August 2023

Maryland HealthChoice Program

Member Handbook

Wellpoint

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Welcome to Wellpoint. We look forward to learning more about you and supporting your health and well-being.

This member handbook tells you how your plan works, and how to help keep your family healthy. It also tells you how you can receive healthcare when you need it.

In a few days, you should receive your Wellpoint ID card and more information about your health plan in the mail. Your ID card will tell you when your Wellpoint membership starts. The name of your primary care provider (PCP) is on the card, too. If the PCP's name on the card is not correct, please call us.

If you also are covered by another health insurance plan, please still bring your Wellpoint member ID card to your appointments. You will not be turned away for having more than one health insurance ID card.

If you have questions or need to reach us, you can live chat Member Services at wellpoint.com/md/medicaid. You also can call Member Services at 833-707-0867 (TTY 711), Monday through Friday from 8 a.m. to 6 p.m. Eastern time. When you contact us, you can:

- Speak with a Member Services representative about your benefits
- Ask for an interpreter or translator
- Choose or find a PCP in the Wellpoint plan
- Change your PCP
- Update your address or phone number on file
- Ask for a member handbook, provider directory, or ID card

If you need to reach a nurse for advice anytime, day or night, call us at the 24-hour Nurse HelpLine at 833-707-0867 (TTY 711). Our registered nurses are here to help you with questions about your health.

Thank you for choosing us to be your family's health plan. By listening to you and understanding your healthcare needs, we strive to help you receive care close to home.

Sincerely,

Darrell Gray II, President
Wellpoint

Language Accessibility Statement

Interpreter Services Are Available for Free

Help is available in your language: 800-600-4441 (TTY: 711).

These services are available for free.

Español/Spanish
Hay ayuda disponible en su idioma: **800-600-4441 (TTY: 711)**. Estos servicios están disponibles gratis.

አማርኛ/**Amharic**
እገዛ በ ቋንቋዎ ማግኘት ይችላሉ፡- **800-600-4441 (TTY: 711)** ። እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻ ናቸው

العربية **/Arabic**
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **800-600-4441**
(رقم هاتف الصم والبكم: **711**)

Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ /Bassa

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓé ìn m̀ gbo kpáa. Đá **800-600-4441 (TTY: 711)**

中文**/Chinese**
用您的语言为您提供帮助： **800-600-4441 (TTY: 711)**。 这些服务都是免费的

فارسی **/Farsi**
خط تلفن کمک به زبانی که شما صحبت می کنید : **800-600-4441** (خط تماس افراد ناشنوا **711**)
این خدمات به صورت رایگان در دسترس هستند

Français/French
Vous pouvez disposer d'une assistance dans votre langue : **800-600-4441 (TTY: 711)**. Ces services sont disponibles pour gratuitement.

ગુજરાતી**/Gujarati**
તમારી ભાષામાં મદદ ઉપલબ્ધ છે: **800-600-4441** (ટીટીવાય: **(TTY: 711)**. સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole
Gen èd ki disponib nan lang ou: **800-600-4441 (TTY: 711)**. Sèvis sa yo disponib gratis.

Igbo
Enyemaka di na asusu gi: **800-600-4441 (TTY: 711)**. Ọrụ ndị a dị na enweghi ugwo i ga akwu maka ya.
한국어**/Korean**

사용하시는 언어로 지원해드립니다: **800-600-4441 (TTY: 711)**. 무료로 제공 됩니다

Português/Portuguese
A ajuda está disponível em seu idioma: **800-600-4441 (TTY: 711)**. Estes serviços são oferecidos de graça.

Русский/Russian
Помощь доступна на вашем языке: **800-600-4441 (TTY: 711)**. Эти услуги предоставляются бесплатно.

Tagalog
Makakakuha kayo ng tulong sa iyong wika: **800-600-4441 (TTY: 711)**. Ang mga serbisyong ito ay libre.

Urdu/اردو
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال **800-600-4441 (TTY: 711)**.

Tiếng Việt/Vietnamese
Hỗ trợ là có sẵn trong ngôn ngữ của quí vị **800-600-4441 (TTY: 711)**. Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba
Ìrànlọ́wọ́ wà ní àrọ́wọ́tó ní èdè rẹ: **800-600-4441 (TTY: 711)**. Awon ise yi wa fun o free.

Interpretation Services and Auxiliary Aids

Interpreter services are available for all HealthChoice members regardless of their primary spoken language. Interpreter services also provide assistance to those who are deaf, hard of hearing, or have difficulty speaking.

To request an interpreter, call MCO Member Services. Individuals who are deaf, hard of hearing, or have difficulty speaking can use the Maryland Relay Service (711). MCOs are required to provide auxiliary aids at no cost to you when requested. Auxiliary aids include assistive listening devices, written material, and modified equipment/devices.

If you need interpreter services for an appointment with a provider, contact your provider's office. It is best to notify them in advance of an appointment to ensure there is enough time to set-up the interpreter service and to avoid a delay in your medical care services. In some situations, the MCO may help facilitate interpreter services for provider appointments. Call MCO Member Services if you have questions.

Table of Contents

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 members;
- 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 healthcare 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 healthcare benefits through the Medicaid fee-for-service system.

MCOs are healthcare organizations that provide healthcare benefits to Medicaid recipients in Maryland. General healthcare benefits include (see pages 15-19 for a full listing of HealthChoice benefits):

- Physician Services - services provided by an individual licensed to provide inpatient/outpatient healthcare
- 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 healthcare professionals (providers) to provide covered services to their enrollees, called a network. MCOs are responsible to provide or arrange for the full range of healthcare 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 members; and
        - Children, and former foster care children.
    - Online: marylandhealthconnection.gov
    - Calling**: 855-642-8572 (TTY: 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 **800-332-6347**
    - To get connected with a LHD see page 11

D. HealthChoice/MCO Enrollment

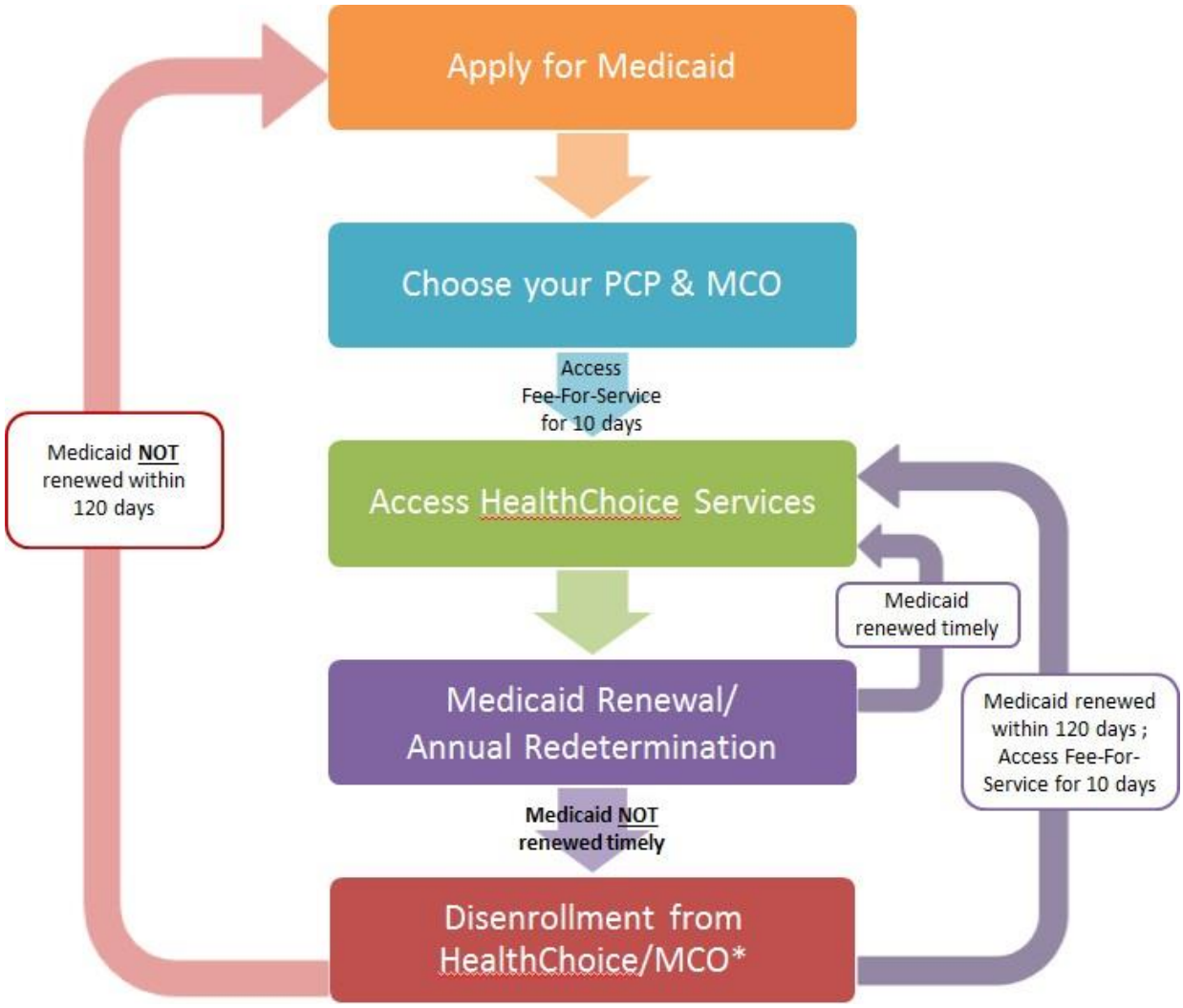
If you received this MCO Member Manual, you have been successfully enrolled in HealthChoice. The State sent you an enrollment packet explaining how to select an MCO. If you did not choose an MCO, the State automatically assigned you to an MCO in your area. It takes 10 -15 days after you chose or were 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 Health Choice Help Line (**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 MCO Member Services (see Attachment A).

Communication is key in ensuring your healthcare needs are met. Help the MCO to better serve you. If you enrolled by phone or online, 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 in a timely manner.

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); or
- 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)	marylandhealthconnection.gov
General Questions about ***HealthChoice***	**410-767-5800** (local) **800- 492-5231** (rest of state) TDD (for hearing impaired) **800-735-2258**	mmcp.health.maryland.gov/healthchoice/pages/Home.aspx
HealthChoice Help Line - for problems and complaints about access, enrollment process, and quality of care.	**800-284-4510**	
Pregnant members and family planning	**800-456-8900**	
Healthy Kids, EPSDT	**410-767-1903**	mmcp.health.maryland.gov/EPSDT/Pages/Home.aspx
Healthy Smiles Dental Program	**855-934-9812**	health.maryland.gov/mmcp/Pages/maryland-healthy-smiles-dental-program.aspx
Rare and Expensive Case Management Program (REM) - for questions about referrals, eligibility, grievances, services	**800-565-8190**	health.maryland.gov/mmcp/longtermcare/Pages/REM-Program.aspx
Mental Health and substance use disorders- for referrals, provider information, grievances, preauthorization	**800-888-1965**	health.maryland.gov/bha/Pages/HELP.aspx
Maryland Health Connection Consumer Support Center	**855-642-8572** TDD (for hearing impaired) **855-642-8573**	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	http://www.alleganyhealthdept.com/
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	http://www.aahealth.org/
Baltimore City	410-396-4398	410-396-7633	410-640-5000	http://health.baltimorecity.gov/
Baltimore County	410-887-2243	410-887-2828	410-887-8741	http://www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	http://www.calverthealth.org/
Caroline	410-479-8000	410-479-8014	410-479-8189	http://dhmh.maryland.gov/carolinecoun ty
Carroll	410-876-2152	410-876-4813	410-876-4941	http://cchd.maryland.gov/
Cecil	410-996-5550	410-996-5171	410-996-5130	http://www.cecilcountyhealth.org
Charles	301-609-6900	301-609-6923	301-609-6760	http://www.charlescountyhealth.org/
Dorchester	410-228-3223	410-901-2426	410-901-8167	http://www.dorchesterhealth.org/
Frederick	301-600-1029	301-600-3124	301-600-3124	http://health.frederickcountymd.gov/
Garrett	301-334-7777	301-334-7727	301-334-7771	http://garretthealth.org/
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com/
Howard	410-313-6300	877-312-6571	410-313-7323	https://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	240-777-1635	http://www.montgomerycountymd.gov/hhs/
Prince George's	301-883-7879	301-856-9555	301-856-9550	http://www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4456	www.qahealth.org/
St. Mary's	301-475-4330	301-475-4296	301-475-4330	http://www.smchd.org/
Somerset	443-523-1700	443-523-1722	443-523-1758	http://somersethealth.org/
Talbot	410-819-5600	410-819-5609	410-819-5600	http://talbothealth.org
Washington	240-313-3200	240-313-3264	240-313-3229	http://dhmh.maryland.gov/washhealth
Wicomico	410-749-1244	410-548-5142	410-543-6942	https://www.wicomicohealth.org/
Worcester	410-632-1100	410-632-0092	410-629-0614	http://www.worcesterhealth.org/

3. Rights and Responsibilities

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

- Receive healthcare 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, and have a candid discussion of appropriate or medically necessary treatment options for your conditions, 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.
- 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 healthcare 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 based on 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 to comply with Section 1557.

Any person who believes someone has been subjected to discrimination based on 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 investigate 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 http://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) requires 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.

4. Benefits and Services

A. HealthChoice Benefits

The table below 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 healthcare service), you should never be charged for any of these healthcare services. Your PCP will assist you in coordinating these benefits to best suit your healthcare 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 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) Services for Children	Regular well-child check-ups, immunizations (shots), developmental screens and wellness advice. These services provide whatever is needed to take care of sick children and to keep healthy children well.	Under age 21.	
Pregnancy-related Services	Medical care during and after pregnancy, including hospital stays, doula support and, when needed, home visits after delivery.	Members who are pregnant, and for one year 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.	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
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 **800-888-1965** for specialty mental health services.	All members.	You do not get specialty mental health services from the MCO. For treatment of serious emotional problems your PCP or specialist will refer you or you can call the Public Behavioral Health System at: **800-888-1965.**
Dental Services	The Maryland Healthy Smiles Dental Program covers a wide range of dental services including regular checkups, teeth cleaning, fluoride treatments, X-rays, fillings, root canals, crowns, extractions, and anesthesia. To find a dentist, replace a member ID or handbook, or to learn more about covered services, call Maryland Healthy Smiles Member Services at **855-934-9812.**	All members.	
Prescription Drug Coverage (Pharmacy Services)	Prescription drug coverage includes prescription drugs (drug dispensed only with a prescription from an authorized prescriber) insulin, needles and syringes, birth control pills and devices, coated aspirin for arthritis, iron pills (ferrous sulfate), and chewable vitamins for children younger than age 12. You can get latex condoms and emergency contraceptives from the pharmacy without a doctor's order.	All members. There are no copays for children under age 21, pregnant members, individuals in a nursing facility or hospice, or for birth control.	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
Specialist Services	Healthcare services provided by specially 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 tests and X-rays to help find out the cause of an illness.	All members.	
Home Healthcare	Healthcare 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)
Case Management	A case manager may be assigned to help you plan for and receive healthcare services. The case manager also keeps track of what services are needed and what has been provided. You must communicate with the case manager to receive effective case management.	(1) Children with special healthcare needs; (2) Pregnant and Postpartum members; (3) Individuals with HIV/AIDS; (4) Individuals who are Homeless; (5) Individuals with physical or developmental disabilities; (6) Children in State-supervised care (7) Case management provided by MCO for other members as needed	
Diabetes Care	Special services, medical equipment, and supplies for members with diabetes.	Members who have been diagnosed with diabetes.	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
Diabetes Prevention Program	A program to prevent diabetes in members who are at risk.	Members 18 to 64 years old who are overweight and have elevated blood glucose level or a history of diabetes during pregnancy.	Not eligible if previously diagnosed with diabetes or if pregnant.
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	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 visits, and authorized outpatient procedures.	All members.	MCOs are not required to cover hospital observation services beyond 24 hours.

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 ages 21 and older. Members under 21 are eligible under EPSDT (see section 6 E).	
Habilitation Services/Devices	Services/devices that help a member function for daily living. Services include Physical Therapy, Occupational Therapy, and Speech Therapy	Eligible members; benefits may be limited.	
Audiology	Assessment and treatment of hearing loss.	All members.	Members over 21 must meet certain criteria for hearing devices.
Blood and Blood Products	Blood used during an operation, etc.	All members.	
Dialysis	Treatment for kidney disease.	All members.	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DO NOT GET WITH THIS BENEFIT
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	DME (can use repeatedly) are things like crutches, walkers, and wheelchairs) DMS (cannot be used 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 life-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 healthcare, 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 if 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
- Laboratory tests to detect COVID-19 infection

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 healthcare 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 your 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 one year after the baby is born for follow-up, so long as the non-participating provider agrees to continue to see you.

Doula support is available for prenatal visits, attendance at labor and delivery, and postpartum visits. You also have access to home visiting services. Home visiting services provide support to pregnant members during pregnancy and childbirth, as well as support for parents and children during the postpartum period and up to two or three years of age. Home visiting services include prenatal home visits, postpartum home visits, and infant home visits. Group-based support with CenteringPregnancy is also available to provide education and support with members that are due around the same time as 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 check-up 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 check-up before the baby is ready to go home from the hospital, the MCO will pay for the on-call provider to do the check-up 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. Services include:

- Office visits and treatment for acute or urgent physical illness, including needed medicine;

- Follow up to EPSDT visits when needed; and
- Self-referred family planning services.

Check-up for children entering State custody

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

Certain providers for children with special healthcare 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 healthcare needs will depend on whether the condition that is the basis for the child's special healthcare 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 healthcare 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 can 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 (**800-284-4510**).

BENEFIT	DESCRIPTION
Dental Services	General dentistry, including regular and emergency treatment, is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program administered by SKYGEN USA. If you are eligible for the Dental Services Program, you will receive information and a dental card from SKYGEN USA. If you have not received your dental ID card or have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at **855-934-9812.**
Occupational, Physical, Speech Therapies 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 **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 **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.
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: o The patient will have serious physical or mental health problems, or could die, if the patient has the baby; o The patient is pregnant because of rape or incest, and reported the crime; or o The baby will have very serious health problems. Members eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.

BENEFIT	DESCRIPTION
Transportation Services	**Emergency Medical Transportation:** Medical services while transporting the member to a healthcare 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:

- 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;

- 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; or
- 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 Healthcare Locations

When there is a change in a healthcare 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 healthcare 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.

To view a list of participating providers within a MCO, provider directories are available on the MCOs website. This is a list of all the doctors, clinics, hospitals, labs, and others who are participating in the Wellpoint network. You can get all your healthcare from these providers. The provider directory lists the address, phone number, and special training of the doctors. You can browse our provider directory at **wellpoint.com/md/medicaid**. Just choose Find a Doctor. If you would like a paper copy of the provider directory mailed to you, contact MCO Member Services **at 833-707-0867 (TTY 711)**, Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

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

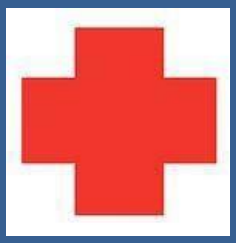
To cancel an appointment with your PCP or another provider, call the provider's office as soon as you know you cannot make the appointment. Canceling appointments allows for provider's to see other patients. Reschedule the appointment as soon as you can to stay up to date with your healthcare needs.

B. Referral to a Specialist or Specialty Care

Your PCP oversees 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.

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. Below is a guide to help choose the right place based on your health needs.

		
Doctor's Office	**Urgent Care Center**	**Emergency Room**
● Check-ups ● 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

<u>After Hours</u>

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.

<u>Urgent Care</u>

If you have an illness or injury that could turn into an emergency within 48 hours 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 Maryland Health Connection (**855-642-8572**). 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 22).

Healthy Kids is the preventative well-child component of EPSDT. The State will certify your child's PCPs to ensure that they know 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 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.

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 members with internal reproductive organs 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 (via 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 members with internal reproductive organs ages 21-29, every 5 years for members 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 healthcare 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 healthcare 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 Members During Pregnancy and One Year 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 members 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 one year 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 one year after delivery.

If you have questions, call the Help Line for Pregnant Members (**800-456-8900**) or MCO Member Services. For additional information, see Special Services for Pregnant Members (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 so long as the provider agrees to see you and accept payment from the MCO. Additionally, MCOs are not allowed to charge copays for family planning services. Family Planning services include but not limited to:

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

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

J. Dental Care

Maryland Medicaid will provide coverage of dental services to adults under the Maryland Healthy Smiles Dental Program. There are no premiums, deductibles, or copays for covered services. There is no maximum benefit amount each year. Member should never pay for covered services out of pocket. Maryland Healthy Smiles Dental Program services include but not limited to:

- Regular checkups
- Teeth cleaning

- Fluoride treatments
- X-rays
- Fillings
- Root canals
- Crowns
- Pulling teeth – extractions
- Anesthesia

Call Maryland Healthy Smiles Member Services at **855-934-9812** if you have 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.

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 healthcare. 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 (**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; and
- Residential Treatment Centers.

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 members and members who have just given birth;
- Children with special healthcare needs;
- Children in State – supervised care;
- Adults or children with a physical disability or developmental disability;
- Adults and children with HIV/AIDS; and
- 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 healthcare services; and
    - 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 Members and Members 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 members 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.

   - **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 HealthChoice recipients are eligible to receive dental services through the State's Maryland Healthy Smiles Dental Program. Call Healthy Smiles (855-934-9812) if you have questions about your dental benefits.

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

   - **Nutrition counseling -** Pregnant members will be offered nutritional

information to teach them to eat healthy.

- **Smoking Counseling -** Pregnant members 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 members.

2. **Children with Special Healthcare 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 healthcare needs will depend on whether the condition that is the basis for the child's special healthcare 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.

- **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 healthcare 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.

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 (**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 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.

Clinical Practice Guidelines

To help providers and health plan employees choose the best care for specific health issues, we have a process to create, change and distribute nationally known Clinical Practice Guidelines (CPGs) and health service delivery standards to all our providers. Members can also request a copy of the guidelines by contacting Member Services at **833-707-0867 (TTY 711)** or live chat on the member website https://www.wellpoint.com/contact-us.

CPGs are based on scientific evidence and focus on a broad range of healthcare, including, but not limited to:

- Preventive health (keeping you healthy).
- Maternity care to help ensure healthy moms and babies.
- Diabetes.
- Cardiac care.
- Mental health.
- Other conditions.

Maryland Wellpoint measures how often you need care and the quality of care you receive through a set of standard performance measures related to these guidelines, including, but not limited to:

- Frequency of childhood wellness visits.
- Childhood immunizations
- Lead screenings.
- Mammograms and Pap smears.
- Pregnancy care.
- Diabetes screenings and test

B. Preauthorization/Prior Approval

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 healthcare 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 calendar days if there was a request for an extension. You will be given the right to file an appeal for the denied preauthorization. (See Section 10: Complaints, Grievance, and Appeals.)

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.

See Attachment F for the MCO's 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 healthcare 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 healthcare 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 healthcare provider may also contact us on your behalf about the preauthorization.

- 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 healthcare 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. Your parent, guardian, designee, or healthcare provider may also contact us on your behalf to request the right for you to 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 healthcare 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 **800-284-4510**.

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

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 healthcare 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 healthcare, 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 healthcare access. Providing telehealth services can improve:

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

9. Billing

A. Explanation of Benefits or Denial of Payment Notices

From time to time, you may receive a notice from the MCO that your provider's claim has been paid or denied.

Explanation of Benefits (EOB) or Denial of Payment notices are not a bill. The notices may list the type of service, date of service, amount billed, and amount paid by the MCO on your behalf. The purpose of the notice is to summarize which provider charges are a covered service or benefit. If you feel that there is an error, 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. Your provider should not charge you. If you have questions call MCO member services.

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 be done to resolve the problem.
    - If the MCO does not resolve the problem, contact the HealthChoice Help Line (**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.)

- 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.

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 (a denial, in whole or in part, of a payment for a service because the claim is not "clean" is not an adverse benefit determination);
- 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 your provider thinks 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 must file it within 60 days from the date on 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 decide. 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 decide.

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 of if this information was submitted for the previous decision; and
- Will decide 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.

If your appeal is about a service that was already authorized, the 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.

See Attachment F for the MCO's 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 or in writing. You can appeal verbally by calling the MCO's Member Services line. 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 MCO's internal complaint procedure. If you need a copy of the MCO's 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 healthcare and the MCO has not solved the issue to your satisfaction, you can ask the State for help. The HealthChoice Help Line (800-284-4510) is open Monday through Friday between 8:00 a.m. and 5:00 p.m. 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.

You can contact the HealthChoice Help Line at (**800-284-4510**) and tell the representative that you would like a review of the MCOs decision. Your request 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 contacted and provided with more options.

When the Complaint Resolution Unit is finished working on your request, 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, you will again be given the opportunity to request a State Fair Hearing.

Fair hearings

To appeal the MCO's decision, 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 MCO's notice of appeal resolution.
The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

If the Office of Administrative Hearings decides against you, you may appeal to the Circuit Court.

Continuing services during the fair hearing
There are times when you may be able to keep getting a service while the State reviews your fair hearing. This can happen if your fair hearing 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 (**800-284-4510**) for more information. If you do not win your fair hearing, you may have to pay for the services that you received while the appeal was being reviewed.

E. Reversed Appeal Resolutions

If the State 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 or fair hearing process, the MCO will pay for the services received during the appeal or fair hearing 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 MCO's attention, call MCO Member Services. MCOs are interested in both hearing from you and ways to enhance your experience receiving healthcare.

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.

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 Your MCO

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 automatically 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. (This does not apply to newborns, newborns must remain in the MCO that the mother was in at the time of delivery for the first 90 days.)

- 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 Maryland Health Connection (**855-642-8572**). Note that:

- MCOs are not allowed to authorize changes. Only the State can change your MCO.

- If you are hospitalized or in a nursing facility you are not allowed 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 healthcare 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
    - **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
    - **800-447-8477**
    - https://oig.hhs.gov/fraud/report-fraud/index.asp

wellpoint.com/md/medicaid

ATTACHMENT A – Managed Care Organization Contact Information

Wellpoint	
Member Services	**833-707-0867**
	TTY: 711
24/7 Nurse Advice Line	**833-707-0867**
	TTY: 711
Website	**wellpoint.com/md/medicaid**
Online Member Portal	**https://member.wellpoint.com/public/login**
Nondiscrimination Coordinator	APPEALS/GRIEVANCES DEPARTMENT PLAN - COMPLIANCE OFFICER WELLPOINT P.O. BOX 61599 VIRGINIA BEACH, VA 23466-1599 833-707-0867 (TTY 711)
Complaints, Grievance, Appeals Address	APPEALS/GRIEVANCE DEPARTMENT WELLPOINT P.O. BOX 61599 VIRGINIA BEACH, VA 23466-1599
Reporting Fraud and Abuse Address	SPECIAL INVESTIGATIONS UNIT 740 W PEACHTREE STREET NW ATLANTA, GA 30308 866-847-8247

ATTACHMENT B – Notice of Privacy Practices

HIPAA notice of privacy practices

The original effective date of this notice was April 14, 2003. This notice was most recently revised in June 2022.

Please read this notice carefully. This tells you who can see your protected health information (PHI). It tells you when we have to ask for your OK before we share it. It tells you when we can share it without your OK. It also tells you what rights you have to see and change your information.

Information about your health and money is private. The law says we must keep this kind of information, called PHI, safe for our members. That means if you're a member right now or if you used to be, your information is safe.

We get information about you from state agencies for Medicaid and the Children's Health Insurance Program after you become eligible and sign up for our health plan. We also get it from your doctors, clinics, labs, and hospitals so we can OK and pay for your healthcare.

Federal law says we must tell you what the law says we have to do to protect PHI that's told to us, in writing, or saved on a computer. We also have to tell you how we keep it safe. To protect PHI:

- On paper (called physical), we:
  - Lock our offices and files
  - Destroy papers with health information so others can't get it
- Saved on a computer (called technical), we:
  - Use passwords so only the right people can get in
  - Use special programs to watch our systems
- Used or shared by people who work for us, doctors, or the state, we:
  - Make rules for keeping information safe (called policies and procedures)
  - Teach people who work for us to follow the rules

When is it OK for us to use and share your PHI?
We can share your PHI with your family or a person you choose who helps with or pays for your healthcare if you tell us it's OK. Sometimes, we can use and share it **without** your OK:

- **For your medical care**
  - To help doctors, hospitals, and others get you the care you need

- **For payment, healthcare operations, and treatment**
  - To share information with the doctors, clinics, and others who bill us for your care
  - When we say we'll pay for healthcare or services before you get them
  - To find ways to make our programs better, and to support you and help you get available benefits and services. We may get your PHI from public sources, and we may give your PHI to health information exchanges for payment, healthcare operations, and treatment. If you don't want this, please visit **wellpoint.com/privacy** for more information.
- **For healthcare business reasons**
  - To help with audits, fraud and abuse prevention programs, planning, and everyday work
  - To find ways to make our programs better
- **For public health reasons**
  - To help public health officials keep people from getting sick or hurt
- **With others who help with or pay for your care**
  - With your family or a person you choose who helps with or pays for your healthcare, if you tell us it's OK
  - With someone who helps with or pays for your healthcare, if you can't speak for yourself and it's best for you

We must get your OK in writing before we use or share your PHI for all but your care, payment, everyday business, research, or other things listed below. We have to get your written OK before we share psychotherapy notes from your doctor about you.

You may tell us in writing that you want to take back your written OK. We can't take back what we used or shared when we had your OK. But, we will stop using or sharing your PHI in the future.

Other ways we can — or the law says we have to — use your PHI:

- To help the police and other people who make sure others follow laws
- To report abuse and neglect
- To help the court when we're asked
- To answer legal documents
- To give information to health oversight agencies for things like audits or exams
- To help coroners, medical examiners, or funeral directors find out your name and cause of death
- To help when you've asked to give your body parts to science
- For research
- To keep you or others from getting sick or badly hurt
- To help people who work for the government with certain jobs
- To give information to workers' compensation if you get sick or hurt at work

What are your rights?

- You can ask to look at your PHI and get a copy of it. We will have 30 days to send it to you. If we need more time, we have to let you know. We don't have your whole medical record, though. **If you want a copy of your whole medical record, ask your doctor or health clinic.**

- You can ask us to change the medical record we have for you if you think something is wrong or missing. We will have 60 days to send it to you. If we need more time, we have to let you know.
- Sometimes, you can ask us not to share your PHI. But we don't have to agree to your request.
- You can ask us to send PHI to a different address than the one we have for you, or in some other way. We can do this if sending it to the address we have for you may put you in danger.
- You can ask us to tell you all the times over the past six years we've shared your PHI with someone else. This won't list the times we've shared it because of healthcare, payment, everyday healthcare business, or some other reasons we didn't list here. We will have 60 days to send it to you. If we need more time, we have to let you know.
- You can ask for a paper copy of this notice at any time, even if you asked for this one by email.
- If you pay the whole bill for a service, you can ask your doctor not to share the information about that service with us.

What do we have to do?
- The law says we must keep your PHI private, except as we've said in this notice.
- We must tell you what the law says we have to do about privacy.
- We must do what we say we'll do in this notice.
- We must send your PHI to some other address, or in a way other than regular mail if you ask for reasons that make sense, like if you're in danger.
- We must tell you if we have to share your PHI after you've asked us not to.
- If state laws say we have to do more than what we've said here, we'll follow those laws.
- We have to let you know if we think your PHI has been breached.

Contacting you
We, along with our affiliates and/or vendors, may call or text you using an automatic telephone dialing system and/or an artificial voice. We only do this in line with the Telephone Consumer Protection Act (TCPA). The calls may be to let you know about treatment options or other health-related benefits and services. If you do not want to be reached by phone, just let the caller know, and we won't contact you in this way anymore. Or you may call **844-203-3796** to add your phone number to our Do Not Call list.

What if you have questions?
If you have questions about our privacy rules or want to use your rights, please call Member Services at **833-707-0867**. If you're deaf or hard of hearing, call **TTY 711**.

To see more information
To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy webpage at **wellpoint.com/privacy**.

What if you have a complaint?
We're here to help. If you feel your PHI hasn't been kept safe, you may call Member Services or contact the Department of Health and Human Services. Nothing bad will happen to you if you complain.

Write to or call the Department of Health and Human Services:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201
Phone: **800-368-1019**
TDD: **800-537-7697**

We reserve the right to change this Health Insurance Portability and Accountability Act (HIPAA) notice and the ways we keep your PHI safe. If that happens, we'll tell you about the changes in a newsletter. We'll also post them on the web at **wellpoint.com/privacy**.

Race, ethnicity, language, sexual orientation, and gender identity
We get race, ethnicity, language, sexual orientation, and gender identity information about you from the state Medicaid agency and the Children's Health Insurance Program. We protect this information as described in this notice.

We use this information to:
- Make sure you get the care you need.
- Create programs to improve health outcomes.
- Create and send health education information.
- Let doctors know about your language needs.
- Provide interpretation and translation services.

We do **not** use this information to:
- Issue health insurance.
- Decide how much to charge for services.
- Determine benefits.
- Share with unapproved users.

Your personal information
We may ask for, use, and share personal information (PI) as we talked about in this notice. Your PI is not public and tells us who you are. It's often taken for insurance reasons.
- We may use your PI to make decisions about your:
  - Health
  - Habits
  - Hobbies
- We may get PI about you from other people or groups like:
  - Doctors

  - Hospitals
  - Other insurance companies
- We may share PI with people or groups outside of our company without your OK in some cases.
- We'll let you know before we do anything where we have to give you a chance to say no.
- We'll tell you how to let us know if you don't want us to use or share your PI.
- You have the right to see and change your PI.
- We make sure your PI is kept safe.

This information is available for free in other languages. Please contact Member Services at **833-707-0867 (TTY 711)** Monday through Friday from 8 a.m. to 6 p.m. Eastern time.

Revised June 2022

ATTACHMENT C – Additional Services Offered By Wellpoint

BENEFIT	WHAT IT IS	WHO CAN RECEIVE THIS BENEFIT	LIMITATIONS
Prescription medicines	Your benefits include a wide range of prescription and over-the-counter drugs. We work with CarelonRx to provide these benefits.	All members.	• Copay for prescriptions is $3 for brand-name drugs. • There is no copay for generic drugs. • Members under age 21 and pregnant members do not have a copay.
Over-the-counter (OTC) medications and products	$30 worth of OTC every quarter.	All members.	
Public transportation	Medically necessary transportation as need is determined.	Certain SSI and diabetic enrollees.	Up to $25 in public transportation.
Healthy Rewards incentive	Gift cards for completing various health promotion activities.	All members.	Benefits vary per age.
Vision benefits	Members under age 21 • Annual eye exam. • Glasses — every year or • Contact lens allowance — every year. Adults age 21 and older • Annual eye exam • Glasses — every year, or • Contact lens allowance — every year.	All members.	Benefits vary per age.

ATTACHMENT D - Prenatal/Postpartum Programs Special care for pregnant members

Special care for pregnant members

Taking Care of Baby and Me® is the Wellpoint program for all pregnant members. It is very important to see your PCP or OB/GYN for care when you are pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you have already had a baby. With our program, members receive health information and baby gifts for prenatal care and postpartum care.

Our program also helps pregnant members with complex healthcare needs. Nurse case managers work closely with these members to help teach them about these needs. They also give emotional support and help members to follow their PCP's care plan. Our nurses also work with PCPs. They help with other services members may need. The goal is to promote better health for members and the birth of healthy babies.

My Advocate®

As part of Taking Care of Baby and Me, you are also part of My Advocate which delivers prenatal, postpartum, and well-child health education by phone, web, and smartphone app that is both helpful and fun. You will speak to MaryBeth, the My Advocate automated personality. MaryBeth will respond to your changing needs as your baby grows and develops.
You can count on:

- Education you can use.
- Communication with your case manager based on My Advocate messaging should questions or issues arise.
- An easy communication schedule.
- No cost to you.

With My Advocate, your information is kept secure and private. Each time MaryBeth calls, she will ask you for your year of birth. Please do not hesitate to tell her. She needs the information to be sure she is talking to the right person.

Helping you and your baby stay healthy

My Advocate gives you answers to your questions, plus medical support if you need it. There will be one important health screening call followed by ongoing educational outreach. All you need to do is listen, learn, and answer a question or two over the phone. If you tell MaryBeth you have a problem, you will receive a call back from a case manager. My Advocate topics include:

- Pregnancy and postpartum care.
- Well-child care.
- Postpartum depression.
- Immunizations.
- Healthy living tips.

To learn more about My Advocate, visit myadvocatehelps.com.

When you become pregnant

If you think you are pregnant, call your PCP or OB/GYN provider right away. You do not need a referral from your PCP to see an OB/GYN provider. We can help you find an OB/GYN in the Wellpoint plan, if needed.

You must also call Member Services when you find out you are pregnant. This will help you make sure you choose a PCP for your baby. If you are a new Wellpoint member who is pregnant and have been seen by a non-Wellpoint provider for at least one complete prenatal checkup before you joined Wellpoint, then you may be able to keep seeing that provider throughout your pregnancy, delivery, and up to one year after your baby is born, if the provider agrees to continue treating you.

We will send you an educational booklet, called the *Pregnancy and Beyond Resource Guide*. The book includes:

- Self-care information about your pregnancy.
- A section of the book for writing down things that happen during your pregnancy.
- Details on My Advocate® that tells you about the program and how to enroll and get health information to your phone by automated voice, web, or smartphone app.
- A Labor, Delivery, and Beyond section with information on what to expect during your third trimester.
- Healthy Rewards program information on how to redeem your rewards for prenatal, postpartum, and well-baby care.
- A section of the book on having a healthy baby, postpartum depression, and caring for you newborn, with helpful resources.
- Information about Making a Family Life Plan and long acting reversible contraception (LARC) with information on long acting reversible birth control.

When you are pregnant, you must go to your PCP or OB/GYN at least:

- Every four weeks for the first six months.
- Every two weeks for the seventh and eighth months.
- Every week during the last month.

Your PCP or OB/GYN may want you to visit more than this based on your health needs.

While you are pregnant, you need to take good care of your health. You may be able to receive healthy food from the **Women, Infants, and Children Program (WIC)**. For a list of WIC sites near you, you can call the WIC phone number for your county or city below:

Anne Arundel County	410-222-6797	Harford County	410-273-5656
Baltimore City	410-396-9427	Howard County	410-313-7510
Baltimore County	410-887-6000	Montgomery County	301-762-9426
Calvert County	877-631-6182	Prince George's County	301-856-9600
Caroline County	410-479-8060	Queen Anne's County	410-758-0720
Carroll County	410-876-4898	Somerset County	410-749-2488
Cecil County	410-996-5255	St. Mary's County	877-631-6182
Charles County	301-609-6857	Talbot County	410-479-8060
Dorchester County	410-479-8060	Wicomico County	410-749-2488
Frederick County	301-600-2507	Worcester County	410-749-2488
Garrett County	301-334-7710		

When you have a new baby

When you deliver your baby, you and your baby may stay in the hospital at least:

- 48 hours after a vaginal delivery.
- 72 hours after a cesarean section (C-section).

You may stay in the hospital less time if your PCP or OB/GYN and the baby's provider see that you and your baby are doing well. If you and your baby leave the hospital early, your PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

After you have your baby, you must:

- Call Member Services as soon as you can to let us know you had your baby. We will need details about your baby.
- Call your Medicaid agency at **855-642-8572** to apply for Medicaid for your baby.

When you have your new baby

If you enrolled in My Advocate and received educational calls during your pregnancy, you will now receive calls on postpartum and well-child education up to 12 weeks after your delivery.

It is important to set up a visit with your PCP or OB/GYN after you have your baby for a postpartum checkup. You may feel well and think you are healing, but it takes the body at least six weeks to mend after delivery.

- It is important to have a follow-up visit with your OB provider after you deliver. It would be best to see them within 1-3 weeks, but no later than 12 weeks after delivery. Your health is important to the whole family.

- Your OB doctor may want to see you sooner than three weeks if you had certain issues before or during delivery, such as high blood pressure or if you had a cesarean section (C-section).

After you have your baby, you will need to call Wellpoint Member Services as soon as you can to let us know you had your baby. We will need to receive information about your baby.

You may have already picked a PCP for your baby before they were born. If not, we will try to help you pick a PCP for your baby and have your baby enrolled in Medical Assistance. If you do not know who your baby's PCP is, call Member Services.

ATTACHMENT E - Health Education Programs

The National Medicaid Quality Member Enablement team and local Quality Management department collaborates with Wellpoint internal departments, network providers, and external organizations to develop a systematic delivery of health education initiatives and activities to educate and motivate members to adopt healthier behaviors, to reduce the incidence of disease, improve health outcomes, and to provide better access to healthcare services.

In order to meet program goals, the Health Education program and activities will address health problem needs identified through population assessments and analysis identified through enrollee data.

National Medicaid Quality Member Enablement and the local health plan will implement and track the outcomes of health education activities and topics that support the Maryland Plan Quality metrics, and address the topics such as ER utilization, avoidable hospital admissions, utilization of preventive services, and the following populations listed below:

- Children with special healthcare needs;
- Individuals with a physical disability;
- Individuals with a developmental disability;
- Pregnant and postpartum members;
- Individuals who are homeless; and
- Individuals with HIV/AIDS
- Children in State-supervised care.

Health Education strategies employ a multi-faceted member education process with a goal of having members actively participate in their healthcare. Health education is important in managing the care of members with disabling, debilitating, and life-threatening medical conditions.

ATTACHMENT F – MCO Internal Complaint/Appeals Procedure

Appeal and grievance rights	
What is an appeal?	An appeal is a review by the MCO/Managed Care Organization (Wellpoint) or the Maryland Department of Health (the Department) when you are not satisfied with a decision that impacts your care.

Why would I appeal?	Examples of reasons to file an appeal include:
	• Your MCO denies covering a service your provider orders/prescribes for you because:
	  o The treatment is not needed for your condition, or would not help you in diagnosing your condition.
	  o Another more effective service could be provided instead.
	  o The service could be offered in a more appropriate setting, such as a provider's office instead of the hospital.
	• Your MCO limits, reduces, suspends, or stops a service that you are already receiving.
	• Your MCO denies all or part of payment to a provider for one of your services.
	• Your MCO takes too long to authorize a service you or your provider requested.
	• Your MCO denies your request to speed up (or expedite) the decision about a medical issue.
	• Your provider charges you money for a service that you think Wellpoint should pay for.

What is a grievance?	A grievance is when you express dissatisfaction with your MCO or your provider.

Why would I file a grievance?	Grievances can be medical or administrative. Examples include: • Your provider's office was dirty, understaffed, or difficult to access, or the provider was rude or unprofessional. • You cannot find a provider that is close to where you live for your healthcare needs. • You are dissatisfied with the help you received from your provider's staff or MCO. • You are having issues with filling your prescriptions, contacting your provider, or making appointments. • You do not feel you are receiving the right care for your health condition. • Your MCO is taking too long to resolve your appeal or grievance. • Your MCO denies your request for a faster appeal about a medical issue.

Filing an appeal	
How do I appeal to my MCO?	You or your representative may appeal an MCO's decision within 60 calendar days from the date of the denial notice by contacting the MCO using the information provided in the letter. Your MCO will send you a letter to confirm your appeal. If you would like help from the Department with appealing to your MCO, call the HealthChoice Help Line at **800-284-4510**.
What is a representative?	A representative is someone who has written permission to act or speak on your behalf, like a family member, a friend, a provider, or a lawyer. You can also represent yourself in the appeal. You must provide your MCO with any written documentation, signed and dated by you, naming a representative for your appeal.

How do I receive the information the MCO used to make its decision?	Your denial notice will explain how your MCO made the decision, including the information reviewed. You may request any of the following information, free of charge, to help with your appeal by calling your MCO: • Your medical records • Any benefit provision, guideline, protocol, or criterion your MCO used to make its decision • Oral interpretation and written translation assistance • Assistance with filling out your MCO's appeal forms You may also call the Maryland Department of Health's HealthChoice Help Line at 800-284-4510 for help with filing an appeal, seeking care alternatives, and learning about your rights and responsibilities.
How long will the MCO take to make a decision in my appeal?	Your MCO will make a decision within 30 calendar days from the date you appeal and send you a letter with the decision. You or your MCO may ask for up to 14 additional calendar days in this process. If the MCO needs more time, the MCO will send you a letter and call you, your representative, and your provider. If you need more time to send information to help the MCO make a decision, you, your representative, or your provider may call your MCO to ask for more time.
How can I receive a faster decision on my appeal?	You can receive a faster decision if your provider tells the MCO you have a serious medical condition. Your provider may call the MCO to ask for a faster decision time. If your MCO agrees, your MCO will contact your provider with an appeal decision within 72 hours. The MCO will also send you a letter. If your MCO denies your request, your MCO will contact you and your provider and make a decision in 30 days.

How can I request a State Fair hearing if I disagree with the result of my Wellpoint appeal?

A State Fair Hearing is a review of the MCO's appeal decision by the Maryland Office of Administrative Hearings. You have the right to ask for a State Fair Hearing within 120 calendar days of the date of the MCO's appeal decision. You can also ask for a State Fair Hearing if the MCO does not make a decision by the decision date on your appeal confirmation letter.

A hearing is a meeting between you, someone from your MCO, and an independent hearing officer. You can talk to them about why you disagree with the MCO's decision, share more information, call witnesses, and more. You would bring any documents or information to help the Hearing Officer understand your concerns. You may also examine any records related to your hearing, including your medical records, free of charge.

To learn more about State Fair Hearings and ask for one, call the HealthChoice Help Line at **800-284-4510**. They will explain what you need to do to ask for a State Fair Hearing. You can also ask for the hearing to happen closer to where you live, share the days and times you are available, and state if you will need transportation to and from the hearing.

Can I continue receiving services during an appeal or a State fair Hearing?

Yes. If you are already receiving services, and the MCO decides that your services should stop or end soon, you may be able to continue receiving those services during the appeal or State Fair Hearing. Call your MCO within 10 days of your notice or before the last day of your services.

Note: If you lose the appeal or State Fair Hearing, you may have to pay for the services you received during the appeal or State Fair Hearing.

Filing a grievance	
How do I file a grievance?	You can file a grievance with your MCO and/or the Department. To file a grievance with your MCO, call your MCO's Member Services line on your MCO identification card. Your MCO is required to respond. To file a grievance with the Department, call the HealthChoice Help Line at **800-284-4510**. A representative will assist you.
When can I file a grievance?	You may file a grievance at any time.
How long does it take the MCO to resolve a grievance?	For administrative grievances, you will receive a letter within 30 calendar days. For medical grievances, you will receive an answer within 24 hours if it is an emergency or within 5 calendar days if it is not an emergency. If the MCO needs more time, your MCO will contact you and ask for up to 14 more calendar days to respond.

ATTACHMENT G – Advance Directives

MARYLAND Health Care Commission

Randolph S. Sergent, Esq., Chairman
Ben Steffen, Executive Director

Your Life, Your Decisions

Advance Directives Information Sheet

Regardless of age or health status, a medical crisis could leave you too ill or injured to communicate decisions about your health care. Thinking about the types of treatment you would or wouldn't like and potential outcomes is important before a medical crisis occurs. Start the conversation with family, friends, health care providers, an attorney, or religious advisor.

ADVANCE CARE PLANNING – DISCUSS

Advance care planning is an ongoing conversation with people you trust to discuss your personal preferences and decisions that might need to be made in a medical crisis, not just end-of-life care. Advance care planning requires careful consideration of your values, religious beliefs, preferences for treatment, and acceptable outcomes, which are documented in an advance directive or a Medical Orders for Life-Sustaining Treatment (MOLST) form. An advance directive is not the same as a MOLST form; to learn more about the Maryland MOLST form, visit marylandmolst.org. These conversations make your wishes known so they can be honored in the event you have limited or no capacity to make decisions for yourself. This eases burden on family and loved ones and helps prevent conflicts about your care. Identifying who can speak on your behalf is important – in Maryland, this individual is called a health care agent. If you don't appoint a health care agent, your next of kin will be designated under law to make decisions for you if you can't speak for yourself.

ADVANCE DIRECTIVE – RECORD

You have the option to create an advance directive, a useful and legal way to direct your medical care when you can't speak for yourself. You can appoint a health care agent to make decisions on your behalf and specify your treatment preferences in future situations, such as when to use life-sustaining treatments. Pick someone you trust to make these serious decisions and talk to that person to make sure they accept the responsibility. Include their name and contact information and any back-up health care agents in your advance directive. Various advance directive forms are available from health care providers, religious organizations, estate planners, lawyers, and others. There is no one form that must be used; you can personalize your advance directive to fit your wishes. Make sure to provide a copy of your advance directive to your family, health care providers, lawyer, or anyone else who should be aware of your decisions. ***Remember – you are not required to have an advance directive, and you can revoke your advance directive and complete a new one at any time.***

ELECTRONIC DOCUMENTATION – SHARE

An advance directive can be most effective if you make it available in electronic form that is easily accessible by a health care provider. Talk to your health care provider about storing a copy of your advance directive and health care agent information in their secure electronic health record system. You may be able to add and update this information outside of clinical visits using the health care provider's patient portal, a secure online website where you can view your health record and communicate with your care team. You can also use a State Recognized electronic advance directives service to create, upload, share, and update your advance directive and health care agent information; learn more about how health care providers involved in your care can access your information at crisphealth.org/for-patients/#advance-directives.

More information about how to get started with your advance directive, including sample forms, is available on the Maryland Attorney General's website: www.marylandattorneygeneral.gov/Pages/HealthPolicy/AdvanceDirectives.aspx

mhcc.maryland.gov

December 2022

833-707-0867 (TTY 711) | wellpoint.com/md/medicaid

HealthChoice is a program of the Maryland Department of Health.

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