your request. If you already started prenatal care before you enrolled in the MCO, you may be able to keep seeing the same prenatal care provider through your pregnancy, delivery, and for two months after the baby is born.

The MCO may also connect you with a case manager. The case manager will work with you and your prenatal care provider to help you get necessary services, education and support. If you have other health problems or were pregnant before and had health problems, the MCO will offer extra help.

The State will automatically enroll your newborn in your MCO. If you qualified for Medicaid because you were pregnant your Medicaid and HealthChoice coverage will end two months after delivery.

If you have questions call the Help Line for Pregnant Women (**1-800-456-8900**) or MCO Member Services. For additional information see Special Services for Pregnant Women (7.1.) and Attachment D.

I. Family Planning (Birth Control)

Family planning services provide individuals with information and means to prevent unplanned pregnancy and maintain reproductive health. You are eligible to receive family planning services without a referral. The MCO will pay a non-participating provider for services as long as the provider agrees to see you and accept payment from the MCO. Additionally, MCOs are not allowed to charge copay's for family planning services. Family Planning services include but not limited to:

- Birth control
- Pregnancy testing
- Voluntary sterilizations (in network with a pre-authorization).

Call MCO Member Services or the State's Help Line (**1-800-456-8900**) for additional information on Family Planning and Self-Referral services.

J. Dental Care

The State and the MCO are not required to offer adult dental care as a HealthChoice benefit to members age 21 and over and or members who are not pregnant.

- If you are under the age of 21, pregnant or a former foster care youth up to age 26 you are eligible for dental care provided through the Maryland Healthy Smiles Dental Program (**1-855-934-9812**).
- If you are age 21 and over and not pregnant, limited dental care may be provided through the MCO. See Attachment C.
- Call MCO Member Services if you have any questions or need help finding a dental provider.

K. Vision Care

- If you are under the age of 21, you are eligible for:
  - Eye exams;
  - Glasses once a year; or
  - Eye contact lenses if medically necessary over glasses.
- If you are age 21 and over, you are eligible for:
  - Eye exams every two years.
- See Attachment C for additional adult vision benefits offered by your MCO.

6. Getting into Care

- Call MCO Member Services if you have questions need finding a vision care provider.

L. Health Education/Outreach

You have access to health education programs offered by your MCO. Health education programs provide information and resources to help you become active in your health and medical care. Programs are delivered in multiple formats and cover different health topics. See Attachment E or call the MCO Member Services to find out what health education programs are available, when they occur, and how you can stay informed about them.

MCOs will also provide outreach services to members they have identified who may have barriers to access their health care. The MCOs outreach plan targets individuals who are difficult to reach or are non-compliant with a plan of care. If the MCO cannot contact you or you have missed appointments, you may be referred to the Administrative Care Coordination Unit (ACCU) at your local health department.

ACCUs are not employed by MCOS. The State contracts with ACCUs to help you understand how the Medicaid and HealthChoice Programs work. If you are contacted by the ACCU from the local health department they will tell you the reason they called. If they cannot contact you by phone they may come to your house. The goal of the ACCU is to help you get and stay connected to appropriate medical care and services.

M. Behavioral Health Services

If you have a mental health or substance use problem call your PCP or MCO Member Services. Your PCP may treat you or may refer you to the Public Behavioral Health System. A range of behavioral health services are covered by the State's Behavioral Health System. You can access these services without a referral from your PCP by calling the Public Behavioral Health System (**1-800-888-1965**). This toll-free help line is open 24-hours a day, 7 days a week. Staff members are trained to handle your call and will help you get the services you need. Behavioral health services include but not limited to:

- Case Management
- Emergency Crisis/Mobile Crisis Services
- In-patient Psychiatric Services
- Outpatient Mental Health Centers
- Residential Treatment Centers

6. Getting into Care

If the Public Behavioral Health System finds that you do not need a specialist to handle your behavioral health needs, your PCP (with your permission) will be informed so that you can receive any needed follow-up care.

7. Special Services

A. Services for Special Needs Populations

The State has named certain groups as needing special support from the MCO. These groups are called "special needs populations" and include:

- Pregnant women and women who have just given birth
- Children with special health care needs
- Children in State – supervised care
- Adults or children with a physical disability or developmental disability
- Adults and children with HIV/AIDS
- Adults and children who are homeless

The MCO has a process to let you know if you are in a special needs population. If you have a question about your special needs call MCO Member Services.

Services Every Special Needs Population Receives

If you or a family member is in one or more of these special needs populations, you are eligible to receive the services below. You will need to work and communicate with the MCO so as to help you get the right amount and the right kind of care:

- **A Case Manager** - A case manager will be a nurse or a social worker or other professional that may be assigned to your case soon after you join a MCO. This person will help you and your PCP develop a patient centered plan that addresses the treatment and services you need. The case manager will:
    - Help develop the plan of care
    - Ensure the plan of care is updated at least every 12 months or as needed
    - Keep track of the health care services
    - Help those who give you treatment to work together

- **Specialists** - Having special needs requires you to see providers who have the most experience with your condition. Your PCP and your case manager will work together to be sure to send you to the right specialists. This will include specialists for supplies and equipment you might need.

- **Follow-up when visits are missed** - If your PCP or specialist finds that you keep missing appointments, they will let us know and someone will try to get in touch

with you by mail, by telephone or by a visit to your home to remind you to call for another appointment. If you still miss appointments, you may be visited by someone from the local health department near where you live.

- **Special Needs Coordinator** – MCOs are required to have a Special Needs Coordinator on staff. The Special Needs Coordinator will educate you about your condition and will suggest places in your area where you can get support from people who know about your needs.

As a member of a special needs population, the MCO will work with you to coordinate all of the services above. Some groups will receive other special services. The following are other special services specific to the special needs population:

1. **Pregnant Women and Women Who Have Just Given Birth:**

- **Appointments -** The MCO will assist in scheduling an appointment for prenatal care within 10 days of your request.

- **Prenatal Risk Assessment -** Pregnant woman will have a prenatal risk assessment. At your first prenatal care visit the provider will complete a risk assessment. This information will be shared with the local health department and the MCO. The MCO will offer a range of services to help you take care of yourself and to help make sure your baby is born healthy. The local health department may also contact you and offer help and advice. They will have information about local resources.

- **Link to a Pediatric Provider -** The MCO will assist you in choosing a pediatric care provider. This may be a pediatrician, family practitioner or nurse practitioner.

- **Length of Hospital Stay -** The length of hospital stay after delivery is 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery. If you elect to be discharged earlier, a home visit will be offered within 24 hours after discharge. If you must remain in the hospital after childbirth for medical reasons, you may request that your newborn remain in the hospital while you are hospitalized, additional hospitalization up to four (4) days is covered for your newborn.

7. Special Services

- **Follow-up –** The MCO will schedule the newborn for a follow-up visit two weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

- **Dental -** Good oral health is important for a healthy pregnancy. All pregnant women are eligible to receive dental services through the State's Maryland Healthy Smiles Dental Program. Call Healthy Smiles (**1-888-696-9596**) if you have questions about your dental benefits. After delivery members age 21 and over will no longer be eligible for dental benefits through Healthy Smiles. The MCO may offer adult dental benefits. See Attachment C.

- **Substance Use Disorder Services -** If you request treatment for a substance use disorder you will be referred to the Public Behavioral Health System within 24 hours of request.

- **HIV Testing and Counseling -** Pregnant women will be offered a test for HIV and will receive information on HIV infection and its effect on the unborn child.

- **Nutrition Counseling -** Pregnant women will be offered nutritional information to teach them to eat healthy.

- **Smoking Counseling -** Pregnant women will receive information and support on ways to stop smoking.

- **EPSDT Screening Appointments -** Pregnant adolescents (up to age 21) should receive all EPSDT screening services in addition to prenatal care.

- See Attachment D for additional services the MCO offers for pregnant women.

2. Children with Special Health Care Needs

- **Work with Schools** – The MCO will work closely with the schools that provide education and family services programs to children with special needs.

- **Access to Certain Non-participating Providers** – Children with special healthcare needs may self-refer to providers outside of the MCO's network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care, and assure that appropriate plans of care are in place. Self-

referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in an MCO. Medical services directly related to a special needs child's medical condition may be accessed out-of-network if specific conditions are satisfied.

3. Children in State-supervised Care

- **State Supervised Care** - Foster and Kinship Care –The MCO will ensure that children in State supervised care (foster care or kinship care) get the services that they need from providers by having one person at the MCO be responsible for organizing all services. If a child in State supervised care moves out of the area and needs another MCO, the State and the current MCO will work together to quickly find the child new providers close to where the child has moved, or if needed, the child can change to another MCO.

- **Screening for Abuse or Neglect** - Any child thought to have been abused physically, mentally or sexually will be referred to a specialist who is able to determine if abuse has occurred. In the case of possible sexual abuse, the MCO will ensure that the child is examined by someone who knows how to find and keep important evidence.

4. Adults and Children with Physical and Developmental Disabilities

- **Materials Prepared in a Way You Can Understand** – The MCO has materials reviewed by people with experience in the needs of people with disabilities. This means that the information will be presented using the right methods so that people with disabilities can understand, whether in writing or by voice translation.

- **DDA Services** - Members that currently receive services through the Developmental Disabilities Administration (DDA) or under the DDA waiver can continue to receive those services.

- **Medical Equipment and Assistive Technology** - MCO providers have the experience and training for both adults and children to provide medical equipment and assistive technology services.

7. Special Services

- **Case Management** - Case managers are experienced in working with people with disabilities.

5. Adults and Children with HIV/AIDS

- **HIV/AIDS Case Management** - The MCO has special case managers trained in dealing with HIV/AIDS issues and in linking persons with the services that they need.

- **Diagnostic Evaluation Service (DES) assessment visits once every year** - One annual diagnostic and evaluation service (DES) visit for any member diagnosed with HIV/AIDS, which the MCO is responsible for facilitating on the member's behalf.

- **Substance Use Disorder Services** - Individuals with HIV/AIDS who need treatment for a substance use disorder will be referred to the Public Behavioral Health System within 24 hours of request.

6. Adults and Children Who Are Homeless

The MCO will attempt to identify individuals who are homeless and link them with a case manager and appropriate health care services. It can be difficult for MCOs to identify when members become homeless. If you find yourself in this situation, contact the MCO member services.

B. Rare and Expensive Case Management Program (REM)

The Rare and Expensive Case Management Program, REM for short, is a program provided by the State for children and adults who have very expensive and very unusual medical problems. The REM program offers Medicaid benefits plus other specialty services needed for special medical problems. Your Primary Care Provider (PCP) and MCO will have a list of the REM diagnoses and will let you know if you or any of your children should consider entering the REM Program. The MCO and your PCP will know if you have one of the diagnoses that may qualify you for the REM Program.

Your PCP or MCO will let you know if you or any of your children should consider entering the REM Program. You will be informed by telephone, by mail, or by a visit from a REM case manager. If you do not want to transfer to the REM program, you can stay in the MCO. Once a member is in REM they will no longer be enrolled in an MCO. This change will happen automatically.

7. Special Services

Once you are enrolled in REM you will be assigned a REM Case Manager. The REM case manager will work with you to transition your care from the MCO. They will help you select the right provider. If possible they will help you arrange to see the same PCP and specialists. If your child is under age 21, and was getting medical care from a specialty clinic or other setting before going into REM you may choose to keep receiving those services. Call the REM Program (**1-800-565-8190**) if you have additional questions.

8. Utilization Management

A. Medical Necessity

You are eligible to receive HealthChoice benefits when needed as described in the benefits and services section of this manual. Some benefits may have limitations or restrictions. **All HealthChoice benefits/services need to be medically necessary in order for you to receive them.**

For a benefit or service to be considered medically necessary it must be:

- Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- Consistent with current accepted standards of good medical practice;
- The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
- Not primarily for the convenience of the member, the member's family, or the provider.

B. Preauthorization/Prior Approval

(All authorizations must be obtained prior to services rendered/given)

There will be times when services and medications will need Preauthorization (also called prior approval or prior authorization) before you can receive that specific service or medication. Preauthorization is the process where a qualified health care professional reviews and determines if a service is medically necessary.

If the preauthorization is approved, then you can receive the service or medication. You will be notified in writing of the decision within 14 calendar days, or 28 calendar days if there was a request for an extension.

If the preauthorization is denied or reduced in amount, duration or scope, then that service or medication will not be covered by the MCO. You will be notified in writing of the decision within 14 calendar days, or 28 calendars if there was a request for an extension. You will be given the right to file an appeal for the denied for a denied preauthorization. (See Complaints, Grievance, and Appeals section on page 59)

8. Utilization Management

There may be times where an expedited authorization is required to avoid potentially serious health complications. In these situations, the MCO must make their decision with 72 hours. If an extension is requested for an expedited authorization, then the MCO has up to 14 calendar days to make their decision.

Note: *The State is in the process of changing the time frames and processes that all MCOs must follow when considering preauthorization/prior approval requests. The information in this section will be effective for services received on or after 1/1/18. See Attachment F for the MCOs current policy.*

C. Continuity of Care Notice

If you are currently receiving treatment and fit in to a category below, then you have special rights in Maryland.

- New to HealthChoice; or
- Switched from another MCO; or
- Switched from another company's health benefit plan.

If your old company gave you preauthorization to have surgery or to receive other services, you may not need to receive new approval from your current MCO to proceed with the surgery or to continue receiving the same services. Also, if you are seeing a doctor or other health care provider who is a participating provider with your old company or MCO, and that provider is a non-participating provider under your new plan, you many continue to see your provider for a limited period of time as though the provider were a participating provider with us. The rules on how you can qualify for these special rights are described below.

Preauthorization for health care services

- If you previously were covered under another company's plan, a preauthorization for services that you received under your old plan may be used to satisfy a preauthorization requirement for those services if they are covered under your new plan with us.

- To be able to use the old preauthorization under this new plan, you will need to contact your current MCO member services to let them know that you have a preauthorization for the services and provide us with a copy of the preauthorization. Your parent, guardian, designee, or health care provider may also contact us on your behalf about the preauthorization.

8. Utilization Management

- There is a time limit for how long you can rely on this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.

- Limitation on Use of Preauthorization: Your special right to use a preauthorization does not apply to:
    - Dental Services
    - Mental Health Services
    - Substance Use Disorder Services
    - Benefits or services provided through the Maryland Medicaid fee-for-service program

- If you do not have a copy of the preauthorization, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the preauthorization within 10 days of your request.

Right to use non-participating providers

- If you have been receiving services from a health care provider who was a participating provider with your old company, and that provider is a non-participating provider under your new health plan with us, you may be able to continue to see your provider as though the provider were a participating provider. You must contact your current MCO to request the right to continue to see the non-participating provider as if the provider were a participating provider with us. Your parent, guardian, designee, or health care provider may also contact us on your behalf to request the right for your continue to see the non-participating provider.

- This right applies only if you are being treated by the non-participating provider for covered services for one or more of the following types of conditions:
    1. Acute conditions;
    2. Serious chronic conditions;
    3. Pregnancy; or
    4. Any other condition upon which we and the out-of-network provider agree.

- Examples of conditions listed above include bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS, and organ transplants.

- There is a time limit for how long you can continue to see a non-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care provider after the baby is born.

Example of how the right to use non-participating providers works:
You broke your arm while covered under Company A's health plan and saw a Company A network provider to set your arm. You changed health plans and are now covered under Company B's plan. Your provider is a non-participating provider with Company B. You now need to have the cast removed and want to see the original provider who put on the cast.

In this example, you or your representative needs to contact Company B so that Company B can pay your claim as if you are still receiving care from a participating provider. If the non-participating provider will not accept Company B's rate of payment, the provider may decide not to provide services to you.

- Limitation on Use of Non-participating Providers: Your special right to use a non-participating provider does not apply to:
  - Dental Services;
  - Mental health services;
  - Substance use disorder services; or
  - Benefits or services provided through the Maryland Medicaid fee-for-service program.

Appeal Rights:
- If your current MCO denies your right to use a preauthorization from your old company or your right to continue to see a provider who was a participating provider with your old company, you may appeal this denial by contacting the MCO Member Services.

- If your current MCO denies your appeal, you may file a complaint with the Maryland Medicaid Program by calling the HealthChoice Help Line at **1-800-284-4510**.

- If you have any questions about this procedure call MCO Member Services or the HealthChoice Help Line at **1-800-284-4510**.

D. Coordination of Benefits - What to Do if You Have Other Insurance

You are required to notify the MCO if you received medical care after an accident or injury. MCOs are required by the State to seek payment from other insurance companies. If you have other medical insurance make sure you inform the MCO and tell your provider. They will need the name of the other insurance policy, the policy holder's name and the membership number. The State does a check of insurance companies to identify individuals that have both Medicaid/HealthChoice and other insurance.

Medicaid/HealthChoice is not a supplemental health insurance plan. Your other health insurance will always be your primary insurance which means participating providers must bill your other insurance first. It is likely that your primary insurance will have paid more than the MCOs allowed amount and therefore the provider cannot collect additional money from you or from the MCO. Talk with MCO Member services to better understand your options. Since other insurers will likely have co-pays and deductibles, in most cases MCOs will require you to use participating providers.

E. Out of Network Services

There may be times that you need a covered service that the MCOs network cannot provide. If this situation occurs, you may be able to receive this service from a provider that is out of the MCOs network (a non-participating provider). You will need preauthorization from your MCO to receive this service out of network. If your preauthorization is denied, you will be given the right to file an appeal.

F. Preferred Drug List

If you need medications, your PCP or specialist will use the MCOs preferred drug list (also called a formulary) to prescribe you medicines. A preferred drug list is a listing of medicines that you and your provider can choose from, that are safe, effective, and cost saving. If you want to know what medicines are on the MCOs preferred drug list, call MCO Member Services or go online and access their website. There are some medicines on the preferred drug list as well as any medicine not on the list that will require preauthorization before the MCO will cover it. If the MCO denies the preauthorization for the medicine, then you will be given the right to file an appeal.

8. Utilization Management

A copy of the preferred drug list can be found on the MCOs website or you can request a paper copy by calling MCOs Member Services.

G. New Technology and Telehealth

As new and advanced health care technology emerges, MCOs have processes in place to review and determine if these innovations will be covered. Each MCO has their own policy on the review of new medical technology, treatments, procedures, and medications. To find out a MCOs policy and procedure on reviewing new technology for health care, contact the MCOs member services.

MCOs are required to provide telehealth services as medically necessary. Telehealth services utilize video and audio technology in order to improve health care access. Providing telehealth services can improve:

- Education and understanding of a diagnosis;
- Treatment recommendations; and
- Treatment planning.

9. Billing

A. Explanation of Benefits

You may be receiving a statement in the mail from the MCO called an Explanation of Benefits (EOB). The EOB will inform you:

- Type of service
- Date of service
- Amount billed
- Amount of the bill that was paid

An EOB is not a bill but will list the services that the MCO has paid on your behalf. The purpose of the EOB is to summarize which provider charges are a covered service or benefit. If you feel that there is an error on the EOB, like finding a service that you never received, contact the MCO member services. If you are copied on a notice that your provider was not paid, you are not responsible for payment.

B. What to Do if you Receive a Bill

- Do not pay for a service that is not your responsibility as you may not be reimbursed. Only providers can receive payment from Medicaid or MCOs. If you receive a medical bill for a covered benefit:
    - First - Contact the provider who sent the bill.
    - If you are told you did not have coverage on the date you received care or that the MCO did not pay, call MCO Member Services.
    - The MCO will determine if there has been an error or what needs to done to resolve the problem.
    - If the MCO does not resolve the problem contact the HealthChoice Help Line (**1-800-284-4510**).

- Providers are required to verify eligibility. Providers must bill the MCO. (If the service is covered by the State and not the MCO, the Eligibility Verification System (EVS) will tell them where to send the bill.)

9. Billing

- With few exceptions Medicaid and HealthChoice providers are not allowed to bill members. Small pharmacy copays and copays for optional services such as adult dental and eyeglasses for adults are examples of services you could be billed for.

***Note**: MCOs will be required to copy you on all claims denials for services provided on or after 1/1/18.*

10. Complaints, Grievances and Appeals

A. Adverse Benefit Determination, Complaints and Grievances

Adverse Benefit Determination

An adverse benefit determination is when a MCO does any of the following:

- Denies or limits a requested service based on type or level of service, meeting medical necessity, appropriateness, setting, effectiveness;
- Reduces, suspends, or terminates a previously authorized service;
- Denies partial or full payment of a service;
- Fails to make an authorization decision or to provide services in a timely manner;
- Fails to resolve a grievance or appeal in a timely manner;
- Does not allow members living in a rural area with only one MCO to obtain services outside the network; or
- Denies a member's request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities.

Once a MCO makes an adverse benefit determination, you will be notified in writing at least 10 days before the adverse benefit determination goes into effect. You will be given the right to file an appeal and can request a free copy of all of the information the MCO used when making their determination.

Complaints

If you disagree with the MCO or provider about an adverse benefit determination, this is called a complaint. Examples of complaints include reducing or stopping a service you are receiving, being denied a medication not on the preferred drug list, or having a preauthorization for a procedure denied.

Grievances

If your complaint is about something other an adverse benefit determination, this is called a grievance. Examples of grievances include quality of care, not being allowed to exercise your rights, not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at the MCO or at your doctor's office. See Attachment F for the MCOs internal complaint procedure.

B. Appeals

If your complaint is about a service you or a provider feels you need but the MCO will not cover, you can ask the MCO to review your request again. This request for a review is called an appeal.

If you want to file an appeal you have to file it within 60 days from the date that you receive the letter saying the MCO would not cover the service you wanted.

Your doctor can also file an appeal for you if you sign a form giving him or her permission. Your doctor won't be penalized for acting on your behalf. Other people can also help you file an appeal, like a family member or a lawyer.

When you file an appeal, be sure to let the MCO know of any new information that you have that will help them make a decision. The MCO will send you a letter letting you know that they received your appeal within five business days. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help the MCO make a decision.

When reviewing your appeal, the MCO reviewers:

- Will be different from the medical professionals who made the previous decision;
- Will not be a subordinate of the reviewers who made the previous decision;
- Will have the appropriate clinical knowledge and expertise to perform the review;
- Will review all information submitted by the member or representative regardless if this information was submitted for the previous decision; and
- Will make a decision about your appeal within 30 calendar days.

The appeal process may take up to 44 days if you ask for more time to submit information or the MCO needs to get additional information from other sources. The MCO will call and send you a letter within two days if they need additional information.

If your doctor or MCO feels that your appeal should be reviewed quickly due to the seriousness of your condition, you will receive a decision about your appeal within 72 hours.

If your appeal does not need to be reviewed quickly, the MCO will try to call you and send you a letter letting you know that your appeal will be reviewed within 30 days.

10. Complaints, Grievances and Appeals

If your appeal is about a service that was already authorized, the time period has not expired, and you were already receiving, you may be able to keep getting the service while your appeal is under review. You will need to contact the MCO's member services and request to keep getting services while your appeal is reviewed. You will need to contact member services within 10 days from when the MCO sent the determination notice or before the intended effective date of the determination. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Once the review is complete, you will receive a letter informing you of the decision. If the MCO decides that you should not receive the denied service, the letter will tell you how to ask for a State Fair Hearing.

If you file a grievance and it is:

- About an urgent medical problem you are having, it will be solved within 24 hours.
- About a medical problem but it is not urgent, it will be solved within 5 days.
- Not about a medical problem, it will be solved within 30 days.

Note: *See Attachment F for the MCOs current policy.*

C. How to File a Complaint, Grievance or Appeal

To submit a complaint or grievance, you can contact the MCOs Member Services. If you need auxiliary aids or interpreter services, let the member services representative know (hearing impaired members can use the Maryland Relay Service, 711). The MCOs customer service representatives can assist you with filing a complaint, grievance, or appeal.

You can request to file an appeal verbally but will need to confirm the appeal request in writing, unless it is an expedited resolution request. To file the appeal in writing the MCO can send you a simple form that you can complete, sign, and mail back. The MCO can also assist you in completing the form if you need help. You will also be given the opportunity to give the MCO your testimony and factual arguments prior to the appeal resolution.

See Attachment F for the MCOs internal complaint procedure. If you need a copy of the MCOs official internal complaint procedure, call MCO Member Services.

D. The State's Complaint/Appeal Process

Getting Help From the HealthChoice Help Line

If you have a question or complaint about your health care and the MCO has not solved the issue to your satisfaction, you can ask the State for help. The HealthChoice Help Line (**1-800-284-4510**) is open Monday through Friday between 8 AM and 5 PM. When you call the Help Line, you can ask your question or explain your problem to one of the Help Line staff, who will:

- Answer your questions;
- Work with the MCO to resolve your problem; or
- Send your complaint to a Complaint Resolution Unit nurse who may:
  - Ask the MCO to provide information about your case within five days;
  - Work with your provider and MCO to assist you in getting what you need;
  - Help you to get more community services, if needed; or
  - Provide guidance on the MCOs appeal process and when you can request a State Fair Hearing.

Asking the State to Review the MCO's Decision

If you appealed the MCOs initial decision and you received a written denial, you have the opportunity for the State to review your decision. This is called an appeal.

You can contact the HealthChoice Help Line at (**1-800-284-4510**) and tell the representative that you would like to appeal the MCOs decision. Your appeal will be sent to a nurse in the Complaint Resolution Unit. The Complaint Resolution Unit will attempt to resolve your issue with us in 10 business days. If it cannot be resolved in 10 business days, you will be sent a notice that gives you your options.

When the Complaint Resolution Unit is finished working on your appeal, you will be notified of their findings.

- If the State thinks the MCO should provide the requested service, it can order the MCO to give you the service; or

- If the State thinks that the MCO does not have to give you the service, you will be told that the State agrees with the MCO.

- If you do not agree with the State's decision, which you will receive in writing, you will again be given the opportunity to request a State Fair Hearing.

Types of State Decisions You Can Appeal

You have the right to appeal three types of decisions made by the State. When the State:

- Agrees with the MCO that we should not cover a requested service;
- Agrees with the MCO that a service you are currently receiving should be stopped or reduced; or
- Denies your request to enroll in the Rare and Expensive Case Management (REM) Program.

Continuing Services During the Appeal

There are times when you may be able to keep getting a service while the State reviews your appeal. This can happen if your appeal is about a service that was already authorized, the time period for the authorization has not expired, and you were already receiving the service. Call the HealthChoice Help Line (**1-800-284-4510**) for more information. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Fair Hearings

To appeal one of the State's decisions, you must request that the State file a notice of appeal with the Office of Administrative Hearings on your behalf. The request for a State Fair Hearing must be submitted no later than 120 days from the date of the MCOs notice of resolution. The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

- If the appeal is about the MCO reducing or not giving you a service because both the State and MCO thinks you do not have a medical need for the service, the Office of Administrative Hearings will set a hearing date within 20 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.
- You can ask for an expedited appeal. If the State thinks your hearing should be held more quickly due to the seriousness of your health condition, a hearing will be held and a decision will be made within 72 hours.

- For all other appeals, the Office of Administrative Hearings will set a hearing date within 30 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

The Board of Review/Judicial Appeal

- If the Office of Administrative Hearings decides against you, you may appeal to the State's Board of Review. You will get the information on how to appeal to the Board of Review with the decision from the Office of Administrative Hearings.

If the Board of Review decides against you, you may appeal to the Circuit Court.

E. Reversed Appeal Resolutions

If the MCO reverses a denial, termination, reduction, or delay in services, that were not provided during the appeal process, the MCO will have to provide the services no later than 72 hours from the date it receives the reverse appeal notice.

If the MCO reverses a denial, termination reduction, or delay in services that a member was receiving during the appeal process, the MCO will pay for the services received during the appeal process.

If you need to appeal a service covered by the State, follow the directions provided in the adverse determination letter.

F. Making Suggestions for Changes in Policies and Procedures

If you have an idea on ways to improve a process or want to bring a topic to the MCOs attention, call MCO Member Services. MCOs are interested in both hearing from you and ways to enhance your experience receiving health care.

Each MCO is required to have a consumer advisory board. The role of the consumer advisory board is to provide member input to the MCO. The consumer advisory board is made up of members, members' families, guardians, caregivers and member representatives who meet regularly throughout the year. If you would like more information about the consumer advisory board, call MCO Member Services.

10. Complaints, Grievances and Appeals

You may be contacted about services you receive from the MCO. If contacted, provide accurate information as this helps to determine the access and quality of care provided to HealthChoice members.

11. Changing MCOs

A. 90 Day Rules

- The first time you enroll in the **HealthChoice Program** you have one opportunity to request to change MCOs. You must make this request within the **first 90 days**. You can make this one time change even if you originally selected the MCO.
- If you are out of the MCO for more than 120 days and the State auto assigned you to the MCO you can request to change MCOs. You must make this request within **90 days.**

B. Once Every 12 Months

You may change your MCO if you have been with the same MCO for 12 or more months.

C. When There is an Approved Reason to Change MCOs

You may change your MCO and join another MCO near where you live for any of the following reasons at any time:

- If you move to another county where your current MCO does not offer care
- If you become homeless and find that there is another MCO closer to where you live or have shelter, which would make getting to appointments easier
- If you or any of your family has a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO
- If you have a foster child placed in your home and you or your family members receive care by a doctor in a different MCO than the foster child, the foster child being placed can switch to the foster family's MCO.
- If the MCO terminates your PCP contract for reasons other than listed below, then you will be notified by the state.
    - Your MCO has been purchased by another MCO;
    - The provider and the MCO cannot agree on a contract for certain financial reasons; or
    - Quality of care.

D. How to Change Your MCO

Contact the State's Maryland Health Connection (855-642-8572) . Note that:

11. Changing MCOs

- MCOs are not allowed to authorize changes. Only the State can change your MCO.
- If you are hospitalized or in a nursing facility they may not allow you to change MCOs.
- If you lose Medicaid eligibility but are approved again within 120 days, you will automatically be enrolled with the same MCO that you had prior to losing eligibility.

12. Reporting Fraud, Waste and Abuse

A. Types of Fraud, Waste and Abuse

Medicaid fraud is the intentional deception or misrepresentation by a person who is aware that this action could result in an unauthorized benefit for themselves or others. Waste is overusing or inappropriate use of Medicaid resources. Abuse is the practice of causing unnecessary cost to the Medicaid program. Fraud, waste, and abuse require immediate reporting and can occur at all levels in the health care system. Examples of Medicaid fraud, waste, and abuse include but are not limited to:

- Member Examples:
  - Falsely reporting your income and or assets to qualify for Medicaid
  - Permanently living in another state while receiving Maryland Medicaid benefits
  - Lending your member ID card or using another member's ID card to obtain health services
  - Selling or making changes to a prescription medicine
- Provider Examples:
  - Providing services that are not medically necessary
  - Billing for services that were not provided
  - Billing multiple times for the same service
  - Altering medical records to cover up fraudulent activity

B. How to Report Fraud, Waste and Abuse

If you suspect or know that fraud, waste, or abuse is occurring, report it immediately. Reporting fraud, waste, and abuse will not affect how you will be treated by the MCO. You have the choice to remain anonymous when you make the report. Provide as much information as possible; this will assist those investigating the report. There are many ways to report fraud, waste, and abuse. See the options below:

- Call MCO Member Services or write the MCO a letter
- Contact the Maryland Department of Health,
  Office of the Inspector General:
  - **1-866-770-7175**
  - **http://dhmh.maryland.gov/oig/Pages/Report_Fraud.aspx**
- Contact the U.S. Department of Health and Human Services, Office of the Inspector General
  - **1-800-447-8477**
  - **https://oig.hhs.gov/fraud/report-fraud/index.asp**

13. Attachment A – MCO Contacts

13. Attachment A – MCO Contacts

Managed Care Organization - Aetna Better Health® of Maryland	
Member Services	**1-866-827-2710**
	TTY: **711**
24/7 Nurse Advice Line	**1-866-827-2710**
	TTY: **711**
Language Line Services Call Member Services	**1-866-827-2710**
	TTY: **711**
Pharmacy Services Call Member Services	**1-866-827-2710**
	TTY: **711**
Prescriptions by Mail CVS (24 hours a day, 7 days a week)	**1-855-271-6603**
	TTY: **711**
Superior Vision (vision care services- M-F, 8 AM-5 PM)	**1-800-879-6901**
	TTY: **711**
Website	**AetnaBetterHealth.com/Maryland**
Online Member Portal	**AetnaBetterHealth.com/Maryland**
Nondiscrimination Coordinator	Civil Rights Coordinator 4500 East Cotton Center Boulevard Phoenix, AZ 85040 **1-888-234-7358, TTY 711**
Complaints, Grievance, Appeals Address	Aetna Better Health of Maryland PO Box 81139 5801 Postal Road Cleveland, OH 44181 Fax: **1-844-312-4257**
Reporting Fraud and Abuse Address	Aetna Better Health of Maryland Attn: Fraud and Abuse 509 Progress Drive, Suite 117 Linthicum, MD 21090 **1-855-877-9735**

14. Attachment B – Notice of Privacy Practices

Aetna Better Health® of Maryland

Notice of Privacy Practices

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

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

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

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

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

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

_____

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

15 Attachment C – Additional Services Offered by MCO

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

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

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

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

Sharing with other businesses

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

Other reasons we might share your health information

We also may share your health information for these reasons:

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

15 Attachment C – Additional Services Offered by MCO

Reasons that we will need your written okay

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

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

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

What are your rights

You have the right to look at your health information.

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

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

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

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

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

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

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

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

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

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

15 Attachment C – Additional Services Offered by MCO

Call us toll free at **1-866-827-2710** to:

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

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

Aetna Better Health of Maryland
PO Box 81139
5801 Postal Road
Cleveland, OH 44181

You also can file a complaint with the Department of Health and Human Services, Office of Civil Rights. Call us to get the address at **1-866-827-2710**. If you are unhappy and tell the Office of Civil Rights, you will not lose plan membership or health care services. We will not use your complaint against you.

Protecting your information

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

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

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

Will we change this notice

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

15. Attachment C– Additional Services offered by MCO

Additional Services Offered By Aetna Better Health of Maryland

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	LIMITATIONS
Pharmacy Copays	**No copays**	All members – Adults and Children	
Adult vision	**Eye exam every year**, Glasses or contacts every year	Adults	$25 limit for glasses or contacts
Adult dental	**Oral exam** and **cleaning** twice a year plus **X-rays**	Adults 21 and older	

16. Attachment D – Prenatal/Postpartum Program

Aetna Better Health of Maryland will provide our Promise Program for pregnant women, infants with special needs [including Neonatal Abstinence Syndrome (NAS)] and help them to access to community family planning providers, women's health specialists, obstetrical services, and perinatal care, including postpartum care services and specialized providers for infants.

Our maternity care program is designed to assure the health of women during their pregnancies and reduce the risk of preterm birth and low birth weight infants. It helps you learn how to take care of yourself and your baby. You will get support and help throughout your pregnancy. Aetna Better Health will identify pregnant members early to start prenatal care, identify risk factors, such as smoking or other health conditions, and assign a care manager to the member. Our case managers encourage pregnant members to make early and regular prenatal and postnatal visits. Members, Providers and Care Givers or other member's circle of support may refer members to care management simply by calling member services.

Infants with Special Needs will be assigned a care manager who will work with the member's PCP, parents and care givers to maintain their health at home, while evaluating and supporting the parents or care givers of these infants, who may also have complex medical or social problems. Members can sign up for **Text4baby™**, a free text service that sends health tips and reminders throughout your pregnancy and after your baby is born.

The Promise Program is a benefit for you before and after your baby is born.

- You will earn a $10 gift card when you complete at least 7 prenatal visits.
- You will earn a second $10 gift card when you complete your postpartum visit. This visit must be within 21-56 days after your baby is born.
- You can earn an additional $5 gift card for attending each of the below:
  - A birthing class
  - A parenting class
  - A first aid, safety or CPR class

Sometimes babies are born early even with prenatal care. If this does happen, we still want to reward you for taking care of yourself and the baby:

- If you complete a CPR class and attend all trainings at the hospital prior to baby's discharge you will earn a $5 gift card
- Attend a parenting class you can earn a $5 gift card

17. Attachment E – Health Education Program

Disease Management Program

Aetna Better Health works with members to address issues related to their asthma, diabetes, heart failure, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), depression, pregnancy or other conditions based on the member's needs. Aetna Better Health education activities are based on national clinical guidelines and include: physical and mental health evaluations, evidence-based interventions, collaboration with providers, health homes and external case management entities, educational materials, and referrals for additional resources.

Condition management interventions include telephonic and print education on self-monitoring, health behaviors, referral for appropriate medical testing, assistance with techniques to better adhere to medication and treatment plans. Further, as behavioral health and substance use issues are commonly co-occurring, each member identified as having problems in one of these areas (either by self-report, referral, initial assessment or claims data) is screened for both issues so that the appropriate resources and services can be arranged. These assessments are based on national clinical guidelines for care and self-management of specific chronic illnesses.

- Asthma (adult and pediatric modules)
- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Depression
- Diabetes
- Heart failure (HF)

Culturally aligned individualized letters are sent to members when they are identified with a chronic condition. These letters inform the member how they became eligible for the program; including how to use the services and get more information and how to opt out if they so choose.

The Aetna Better Health of Maryland website, **AetnaBetterHealth.com/Maryland,** is a resource for members and providers regarding chronic condition management programs and interventions. Providers can request to enroll members in integrated care management using a form found on the website. Providers are educated regarding the Community Health Workers program through multiple sources such as; in-person introductions, Frequently Asked Questions (FAQ) tip sheet, or by contacting our Member Services team at **1-866-827-2710 (TTY: 711)**.

17. Attachment E – Health Education Program

Ted E Bear M.D. Club (members age 5 to 18)

- **Scouts membership**
  The Ted E. Bear M.D. Club will pay the cost for an annual Scout membership for members age 5 to 18. This applies to both Boy Scouts and Girl Scouts. As a bonus, Club members who stay in Boy Scouts get the *Boys' Life* magazine. Girl Scouts members can get *A Girl's Guide to Girl Scouting* plus one *Journey* book or a basic uniform after 6 months of joining **OR** we will also pay the annual membership for a local youth organization ($60 annual value).

- **Weight Management Program**
  We offer a weight management program. Members receive gifts for joining the program. Each member then works with a case manager to set goals based on the child's weight and height needs. Members can earn gift cards from $15 to $30 as they meet the weight loss goals.

- **Stop Smoking Program**
  We offer teens a program to help them **stop smoking.** This includes members who use cigarettes, smokeless tobacco, hookah, e-cigs, even second hand-smoke. Teens work with a case manager to create a stop smoking plan. They will throw away all tobacco products and receive a $10 gift card. If they remain tobacco free for 30 days they will get another $10 gift card.

- **Third inhaler Program**
  School-age kids with asthma can get a third inhaler – one for home, one for their backpack and one for school.

Asthma Program

Members with asthma can enroll in the Asthma Management program. For school-age kids with asthma, we offer a second inhaler; one to stay at home and one to go to school.

Once you are enrolled in the program:

- Members with asthma can get a $10 gift card for managing their asthma by having an asthma action plan and reducing ED visits.
- You can get a $10 gift card for follow-up with a PCP visit after an ED visit.
- We also offer a $10 gift card for an in-home environmental assessment for members with asthma.

17. Attachment E – Health Education Program

Flu Shots

Flu shots are available for free each year during the flu season starting in September through May. Flu shots are for individuals 6 months and older. It is recommended to have a flu shot if you have a chronic health condition such as asthma or chronic lung disease.

18. Attachment F – MCO Internal Complaint/Appeal Process

How to File an Appeal - Member

You have the right to appeal any adverse benefit determination (decision) by Aetna Better Health that you disagree with that relates to coverage or payment of services.

For example, you can appeal if Aetna Better Health denies:

- A request for a health care service, supply, item or drug that you think you should be able to get, or
- A request for payment of a health care service, supply, item, or drug that Aetna Better Health denied.

You can also appeal if Aetna Better Health stops providing or paying for all or a part of a service or drug that you think you still need.

Authorized Representative

You may wish to authorize someone you trust to appeal on your behalf. This person is known as your authorized representative. You must inform Aetna Better Health of the name of your authorized representative. You can do this by calling our Member Services Department at **1-866-827-2710 (TTY: 711).** We will provide you with a form that you can fill out and sign stating who your representative will be.

How to Submit Your Appeal

If you are not satisfied with a decision we made about your service authorization request, you have 60 days after hearing from us to file an appeal. You can do this yourself or ask someone you trust to file the appeal for you. You can call Member Services at **1-866-827-2710 (TTY: 711)** if you need help filing an appeal or if you need assistance in another language or require an alternate format. We will not treat you unfairly because you file an appeal.

You can file your appeal by phone or in writing. You can send the appeal as a standard appeal or an expedited (fast) appeal request.

You or your doctor can ask to have your appeal reviewed under the expedited process if you believe your health condition or your need for the service requires an expedited review. Your doctor will have to explain how a delay will cause harm to your physical or behavioral health. If your request for an expedited appeal is denied we will tell you and

your appeal will be reviewed under the standard process.

Send your Appeal request to:

Aetna Better Health of Maryland
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
Fax: **1-844-312-4257**

If you request your standard appeal by phone, it must be followed up in writing. Expedited process appeals submitted by phone do not require you to submit a written request.

Continuation of Benefits

In some cases you may be able to continue receiving services that were denied by us while you wait for your appeal to be decided. You may be able to continue the services that are scheduled to end or be reduced if you ask for an appeal:

- Within ten days from being told that your request is denied or care is changing; or
- By the date the change in services is scheduled to occur.

If your appeal results in another denial you may have to pay for the cost of any continued benefits that you received if the services were provided solely because of the requirements described in this Section.

What Happens After We Get Your Appeal

Within 5 business days, we will send you a letter to let you know we have received and are working on your appeal.

Appeals of clinical matters will be decided by qualified health care professionals who did not make the first decision and who have appropriate clinical expertise in treatment of your condition or disease.

Before and during the appeal, you or your authorized representative can see your case file, including medical records and any other documents and records being used to make a decision on your case. This information is available at no cost to you.

You can also provide information that you want to be used in making the appeal decision in person or in writing to:

18. Attachment F – MCO Internal Complaint/Appeal Process

Aetna Better Health of Maryland
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
Fax: **1-844-312-4257**

You may call Member Services at **1-866-827-2710 (TTY: 711)** if you are not sure what information to give us.

Timeframes for Appeals

Standard Appeals
If we have all the information we need we will tell you our decision within 30 days of when we receive your appeal request. We will tell you within 2 calendar days after receiving your appeal if we need more information. A written notice of our decision will be sent to you within 2 calendar days from when we make the decision.

Expedited Appeals
If we have all the information we need, expedited appeal decisions will be made within 72 hours of receipt of your appeal. We will tell you within 2 days after receiving your appeal if we need more information. We will tell you our decision by phone and send a written notice within 2 days from when we make the decision.

If We Need More Information
If we can't make the decision within the needed timeframes because we need more information we will:

- Write you and tell you what information is needed. If your request is in an expedited review, we will call you right away and send a written notice later;
- Tell you why the delay is in your best interest; and
- Make a decision no later than 14 days longer than number of days we originally told you.

You, your provider, or someone you trust may also ask us to take more time to make a decision. This may be because you have more information to give Aetna Better Health to help decide your case. You may ask for an extension by calling Member Services at **1-866-827-2710 (TTY: 711)** or writing to:

Aetna Better Health of Maryland
PO Box 81139
5801 Postal Road

Cleveland, OH 44181
Fax: **1-844-312-4257**

You or your representative can file a complaint with Aetna Better Health if you do not agree with our decision to take more time to review your appeal.

You or your representative can also file a complaint about the way Aetna Better Health is handling your appeal to the Maryland Department of Health or to your Ombudsman.

If we do not tell you our decision about your appeal on time, you have the right to appeal to the State through the State Fair Hearing process. An untimely response by us is considered a valid reason for you to appeal further through the State Fair Hearing process.

Written Notice of Appeal Decision

We will tell you and your provider in writing if your request is denied or approved in an amount less than requested. We will also tell you the reason for the decision and the contact name, address, and telephone number of the person responsible for making the adverse determination. We will explain your right to appeal through the State Fair Hearing Process if you do not agree with our decision.

Your Right to File a Complaint (Grievance)

Aetna Better Health will try its best to deal with your concerns as quickly as possible to your satisfaction. Depending on what type of concern you have, it will be handled as a complaint (also known as a grievance) or as an appeal.

What Kinds of Problems Should be Complaints

The complaint process is used for concerns related to quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the Aetna Better Health's complaint process.

Complaints about quality

- You are unhappy with the quality of care, such as the care you got in the hospital.

Complaints about privacy

- You think that someone did not respect your right to privacy or shared information about you that is confidential or private.

18. Attachment F – MCO Internal Complaint/Appeal Process

Complaints about poor customer service

- A health care provider or staff was rude or disrespectful to you.
- Aetna Better Health staff treated you poorly.
- Aetna Better Health is not responding to your questions.
- You are not happy with the assistance you are getting from your Care Coordinator.

Complaints about accessibility

- You cannot physically access the health care services and facilities in a doctor or provider's office.
- You were not provided requested reasonable accommodations that you needed in order to participate meaningfully in your care.

Complaints about communication access

- Your doctor or provider does not provide you with a qualified interpreter for the deaf or hard of hearing or an interpreter for another language during your appointment.

Complaints about waiting times

- You are having trouble getting an appointment, or waiting too long to get it.
- You have been kept waiting too long by doctors, pharmacists, or other health professionals or by Member Services or other Aetna Better Health staff.

Complaints about cleanliness

- You think the clinic, hospital or doctor's office is not clean.

Complaints about communications from us

- You think we failed to give you a notice or letter that you should have received.
- You think the written information we sent you is too difficult to understand.
- You asked for help in understanding information and did not receive it.

There Are Different Types of Complaints

You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by Aetna Better Health. An external complaint is filed with and reviewed by an organization that is not affiliated with Aetna Better Health.

Internal Complaints

To make an internal complaint, call Member Services at **1-866-827-2710 (TTY: 711)**. You can also write your complaint and send it to us. If you put your complaint in writing, we

will respond to your complaint in writing. You can file a complaint in writing, by mailing or faxing it to us at:

Aetna Better Health of Maryland
PO Box 81139
5801 Postal Road
Cleveland, OH 44181
Fax: **1-844-312-4257**

So that we can best help you, include details on who or what the complaint is about and any information about your complaint. Aetna Better Health will review your complaint and request any additional information. You can call Member Services at **1-866-827-2710 (TTY: 711)** if you need help filing a complaint or if you need assistance in another language or format.

If your complaint is about an extension we want to take or if we denied your request for a fast appeal, we will review your grievance and give you an answer in 24 hours. If your complaint is about a medically urgent need, we will notify you of the outcome within 5 working days of your call. All other types of complaints may take us longer to investigate and get you an answer as quickly as possible, but no later than 30 days after we receive your complaint.

External Complaints

You Can File a Complaint with the HealthChoice Help Line

You can make a complaint about Aetna Better Health to the HealthChoice Help Line. Contact the HealthChoice Help Line at **1-800-284-4510** or Maryland Relay 711.

You Can File a Complaint with the Office for Civil Rights

You can make a complaint to the Department of Health and Human Services' Office for Civil Rights if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. You can also visit **www.hhs.gov/ocr** for more information.

You may contact the local Office for Civil Rights office at:

Office of Civil Rights- Region III
Department of Health and Human Services
150 S Independence Mall West Suite 372
Public Ledger Building
Philadelphia, PA 19106

Voice: **1-800-368-1019**

Fax: 215-861-4431

TDD : **1-800-537-7697**

18. Attachment F – MCO Internal Complaint/Appeal Process

You Can File a Complaint with the Office of the State Long-Term Care Ombudsman

The State Long-Term Care Ombudsman serves as an advocate for older persons and individuals with disabilities receiving long-term care services, and their families. Local Ombudsmen provide information, advocacy, and assistance in resolving care problems and complaints. The services are free.

The State's Long-Term Care Ombudsman program offers assistance to persons receiving long term care services, whether the care is provided in a nursing facility or assisted living facility, or through community-based services to assist persons still living at home. A Long-Term Care Ombudsman does not work for the facility, the State, or Aetna Better Health. This helps them to be fair and objective in resolving problems and concerns.

Maryland Department of Aging
301 West Preston Street
Suite 1007
Baltimore, Maryland 21201

Voice: **1-800-243-3425**

Fax: **410-333-7943**

TDD : 711

19. Attachment G – Aetna Better Health of Maryland Additional Information

Website

Our website is **AetnaBetterHealth.com/Maryland.** It has information to help you get health care plus help you:

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

Secure web portal

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

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

Find support where you need it most

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

Get personalized health information

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

Learn more about your pharmacy benefits

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

19. Attachment G - Aetna Better Health of Maryland Additional Information

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

Get instant access to claims details

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

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

Mobile app

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

Mobile app features

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

Download app

To get the mobile app, you can download it from Apple's App Store or Google's Play Store. Search for "Aetna Better Health" to locate the app. It is free to download and free to use. This application is available on certain devices and operating systems (OS).

19. Attachment G - Aetna Better Health of Maryland Additional Information

Free cell phones

Aetna Better Health of Maryland members may be eligible for a Smartphone at NO COST. Now you can stay connected with those who care about you. Call your doctor, your family and your friends. You may be eligible for a new phone and or a data package that includes:

- Android smartphone
- Voice minutes
- Data packages
- Unlimited text messaging
- Unlimited calls to Aetna Better Health

To learn more or see if you're eligible go to **AetnaBetterHealth.com/Maryland** or call Member Services at **1-866-827-2710 (TTY: 711)**.

Identification Card

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

The ID card lists:

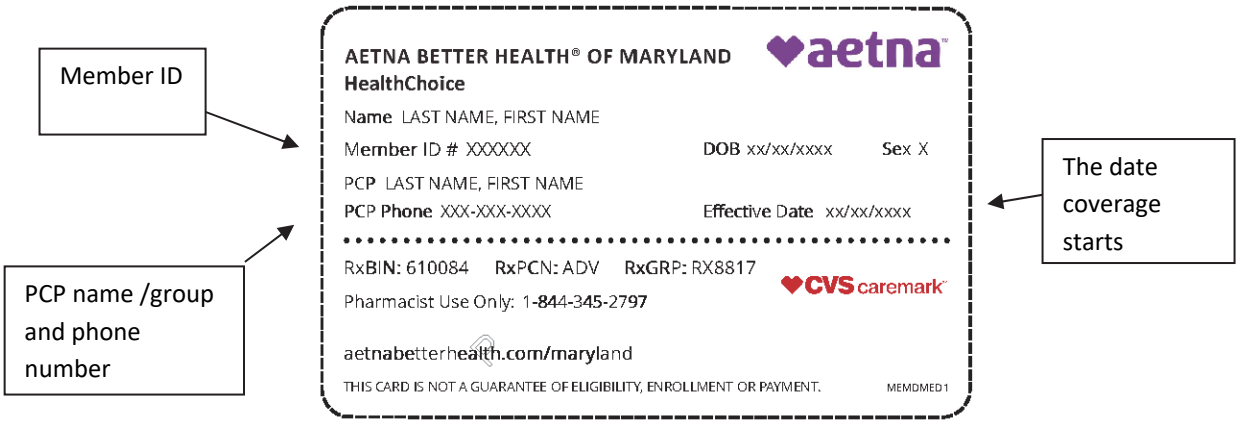
- Your name
- Member ID number
- Your Primary Care Provider's name or the group name for your PCP and phone number
- On the back is important information like what you should do in an emergency

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

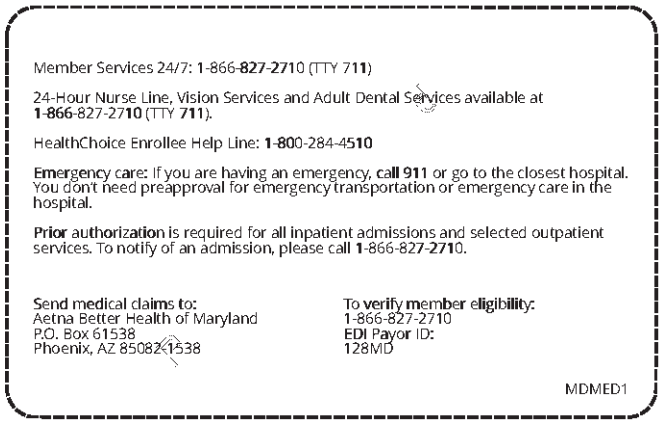
Aetna Better Health of Maryland members will get a Medicaid card and an Aetna Better Health of Maryland ID card. The Medicaid ID card may be used for services the Plan does not cover. Always carry your Medicaid ID card and your Aetna Better Health of Maryland ID card with you in case you need those services.

19. Attachment G - Aetna Better Health of Maryland Additional Information

Front of card:



Back of ID card:



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

Look at your card to make sure the name, address, and date of birth are correct. Call Member Services at **1-866-827-2710 (TTY: 711)** if:

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

20. Attachment H – Advance Directives

MARYLAND ADVANCE DIRECTIVE:

PLANNING FOR FUTURE HEALTH CARE DECISIONS

A Guide to

Maryland Law on

Health Care Decisions

(Forms Included)

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

Brian E. Frosh
Attorney General

August 2019

20. Attachment H – Advance Directives

Dear Fellow Marylander:

I am pleased to send you an advance directive form that you can use to plan for future health care decisions. The form is *optional;* you can use it if you want or use others, which are just as valid legally. If you have any legal questions about your personal situation, you should consult your own lawyer. If you decide to make an advance directive, be sure to talk about it with those close to you. The conversation is just as important as the document. Give copies to family members or friends and your doctor. Also make sure that, if you go into a hospital, you bring a copy. Please *do not* return completed forms to this office.

Life-threatening illness is a difficult subject to deal with. If you plan now, however, your choices can be respected and you can relieve at least some of the burden from your loved ones in the future. You may also use another enclosed form to make an organ donation or plan for arrangements after death.

Here is some related, important information:

- If you want information about Do Not Resuscitate (DNR) Orders, please visit the website http://marylandmolst.org or contact the Maryland Institute for Emergency Medical Services Systems directly at (410) 706-4367. A Medical Orders for Life-Sustaining Treatment (MOLST) form contains medical orders regarding cardiopulmonary resuscitation (CPR) and other medical orders regarding life-sustaining treatments. A physician or nurse practitioner may use a MOLST form to instruct emergency medical personnel (911 responders) to provide comfort care instead of resuscitation. The MOLST form can be found on the Internet at: http://marylandmolst.org. From that page, click on "MOLST Form."
- The Maryland Department of Health makes available an advance directive focused on preferences about mental health treatment. This can be found on the Internet at: http://bha.dhmh.maryland.gov/SitePages/Forms.aspx. From that page, under "Forms," click on "Advance Directive for Mental Health Treatment."

I hope that this information is helpful to you. **I regret that overwhelming demand limits us to supplying one set of forms to each requester.** But please feel free to make as many copies as you wish. Additional information about advance directives can be found on the Internet at: http://www.oag.state.md.us/healthpol/advancedirectives.htm.

Brian E. Frosh
Attorney General

20. Attachment H – Advance Directives

HEALTH CARE PLANNING
USING ADVANCE DIRECTIVES
Optional Form Included
Your Right To Decide

Adults can decide for themselves whether they want medical treatment. This right to decide - to say yes or no to proposed treatment - applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.

A Maryland law called the Health Care Decisions Act says that you can do health care planning through "advance directives." An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

The State offers a form to do this planning, included with this pamphlet. The form as a whole is called "Maryland Advance Directive: Planning for Future Health Care Decisions." It has three parts to it: Part I, Selection of Health Care Agent; Part II, Treatment Preferences ("Living Will"); and Part III, Signature and Witnesses. This pamphlet will explain each part.

The advance directive is meant to reflect your preferences. You may complete all of it, or only part, and you may change the wording. You are *not* required by law to use these forms. Different forms, written the way you want, may also be used. For example, one widely praised form, called *Five Wishes,* is available (for a small fee) from the nonprofit organization Aging With Dignity. You can get information about that document from the Internet at www.agingwithdignity.org or write to: Aging with Dignity, P.O. Box 1661, Tallahassee, FL 32302.

This optional form can be filled out without going to a lawyer. But if there is anything you do not understand about the law or your rights, you might want to talk with a lawyer. You can also ask your doctor to explain the medical issues, including the potential benefits or risks to you of various options. You should tell your doctor that you made an advance directive and give your doctor a copy, along with others who could be involved in making these decisions for you in the future.

In Part III of the form, you need two witnesses to your signature. Nearly any adult can be a witness. If you name a health care agent, though, that person may not be a witness. Also, one of the witnesses must be a person who would not financially benefit by your death or handle your estate. You do not need to have the form notarized.

This pamphlet also contains a separate form called "After My Death." Like the advance directive, using it is optional. This form has four parts to it: Part I, Organ Donation; Part II, Donation of Body; Part III, Disposition of Body and Funeral Arrangements; and Part IV, Signature and Witnesses

Once you make an advance directive, it remains in effect unless you revoke it. It does not expire, and neither your family nor anyone except you can change it. You should review what you've done once in a while. Things might change in your life, or your attitudes might change. You are free to amend or revoke an advance directive at any time, as long as you still have decision-making capacity. Tell your doctor and anyone else who has a copy of your advance directive if you amend it or revoke it.

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that document is *still valid*. Also, if you made

an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

Part I of the Advance Directive: Selection of Health Care Agent

You can name anyone you want (except, in general, someone who works for a health care facility where you are receiving care) to be your health care agent. **To name a health care agent, use Part I of the advance directive form**. (Some people refer to this kind of advance directive as a "durable power of attorney for health care.") Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make health care decisions. You can also decide when you want your agent to have this power—right away, or only after a doctor says that you are not able to decide for yourself.

You can pick a family member as a health care agent, but you don't have to. Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Choose the person best qualified to be your health care agent. Also, consider picking one or two back-up agents, in case your first choice isn't available when needed. Be sure to inform your chosen person and make sure that he or she understands what's most important to you. When the time comes for decisions, your health care agent should follow your written directions.

We have a helpful booklet that you can give to your health care agent. It is called *"Making Medical Decisions for Someone Else: A Maryland Handbook."* You or your agent can get a copy on the Internet by visiting the Attorney General's home page at: www.marylandattorneygeneral.gov/Health%20Policy%20Documents/ProxyHandbook. You can request a copy by calling 410-576-7000.

The form included with this pamphlet does *not* give anyone power to handle your money. We do not have a standard form to send. Talk to your lawyer about planning for financial issues in case of incapacity.

Part II of the Advance Directive: Treatment Preferences ("Living Will")

You have the right to use an advance directive to say what you want about future life-sustaining treatment issues. You can do this in Part II of the form. If you both name a health care agent and make decisions about treatment in an advance directive, it's important that you say (in Part II, paragraph G) whether you want your agent to be strictly bound by whatever treatment decisions you make.

Part II is a living will. It lets you decide about life-sustaining procedures in three situations: when death from a terminal condition is imminent despite the application of life-sustaining procedures; a condition of permanent unconsciousness called a persistent vegetative state; and end-stage condition, which is an advanced, progressive, and incurable condition resulting in complete physical dependency. One example of end-stage condition could be advanced Alzheimer's disease.

20. Attachment H – Advance Directives

FREQUENTLY ASKED QUESTIONS ABOUT ADVANCE DIRECTIVES IN MARYLAND

1. ***Must I use any particular form?***
No. An optional form is provided, but you may change it or use a different form altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

2. ***Who can be picked as a health care agent?***
Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

3. ***Who can witness an advance directive?***
Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (but be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for your advance directive. Also, **one** of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) is not the one you have named to handle your estate after your death.

4. ***Do the forms have to be notarized?***
No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

5. ***Do any of these documents deal with financial matters?***
No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

6. ***When using these forms to make a decision, how do I show the choices that I have made?***
Write your **initials** next to the statement that says what you want. **Don't** use checkmarks or X's. If you want, you can also draw lines all the way through other statements that do not say

7. ***Should I fill out both Parts I and II of the advance directive form?***
It depends on what you want to do. If all you want to do is name a health care agent, just fill out Parts I and III, and talk to the person about how they should decide issues for you. If all you want to do is give treatment instructions, fill out Parts II and III. If you want to do both, fill out all three parts.

8. ***Are these forms valid in another state?***
It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

9. ***How can I get advance directive forms for another state?***
Contact the National Hospice and Palliative Care Organization (NHPCO) at 1-800-658-8898 or on the Internet at: https://www.nhpco.org/patients-and-caregivers/advance-care-[lanning/advance-directives/downloading-your-states-advance-directive.

10. ***To whom should I give copies of my advance directive?***
Give copies to your doctor, your health care agent and backup agent(s), hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes. Consider carrying a card in your wallet saying you have an advance directive and who to contact.

11. ***Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?***
Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the form.

12. ***Can my health care agent or my family decide treatment issues differently from what I wrote?***
It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

20. Attachment H – Advance Directives

13. Is an advance directive the same as a "Patient's Plan of Care", "Instructions on Current Life-Sustaining Treatment Options" form, or Medical Orders for Life-Sustaining Treatment (MOLST) form? No. These are forms used in health care facilities to document discussions about current life-sustaining treatment issues. These forms are not meant for use as anyone's advance directive. Instead, they are medical records, to be done only when a doctor or other health care professional presents and discusses the issues. A MOLST form contains medical orders regarding life-sustaining treatments relating to a patient's medical condition.

14. Can my doctor override my living will? Usually, no. However, a doctor is not required to provide a "medically ineffective" treatment even if a living will asks for it.

15. If I have an advance directive, do I also need a MOLST form?
It depends. If you **don't** want emergency medical services personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have a MOLST form containing a DNR order signed by your doctor. nurse practitioner, or physician assistant. A signed EMS/DNR order approved by the Maryland Institute for Emergency Medical Services Systems would also be valid.

16. Does the DNR Order have to be in a particular form? Yes. Emergency medical services personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, the standardized MOLST form has been developed. Have your doctor or health care facility visit the MOLST web site at http://marylandmolst.org or contact the Maryland Institute for Emergency Medical Services System at (410) 706-4367 to obtain information on the MOLST form.

17. Can I fill out a form to become an organ donor? Yes, Use Part I of the "After My Death" form.

18. What about donating my body for medical education or research? Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-800-879-2728 for that form and additional information.

19. If I appoint a health care agent and the health care agent and any back-up agent dies or otherwise becomes unavailable, a surrogate decision maker may need to be consulted to make the same treatment decisions that my health care agent would have made. Is the surrogate decision maker required to follow my instructions given in the advance directive?
Yes, the surrogate decision maker is required to make treatment decisions based on your known wishes. An advance directive that contains clear and unambiguous instructions regarding treatment options is the best evidence of your known wishes and therefore must be honored by the surrogate decision maker.

Part II, paragraph G enables you to choose one of two options with regard to the degree of flexibility you wish to grant the person who will ultimately make treatment decisions for you, whether that person is a health care agent or a surrogate decision maker. Under the first option you would instruct the decision maker that your stated preferences are meant to guide the decision maker but may be departed from if the decision maker believes that doing so would be in your best interests. The second option requires the decision maker to follow your stated preferences strictly, even if the decision maker thinks some alternative would be better. **REVISED AUGUST 2019**

IF YOU HAVE OTHER QUESTIONS, PLEASE TALK TO YOUR DOCTOR OR YOUR LAWYER. OR, IF YOU HAVE A QUESTION ABOUT THE FORMS THAT IS NOT ANSWERED IN THIS PAMPHLET, YOU CAN CALL THE HEALTH POLICY DIVISION OF THE ATTORNEY GENERAL'S OFFICE AT (410) 767-6918 OR E-MAIL US AT ADFORMS@OAG.STATE.MD.US.
MORE INFORMATION ABOUT ADVANCE DIRECTIVES CAN BE OBTAINED FROM OUR WEBSITE AT:
www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx

20. Attachment H – Advance Directives

MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS

By: _____ **Date of Birth:** _____
(Print Name) (Month/Day/Year)

Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.

This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.

➔ You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.

Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

B. Selection of Back-up Agents
(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

_____

Telephone Numbers: _____
(home and cell)

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

_____

Telephone Numbers: _____
(home and cell)

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
    a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
    b. Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations:
(Optional; form valid if left blank)

_____

_____

_____

_____

_____

_____

D. How my Agent is to Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this advance directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.

E. People My Agent Should Consult
(Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

Name(s)	**Telephone Number(s):**
_____	_____
_____	_____
_____	_____
_____	_____

F. In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

_____

_____

20. Attachment H – Advance Directives

G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of this Part

(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

✎_____

>>OR<<

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability **permanently**.

✎_____

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the advance directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.

20. Attachment H – Advance Directives

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values
(Optional: Form valid if left blank)

I want to say something about my goals and values, and especially what's most important to me during the last part of my life:

_____

_____

_____

_____

B. Preference in Case of Terminal Condition
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

C. Preference in Case of Persistent Vegetative State
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

A. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

D. Preference in Case of End-Stage Condition
(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

✎_____

>>OR<<

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

✎_____

20. Attachment H – Advance Directives

E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In Case of Pregnancy

(Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

_____

_____

_____

_____

G. Effect of Stated Preferences

(Read both of these statements carefully. Then, initial **one** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

   ✎_____

   >>OR <<

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

   ✎_____

20. Attachment H – Advance Directives

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.

_____ _____

(Signature of Declarant) (Date)

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this advance directive.

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

_____ _____

(Signature of Witness) (Date)

_____

Telephone Number(s):

(**Note:** Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does **not** require this document to be notarized.)

20. Attachment H – Advance Directives

AFTER MY DEATH
(This document is optional. Do only what reflects your wishes.)

By: _____ **Date of Birth:** _____
(Print Name) (Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate: ✎_____
Any needed organs, tissues, or eyes. ✎_____

Only the following organs, tissues or eyes:

_____

_____

_____

I authorize the use of my organs, tissues, or eyes:

For transplantation ✎_____

For therapy ✎_____

For research ✎_____

For medical education ✎_____

For any purpose authorized by law ✎_____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

✎_____

20. Attachment H – Advance Directives

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my advance directive. ✎_____

>>OR<<

This person:

Name: _____

Address: _____

_____

Telephone Number(s): _____
(Home and Cell)

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

_____

_____

_____

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

_____ _____
(Signature of Donor) (Date)

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

_____ _____
(Signature of Witness) (Date)

_____
Telephone Number(s):

_____ _____
(Signature of Witness) (Date)

_____
Telephone Number(s):

AFTER MY DEATH

Part II: Donation of Body

The State Anatomy Board, a unit of the Maryland Department of Health administers a statewide Body Donation Program. Anatomical Donation allows individuals to dedicate the use of their bodies upon death to advance medical education, clinical and allied-health training and research study to Maryland's medical study institutions. The Anatomy Board requires individuals to pre-register prior to death as an anatomical donor to the state Body Donation Program. There are no medical restrictions or qualifications to becoming a "Body Donor". At death the Board will assume the custody and control of the body for study use. It is truly a legacy left behind for others to have healthier lives. For donation information and forms you can contact the Board toll-free at 1-800-879-2728

Did You Remember To...

- □ Fill out Part I if you want to name a health care agent?
- □ Name one or two back-up agents in case your first choice as health care agent is not available when needed?
- □ Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the advance directive?
- □ If you want to make specific decisions, fill out Part II, choosing carefully among alternatives?
- □ Sign and date the advance directive in Part III, in front of two witnesses who also need to sign?
- □ Look over the "After My Death" form to see if you want to fill out any part of it?
- □ Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?
- □ Give a copy of your advance directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?

AetnaBetterHealth.com/Maryland

92.07.305.0-MD A