CareFirst Community Health Plan Maryland

Maryland Department of Health Maryland HealthChoice Program

Member Handbook

carefirstchpmd.com ▪ 410-779-9369 ▪ 800-730-8530 ▪ TTY: 711 ▪ January 2023

CareFirst Community Health Plan Maryland

Dear Member:

Thank you for choosing CareFirst BlueCross BlueShield Community Health Plan Maryland (CareFirst CHPMD) as your HealthChoice Managed Care Organization (MCO) health plan.

As a part of CareFirst CHPMD, you will continue to receive quality care through the plan's network and CareFirst BlueCross BlueShield Community Health Plan Maryland's member benefits. We continue to support you in getting the care you deserve.

This Member Handbook contains important information about your health care benefits such as phone numbers and provider services, how to access care and more. A member services representative can explain this handbook, answer any questions you may have or direct you to an interpreter for non-English translation.

To learn more, visit our website at **carefirstchpmd.com**.

If you have any questions about your benefits or how to get care, please call Member Services at 410-779-9369 or toll-free at 1-800-730-8530 (TTY:711) Monday–Friday, 8 AM–5 PM.

We look forward to serving you.

Sincerely,

Mike Rapach
CareFirst BlueCross BlueShield Community Health Plan Maryland CEO

Si necesita una copia de este manual en español, llámenos.

Language Accessibility

Interpreter Services Are Available for Free.

Help is available in your language: **1-800-730-8530** (TTY: 711).
These services are available for free.

Español/Spanish
Hay ayuda disponible en su idioma: *830.730.7530 (TTY: 711)***.** Estos servicios están disponibles gratis.

አማርኛ/Amharic
እገዛ በ ቋንቋዎ ማግኘት ይችላሉ፡-: *830.730.7530 (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 TTY:711 (رقم هاتف الصم والبكم: (830.730.7530.

Bàsɔ́ɔ̀-wùɖù-po-nyɔ̀ /Bassa
Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Bàsɔ́ ɔ̀ -wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ ìn m̀ gbo kpáa. Đá *830.730.7530 (TTY: 711)*

中文/Chinese
用您的语言为您提供帮助：*830.730.7530 (TTY: 711)*。 这些服务都是免费的

فارسی /Farsi
خط تلفن کمک به زبانی که شما صحبت می کنید : TTY: 711 (خط تماس افراد ناشنوا
این خدمات به صورت رایگان در دسترس هستند *830.730.7530*

Français/French
Vous pouvez disposer d'une assistance dans votre langue : *830.730.7530 (TTY: 711)*. Ces services sont disponibles pour gratuitement.

ગુજરાતી/Gujarati
તમારી ભાષામાં મદદ ઉપલબ્ધ છે: *830.730.7530* (ટીટીવાય: *(TTY : 711*). સેવાઓ મફત ઉપલબ્ધ છે

Language Accessibility

kreyòl ayisyen/Haitian Creole
Gen èd ki disponib nan lang ou: *830.730.7530 (TTY:* 711*)*. Sèvis sa yo disponib gratis.

Igbo
Enyemaka di na asusu gi: *830.730.7530 (TTY: 711)*. Ọrụ ndị a dị na enweghi ugwo i ga akwu maka ya.

한국어/Korean
사용하시는 언어로 지원해드립니다: *830.730.7530 (TTY: 711)*. 무료로 제공 됩니다

Português/Portuguese
A ajuda está disponível em seu idioma: *830.730.7530 (TTY: 711)*. Estes serviços são oferecidos de graça.

Русский/Russian
Помощь доступна на вашем языке: *830.730.7530 (TTY: 711)*. Эти услуги предоставляются бесплатно.

Tagalog
Makakakuha kayo ng tulong sa iyong wika: *830.730.7530 (TTY:* 711*)*. Ang mga serbisyong ito ay libre.

اردو/Urdu).
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال
830.730.7530 (TTY: 711*)*. کر

Tiếng Việt/Vietnamese
Hỗ trợ là có sẵn trong ngôn ngữ của quí vị *830.730.7530 (TTY: 711)*. Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba
Ìrànlọ́wọ́ wà ní àrọ́wọ́tó ní èdè rẹ: *830.730.7530 (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.

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1. HealthChoice Overview

A. What is Medicaid

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

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

B. What is HealthChoice

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

MCOs are health care organizations that provide health care benefits to Medicaid recipients in Maryland. General health care benefits include (see pages 17–26 for a full listing of HealthChoice benefits):

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

MCOs contract with a group of licensed/certified health care professionals (providers) to provide covered services to their enrollees, called a network. MCOs are responsible to provide or arrange for the full range of health care services covered by the HealthChoice program. There are some benefits that your MCO is not required to cover but the State will cover.

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

C. How To Renew Medicaid Coverage

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

Maryland Health Connection

- Individuals eligible to apply/renew through Maryland Health Connection:
  - Adults under age of 65;
  - Parent/caretaker relatives;
  - Pregnant women; and
  - Children and former foster care children.
- Online: **marylandhealthconnection.gov**
- Calling: 1-855-642-8572 (TTY: 1-855-642-8573)

myDHR

- Individuals eligible to apply/renew through myDHR:
  - Aged, blind or disabled (ABD);
  - Current foster care children or juvenile justice;
  - Receiving Supplemental Security Income (SSI); and
  - Qualified Medicare Beneficiaries (QMB) or Specified Low-income Medicare Beneficiaries (SLMB).
- Online: **https://mydhrbenefits.dhr.state.md.us**

Department of Social Services (DSS) or Local Health Department (LHD)

- All individuals can apply
- To get connected with DSS call 800-332-6347
- To get connected with a LHD see page 10

D. HealthChoice/MCO Enrollment

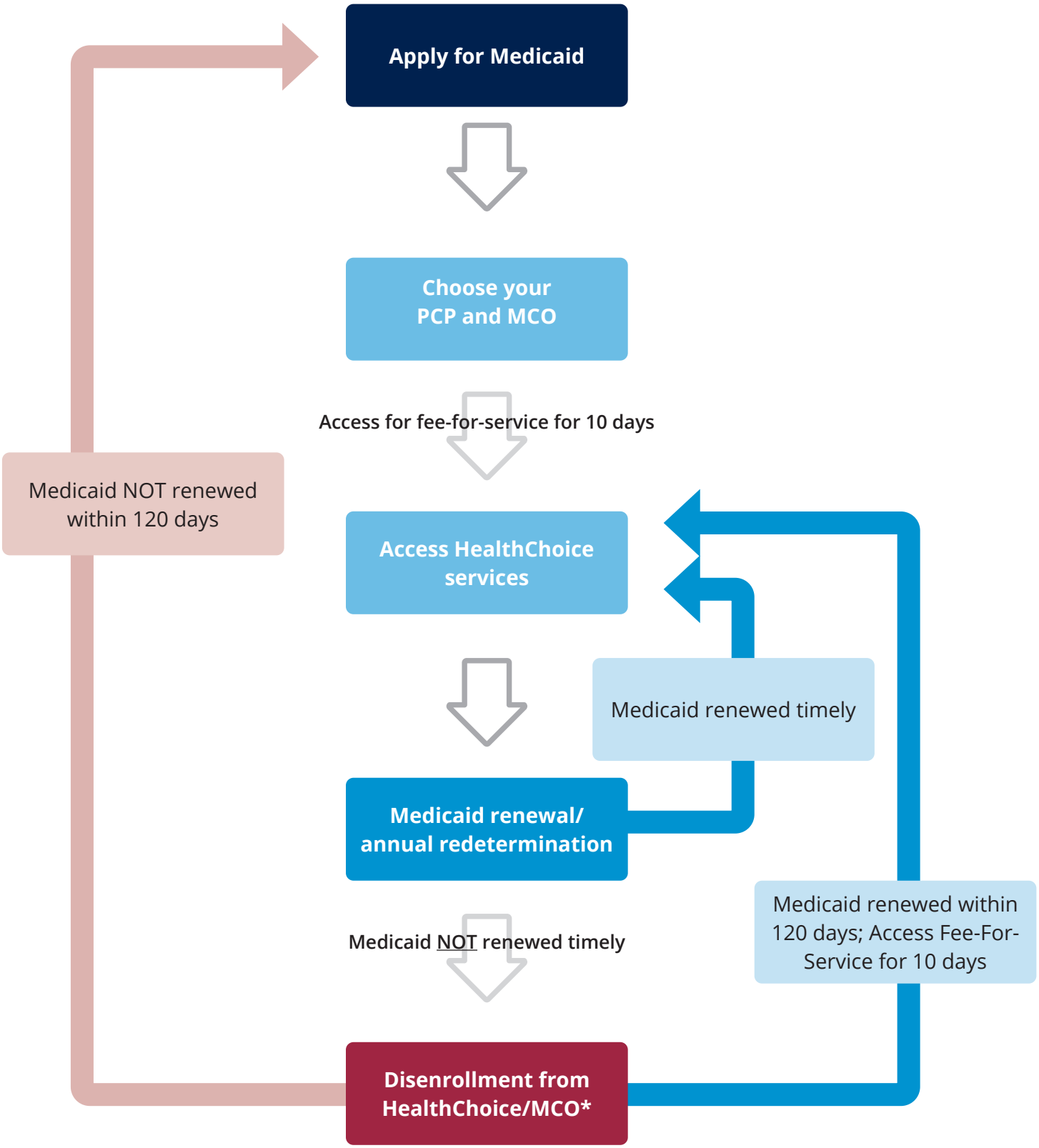
If you received this MCO Member Manual you have been successfully enrolled in HealthChoice. The State sent you an enrollment packet explaining how to select an MCO. If you did not choose an MCO, the State automatically assigned you to an MCO in your area. It takes 10–15 days after you chose or were automatically 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 health care needs are met. Help the MCO to better serve you. If you enrolled by phone or on-line, you were asked to complete the Health Service Needs Information form. This information helps the MCO to determine what kinds of services you may need and how quickly you need services. If the form is not completed, we will make efforts to contact you so we know what your needs are.

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

E. HealthChoice Enrollment Process



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

F. HealthChoice Eligibility/ Disenrollment

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

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

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

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

Always make sure the provider accepts your insurance otherwise you may be responsible for the bill. Also, remember Medicaid and HealthChoice are State run programs. They are not like the federal Medicare program for the elderly and the 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) 800-977-7389	**https://www.marylandhealthconnection.gov**
General Questions about HealthChoice	410-767-5800 (local) 800-492-5231 (rest of state) TDD (for hearing impaired) 800-735-2258	**https://health.maryland.gov/mmcp/healthchoice/pages/home.aspx**
HealthChoice Help Line—for problems and complaints about access, enrollment process and quality of care	800-284-4510	
Pregnant women and family planning	800-456-8900	
Healthy Kids, EPSDT	410-767-1903	**https://mmcp.health.maryland.gov/EPSDT/Pages/Home.aspx**
Healthy Smiles Dental Program	855-934-9812	**https://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	**https://health.maryland.gov/mmcp/longtermcare/Pages/REM-Program.aspx**
Mental health and substance use disorders—for referrals, provider information, grievances, preauthorization	800-888-1965	**http://bha.health.maryland.gov/Pages/ HELP.aspx**
Maryland Health Connection Consumer Support Center	855-642-8572 TDD (for hearing impaired) 855-642-8573	**www.marylandhealthconnection.gov**

B. Local Health Department Contact Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	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/ carolinecounty
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	443-262-4485	www.qahealth.org/

B. Local Health Department Contact Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
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 Option # 1	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 health care and services that are culturally competent and free from discrimination.
- Be treated with respect to your dignity and privacy.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Request and receive a copy of your medical records and 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 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 services provided by your Managed Care Organization including information about practitioners and providers within its network.
- Receive information about your rights and responsibilities and make recommendations regarding those rights and responsibilities.

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

- Inform your provider and MCO if you have any other health insurance coverage.
- Treat HealthChoice staff, MCO staff and health care providers and staff with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if you need to cancel an appointment.
- Show your membership card when you check in for every appointment. Never allow anyone else to use your Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call your MCO if you have a problem or a complaint.
- Work with your Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Ask questions about your care and let your provider know if there is something you do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.

- Update the State if there has been a change in your status.
- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform caregivers about any changes in your Advanced Directive.

C. Nondiscrimination Statement

- It is the policy of all HealthChoice MCOs not to discriminate on the basis of race, color, national origin, sex, age or disability. MCOs have adopted an internal grievance procedures providing for prompt and equitable resolution of complaints alleging any action prohibited by Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age or disability in certain health programs and activities. Section 1557 and its implementing regulations may be examined in the office of each MCO's nondiscrimination coordinator who has been designated to coordinate the efforts of each MCO in order to comply with Section 1557.
- Any person who believes someone has been subjected to discrimination on the basis of race, color, national origin, sex, age or disability may file a grievance under this procedure. It is against the law for an MCO to retaliate against anyone who opposes discrimination, files a grievance, or participates in the investigation of a grievance.

Procedure:

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

The availability and use of this grievance procedure does not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination on the basis of race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**,or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.,
Room 509F, HHH Building
Washington, DC 20201
800-368-1019, TDD 800-537-7767

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

To file a complaint, see contact information below:

- Provider: call your provider's office
- MCO: call MCO Member Services
- U.S. Department of Health and Human Services
  - Online at: **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**
  - Email: **OCRComplaint@hhs.gov**
  - In writing at:
    Centralized Case Management Operations
    U.S. Department of Health and Human Services
    200 Independence Avenue, S.W.
    Room 509F HHH Bldg.
    Washington, D.C. 20201

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

4. Benefits and Services

A. HealthChoice Benefits

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

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

Benefit	What it is	Who can get this benefit	What you do not get with this benefit
Primary Care Services	These are all of the basic health services you need to take care of your general health needs, and are usually provided by your primary care provider (PCP). A PCP can be a doctor, advanced practice nurse, or physician assistant.	All members	
Early Periodic Screening Diagnosis Treatment (EPSDT) Services for Children **https://mmcp.health.maryland.gov/EPSDT/Pages/Home.aspx**	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.	Women 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 1-855-934-9812.	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 women, and for birth control.	

4. Benefits and Services

Benefit	What it is	Who can get this benefit	What you do not get with this benefit
Specialist Services	Health care services provided by specially trained doctors, advanced practice nurses or physicians 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 Health Care	Health care services received in-home that includes nursing and home health aide care.	Those who need skilled nursing care (care provided by or under the supervision of a registered nurse) in their home, usually after being in a hospital.	No personal care services (help with daily living)
Case Management	A case manager may be assigned to help you plan for and receive health care services. The case manager also keeps track of what services are needed and what has been provided. You must communicate with your case manager to receive effective case management.	(1) Children with special health care needs; (2) Pregnant and postpartum women; (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.	
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.

Benefit	What it is	Who can get this benefit	What you do not get with this benefit
Podiatry	Foot care when medically needed.	All members	Routine foot care; unless you are under 21 years of age or have diabetes or vascular disease affecting the lower extremities.
Vision Care	**Eye Exams:** ■ Under 21: one exam every year. ■ 21 and Older: one exam every two years **Glasses and Contact Lenses:** ■ Under 21: 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 of 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 visit, and authorized outpatient procedures.	All members	MCOs are not required to cover hospital observation services beyond 24 hours.
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	

Benefit	What it is	Who can get this benefit	What you do not get with this benefit
Hospice Services	Home or inpatient services designed to meet the physical, psychological, spiritual, and social needs for people who are terminally ill.	All members	
Nursing Facility/Chronic Hospital	Skilled nursing care or rehab care up to 90 days.	All members	
Rehabilitation Services/ Devices	Outpatient services/ devices that help a member function for daily living. Services include: Physical, Occupational, and Speech Therapy	Members age 21 and older Members under 21 are eligible under EPSDT (see section 6 E)	
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 criteria.
Blood and Blood Products	Blood used during an operation, etc.	All members	
Dialysis	Treatment for kidney disease.	All members	
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	DME (can use repeatedly) are things like crutches, walkers, and wheelchairs) DMS (cannot use repeatedly) are equipment and supplies that have no practical use in the absence of illness, injury, disability or health condition. DMS are things like finger stick supplies, dressings for wounds, and incontinence supplies	All members	
Transplants	Medically necessary transplants.	All members	No experimental transplants.

Benefit	What it is	Who can get this benefit	What you do not get with this benefit
Clinical Trials	Members costs for studies to test the effectiveness of new treatments or drugs	Members with little threatening conditions, when authorized.	
Plastic and Restorative Surgery	Surgery to correct a deformity from disease, trauma, congenital or development abnormalities or to restore body functions.	All members.	Cosmetic surgery to make you look better.

B. Self-Referral Services

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

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

Emergency Services

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

Family Planning Services (Birth Control)

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

Pregnancy Services

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

Birthing Centers

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

Baby's first 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.

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

Check-up for children entering State custody

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

Certain providers for children with special health care needs

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

- **New Member:** A child who at the time of initial enrollment was receiving these services as part of a current plan of care may continue to receive these specialty services provided the pre-existing non-participating provider submits the plan of care for review and approval within 30 days of the child's effective date of enrollment. The approved services must be medically necessary.
- **Established Member:** A child who is already enrolled in a MCO when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific non-participating provider. The MCO must grant the request unless the MCO has a local participating specialty provider with the same professional training and expertise who is reasonably available and provides the same services.

Diagnostic Evaluation Service (DES)

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

Renal Dialysis

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

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

Benefits in the table below are not covered by the MCO. If you need these services you can get them through the State using your red and white Medicaid or dental card. If you have questions on how to access these benefits, call the HealthChoice Help Line (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 & Audiology for Children Under the Age of 21	The State pays for these services if medically needed. For help in finding a provider, you can call the State's Hotline at 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: ■ The patient will probably have serious physical or mental health problems, or could die, if she has the baby; ■ She is pregnant because of rape or incest, and reported the crime; or ■ The baby will have very serious health problems. Women eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.

BENEFIT	DESCRIPTION
Transportation Services	■ **Emergency medical transportation:** Medical services while transporting the member to a health care facility in response to a 911 call. This service is provided by local fire companies. If you are having an emergency medical condition, call 911. ■ **Non-emergency medical transportation:** MCOs are not required to provide transportation for non-emergency medical visits. The exception is when you are sent to a far-away county to get treatment that you could get in a closer county. ■ Certain MCOs may provide some transportation services such as bus tokens, van services, and taxis to medical appointments. Call your MCO to see if they provide any transportation services. ■ Local health departments (LHD) provide non-emergency medical transportation to qualified individuals. The transports provided are only to Medicaid covered services. Transportation through the LHD is meant for individuals who have no other means of getting to their appointments. If you select a MCO that is not offered within your service area, both the LHD and MCO are not required to provide non- emergency medical transportation services. ■ For assistance with transportation from your local health department, call the local health department's transportation program.

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

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

E. Excluded Benefits and Services Not Covered by the MCOs 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.
- Hearing aids for people 21 years and older.
- Non-prescription drugs. (Except coated aspirin for arthritis, insulin, iron pills, and chewable vitamins for children younger than age 12.)
- Routine foot care for adults 21 years and older who do not have diabetes or vascular problems.

- Special (orthopedic) shoes and supports for people who do not have diabetes or vascular problems.
- Shots for travel outside the continental United States or medical care outside the United States.
- Diet and exercise programs, to help you lose weight.
- Cosmetic surgery to make you look better, but you do not need for any medical reason.
- Fertility treatment services, including services to reverse a voluntary sterilization
- Private hospital room for people without a medical reason such as having a contagious disease.
- Private duty nursing for people 21 years and older.
- Autopsies.
- Anything experimental unless part of an approved clinical trial.
- Anything that you do not have a medical need for.

F. Change of Benefits and Service Locations

Change of Benefits

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

Loss of Benefits

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

Change of Health Care Locations

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

5. Information on Providers

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

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

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

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

B. Selecting or Changing Providers

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

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

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

See Attachment G for more PCP information.

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 providers to see other patients. Reschedule the appointment as soon as you can to stay up to date with your health care needs.

B. Referral to a Specialist or Specialty Care

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

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

- Check-ups
- Health screenings
- If something causes you concern
- Cough/cold
- Fever
- Lingering pain
- Unexplained weight loss

Urgent Care Center

- Minor illness/injury
- Flu/fever
- Vomiting/diarrhea
- Sore throat, earache or eye infection
- Sprains/strains
- Possible broken bones
- Sports injuries

Emergency Room

- Unconsciousness
- Difficulty breathing
- Serious head, neck or back injury
- Chest pain/pressure
- Severe bleeding
- Poisons
- Severe burns
- Convulsions/seizures
- Severely broken bone
- Sexual assault

After hours

If you need non-emergency care after normal business hours, call your PCP's office. Your doctor or their answering service will be able to answer your questions, provide you instructions, and can arrange any necessary services.

Urgent care

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. Their number is 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

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 21).

Healthy Kids is the preventative well child component of EPSDT. The State will certify your child's PCPs to ensure that he/she knows the Healthy Kids/EPSDT requirements, is prepared to perform the required screenings and has the required vaccines so your child receives immunizations at the appropriate times. We highly recommend that you select a PCP for your child who is EPSDT certified. If you choose a provider that is not EPSDT certified, the MCO will notify you. You can switch your child's PCP at any time. Contact 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 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 colonscopy—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, other based on risk Hepatitis B—adults at increased risk Chlamydia/Gonorrhea—Yearly for women age 16 to 24 if sexually active, based on risk for age 25+ Syphilis—Adults at increased risk
Influenza Vaccine	Yearly
TdaP (tetanus, diphtheria, acellular Pertussis) Vaccine	Once as an adult (if didn't receive at age 11–12), during every pregnancy
Td (tetanus) Vaccine	Every 10 years, additional doses if dictated by risk
Shingles (zoster) Vaccine	Once for all adults age 60 and older
Pneumococcal Vaccine (PPSV23)	Once for everyone (age 2–64) with diabetes, lung disease, heart disease, smokers, alcoholism or other risk factors (talk to your doctor to determine your risk)
Breast Cancer Screening (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 women ages 21–29, every 5 years for women ages 30–65
Substance Use/Misuse: Alcohol, Tobacco, Other	Adults 18 and over. Yearly or more frequently depending on risk.

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

G. Case Management

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

For information on Case Management and referral for case management, see attachment H.

H. Care for Women During Pregnancy and Two Months after Delivery

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

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

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

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

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

I. Family Planning (Birth Control)

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

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

Call MCO Member Services or the State's Help Line (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 1-855-934-9812 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 health care. The MCOs outreach plan targets individuals who are difficult to reach or are non-compliant with a plan of care. If the MCO cannot contact you or you have missed appointments, you may be referred to the Administrative Care Coordination Unit (ACCU) at your local health department.

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

M. Behavioral Health Services

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

- Case management
- Emergency crisis/mobile crisis services
- In-patient psychiatric services
- Outpatient mental health centers
- Residential treatment centers

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

7. Special Services

A. Services for Special Needs Populations

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

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

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

Services every special needs population receives:

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

- **A case manager**—A case manager will be a nurse or a social worker or other professional that may be assigned to your case soon after you join a MCO. This person will help you and your PCP develop a patient-centered plan that addresses the treatment and services you need. The case manager will:
  - Help develop the plan of care
  - Ensure the plan of care is updated at least every 12 months or as needed
  - Keep track of the health care services
  - Help those who give you treatment to work together
- **Specialists**—Having special needs requires you to see providers who have the most experience with your condition. Your PCP and your case manager will work together to be sure to send you to the right specialists. This will include specialists for supplies and equipment you might need.
- **Follow-up when visits are missed**—If your PCP or specialist finds that you keep missing appointments, they will let us know and someone will try to get in touch with you by mail, by telephone or by a visit to your home to remind you to call for another appointment. If you still miss appointments, you may be visited by someone from the local health department near where you live.
- **Special Needs Coordinator**—MCOs are required to have a Special Needs Coordinator on staff. The Special Needs Coordinator will educate you about your condition and will suggest places in your area where you can get support from people who know about your needs.

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

Pregnant women and women who have just given birth:

- **Appointments**—The MCO will assist in scheduling an appointment for prenatal care within 10 days of your request.
- **Prenatal Risk Assessment**—Pregnant woman will have a prenatal risk assessment. At your first prenatal care visit the provider will complete a risk assessment. This information will be shared with the local health department and the MCO. The MCO will offer a range of services to help you take care of yourself and to help make sure your baby is born healthy. The local health department may also contact you and offer help and advice. They will have information about local resources.

- **Link to a pediatric provider**—The MCO will assist you in choosing a pediatric care provider. This may be a pediatrician, family practitioner or nurse practitioner.
- **Length of hospital stay**—The length of hospital stay after delivery is 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery. If you elect to be discharged earlier, a home visit will be offered within 24 hours after discharge. If you must remain in the hospital after childbirth for medical reasons, you may request that your newborn remain in the hospital while you are hospitalized, additional hospitalization up to four (4) days is covered for your newborn.
- **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 women will be offered a test for HIV and will receive information on HIV infection and its effect on the unborn child.
- **Nutrition counseling**—Pregnant women will be offered nutritional information to teach them to eat healthy.
- **Smoking counseling**—Pregnant women will receive information and support on ways to stop smoking.
- **EPSDT screening appointments**—Pregnant adolescents (up to age 21) should receive all EPSDT screening services in addition to prenatal care.

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

Children with special health care needs

- **Work with schools**—The MCO will work closely with the schools that provide education and family services programs to children with special needs.
- **Access to certain non-participating providers**—Children with special health care needs may self-refer to providers outside of the MCO's network under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care, and assure that appropriate plans of care are in place. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in an MCO. Medical services directly related to a special needs child's medical condition may be accessed out-of-network if specific conditions are satisfied.

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.

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.

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.

Adults and children who are homeless

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

B. Rare and Expensive Case Management Program (REM)

The Rare and Expensive Case Management Program, REM for short, is a program provided by the State for children and adults who have very expensive and very unusual medical problems. The REM program offers Medicaid benefits plus other specialty services needed for special medical problems. Your primary care provider (PCP) and MCO will have a list of REM diagnosis 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 in order for you to receive them.**

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

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

B. Preauthorization/Prior Approval

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

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

If the preauthorization is denied or reduced in amount, duration or scope, then that service or medication will not be covered by the MCO. You will be notified in writing of the decision within 14 calendar days, or 28 calendar days, if there was a request for an extension. You will be given the right to file an appeal for a denied 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

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

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

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

The rules on how you can qualify for these special rights are described below.

Preauthorization for health care services

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

- To be able to use the old preauthorization under this new plan, you will need to contact your current MCO member services to let them know that you have a preauthorization for the services and provide us with a copy of the preauthorization. Your parent, guardian, designee or health care provider may also contact us on your behalf about the preauthorization.
- There is a time limit for how long you can rely on this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.
- Limitation on Use of Preauthorization: Your special right to use a preauthorization does not apply to:
  - Dental Services
  - Mental Health Services
  - Substance Use Disorder Services
  - Benefits or services provided through the Maryland Medicaid fee-for-service program
- If you do not have a copy of the preauthorization, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the preauthorization within 10 days of your request.

Right to use non-participating providers

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

Example of how the right to use non-participating providers works

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

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

- Limitation on Use of Non-Participating Providers: Your special right to use a non-participating provider does not apply to:

- Dental Services;
- Mental health services;
- Substance use disorder services; or
- Benefits or services provided through the Maryland Medicaid fee-for-service program.

Appeal rights

- If your current MCO denies your right to use a preauthorization from your former company or your right to continue to see a provider who was a participating provider with your former 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 copays 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 health care technology emerges, MCOs have processes in place to review and determine if these innovations will be covered. Each MCO has their own policy on the review of new medical technology, treatments, procedures and medications. To find out a MCOs policy and procedure on reviewing new technology for health care, contact the MCOs member services.

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

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

9. Billing

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

Once an 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 the information the MCO used when making their determination.

Complaints

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

Grievances

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

B. Appeals

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

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

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

When you file an appeal, be sure to let the MCO know of any new information that you have that will help them make a decision. The MCO will send you a letter letting you know that they received your appeal within five business days. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help the MCO 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 if this information was submitted for the previous decision; and
- Will make a decision about your appeal within 30 calendar days.

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

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

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

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 MCO's customer service representatives can assist you with filing a complaint, grievance, or appeal.

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

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

D. The State's Complaint/Appeal Process

Getting help from the HealthChoice Help Line

If you have a question or complaint about your health care and the MCO has not solved the issue to your satisfaction, you can ask the State for help. The HealthChoice Help Line (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. This is called an appeal.

You can contact the HealthChoice Help Line at (800-284-4510) and tell the representative that you would like to appeal 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.

Types of state decisions you can appeal

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

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

Continuing services during the 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 appeal is about a service that was already authorized, the time period for the authorization has not expired, and you were already receiving the service. Call the HealthChoice Help Line (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.

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

The Board of Review/judicial appeal

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

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 MCOs attention, call MCO Member Services. MCOs are interested in both hearing from you and ways to enhance your experience receiving health care.

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

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

11. Changing MCOs

A. 90 Day Rules

- The first time you enroll in the HealthChoice Program you have one opportunity to request to change MCOs. You must make this request within the first 90 days. You can make this one time change even if you originally selected the MCO.
- If you are out of the MCO for more than 120 days and the State 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 are assigned to the MCO the mother is enrolled in at the time of delivery. 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 may not allow you to change MCOs.
- If you lose Medicaid eligibility but are approved again within 120 days, you will automatically be enrolled with the same MCO that you had prior to losing eligibility.

12. Reporting Fraud, Waste and Abuse

A. Types of Fraud, Waste and Abuse

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

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

B. How to Report Fraud, Waste and Abuse

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

- Call MCO Member Services or write the MCO a letter
- Contact the Maryland Department of Health, Office of the Inspector General:
  - 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

13. Attachment A
Managed Care Organization Contact Information

CareFirst BlueCross BlueShield Community Health Plan Maryland	
Member Services	410-779-9369 or 800-730-8530 TTY: 711
Website	**www.carefirstchpmd.com**
Online Member Portal	**members.carefirstchpmd.com/login**
Civil Rights Coordinator	Office of the Civil Rights Coordinator CareFirst BlueCross BlueShield Community Health Plan Maryland P.O. Box 8894 Baltimore, MD 21224 Fax: 410-505-2011 Email: **civilrightscoordinator@carefirst.com**
Appeals and Grievances Address	CareFirst BlueCross BlueShield Community Health Plan Maryland Attn: Appeals and Grievances Department P.O. Box 915 Owings Mills, MD 21117
Reporting Fraud and Abuse Address	CareFirst BlueCross BlueShield Community Health Plan Maryland Attn: Director of Compliance P.O. Box 915 Owings Mills, MD 21117 410-779-9369 or 1-800-730-8530 TTY: 711

14. Attachment B
Notice of Privacy Practices

This notice describes how medical and financial information about you may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your medical and financial information is important to us.

This notice applies to members of fully-insured groups and individual policyholders only. If you are a member of a self-insured group, while we continue to safeguard your personal information with the same safety mechanisms, you will get a Notice of Privacy Practices from your group health plan. If you are unsure if you are a fully insured or self-insured member, please contact your group administrator. This notice applies to the privacy practices of CareFirst of Maryland, Inc., Group Hospitalization and Medical Services, Inc., CareFirst BlueChoice, Inc., FirstCare, Inc. (CareFirst), CareFirst Advantage, Inc., and CareFirst Advantage DSNP, Inc. We may share your financial and protected health information (oral, written or electronic) as well as the protected health information of others on your insurance policy as needed for payment or health care operations purposes.

Uses & disclosures of medical information

Our legal duty

This notice describes our privacy practices, which include how we may use, disclose (share or give out), collect, handle and protect our members' protected health information. We are required by certain federal and state laws to maintain the privacy of your protected health information. We also are required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect October 1, 2016 and is intended to amend the notice of CareFirst privacy practices with an effective date of April 14, 2003.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all protected health information that we maintain, including protected health information we created or received before we made the changes. If we make a significant change in our privacy practices, we will change this notice and post the new notice on our website, **www.carefirst.com**, and provide the revised notice or information about the changes and how to get the revised notice in our next annual mailing to our health plan subscribers.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

We maintain physical, electronic and procedural safeguards in accordance with federal and state standards to protect your health information. All of our associates receive training on these standards at the time they are hired and thereafter receive annual refresher training. Access to your protected health information is restricted to appropriate business purposes and requires pass codes to access our computer systems and badges to access our facilities. Associates who violate our standards are subject to disciplinary actions.

Primary uses and disclosures of protected health information

We use and disclose protected health information about you for payment and health care operations. The federal health care privacy regulations ("HIPAA Privacy Rule") generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater

privacy protections. As a result, applicable state or federal privacy laws might impose a privacy standard under which we will be required to operate. For example, we will follow more stringent state privacy laws that relate to uses and disclosures of the protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing and reproductive rights. In addition to these state law requirements, we also may use or disclose your protected health information for health benefits administration purposes (such as claims and enrollment processing, care management and wellness offerings, claims payment, and fraud detection and prevention efforts), for our business operations (including for quality measurement and enhancement and benefit improvement and development) and in the following situations:

- **Payment:** We may use and disclose your protected health information for all activities that are included within the definition of "payment" as written in the HIPAA Privacy Rule. For example, we might use and disclose your protected health information to pay claims for services provided to you by doctors, hospitals, pharmacies and others that are covered by your health plan. We also may use your information to determine your eligibility for benefits, coordinate benefits, examine medical necessity, obtain premiums and issue explanations of benefits to the person who subscribes to the health plan in which you participate.
- **Health care operations:** We may use and disclose your protected health information for all activities that are included within the definition of "health care operations" as defined in the HIPAA Privacy Rule. For example, we may use and disclose your protected health information to determine our premiums for your health plan, conduct quality assessment and improvement activities, engage in care coordination or case management, and manage our business.
- **Business associates:** In connection with our payment and health care operations activities, we contract with individuals and entities (called "business associates") to perform various functions on our behalf or to provide certain types of services (such as member service support, utilization management, subrogation or pharmacy benefit management). We may share your contact information and phone number including your mobile number with our business associates. To perform these functions or to provide the services, our business associates will receive, create, maintain, use or disclose protected health information, but only after we require the business associates to agree in writing to contract terms designed to appropriately safeguard your information.
- **Other covered entities:** We may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain of their health care operations. For example, we may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and we might disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing.

Other possible uses and disclosures of protected health information

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your protected health information:

- **To you or with your authorization:** We must disclose your protected health information to you, as described in the Individual Rights section of this notice. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose not listed in this notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures that we made as permitted by your authorization while it was in effect. To the

extent (if any) that we maintain or receive psychotherapy notes about you, most disclosures of these notes require your authorization. Also, to the extent (if any) that we use or disclose your information for our fundraising practices; we will provide you with the ability to opt out of future fundraising communications. In addition, most (but not all) uses and disclosures of medical information for marketing purposes, and disclosures that constitute a sale of protected health information, require your authorization. Without your written authorization, we may not use or disclose your protected health information for any reason except those described in this notice.

- **Disclosures to the Secretary of the U.S. Department of Health and Human Services:** We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services (DHHS) when the Secretary is investigating or determining our compliance with the federal Privacy Regulations.
- **To plan sponsors:** Where permitted by law, we may disclose your protected health information to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan sponsor may contact us seeking information to evaluate future changes to your benefit plan. We also may disclose summary health information (this type of information is defined in the HIPAA Privacy Rule) about the enrollees in your group health plan to the plan sponsor to obtain premium bids for the health insurance coverage offered through your group health plan or to decide whether to modify, amend or terminate your group health plan.
- **To family and friends:** If you agree (or if you are unavailable to agree), such as in a medical emergency situation or at the time of death, we may disclose your protected health information to a family member, friend or other person to the extent necessary to help with your health care or with payment of your health care.
- **Underwriting:** We might receive your protected health information for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or disclose protected health information that is genetic information of an individual for such purposes. We will not use or further disclose this protected health information received under these circumstances for any other purpose, except as required by law, unless and until you enter into a contract of health insurance or health benefits with us.
- **Health oversight activities:** We might disclose your protected health information to a health oversight agency for activities authorized by law, such as: audits, investigations, inspections, licensure or disciplinary actions, or civil, administrative or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system, (ii) government benefit programs, (iii) other government regulatory programs and (iv) compliance with civil rights laws.
- **Abuse or neglect:** We may disclose your protected health information to appropriate authorities if we reasonably believe that you might be a possible victim of abuse, neglect, domestic violence or other crimes.
- **To prevent a serious threat to health or safety:** Consistent with certain federal and state laws, we may disclose your protected health information if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Coroners, medical examiners, funeral directors and organ donation:** We may disclose protected health information to a coroner or medical examiner for purposes of identifying you after you die, determining your cause of death or for the coroner or medical examiner to perform other duties authorized by law. We also might disclose, as authorized by law, information to funeral directors so that they may carry out their duties on your behalf. Further, we might disclose protected health information to organizations that handle organ, eye or tissue donation and transplantation.

- **Research:** We may disclose your protected health information to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.
- **Inmates:** If you are an inmate of a correctional institution, we may disclose your protected health information to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to you, (2) your health and safety and the health and safety of others or (3) the safety and security of the correctional institution.
- **Workers' compensation:** We may disclose your protected health information to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- **Public health and safety:** We may disclose your protected health information to the extent necessary to avert a serious and imminent threat to your health or safety or the health or safety of others.
- **Required by law:** We may use or disclose your protected health information when we are required to do so by law. For example, we must disclose your protected health information to DHHS upon their request for purposes of determining whether we are in compliance with federal privacy laws.
- **Legal process and proceedings:** We may disclose your protected health information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, we may disclose your protected health information to law enforcement officials.
- **Law enforcement:** We may disclose to a law enforcement official limited protected health information of a suspect, fugitive, material witness, crime victim or missing person. We might disclose protected health information where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
- **Military and national security:** We may disclose to military authorities the protected health information of Armed Forces personnel under certain circumstances. We might disclose to federal officials protected health information required for lawful counterintelligence, intelligence and other national security activities.
- **Other uses and disclosures of your protected health information:** Other uses and disclosures of your protected health information that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of protected health information. However, the revocation will not be effective for information that we already have used or disclosed in reliance on your authorization.

Individual rights

Access

You have the right to look at or get copies of the protected health information contained in a designated record set, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot reasonably do so. You must make a request in writing to obtain access to your protected health information. You may request the information be as an electronic copy in certain circumstance, if you make the request in writing. You also may request access by sending a letter to the address at the end of this notice. If you request copies, we might charge you a reasonable fee for each page and postage if you want the copies mailed to you. If you request an alternative format, we might charge a cost-based fee for providing your protected health information in that format. If you prefer, we will prepare a summary or an explanation of your protected health information, but we might charge a fee to do so.

We may deny your request to inspect and copy your protected health information in certain limited circumstances. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not

reviewable. If you are denied access to your information and the denial is subject to review, you may request that the denial be reviewed. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same person who denied your initial request.

Disclosure accounting

You have the right to receive a list of instances in which we or our business associates disclosed your protected health information for purposes other than treatment, payment, health care operations and certain other activities. We will provide you with the date on which we made the disclosure, the name of the person or entity to which we disclosed your protected health information, a description of the protected health information we disclosed, the reason for the disclosure and certain other information. Your request may be for disclosures made up to six years before the date of your request.

You may request an accounting by submitting your request in writing using the information listed at the end of this notice. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction requests

You have the right to request that we place additional restrictions on our use or disclosure of your protected health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency) until or unless we receive a written request from you to terminate the restriction. Any agreement that we might make to a request for additional restrictions must be in writing and signed by a person authorized to make such an agreement on our behalf. We will not be liable for uses and disclosures made outside of the requested restriction unless our agreement to restrict is in writing. We are permitted to end our agreement to the requested restriction by notifying you in writing.

You may request a restriction by writing to us using the information listed at the end of this notice. In your request tell us: (1) the information of which you want to limit our use and disclosure and (2) how you want to limit our use and/or disclosure of the information. You may also use the information listed at the end of this notice to send a written request to terminate an agreed upon restriction.

Confidential communication

If you believe that a disclosure of all or part of your protected health information may endanger you, you have the right to request that we communicate with you in confidence about your protected health information. This means that you may request that we send you information by alternative means, or to an alternate location. We may accommodate your request if it is reasonable, specifies the alternative means or alternate location, and specifies how payment issues (premiums and claims) will be handled.

You may request a confidential communication by writing to us using the information listed at the end of this notice.

Amendment

You have the right to request that we amend your protected health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic notice

Even if you agree to receive this notice on our Website or by electronic mail (email), you are entitled to receive a paper copy as well. Please contact us using the information listed at the end of this notice to obtain this notice in written form. If the email transmission has failed, and CareFirst is aware of the failure, then we will provide a paper copy of the notice to you.

Breach notification

In the event of breach of your unsecured health information, we will provide you notification of such a breach as required by law or where we otherwise deem appropriate.

Collection of Personal Financial Information & Uses and Disclosures of Financial Information

We may collect personal financial information about you from many sources, including:

- Information you provide on enrollment applications or other forms, such as your name, address, social security number, salary, age and gender.
- Information about your relationship with CareFirst our affiliates and others, such as your policy coverage, premiums and claims payment history.
- Information as described above that we obtain from any of our affiliates.
- Information we receive about you from other sources such as your employer, your provider, your broker and other third parties.
- Information we receive about you when you log on to our Website. We have the capability through the use of "cookies" to track certain information, such as finding out if members have previously visited the CareFirst Website or to track the amount of time visitors spend on the Website. These cookies do not collect personally identifiable information and we do not combine information collected through cookies with other personal financial information to determine the identity of visitors to its Website. We will not disclose cookies to third parties.

How your information is used

We use the information we collect about you in connection with underwriting or administration of an insurance policy or claim or for other purposes allowed by law. At no time do we disclose your financial information to anyone outside of CareFirst unless we have proper authorization from you, or we are permitted or required to do so by law. We maintain physical, electronic and procedural safeguards in accordance with federal and state standards that protect your information. In addition, we limit access to your financial information to those CareFirst employees, business partners, providers, benefit plan administrators, brokers, consultants and agents who need to know this information to conduct CareFirst business or to provide products or services to you.

Disclosure of your financial information

In order to protect your privacy, third parties that are either affiliated or non affiliated with CareFirst are also subject to strict privacy laws. Affiliated entities are companies that are part of the CareFirst corporate family and include health maintenance organizations (HMOs), third party administrators, health insurers, long term care insurers and insurance agencies. In some situations, related to our insurance transactions involving you, we will disclose your personal financial information to a non-affiliated third party that helps us to provide services to or for you. When we disclose information to these third parties, we require them to agree to protect your financial information and to use it only for its intended purpose, and to comply with all relevant laws.

Changes in our privacy policy

CareFirst periodically reviews its policies and reserves the right to change them. If we change the substance of our privacy policy, we will continue our commitment to keep your financial information secure—it is our highest priority. Even if you are no longer a CareFirst customer, our privacy policy will continue to apply to your records.

Questions and complaints

Information on CareFirst privacy practices

You may request a copy of our notices at any time. If you want more information about our privacy practices, if you would like additional copies of this notice, or have questions or concerns, please call the Member Services number on your ID card or contact the CareFirst Privacy Office using the information below.

Filing a complaint

If you are concerned that we might have violated your privacy rights, or you disagree with a decision

we made about your individual rights, you may use the contact information listed at the end of this notice to complain to us. You also may submit a written complaint to DHHS. We will provide you with the contact information for DHHS upon request.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with DHHS.

Contact information

CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc.
Privacy Office CT 10-03
10455 Mill Run Circle
Owings Mills, MD 21117
Phone: 800-853-9236
Fax: 410-505-6692
Email: **privacy.office@carefirst.com**

CareFirst Community Health Plan Maryland

HIPAA Privacy Consent & Authorization Form

Consent and Notice of Privacy Practices

This consent form allows CareFirst BlueCross BlueShield Community Health Plan Maryland to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This information may be used or disclosed to carry out treatment, payment, or health care operations.

CareFirst BlueCross BlueShield Community Health Plan Maryland has provided me with a Notice of Privacy Practices, which completely describes uses and disclosures of my protected health information. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

I understand that the terms of the Notice of Privacy Practices may change and that I may obtain revised notices by either writing to CareFirst BlueCross BlueShield Community Health Plan Maryland at the address provided below:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attention: Compliance Department
P.O. Box 915
Owings Mills, MD 21117

Or by calling CareFirst BlueCross BlueShield Community Health Plan Maryland Member Services Department at the telephone numbers provided below:

Local: 410-779-9369; Toll Free: 1-800-730-8530; TTY: 711
Hours of Operation: 8 AM to 5 PM, Monday through Friday

Right to Request Plan's Use and Disclosure of Protected Health Information

I understand that I have the right to request—now and in the future—how protected health information is used or disclosed to carry out treatment, payment, and health care operations. I understand that while CareFirst BlueCross BlueShield Community Health Plan Maryland is not required to agree to my requested restrictions, if it does agree, it is bound by that agreement. I understand that CareFirst BlueCross BlueShield Community Health Plan Maryland may refuse me services if I refuse to sign this consent.

Authorization to Use and Disclose My Protected Health Information to individuals I have specifically designated below:

This also serves as an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR § 164.508]. It authorizes CareFirst BlueCross BlueShield Community Health Plan Maryland staff to use and/or disclose my protected health information (PHI) with the individual(s) I have listed below for the purpose(s) designated by me. This authorization is valid until such time as I elect to revoke it.

Name	Telephone Number	Relationship to Member

Purpose(s): Check those applicable for the individual listed above

- ○ Authorized to act as my representative in requesting services and/or payment of claims from the health plan only.
- ○ Authorized to make any changes to the demographics in my membership record, including but not limited to address changes, telephone number changes, email address changes, and request for a replacement ID card only.
- ○ Authorized to act as my representative in connection with my claim or asserted right under the Code of Maryland Regulations (COMAR), 10.01.04-12, 10.09.71.05, and 10.09.75.05. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals and grievance information; and to receive any notice in connection with my appeal or grievance, wholly in my stead. I understand that personal medical information related to my appeal or grievance may be disclosed to the representative indicated above.
- ○ Authorized for all of the above actions.

Name	Telephone Number	Relationship to Member

Purpose(s): Check those applicable for the individual listed above

- ○ Authorized to act as my representative in requesting services and/or payment of claims from the health plan only.
- ○ Authorized to make any changes to the demographics in my membership record, including but not limited to address changes, telephone number changes, email address changes, and request for a replacement ID card only.
- ○ Authorized to act as my representative in connection with my claim or asserted right under the Code of Maryland Regulations (COMAR), 10.01.04-12, 10.09.71.05, and 10.09.75.05. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals and grievance information; and to receive any notice in connection with my appeal or grievance, wholly in my stead. I understand that personal medical information related to my appeal or grievance may be disclosed to the representative indicated above.
- ○ Authorized for all of the above actions.

Name	Telephone Number	Relationship to Member

Purpose(s): Check those applicable for the individual listed above

- ○ Authorized to act as my representative in requesting services and/or payment of claims from the health plan only.
- ○ Authorized to make any changes to the demographics in my membership record, including but not limited to address changes, telephone number changes, email address changes, and request for a replacement ID card only.
- ○ Authorized to act as my representative in connection with my claim or asserted right under the Code of Maryland Regulations (COMAR), 10.01.04-12, 10.09.71.05, and 10.09.75.05. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals and grievance information; and to receive any notice in connection with my appeal or grievance, wholly in my stead. I understand that personal medical information related to my appeal or grievance may be disclosed to the representative indicated above.
- ○ Authorized for all of the above actions.

Right to revoke this consent and authorization

I understand that I have the right to revoke this consent and authorization at any time provided that I do so in writing, but that CareFirst BlueCross BlueShield Community Health Plan Maryland and any other entity working directly with CareFirst BlueCross BlueShield Community Health Plan Maryland for the purposes of carrying out treatment, payment, or health care operations on my behalf may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that CareFirst BlueCross BlueShield Community Health Plan Maryland may refuse me further service if I revoke consent.

Signature of Member	Date
Member ID Number (from membership ID card):	

15. Attachment C
Additional Services Offered By MCO

Benefit	What it is	Who can get this benefit	Limitations
Acupuncture	CareFirst will provide acupuncture services to members diagnosed with a substance abuse addiction. The benefit will be limited to 2 treatments per week up to 70 treatments per year.	Adults 21 and older	The service will be provided by a limited number of contracted providers within Baltimore City only
Prenatal Benefits	CareFirst will provide one (1) $105 gift card for new parents to BuyBuyBaby for Pack-n-play, car seat or other baby safety/health needs.		Effective beginning January 1, 2023
Prenatal Benefits	CareFirst will provide one (1) nutrition consultation appointment per pregnancy.		Effective beginning January 1, 2023
Prenatal Benefits	CareFirst will provider one (1) birthing and breastfeeding class 1 month prior to delivery.		Effective beginning January 1, 2023
Adult Vision	The mandatory HealthChoice benefit allows for adults to receive a vision exam every two years. CareFirst will provide one pair of glasses or contact lenses every two years to all adult members in the event the exam outlines the needed for glasses.	Adults 21 and older	$150 limit for glasses or contact lenses. Please contact Superior Vision at 1-800-879-6901.
Over the Counter Medications and Supplies (OTC)	CareFirst will provide members with a $15 per quarter OTC benefit for such items such as aspirin, cold suppressants, ointments, vitamins and herbal supplements. These items must be prescribed by a physician.	All members	$15 per member per quarter

15. Attachment C

Benefit	What it is	Who can get this benefit	Limitations
Home Delivered Meals Post- Discharge from a Hospital Stay	CareFirst will provide members with up to 18 nutritious meals to eligible members recovering from an inpatient stay in a hospital who have no support at home upon discharge.	All members	Members will need their physicians or facility discharge planners to obtain prior authorization for meals from CareFirst BlueCross BlueShield Community Health Plan Maryland case managers

16. Attachment D
Prenatal/Postpartum Programs

When you are pregnant, CareFirst BlueCross BlueShield Community Health Plan Maryland will send you a pregnancy education package. It will include:

- A letter welcoming you to our Baby Steps Program
- How to contact your dedicated OB Case Manager
- Information on our text program delivering prenatal health and nutrition information
- Pregnancy resources on prenatal health, WIC program, car seat safety, MD Healthy Smiles Dental Program, Babies Born Healthy, and local health department contact information

To ensure the healthiest pregnancy possible, your first prenatal visit should be in your first trimester of pregnancy or within 42 days of enrolling with CareFirst CHPMD.

Services that may be done at your 1st visit:

- Early sonogram to confirm your pregnancy and due date
- Hear your baby's heartbeat
- Blood work to determine pregnancy risk factors

If you haven't already, please schedule your first OB visit today

During your pregnancy, your OB Case Manager will:

- Contact you periodically to make sure you are getting the care you need
- Send you additional information on Breastfeeding, Family Planning, and the Maternal, Infant, and Early Childhood home visiting program.
- Discuss birth control options for after delivery
- Connect you to a pediatrician in your area that treats children from birth to age 21
- Address any concerns or questions you might have, as well as connect you to community resources available in your area

After you have your baby, CareFirst CHPMD will send you a postpartum education package. It will include:

- A letter congratulating you on the birth of your baby and the importance of postpartum follow-up care
- Baby-care information including Safe Sleep and Never Shake a Baby
- Recommended child and adolescent vaccination schedule
- Links to resources about Postpartum Depression and Domestic Violence
- How to contact HealthChoice to find out if you need to reapply for your health insurance

17. Attachment E
Health Education Programs

CareFirst BlueCross BlueShield Community Health Plan Maryland works to keep you healthy and will link you to health education materials, programs and classes. Call Member Services and ask for Health Education to be connected to someone who can help you get the information you need to care for yourself better.

Below are some of the resources we can help connect you with:

- **Childbirth preparation**—Many providers and hospitals offer classes on childbirth preparation. Your OB Case Manager can help connect you with classes in childbirth, infant care and breastfeeding education when available in your local community. You can call us at 1-800-730-8530 and ask to speak with your OB Case Manager for more information.
- **Postpartum support**—A good resource for social support and resources to women and their families after giving birth is the Postpartum Support International (PSI) organization. They offer local groups, telephone support, and services available at no charge. To get more information, contact your OB Case Manager by calling 1-800-730-8530. You can also contact PSI directly by calling 1-800-944-4773 or visit their website **http://www.Postpartum.Net/locations/maryland/**.
- **Quitting cigarette smoking**—Our provider network is committed to helping you quit smoking. Your PCP can offer educational tools and tips to help you stop smoking. You can also call 800-QUIT-NOW (784-8669) to access the Maryland Smoking Cessation line for assistance.
- **Many other classes and resources about different health topics**—Call Member Services at 1-800-730-8530 and ask for Health Education to get more information about the health topic you are interested in. If you have a case manager or special needs coordinator, you should contact them to discuss your specific needs.

In some cases, CareFirst BlueCross BlueShield Community Health Plan Maryland may request information from your PCP or treating provider to determine if health education can be provided at the medical practice or through qualified staff at the practice. For example, some of our larger medical sites show in-office health videos on prenatal care, infant care, well baby vaccines and wellness visits, nutrition, diabetes and other important health topics.

- **Website**—CareFirst BlueCross BlueShield Community Health Plan Maryland's Website, **www.carefirstchpmd.com** has member education you can view on-line or print. The Community Calendar of Health Education Events is also posted on the website.
- **Newsletter**—You may also receive a CareFirst BlueCross BlueShield Community Health Plan Maryland newsletter in the mail to keep you up to date on changes and provide health education information. This newsletter provides you with health information about wellness care, managing your illness, parenting and many other topics. The newsletter is also posted on CareFirst BlueCross BlueShield Community Health Plan Maryland website, **www.carefirstchpmd.com**.

18. Attachment F
MCO Internal Complaint/Appeals Procedure

Grievances and Appeals

CareFirst BlueCross BlueShield Community Health Plan Maryland's member services and hotline information

You can call our Member Services department at 410-779-9369 or 1-800-730-8530, Monday through Friday from 8:00 am–5:00 pm.

CareFirst BlueCross BlueShield Community Health Plan Maryland's internal grievance procedures

If you have a complaint, you can contact us at 410-779-9369 or 1-800-730-8530 (TTY users should call 711) or you can send us a complaint in writing at the address provided below.

Appeals

If your complaint is about a service you or a provider feel you need but we will not cover, you can ask us to review your request again. This is called an appeal.

If you want to file an appeal you have to file it within 90 days for a Level I Appeal, from the date that you received the letter saying that we would not cover the service you wanted; and 15 days for a Level II Appeal, from the date on the Level I Appeal outcome letter.

You may file your appeal in writing. We have a simple form you can use to file your appeal. Please call Member Services at 410-779-9369 or 1-800-730-8530 to get one. We will mail or fax the appeal form to you and provide assistance if you need help completing it. This form can also be found on our website at **www.carefirstchpmd.com**.

Once you complete the form, you should mail it to:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attention: Appeals & Grievance Department
P.O. Box 915
Owings Mills, MD 21117

Your doctor can also file an appeal for you if you sign a form giving him or her permission. Other people can also help you file an appeal, like a family member or a lawyer, when they file a form (i.e., an Appointment of Representative Form) allowing them to file on your behalf.

When you file an appeal, be sure to let us know any new information that you have that will help us make our decision. We will send you a letter letting you know that we received your appeal within 5 business days of receipt in the company. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help us make our decision.

When reviewing your appeal, we will:

- Use doctors who know about the type of illness you have.
- Not use the same people who denied your request for a service.
- Make a decision about your appeal within 30 days.

The appeal process may take up to 44 days if you ask for more time to submit information or we need to get additional information from other sources. We will send you a letter if we need additional information.

If your doctor or CareFirst BlueCross BlueShield Community Health Plan Maryland feels that your appeal should be reviewed quickly due to the seriousness of your condition, this is called an

expedited appeal. A CareFirst BlueCross BlueShield Community Health Plan Maryland Medical Director will review the request and determine if your issue is life threatening. You will receive a decision about your appeal within 72 hours. When you ask for an expedited appeal, you may do so by calling us, or asking us in writing.

If we do not feel that your appeal needs to be reviewed quickly, we 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 and you were already receiving, you may be able to keep getting the service while we review your appeal. Contact us at 800-730-8530 if you would like to keep getting services while your appeal is reviewed. 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 we complete our review, we will send you a letter letting you know our decision. If we decide that you should not receive the denied service, that letter will tell you how to file another appeal or ask for a State Fair Hearing.

Grievances

If your complaint is about something other than not receiving a service, this is called a grievance. Examples of grievances would be, not being able to find a doctor, trouble getting an appointment, or not being treated fairly by someone who works at CareFirst BlueCross BlueShield Community Health Plan Maryland or at your doctor's office.

If your grievance 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.

If you would like a copy of our official complaint procedure, or if you need help filing a complaint, please call CareFirst BlueCross BlueShield Community Health Plan Maryland at 410-779-9369 or 1-800-730-8530. You may also submit your grievance in writing. We have a simple form you can use to submit your grievance. Please call Member Services at
410-779- 9369 or 1-800-730-8530 to get one. We will mail or fax the appeal form to you and provide assistance if you need help completing it. This form can also be found on our website at **www.carefirstchpmd.com**.

Once you complete the form, you should mail it to:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attn: Appeals & Grievance Department
P.O. Box 915
Owings Mills, MD 21117

Appeals and Grievance Form

CareFirst Community Health Plan Maryland

Use this form if you want to tell us you have a complaint or when you don't agree with a decision we made about your health care (an appeal). For help with this form, please call us at 1-410-779-9369 or 1-800-730-8530. TTY users should call 711. Our Member Services staff can talk to you Monday to Friday from 8 am to 5 pm.

Member Last Name	Member First Name	MI	Today's Date / /
Member ID Number			
Phone ( )	Cell ( )	Other ( )	

Please tell us why you are filing this complaint:

You don't agree with a decision we made not to cover a service your doctor asked for (appeal)

You have a complaint (grievance)

Tell us more (you can attach a separate piece of paper if you need more room)

Name of Member's Primary Care Provider (if applicable)

Date(s) of Service (if needed)

It may take us up to 30 days to get back to you.

Do you or your doctor think that waiting 30 days could be bad for your health?

Yes No

If yes, please tell us why (you can attach a separate piece of paper if you need more room)

Signature of CareFirst BlueCross BlueShield Community Health Plan Maryland Member

Please fax the form to **844-405-2158** or mail it to:

CareFirst BlueCross BlueShield Community Health Plan Maryland
Attention: Appeals & Grievances Department
P.O. Box 915
Owings Mills, MD 21117

If you are NOT the CareFirst BlueCross BlueShield Community Health Plan Maryland member, but are filing this on behalf of the CareFirst BlueCross BlueShield Community Health Plan Maryland member, complete this section. Unless you are the parent of the member, federal and state laws require us to get official authorization for you to represent our member. If the CareFirst BlueCross BlueShield Community Health Plan Maryland member has not signed this document, you need to attach a completed Appointment of Representative Form; a letter from our member letting us know that you can represent them; proof of guardianship; or Durable Power of Attorney for Health Care.

Signature of Representative		Your Name
Relationship to the Member		
Phone ( )	Cell ( )	Other ( )

19. Attachment G
Information About Your PCP and Specialists

If you need more information about your PCP, specialist or other CareFirst BlueCross BlueShield Community Health Plan Maryland provider please call Member Services at 410-779-9369 or 800-730-8530 (TTY: 711). Member Services Representatives can give you information about your practitioner including:

- Contact information
- Office locations
- Professional qualifications
- Medical specialty
- Medical education and training
- Board certification status

For female enrollees, if your PCP is not a women's health specialist, you have the right to see a women's health specialist within the CareFirst BlueCross BlueShield Community Health Plan Maryland network without a referral for covered routine and preventive health care services.

20. Attachment H
Case Management & Referral for Case Management

If you are a living with a chronic condition, you may be able to benefit from participating in the CareFirst BlueCross BlueShield Community Health Plan Maryland case management program.

This program is customized to support members with chronic conditions such as:

- Asthma
- Diabetes
- Chronic Heart Failure (CHF)
- Chronic Obstructive Pulmonary Disease (COPD)
- Coronary Artery Disease (CAD)
- High Blood Pressure, and
- High Cholesterol

The program is designed with you in mind.

- to help you understand the day-to-day management of your condition
- to help you follow your doctor's plan of care
- to help you improve your quality of life

It also provides individual self-assessment and educational tools. When appropriate, a health coach will contact you to help you take a more active role in your own health management.

Program Benefits and Advantages

- Increase your understanding of your condition
- Improve your ability to follow your treatment plan
- Help reduce complications
- Deliver educational materials

Referral for Case Management

CareFirst BlueCross BlueShield Community Health Plan Maryland Case Management Programs are voluntary and are provided at no cost to you. Members identified with certain needs may be automatically enrolled, but are under no obligation to participate in these programs.

CareFirst BlueCross BlueShield Community Health Plan Maryland offers Case Management to members who have had a critical medical event, been diagnosed with a chronic illness, and have multiple illnesses or complications.

We will work with you and your doctors to help you get the services, resources and one-on-one coaching you may need to better take care of your health.

You will get your own CareFirst CHPMD Case Manager. Your Case Manager will:

- Help you set goals and make a care plan to reach them
- Make sure you get the care you need when you need it
- Make sure you have what you need to get care, such as a way to get to and from the doctor
- Find ways to help you manage your symptoms so you can feel better
- Answer questions about your health and health care
- Keep you up to date with information about your health
- Answer any questions you may have about your health over the phone
- If you want us to visit you in your home or at your doctor's office, we can do that too.

20. Attachment H

If you think case management programs could help you, call Member Services at 1-410-779-9369 or 1-800-730-8530. TTY users should call 711. We can talk to you Monday to Friday from 8 a.m. to 5 p.m. Or, you can email us at **CHPMDhealthservices@carefirst.com**.

21. Attachment I
Services for Victims of Domestic Violence

Domestic violence is abuse. Abuse is unhealthy. Abuse is unsafe. It is never OK for someone to hit you. It is never OK for someone to make you afraid. Domestic violence causes harm and hurt on purpose. Domestic violence in the home can affect your children and it can affect you. Domestic violence can be physical, emotional, sexual, financial or psychological.

If you feel you may be a victim of abuse, call or talk to your PCP. Your PCP can talk to you about domestic violence. Safety tips for your protection:

- Call the domestic violence hotline for help. They can tell you about safe shelter areas.
- If you are hurt, call your PCP. Call 911 or go to the nearest hospital if you need emergency care (see the section on Emergency Care).
- Have a plan on how you can get to a safe place (like a women's shelter or a friend's or relative's home).
- Pack a small bag and give it to a friend to keep for you until you need it.

If you have questions or need help, please call our Member Services Department at 800-730-8530 (TTY:711) and you will be assigned a social worker or call the National Domestic Violence hotline number at 800-799-7233.

22. Attachment J

Access to Utilization Management (UM) Department

- Utilization Management (UM) staff are available by telephone, from 8 a.m. to 5:30 p.m. ET, Monday through Friday (except company holidays), to render UM decisions.
- Obtaining prior authorization is the responsibility of the PCP or treating provider. Members who need prior authorization should work with their provider to submit the required clinical data.
- If you would like to contact CareFirst BlueCross BlueShield Community Health Plan Maryland, please call 1-800-730-8530 or 410-779-9369. If the local telephone number is called the UM Department may accept collect calls. Or you can email us at **CHPMDHealthServices@CareFirst.com**.
- CareFirst BlueCross BlueShield Community Health Plan Maryland staff always identify themselves by name, title and name of organization when initiating of returning calls regarding CareFirst issues.
- Language assistance is available for members to discuss CareFirst issues. CareFirst BlueCross BlueShield Community Health Plan Maryland also offers TDD/TTY services for members who are hard of hearing, deaf, and/or speech disabled.
- CareFirst BlueCross BlueShield Community Health Plan Maryland makes utilization management decisions solely on the appropriateness of care and services and the existence of coverage. CareFirst BlueCross BlueShield Community Health Plan Maryland does not specifically reward providers or other individuals for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. CareFirst BlueCross BlueShield Community Health Plan Maryland does not use incentives to encourage barriers to care and service.

23. Attachment K
Pharmaceutical Management Procedure

The CareFirst BlueCross BlueShield Community Health Plan Maryland Pharmacy and Therapeutics Committee reviews and approves all pharmaceutical management procedures during its quarterly meetings when applicable. Approved policies and procedures are used to aid in the establishment and management of CareFirst BlueCross BlueShield Community Health Plan Maryland list of covered, commonly prescribed drugs and products that you or your provider may choose to help you stay well. Ongoing decisions to add/remove a drug or product to the formulary list are made if the drug or product are based on one or more of the following criteria:

- Treats a condition that is not treated by a drug currently listed;
- Treats a condition in a different way than a drug currently listed;
- Has been reported as safe to use;
- Is easier to use or can increase patient compliance;
- Is readily available;
- Works better than drugs or products currently listed;
- Is lower or equivalent in cost to those currently listed.

CareFirst BlueCross BlueShield Community Health Plan Maryland may also use additional pharmaceutical management procedures to manage the use of pharmaceuticals:

Generic Substitution

CareFirst BlueCross BlueShield Community Health Plan Maryland is required by state rules to dispense generic versions of drugs and products rather than brand-name drugs and products unless a provider requests otherwise.

Prior Authorization

CareFirst BlueCross BlueShield Community Health Plan Maryland may require providers to get approval before prescribing some drugs and products to make sure the drug or product is appropriate. Prior authorization requested by you or your provider may be reviewed by CareFirst BlueCross BlueShield Community Health Plan Maryland pharmacy benefits manager for clinical appropriateness. Please be prepared to provide supporting clinical documentation to show that the member has tried and failed a formulary option. Contact CVS Health at 1-877-418-4133 for medication request review. (A CVS clinical reviewer will provide the prior authorization criteria used for evaluating the requested drugs/products upon request during the call.)

Step Therapy

CareFirst BlueCross BlueShield Community Health Plan Maryland starts therapy with the most cost-effective and safest drugs and products. If needed, more costly or riskier therapies will be used. Contact CVS Health at 1-877-418-4133 for medication request review. (A CVS clinical reviewer will provide the step-therapy criteria used for evaluating the requested drugs/products upon request during the call.)

Quantity Limits

CareFirst BlueCross BlueShield Community Health Plan Maryland limits the amount of specific drugs and/or products covered within a certain time period based on evidence-based treatment durations. Contact CVS Health at 1-877-418-4133 for medication request review. (A CVS clinical reviewer will provide drug or product specific quantity limits upon request during the call.)

23. Attachment K

Age Limits

CareFirst BlueCross BlueShield Community Health Plan Maryland may require prior approval of certain drugs and products based on age. (A CVS clinical reviewer will provide drug or product specific age limits upon request during the call.)

Therapeutic Interchange

CareFirst BlueCross BlueShield Community Health Plan Maryland prohibits a pharmacist from switching a prescribed drug or product to an alternative drug or product within the same therapeutic drug class, except when the pharmacist is servicing patients of a hospital, resident of a comprehensive care or extended care facility with an established procedure for therapeutic interchange.

Medication Exceptions

Non-covered drugs and products requested by you or your provider may be reviewed by CareFirst BlueCross BlueShield Community Health Plan Maryland pharmacy benefits manager when the formulary does not adequately accommodate your clinical needs. Please be prepared to provide supporting clinical documentation to show that the member has tried and failed a formulary option (medical necessity. Contact CVS Health at 1-877-418-4133 for a medication exception request review. Members or providers can initiate a medication exception request by contacting CVS Health.

The complete list of drugs that your provider can prescribe is updated quarterly but changes to the drug list may occur at any time depending on pharmaceutical management procedures. Both quarterly updated drug list and interim formulary changes are available on our website **www.carefirstchpmd.com**. Regular formulary update reminders are distributed to the membership via the Member Newsletter.

22. Attachment L
Advance Directives

MARYLAND ADVANCE DIRECTIVE:

PLANNING FOR FUTURE HEALTH CARE DECISIONS

A Guide to

Maryland Law on

Health Care Decisions

(Forms Included)

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

Brian E. Frosh
Attorney General

August 2019

22. Attachment L

Dear Fellow Marylander:

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

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

Here is some related, important information:

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

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

Brian E. Frosh
Attorney General

22. Attachment L

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

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

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

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

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

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

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

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

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that document is still valid. Also, if you made an advance directive in another state, it is valid in Maryland. You might want to review these documents to see if you prefer to make a new advance directive instead.

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

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

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

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

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

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

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

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

Frequently Asked Questions about Advance Directives in Maryland

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

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

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

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

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

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

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

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

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

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

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

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

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

doctor or other health care professional presents and discusses the issues. A MOLST form contains medical orders regarding life-sustaining treatments relating to a patient's medical condition.

Can my doctor override my living will?

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

If I have an advance directive, do I also need a MOLST form?

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

Does the DNR Order have to be in a particular form?

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

Can I fill out a form to become an organ donor?

Yes, Use Part I of the "After My Death" form.

What about donating my body for medical education or research?

Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 800-879-2728 for that form and additional information.

If I appoint a health care agent and the health care agent and any back-up agent dies or otherwise becomes unavailable, a surrogate decision maker may need to be consulted to make the same treatment decisions that my health care agent would have made. Is the surrogate decision maker required to follow my instructions given in the advance directive?

Yes, the surrogate decision maker is required to make treatment decisions based on your known wishes. An advance directive that contains clear and unambiguous instructions regarding treatment options is the best evidence of your known wishes and therefore must be honored by the surrogate decision maker.

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

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If you have other questions, please talk to your doctor or your lawyer. Or, if you have a question about the forms that is not answered in this pamphlet, you can call the health policy division of the attorney general's office at (410) 767-6918 or e-mail us at **adforms@oag.State.Md.Us**. More information about advance directives can be obtained from our website at: **http://www.marylandattorneygeneral.gov/pages/healthpolicy/advancedirectives.aspx**.

MARYLAND ADVANCE DIRECTIVE

Planning for future health care decisions

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

INSTRUCTIONS

1. Using this advance directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes.
2. This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. **Make sure you talk to your health care agent (and any back-up agents) about this important role.** Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too.
3. **You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new advance directive.**
4. Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

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

Name		
Home Street Address		
City	State	ZIP
Home Phone Number	Cell Phone Number	

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

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

Name		
Home Street Address		
City	State	ZIP
Home Phone Number	Cell Phone Number	

PART I: SELECTION OF HEALTH CARE AGENT (CONTINUED)

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

Name		
Home Street Address		
City	State	ZIP
Home Phone Number	Cell Phone Number	

C: Powers and Rights of Health Care Agent

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

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

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

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

D. How my Agent is to Decide Specific Issues

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

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

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

Name	Phone Number
Name	Phone Number
Name	Phone Number
Name	Phone Number

PART I: SELECTION OF HEALTH CARE AGENT (CONTINUED)

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

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

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

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of this Part

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

My agent's power is in effect:

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

>>OR<<

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

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

PART II: TREATMENT PREFERENCES ("LIVING WILL")

A. Statement of Goals and Values (optional: form valid if left blank)

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

PART II: TREATMENT PREFERENCES ("LIVING WILL")

B. Preference in Case of Terminal Condition

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

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

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

>>OR<<

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

>>OR<<

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

C. Preference in Case of Persistent Vegetative State

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

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

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

>>OR<<

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

>>OR<<

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

D. Preference in Case of End-Stage Condition

(If you want to state what your preference is, initial **one** only. If you do not want to state a preference here, cross through the whole section.)

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

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

>>OR<<

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

>>OR<<

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

E. Pain Relief

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

PART II: TREATMENT PREFERENCES ("LIVING WILL")

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

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

G. Effect of Stated Preferences

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

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

>>OR<<

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

PART III: SIGNATURE AND WITNESSES

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

Signature of Declarant	Date

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

Signature of Witness	Date
Telephone Number	
Signature of Witness	Date
Telephone Number	

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

AFTER MY DEATH

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

By (Print Name)	Date

PART I: ORGAN DONATION

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

Upon my death I wish to donate:

_____Any needed organs, tissues, or eyes.

_____Only the following organs, tissues or eyes:

_____

_____

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

_____For transplantation

_____For therapy

_____For research

_____For medical education

_____For any purpose authorized by law

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

PART II: DONATION OF BODY

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

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

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

_____The health care agent who I named in my advance directive.

>>OR<<

_____This person:

Name
Address
Telephone Number(s)

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

PART IV: SIGNATURE AND WITNESSES	
By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.	
Signature of Donor	Date
The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.	
Signature of Witness	Date
Telephone Number	
Signature of Witness	Date
Telephone Number	

AFTER MY DEATH PART II: DONATION OF BODY

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

Did You Remember To...

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