MCO HealthChoice Member Manual Template Instructions

Make September 1, 2025, Updates

All revisions to the manual are in track changes. Make all changes and review and follow all instructions below.
Do not make any change to the manual without approval from the Maryland Department of Health.

Template Instructions

Branding

The MCO may change font style and font or image color in the template to match their brand standard. However, any change must be 508 compliant.

You may change or add information to the headers and footers, but the footer must at a minimum contain the page number.

Review

1. Report any error immediately.
2. Ensure the table of contents is up to date.
3. Ensure bookmarks work correctly.
4. Ensure hyperlinks work correctly.
5. Ensure QR codes work correctly.
6. Ensure minimum font size is 12 points.
7. Recheck the final version to ensure it remains 508 compliant.

Update MCO Specific Content

1. Insert your branded and graphically designed cover.
2. Insert your MCO welcome message.
3. Search the document for items in <> highlighted in yellow. The MCO is to insert the correct information.
    a. When a phone number is indicated, the MCO may change the preceding text, “member services”, to reflect the correct information.

4. Update the Get in Touch page and table. This is the content formerly in Attachment A. The MCO should add or remove items as needed. The items in the list are for example only.

Special Needs Coordinator
After-Hours Services
Benefits Questions
Customer Service
Billing
Coordination of Benefits
Care Management
Utilization Management
Enrollment Department
Pharmacy Services
Mail-order Pharmacy in Maryland

5. Update the Getting Started with <MCO NAME> page.
    a. See <MCO Name> Sample Member ID Card section.
    b. MCO to insert a photo of the front and back of the card and add explanation for each line and item. See sample graphic and remove it and replace with the MCO graphically designed image.
6. Update Register for the Member Portal. MCO to insert any specific information, instruction or steps.
7. Update Vision Care Services Adults Aged 21+. MCO may remove the second bullet if it does not apply.
8. Update the Value-Added Benefits section. This is the content formerly in Attachment C, D and E.
9. Update the Privacy and Confidentially section. This is the content formerly in Attachment B.
10. Update the How to File a Complaint, Grievance or Appeal section. This is the content formerly in Attachment F.
11. Insert contact information in the Fraud, Waste and Abuse section.
12. You are encouraged to add a short URL and QC code where there is a reference to
    a. MCO Provider Directory Link
    b. MCO DPP page link
    c. MCO Formulary Link
13. Review the final document to ensure each page breaks appropriately.
14. Update the back cover. You may graphically design it to coordinate with the front cover.

HealthChoice Member Manual Template

<MCO Insert Cover>

The cover must include the minimum following information:

- 2025 Member Handbook
- MCO name
- Include in footer Revised September 1, 2025

This page reserved for MCO welcome message.

Get in Touch

Language Services

Need information in an accessible format or another language? Go to pages <## to ###.

TTY Users	
Maryland Relay	Call 711
Medical Emergency	
For life-threatening emergency treatment	Call 911
To arrange for emergency or urgent care, call your primary care provider.	
<MCO NAME> Member Services	
<MCO ADDRESS>	<MCO Member Services Number>
Website	<MCO Website>
Special Needs Coordinator	
After-Hours Services	
Benefits Questions	
Customer Service	
Billing	
Coordination of Benefits	
Care Management	
Utilization Management	
Enrollment Department	
Pharmacy Services	
Mail-order Pharmacy in Maryland	
Specialty Behavioral Health / Substance Abuse Services	
Suicide and Crisis Lifeline	Call or text 988
Maryland Public Behavioral Health System	800-888-1965
Dental Services	
Healthy Smiles Dental Program	855-934-9812
Maryland Medicaid	
HealthChoice Helpline	800-284-4510
Pregnant Members and Family Planning Helpline	800-456-8900
Medicaid Beneficiary Services and Pharmacy Access Hotline	410-767-5800 or 800-492-5231

Maryland Health Connection	
To apply for or renew Medicaid, report a change, and for important notices.	
Consumer Support	855-642-8572
Website and find sign in for your account	marylandhealthconnection.gov

If you need someone to be able to call and speak on your behalf

You must make a request in writing. You can complete an Authorized Representative form. This form lets <MCO NAME> talk to someone other than you. Your authorized representative can be a family member, a friend, a provider, or a lawyer. Call customer service for more information.

Local Health Department Contact Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number
Allegany	301-759-5000	301-759-5123	301-759-5094
Anne Arundel	410-222-7095	410-222-7152	410-222-7541
Baltimore City	410-396-4398	410-396-7633	410-649-0500
Baltimore County	410-887-2243	410-887-2828	410-887-8741
Calvert	410-535-5400	410-414-2489	410-535-5400, ext. 360
Caroline	410-479-8000	410-479-8014	410-479-8189
Carroll	410-876-2152	410-876-4813	410-876-4941
Cecil	410-996-5550	410-996-5171	410-996-5130
Charles	301-609-6900	301-609-6923	301-609-6760
Dorchester	410-228-3223	410-901-2426	410-901-8167
Frederick	301-600-1029	301-600-3124	301-600-3124
Garrett	301-334-7777	301-334-7727	301-334-7771
Harford	410-838-1500	410-638-1671	410-942-7999
Howard	410-313-6300	877-312-6571	410-313-7323

Kent	410-778-1350	410-778-7025	410-778-7035
Montgomery	240-777-0311	240-777-5899	240-777-1635
Prince George's	301-883-7879	301-856-9555	301-856-9550
Queen Anne's	410-758-0720	443-262-4462	443-262-4456
St. Mary's	301-475-4330	301-475-4296	301-475-4330
Somerset	443-523-1700	443-523-1722	443-523-1758
Talbot	410-819-5600	410-819-5609	410-819-5600
Washington	240-313-3200	240-313-3264	240-313-3229
Wicomico	410-749-1244	410-548-5142	410-543-6942
Worcester	410-632-1100	410-632-0092	410-629-0614

Getting Started with <MCO NAME>

You have enrolled in a Maryland Medicaid HealthChoice managed care plan. Although<MCO NAME> provides comprehensive benefits under this health plan, Maryland Medicaid directly covers some of your benefits – like behavioral health and dental care. Read this handbook carefully to learn more and to learn how to access your benefits.

Other Names for Your Medicaid Health Plan

- HealthChoice
- Health insurance
- Managed care organization, or MCO
- Managed care plan

No matter how you may refer to us, we are Medicaid.

Be sure to pick your primary care provider (PCP) who will help you when you need a referral or preauthorization for a procedure, treatment, or medication.

Before you get services from any health care provider, check to see if that provider is in our network - except in an emergency. Visit our <MCO PROVIDER DIRECTORY LINK>.

We are always here to help. Call <MCO Name> member services at <MCO Member Services Number> if you have a question or concern about your coverage or your care.

<MCO NAME> Member ID Card

We will mail you a member ID card. Each member has their own ID number.

You will need your <MCO NAME> card and your red and white Medical Assistance card for all health care services. You will also need your cards when picking up a prescription at the pharmacy. Always carry both cards with you.

Show both cards when a provider asks you about your health insurance. If you have any other health insurance coverage, you will need to show that card too. See Other Insurance.

Never allow anyone else to use your Medicaid or <MCO Name > member card.

Lost or Stolen Card

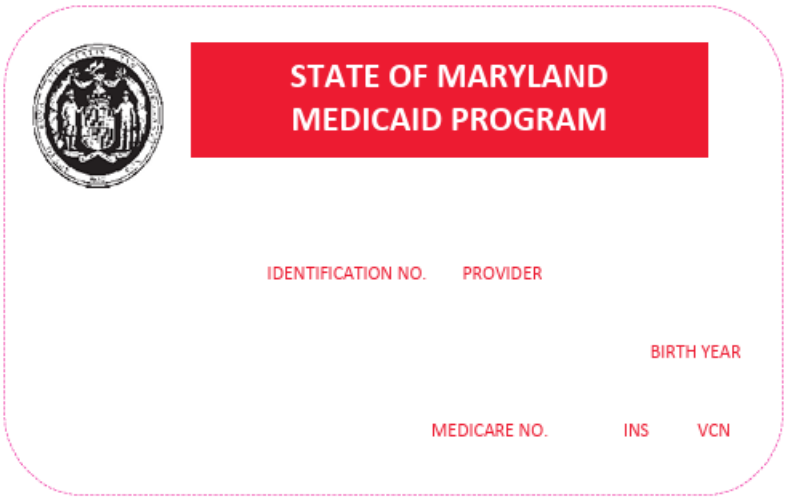
Report a lost or stolen card right away and request a new one. Call member services at <MCO Member Services Number>.

To report a lost or stolen red and white Medicaid ID card, call Beneficiary Services at 1-800-492-5231.

<MCO Name> Sample Member ID Card

MCO to insert photo of front and back of card and add explanation for each line and item. See sample below.

Medicaid Sample Member ID Card



Register for the Member Portal

Go to <MCO MEMBER PORTAL LINK>. You can either sign up to create an account or log in to update your existing account.

MCO to insert any specific information, instruction or steps.

Visit our secure member portal to learn more about your benefits, change your primary care provider, search for other providers, view service history, and more.

Pick Your Primary Care Provider (PCP)

When you join <MCO Name>, you need to pick a PCP from our provider network. If you do not choose a PCP, we will pick one for you.

Visit our <MCO PROVIDER DIRECTORY LINK> to find an in-network doctor that is right for you. You can search by

- Name
- Location
- Language
- And more

You and your household members can choose the same PCP or a different one. For members 21 years old and younger, you can choose a certified Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provider.

If you need help finding a PCP or any provider, call member services at <MCO Member Services Number>.

Changing Your Primary Care Provider

You can change your PCP at any time. If you change your PCP, let us know right away. Call member services at <MCO Member Services Number>.

After Hours, Urgent Care, and Emergency Care

Know Where to Go and When.

Choose the right place for health care based on your needs.

DOCTOR'S OFFICE

- Cough or cold
- Fever
- Health screenings
- Lingering pain
- Routine checkups
- If something causes you concern
- Unexplained weight loss

URGENT CARE CENTER

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

EMERGENCY ROOM

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

Contents

Overview

What is Medicaid?

Medicaid is a public health insurance program. It is free or low-cost health insurance for eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. It is the largest health care program in the United States.

In Maryland, Medicaid covers about 1.6 million people. Nearly one in four Marylanders get their health insurance through Medicaid. Half of those covered are children. Locally, people also call it Medical Assistance.

Understanding Medicaid and HealthChoice

- The **Maryland Department of Health** is the part of the state government that oversees public health.

- **Medicaid** is part of the Maryland Department of Health. Medicaid provides free or low-cost health insurance for those with limited income. Medicaid pays for the health care services that you get from medical providers.
- **HealthChoice** is the name of Maryland Medicaid's managed care program. Only MCOs that are part of the HealthChoice program can work with Medicaid and with you. You can choose your MCO to get your health care – because it is your health and your choice!
- A **Managed Care Organization, or MCO**, is a health care company or health plan. An MCO enters a contract with the Maryland Department of Health to give you covered health services under Medicaid.
- **Maryland Health Connection** is Maryland's official health insurance marketplace. It is where you enroll in Medicaid. Maryland Health Connection takes care of the paperwork you need to get Medicaid. When you sign up for Medicaid through them, you will pick a health care company.
- **MCO Network Providers** are the doctors, hospitals, and other providers who work with the health care plan you choose to give you the care you need.

Renewing Your Medicaid Coverage

You will need to renew your Medicaid coverage every 12 months. When you renew, also known as reapplying, redetermination, or recertification, Medicaid checks your income to be sure you are still eligible. Certain Medicaid programs check your assets too.

- Medicaid will contact you when it is time for you to renew. You will get a notice in the mail or in your online account if you are paperless. You will have 60 days to respond. Renew by the deadline so you do not lose your coverage.
- Most people will renew through Maryland Health Connection. You will renew through DHS if you are aged 65+, blind or disabled or are in a Home and Community-Based Service program.
- Medicaid may be able to auto renew your coverage. You will get a notice to let you know if they do. There is no paperwork for you to fill out and send in when they auto renew you. This is because they were able to verify your eligibility using other sources. If they can't auto renew your coverage, they will send you a letter or email to ask you to apply and tell you how.

Report Changes

Report a change in your income or household within 10 days. You may lose your coverage if you do not. Changes you need to report include:

Family and Household Changes

- Getting married or divorced
- Having a child, adopting a child, or placing a child for adoption or in foster care
- Gaining or losing a dependent
- Change in tax-filing status

Health and Disability Changes

- Getting pregnant
- Having a change in disability status

Income and Financial Changes

- Certain changes in income
- Certain changes in resources for age 65+, blind or disabled

Residency and Citizenship Changes

- Moving to or from Maryland, and a move within Maryland to another county or Baltimore City
- Change of citizenship or immigration status
- Change in status as an American Indian/Alaska Native or tribal status

Legal Changes

- Incarceration or release from incarceration

If you are not sure if you should report a change, call the Maryland Health Connection at 855-642-8572.

Always Keep Your Contact Information Up to Date

A lot can change in a year, like your contact information. Update a change of address, phone number or email right away so you keep getting important information about your Medicaid coverage.

How to Renew Coverage, Report Changes, or Update your Contact Information with Maryland Health Connection

- Log into your Maryland Health Connection account.
- Call 855-642-8572.
- In person at your local Department of Social Services or your Local health department.

What's Covered

There are three types of covered benefits:

1. **Essential Benefits:** All managed care health plans must cover these benefits. You get these no matter which managed care health plan you belong to.
2. **Other Covered Benefits:** Maryland Medicaid covers some benefits directly. No managed health care plan covers these benefits. For more information, see Other Covered Benefits.
3. **<MCO Name> Value-Added Benefits:** These are benefits that we offer that are above and beyond the essential benefits and other benefits covered by Maryland Medicaid. For more information, see Value-Added Benefits.

Essential Benefits

All Maryland Medicaid HealthChoice managed care organizations must cover certain essential medical benefits. Some benefits are for all members, while others are only for certain members like those who are 21 years old and younger, are pregnant, or have special needs.

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCO Name> card when you get these services. Some services may require a referral or preauthorization. See Self- Referral to learn more.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

For more information on benefits, see Other Covered Benefits and <MCO Name> Value-Added Benefits.

Essential Benefits: All Members

Audiology

- Assess and treat hearing loss and ear problems.
- Members 21+ may be eligible for hearing devices. Talk to your provider for more information.

Blood and Blood Products

Blood or parts of blood given to a patient for a variety of reasons and treatments.

Case Management, Case Manager

Medical professionals, known as case managers, can help you and your family assess, plan, coordinate, monitor, and arrange health services to meet your needs for the best possible health. You can choose whether to work with a case manager or not.

<MCO Name> may assign you a case manager when you enroll with us or soon after. If you think you need case management services or need help contacting your case manager, call member services at <MCOPhoneNumber>.
Your case manager can be a registered nurse, a social worker or other health care professional. Your case manager will:

- Help develop a care plan.
    - A care plan is a form that lists a person's health conditions and current treatments for their care written by their care team.
    - You and the people you allow to help you are part of your care team. This could be a family member, friend, lawyer, or other representative.
- Update your care plan at least every 12 months or as needed.
- Keep track of healthcare services you need and receive.
- Talk to you about your options and what is available to help you.
- Help those who give you treatment to work together.

Clinical Trials

You may be eligible for research studies that test new treatments on patients. It must be an approved clinical trial for the treatment of a life-threatening condition. To learn more, talk to your primary care provider or call member services at <MCO Number> for more information.

Diabetes Prevention and Care Services

See Diabetes Prevention and Care Services.

Dialysis

A treatment for kidney disease that uses a machine to filter waste and water from your blood like your kidneys did when they were healthy. See Self-Referral.

You may be eligible for the Rare and Expensive Case Management Program (REM) if you are on dialysis.

Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)

- DME are things like crutches, walkers, and wheelchairs that you use daily or for a long time.
- DMS are things like finger stick supplies, dressings for wounds, and incontinence supplies that are for one time use then thrown away.
- May require preauthorization.

Emergency Care, Emergency Services

For emergency care, go to your nearest hospital's emergency room (ER). If you think the problem is life-threatening, call 911.

- **You do not need preauthorization or a referral for emergency care.**
- You may go to any hospital or emergency facility for emergency care.
- An emergency service is any health care service to evaluate or treat a medical emergency.
- Examples of a medical emergency are:
    - Heart attack symptoms: chest pain, shortness of breath, sweating and nausea
    - Heavy bleeding
    - Bleeding during pregnancy
    - Major burn
    - Loss of consciousness
    - Difficulty breathing
    - Poisoning
    - Severe head pain or dizziness
- See Emergency Medical Transportation and Post-stabilization Care Services.

Family Planning

Family planning coverage includes:

- Office visits

- Lab tests
- Prescription birth control pills and devices
- Latex condoms - from a pharmacy, no prescription needed
- Emergency contraceptives - from a pharmacy, no prescription needed
- Voluntary sterilization – in-network provider and with preauthorization only
    - Sterilization is a medical procedure that leaves you unable to reproduce or get pregnant. For women it is having your tubes tied, also called tubal ligation, or for men it is a vasectomy.
- You do not need a referral when choosing a family planning provider except for sterilization. See Self- Referral.

Hospital Care

- **Inpatient Care**
    - Inpatient care is medical care or treatment in a hospital for one or more nights.
    - Requires preauthorization for scheduled hospital stays and care.
    - **You do not need preauthorization for emergency care**.
    - See Hospital Care, Inpatient Care - Maternity and Long Term Care
- **Outpatient Care**
    - Outpatient care is medical care or treatment in a hospital but with no overnight stay.
    - Some outpatient services may require preauthorization.
    - <MCO name> only covers up to 24 hours of observation.

Laboratory & Diagnostic Services

Lab tests and diagnostic services, like an X-ray, to help find out the cause of your health problem.

Oxygen and Respiratory Equipment

Medical equipment for people who have trouble breathing. See Durable Medical Equipment.

Pharmacy and Prescription Drug Services

See Pharmacy and Prescription Drug Services and <MCO Preferred Drug List>.

Plastic and Restorative Surgery

- Only covers surgery to reconstruct, change or repair a part of your body that is not a normal shape or is oddly shaped due to illness, trauma, that you were born with, or that did not develop in the usual way.
- Does not cover plastic, cosmetic, or reconstructive surgery to make you look better that is not medically necessary.

Podiatry

- Treatment for foot problems or conditions
- Routine foot care for members age 21+ who have vascular disease affecting your body from your hip to your toes.
    - Vascular diseases affect veins, arteries, and capillaries.
- See Diabetes Prevention and Care Services.

Post-Stabilization Care Services

All covered services related to an emergency medical condition given after the patient is stable. See Emergency Care, Emergency Services**.**

Primary Care

Basic health care given by your main provider. Your primary care provider (PCP) can be a doctor, a nurse practitioner, clinical nurse specialist, or a physician assistant. Your PCP also helps you find and get other health care services. See Self- Referral.

Primary Behavioral Health

- Primary behavioral health services are basic mental health services provided by your PCP or another <MCO Name> provider.
- For all other mental health services, see Behavioral Health Services.

Specialist Services/Specialty Care

- A specialist has training in a specific area of medicine. Some specialists only treat a certain group of patients.
- You may need a referral from your PCP before you can see a specialist.

Transplants

- A surgical procedure to remove living tissue or an organ from one person, the donor, and place it in another living person, the recipient.
- No experimental transplants.

Urgent Care / Urgent Care Centers

- Go to an urgent care center when you need care right away but for non-life-threatening conditions only. **No referral or preauthorization needed**.
- You must go to an in-network urgent care center, or you may receive a bill for services. See the <MCO Provider Directory> for more information.

Vision Care

See Vision Care Services.

Essential Benefits: Members 21 Years old and Younger

All Maryland Medicaid HealthChoice managed care organizations must cover certain essential medical benefits. **These benefits are only for those who are 21 years old and younger.**

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit. There is no co-pay for covered prescriptions for those who are younger than 21 years old. For more information, see Pharmacy and Prescription Drug Services.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization. See Self-Referral.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

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

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services to ensure that children and adolescents receive the proper preventive, dental, mental health, and specialty services.

What are EPSDT services?

Early: Assessing and finding problems early.

Periodic: Checking children's health at periodic, age-appropriate intervals.

Screening: Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.

Diagnostic: Performing diagnostic tests to follow up when there is a risk.

Treatment: Control, correct or reduce health problems found.

To see if your child's doctor is an EPSDT-certified provider or to find one, visit <MCO Provider Directory link> or call member services at <MCO Customer Service phone number>.

<MCO Name> EPSDT Covered Services

- Diagnostic Services
- Hearing Services
- Immunizations
- Lead Screening
- Screening services
- Treatment
- Vision Care Services

EPSDT Services Covered by Maryland Medicaid

- Behavioral Health
- Dental Services
- Occupational Therapy
- Physical Therapy
- Speech Therapy

School-Based Health Center Services

School-based health centers are like having a doctor's office in a school. EPSDT-certified doctors and other health care professionals provide onsite preventive and primary health services. **Not all schools have a school-based health center.** See Self-Referral.

For children who go to schools with a school-based health center, they can receive the following services at the center:

- Well-child care
- Vaccines
- Follow up to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services visits when needed
- Family planning services, see Self-Referral

Children with Special Health Care Needs

Children with special health care needs have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions. They need more and different health and related services than their peers. For more information, see Essential Benefits: Special Needs Members.

A special healthcare need can include physical, intellectual, and developmental disabilities, as well as long-standing medical conditions, such as asthma, diabetes, a blood disorder, or muscular dystrophy.

These children may also need long term care services or may be eligible for the Rare and Expensive Case Management Program.

Some children may qualify for other Medicaid home and community-based services waivers or programs. For more information, call our special needs coordinator at <MCO SNC Number>.

Covered services for children with special health care needs include:

- Case management. See Case Management, Case Manager.
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
- Specialist Services/Specialty Care

Some services may require a referral or preauthorization.

Out-of-Network Providers

Sometimes, children with special health care needs can see a specialist outside of our network. You may be able to use an out-of-network specialty provider:

- **Existing <MCO NAME> Member:** The parent or guardian of a child requests approval for a specific out-of-network specialty provider. The child must not have a diagnosed special health care need that requires a plan of care when they enrolled with <MCO Name>. **We only approve requests when we do not have a local, comparable, and available in-network specialty provider**.
- **New <MCO NAME> Member**: You must contact us to request to keep seeing your out-of-network provider. For more information, see Continuity of Care. Also note:
    - The specific out-of-network specialty provider must submit the plan of care for review and approval within 30 days of the child's start date with us to continue to provide services.
    - The child must have a diagnosed special health care need that requires a plan of care before joining <MCO Name>.
    - We only approve these requests when the child is receiving these services before joining <MCO Name>.

For help, call our special needs coordinator at <MCO SNC NUMBER>.

Essential Benefits: Pregnant Members

Care for Members Before, During, and After Pregnancy

Are you pregnant or thinking about becoming pregnant? Call us right away. We can help you get the care you need for a healthy pregnancy and your baby to get a healthy start in life.

All Maryland Medicaid HealthChoice managed care organizations must cover certain essential medical benefits. **These benefits, known as maternity services, are only for pregnant members.**

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit. There is no co-pay for covered prescriptions for pregnant members. For more information, see Pharmacy and Prescription Drug Services.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization. See Self-Referral.

For more information on benefits, see Essential Benefits: Special Needs Members, Other Covered Benefits and <MCO Name> Value-Added Benefits.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

For questions or help, call our special needs coordinator at <MCO SNC Number>. You can also call Maryland Medicaid's Pregnant Members and Family Planning Helpline at 800-456-8900.

Medicaid Coverage and Pregnancy

If you are only eligible for Medicaid because you are pregnant, your Medicaid and HealthChoice coverage will end one year after the end of your pregnancy. If you get your Medicaid coverage under the Healthy Babies Act, your coverage will end four months after the end of your pregnancy. For more information, call member services at<MCO customer service number>.

Dental Care and Pregnancy

Did you know it is safe to go to the dentist at any stage of pregnancy? Taking good care of your teeth and gums is important for you and for your baby's wellness. See Dental for more information about this covered benefit.

Birthing Centers

- A birthing center, or free-standing birthing center, is a free-standing facility that is not associated with a hospital that provides nurse midwife services.
- Our network may include an out-of-state birthing center that borders Maryland.
- See Self-Referral.

Case Management, Case Manager

See Case Management, Case Manager.

CenteringPregnancy

- CenteringPregnancy is care, support, and learning in a group setting - before and after birth.
- It is a new way of getting the care you need as you get ready to give birth.
- Everyone in the group is due around the same time.
- The group talks together, learns together, and supports each other.
- You will spend more time with your provider and care team as part of the group.

Doula Services

- A doula, or birth worker, is a trained professional who provides support and information to you before and after birth, as well as during labor.
- Doulas are non-clinical providers and cannot perform the work of a nurse-midwife, nurse practitioner, or doctor.
- You do not need a referral to see a doula through the end of 2025. See Self-Referral.

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

Pregnant people ages 21 and younger can receive all EPSDT services. See Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services

Emergency Transfer

Transfer for pregnant women, newborns, and infants to a specialty care hospital or medical center.

HIV Counseling and Testing

- Do a risk assessment, that is, gather information from you to find out if there is a chance of having HIV.
- Get professional support and information on how HIV may affect you and your baby.
- See HIV/AIDS Testing and HIV/AIDS Services.

Home Visiting Services

Home Visiting services help you get the care and support you need to have a healthy pregnancy and healthy child. A specially trained professional or a nurse usually provides these services in the home. After pregnancy, your home visitor will continue to support you and your child, up to their second or third birthday, depending on the program that's right for you. The program tailors the type of home visiting services and home visitor to the specific needs of the family. The home visits can teach you about:

- Diet and nutrition
- How your baby grows and learns
- Mental health and stress control
- Parenting skills
- Planning for the future
- Resources available to you in the community
- Self-care

Group-based support is also available.

Hospital Care, Inpatient Care - Maternity

- 48 hours for an uncomplicated vaginal delivery.
- 96 hours for an uncomplicated cesarean delivery.
- If you choose to leave the hospital sooner than the above times, we will provide a home visit. See Baby's First Check-up.
- If you must stay in the hospital after childbirth for medical reasons, ask us to ensure that your newborn can stay too. We will cover up to four days for your newborn to stay with you. For help, call member services at<MCO customer service number>.

Lactation Counseling

Lactation counseling is professional help with breastfeeding. A lactation consultant can give you tips, answer questions, and support you. They can help to make breastfeeding easier for you and your baby.

Nutrition Counseling

You can work with a healthcare professional to learn about healthy food choices during and after your pregnancy. Healthcare professionals may include a licensed dietitian or a nutritionist.

Prenatal Care

Care during pregnancy and before birth.

- Regular check-ups with a family practitioner, obstetrician (OB doctor), or certified nurse midwife to check your health and the health of your unborn baby.
- Counseling and education.
- If you are pregnant, <MCO Name> will help you schedule an appointment for prenatal care within 10 days of your request.
    - **New <MCO NAME> Member:** If you are already seeing a provider who is not in our network, you may be able to continue seeing them. See Essential Benefits: Pregnant Members > Out-of-Network Providers and Continuity of Care.

Prenatal Risk Assessment

The Maryland Prenatal Risk Assessment (MPRA) is a form that collects important health information about pregnant Medicaid members. We use this information to refer you to helpful services, like WIC or home visiting. These services help keep you and your baby healthy before and after birth.

Your provider will complete this assessment at your first prenatal care visit. The information goes to the local health department that will connect you with resources and support services in your area. We do not share information about your HIV status.

Postpartum Care

Care after childbirth

- Counseling and education.
- <MCO Name> will help you to schedule an appointment for postpartum care within 10 days of your request.
    - **New <MCO NAME> Member:** If you are already seeing a provider who is not in our network, you may be able to continue seeing them. See Essential Benefits: Pregnant Members > Out-of-Network Providers and Continuity of Care.

Smoking Cessation Counseling

Get professional support and information on how to stop smoking.

Substance Use Treatment

We will refer you to the Public Behavioral Health System within 24 hours of requesting treatment. See Behavioral Health Services.

Out-of-Network Providers

You may be able to keep seeing an out-of-network provider through your pregnancy and up to your first visit after the baby is born if:

- You were pregnant when you enrolled with us.
- You had at least one full prenatal visit with the out-of-network provider.
- The out-of-network provider agrees to keep seeing you.

You must contact us to request to keep seeing your out-of-network provider. See Continuity of Care. For help, call member services at <MCO Customer Service phone number>

Prenatal Visit Schedule

Prenatal care will help you have a healthy pregnancy and baby. Keep the following appointments with your provider.

When to Go	What to Expect

First Visit - up to 10 Weeks	• Have an ultrasound to confirm pregnancy and figure out due date
	• Review of medical history
	• Get depression screening
	• Get lab work:
	  ○ Blood work
	  ○ STD testing
	• Get a full physical exam and Pap smear
	• Talk about:
	  ○ The health of you and your baby, see Prenatal Risk Assessment
	  ○ Flu vaccine, if needed
	  ○ Genetic screening options

12 Week Visit	• Review lab work • Check baby's heart rate • Do genetic screening - optional • Get early blood sugar testing for gestational diabetes, if needed
16 Week Visit	• Check baby's heart rate • Get baby screened for brain, spine, or spinal cord birth defects – called neural tube defects • Get early blood sugar testing for gestational diabetes, if needed
20 Week Visit	• Have an ultrasound to check that all parts of baby are growing as they should be - called an anatomy ultrasound
24 Week Visit	• Get a check up • Measure your belly, or fundal height, to track how baby is

	growing and baby's position ● Talk about: ○ Blood sugar testing for gestational diabetes on your next visit ○ Childbirth education, see CenteringPregnancy ○ Doula services
28 Week Visit	● Get a check up ● Get depression screening ● Get lab work to check for ○ Gestational diabetes ○ Anemia ○ Infections ● If Rh-negative blood type, get a shot to protect baby ● Get Tdap vaccine, if needed
30 Week Visit	● Get a check up ● Review lab work ● Talk about childbirth
32 Week Visit	● Get a check up ● Talk about RSV vaccine, if needed Certain high-risk patients will begin more testing, screening and ultrasounds.
34 Week Visit	● Get a check up ● Talk about: ○ Labor and pain management ○ Preparing for your baby, including car seats ○ After delivery care for you and baby ○ Choosing your baby's doctor
36 through 40 Week Visits	● Get a checkup and pelvic exam ● Check to see if you are dilating ● Get a Strep B test to check baby's ability to eat and breathe ● Talk about your delivery plan
40 through 42 Week Visits	● Get a checkup and pelvic exam ● Check baby's heart rate ● Get an ultrasound ● Check to see if you are dilating ● Talk about inducing labor, if needed
Postpartum Visit – after delivery	● Get a check up to see how you are healing ● Check your blood pressure ● Get depression screening ● Talk about birth control

Recommendations for prenatal visits are based on the Source: American College of Obstetricians and Gynecologists (ACOG) guidelines. For the latest information, visit acog.org/womens-health.

Getting Ready for Baby's Arrival

It is best to select your baby's doctor before you deliver. We can help find the right pediatric provider for you and your baby. The provider can be a pediatrician, family practitioner, or nurse practitioner.

Maryland Medicaid will automatically enroll your newborn with us. Your newborn must stay a <MCO Name> member for the first 90 days. After that time, you can choose another HealthChoice managed care plan. See Changing Managed Care Plans.

Baby's First Check-up

Your baby usually gets their first check-up while still in the hospital. The pediatrician you choose for your newborn will do a newborn exam in your hospital room. See Self-Referral.

You will stay in the hospital to recover for 48 to 96 hours depending on the type of delivery you have. If you choose to leave the hospital sooner, we will provide a home visit within the next 24 hours. You might also get another home visit if your provider thinks it's needed. See Hospital, Inpatient Care - Maternity.

We will schedule your newborn for a follow-up visit with a pediatrician within two weeks after you get out of the hospital. See Well Child Care for more information.

Essential Benefits: Special Needs Members

All Maryland Medicaid HealthChoice managed care organizations must cover certain essential medical benefits. **These benefits are only for those who are special needs members.**

Special needs members can get certain services, supplies and equipment, and see in-network specialists without a referral.

Maryland Medicaid has identified groups of people who may need special health care management, intervention, services, or programs to access the care they need.

Some people may belong to more than one special needs group. Groups include:

1. Children in state-supervised care
2. Children with special healthcare needs
3. People experiencing homelessness
4. People who are pregnant or who just gave birth
5. People with a developmental disability
6. People with a physical disability
7. People with HIV/AIDS

Children in State-supervised Care

A child in state-supervised care is a child who is in custody of, committed to, or otherwise placed by the local Department of Social Services, Department of Health, Department of Juvenile Services, or private placement agency licensed by the Social Services Administration. This includes foster children and children in the justice system.

We work together with state and local agencies to ensure continuity and coordination of care, especially if the child moves to a new area within Maryland.

For questions or help, call our special needs coordinator at <MCO SNC Number>.

People Experiencing Homelessness

Call our special needs coordinator at <MCO SNC Number> right away if you are experiencing homelessness. We will work with you to connect you with a case manager to get you the help and care you need.

People with a Developmental Disability

Our case managers have the experience and training to provide care for people with developmental disabilities. Talk to your case manager about communications in alternative formats or to ask for a reasonable accommodation.

People with a Physical Disability

We assess the needs of people with physical disabilities to see if they can stay in the community with services that <MCO Name> or Maryland Medicaid provides or if they need intermediate or long-term care facility placement. See Long Term Care.

Talk to your case manager about communications in alternative formats or to ask for a reasonable accommodation.

Benefits for special needs members include:

Case Management, Case Manager

<MCO Name> will assign you a case manager when you enroll with us or soon after. Your case manager can be a registered nurse, a social worker or other health care professional. See Case Management, Case Manager.

Special Needs Coordinator

A special needs coordinator is your point of contact for healthcare information and referrals. A special needs coordinator helps you and your health care providers understand what is available

to address special needs. Special needs coordinators also can answer questions about your rights under the Americans with Disabilities Act.

- See Specialist Services/Specialty Care.
- See Self-Referral.

Other Covered Benefits

<MCO Name> does not cover some benefits that Maryland Medicaid covers directly if they are medically necessary. You will use your red and white Medicaid card when you get these services except for Dental. You will get a dental member ID card from the Maryland Healthy Smiles Dental Program. Some services may require a referral or preauthorization.

Use the Provider Finder to search for a Medicaid provider to get the care you need near you.

Go to the Provider Finder now. Type this link exactly as it appears into your phone or computer's address bar: bit.ly/48s6WxC or scan the QR code.

For more information or questions, call the HealthChoice Helpline 800-284-4510.

For more information on benefits, see Essential Benefits and <MCO Name> Value-Added Benefits.

Other Covered Benefits: All Members

Abortion

Maryland Medicaid covers this procedure. For help, call the HealthChoice Helpline at 800-284-4510.

Dental

You will use your Maryland Healthy Smiles Dental Program card when you get these services.

For more information on dental benefits and services, visit Maryland Healthy Smiles Dental Program or call 855-934-9812.

Go to Maryland Healthy Smiles Dental Program now. Type this link exactly as it appears into your phone or computer's address bar: bit.ly/3VUnZkC or scan the QR code.

Behavioral Health Services

The Maryland Public Behavioral Health System provides substance use disorder and specialty behavioral health services. No referral needed. For more information, call 800-888-1965.

See Primary Behavioral Health for other covered services.

Contact the Suicide and Crisis Lifeline if you are experiencing a mental health or substance use emergency. It's free and confidential. Call or text 988. Chat with a crisis counselor online at https://988lifeline.org/chat/.

Go to Suicide and Crisis Lifeline now. Type this link exactly as it appears into your phone or computer's address bar: bit.ly/3Dnq2K0 or scan the QR code.

HIV/AIDS Testing

- HIV/AIDS drug resistance testing: genotypic, phenotypic, or other
- Viral load testing
- See HIV/AIDS Services.

Speech Augmenting Devices

Equipment that helps people with speech impairment to communicate.

Transportation Services

- Emergency Medical Transportation
    - Call 911 if you are having a medical emergency.
    - Medical services while transporting the member to a healthcare facility in response to a 911 call.
    - Local fire companies provide this service.
- Non-Emergency Medical Transportation

- You may request non-emergency medical transportation (NEMT) to and from a Medicaid covered, medically necessary service when you have no other way to get there.
- To see if you qualify for this service, contact your local health department.
- For more information, email MDH.askNEMT@maryland.gov.

<MCONAME> may cover some non-emergency medical transportation for special reasons. For more information, call member services at <mcophonenumber>.

Other Covered Benefits: Members 21 Years Old and Younger

<MCO Name> does not cover some benefits that Maryland Medicaid covers directly if they are medically necessary. You will use your red and white Medicaid card when you get these services. **These benefits are only for those who are 21 years old and younger.**

Use the Provider Finder to search for a Medicaid provider to get the care you need near you.

Occupational Therapy

The kind of treatment that helps you relearn everyday activities. For example, handwriting or eye-hand coordination.

Physical Therapy

Treatment of disease, injury, or deformity by physical methods such as massage, heat treatment, and exercise rather than by drugs or surgery.

Speech Therapy

Training to help people with speech and language problems to speak more clearly.

<MCOName> may pay for these services if they are part of home health service or an inpatient hospital stay.

Value-Added Benefits

These are benefits that we offer that are above and beyond the essential benefits and other benefits covered by Maryland Medicaid. You will use your <MCOName> card when you get these services. There are no grievance or appeal rights for these benefits. For more information or questions, call member services at <MCOPhoneNumber>.

For more information on benefits, see Essential Benefits and Other Covered Benefits.

MCO to insert benefits here. Formerly attachment C, D and E.

What's Not Covered

There are benefits that Maryland Medicaid does not require any HealthChoice managed care organization to cover. Maryland Medicaid may cover some of these benefits directly if they are medically necessary. A HealthChoice managed care organization may choose to cover some of these benefits, but they do not have to.

Your provider must tell you if Medicaid does not cover a service and if you will be responsible for paying for that service. For more information, see Medicaid Billing Rights and Protections.

These are benefits that Maryland Medicaid does not require any HealthChoice managed care organization to cover:

- Experimental treatment unless you are in an approved clinical trial.
- A service that is not medically necessary**.**
- A service ordered or given by someone who is not a licensed health care provider.
- A service not allowed under the provider's license.
- Non-Emergency Medical Transportation, but they can help you connect to a ride.
- Health services or case management for children when:
    - They are part of the child's Individualized Family Service Plan (IFSP) or Individualized Education Program (IEP).
    - They happen in school or through community-based children's medical program.
- An autopsy.
- Medical care you get **outside the U.S.**
- An abortion.
- A weight loss program or exercise plan.
- Medicine or shots used only to lose weight.
- Help to get pregnant - like in vitro fertilization.
- Surgery to undo sterilization that you chose to have.
- Help to quit smoking, eat healthy, or get fit —unless they choose to cover it.
- Non-medical service for job training, help finding a job, or learning programs.
- A private duty, in-home nurse for an adult 21 or older.
- Care you got **before you joined** their plan.
- Dental or braces.
- Oxygen used only as a backup or once in a while.
- Cosmetic surgery just to change how you look.
- Nutritional drinks, vitamins, or minerals that you take by mouth**.**

- A service that the Maryland Medicaid pays for directly.

For more information on benefits, see Other Covered Benefits and Value-Added Benefits.

If you have other insurance besides Medicaid, they may cover some of these services. Always tell your provider about your other insurance. Give them all your health insurance information when you check in.

For more information or questions, call the HealthChoice Helpline at 800-284-4510.

Diabetes Prevention and Care Services

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit. **These benefits are only for people with a prediabetes or diabetes diagnosis.**

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization. See Self-Referral.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

Benefits for Members with a Diabetes Diagnosis

Benefits include medically necessary special diabetes-related services:

- Diabetes nutrition counseling
    - One initial one-on-one session
    - Four more sessions annually
- Diabetes outpatient education
- Diabetes-related durable medical equipment and disposable medical supplies
    - Blood glucose monitoring supplies
    - Diagnostic reagent strips and tablets
    - Finger-sticking devices for blood glucose testing
    - Blood glucose reflectance meters for home use
- Therapeutic footwear and related services
    - Footwear and services that help improve or heal your condition.
        - Therapeutic footwear, orthopedic shoes

        - Arch supports, orthotic devices, in-shoe supports, elastic support
        - Exam, prescription, fitting, and related services for special footwear to prevent or delay loss of the foot.
- Podiatry
    - Diabetes-related foot care.
    - See Podiatry.
- Diabetes-related vision care
    - See Vision Care Services.

Benefits for Members with a Prediabetes Diagnosis

HealthChoice National Diabetes Prevention Program

If you have prediabetes, the HealthChoice Diabetes Prevention Program lifestyle change program may be for you. It can help you lose weight, become more active, and prevent or delay type 2 diabetes.

To be eligible for the HealthChoice Diabetes Prevention Program, you must meet all the following:

- Be 18 to 64 years old
- Be overweight
- Not be pregnant
- Not diagnosed with type 1 or type 2 diabetes
- Have a recent blood test with results in the prediabetes range or have a history of gestational diabetes

Talk to your primary care provider for more information or call member services at <MCO Member Services Number>.

For more information about the HealthChoice Diabetes Prevention Program, visit <MCO DPP page link>.

Fertility Preservation

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit. **These benefits are only for people whose medical treatment may cause infertility, such as surgery or chemotherapy.**

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCOName> card when you get these services. **You must have preauthorization for these services.**

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

To be eligible for fertility preservation, you must meet all the following:

- Get preauthorization for services.
- Be within reproductive age.
- Submit documentation from a reproductive endocrinologist.

Important: Fertility preservation is only for people whose medical treatment may cause infertility and meet the other eligibility criteria above.

Covered services include:

- Fertility consultation
- Gonadal suppression to reduce ovarian insufficiency
- Hormonal treatment and ovulation induction
- Oocyte retrieval and preservation
- Sperm extraction and preservation

Medicaid does not cover in vitro fertilization (IVF), sperm or oocyte donation, and storage of testicular tissue procedures.

Gender Affirming Care

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit.

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

There is no age limit for care, but members must provide informed consent for all services. Minors must have parental consent according to Maryland Minor Consent Laws.

To be eligible for gender-affirming services, you must:

- Talk to your health care provider about a diagnosis for care.
- Be able to make fully informed decisions and consent to treatment.

Covered services include:

Hormone Therapy

- Cross-Sex Hormone Therapy: This includes hormone replacement and suppression therapy. You can take medications by mouth, as an injection, or on your skin.
- Puberty Suppression Therapy: Slows changes to the body during puberty.
- See Pharmacy and Prescription Drug Services.

Gender-Affirming Surgeries and Therapies

You must get preauthorization for these services.

- Medically necessary surgeries, including genital reassignment and facial procedures.
- Procedures for skin, chest, and voice alterations to align with a person's gender identity.
- Hair removal and hair transplants for gender-related purposes.
- Doctors can revise or reverse gender-affirming surgeries if there are problems or if your gender identity changes.

Post-Transition Services

- Some gender-specific services may be necessary after transitioning, like breast cancer screenings for transgender men or prostate exams for transgender women.
- You do not need preauthorization for post-transition services.

Laboratory Testing

- Routine testing to check hormone therapy. You may need preauthorization for specific tests.
- See Laboratory & Diagnostic Services.

Behavioral Health

Medicaid offers behavioral health services, such as therapy for gender dysphoria. You do not need preauthorization.

- See Behavioral Health Services and Primary Behavioral Health.

HIV/AIDS Services

You will use your <MCOName> card when you get these services except for testing, which Maryland Medicaid covers directly. See HIV/AIDS testing for more information.

Some services may require a referral or preauthorization. See Self- Referral.

You may choose an HIV/AIDS specialist who will coordinate your care with your primary and other specialty care providers. Talk to your provider about access to clinical trials.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>. See Special Needs Coordinator.

If you are pregnant, see Essential Benefits: Pregnant Members, HIV Counseling and Testing.

For more information, See Essential Benefits: Special Needs Members.

Case Management, Case Manager

- You may ask for case management services at any time, even if you declined them before.
- Your case manager will have special training to help with HIV/AIDS care and resources. Your case manager will not share your information about your HIV status.
- See Case Management, Case Manager.

Diagnostic Evaluation Service (DES)

- One diagnostic and evaluation service (DES) assessment per year.
- The DES includes a medical and psychosocial assessment.
- You must select a DES provider from an approved list of sites, but the provider does not have to be in-network with <MCO Name>. See Self-Referral.
- Call member services at <MCO Number> for help with this service.

Substance Use Treatment

We will refer you to the Public Behavioral Health System within 24 hours of requesting treatment. See Behavioral Health Services.

Long Term Care

Long Term Care Facility Services

All Maryland Medicaid HealthChoice managed care organizations must cover long-term care facility services. However, your managed care organization is only responsible for 90 days of care in a row. After more than 90 days, Maryland Medicaid may directly cover your care.

After 90 days, if you still need long-term care in a facility, you will be disenrolled from <MCO Name>. See Disenrollment.

Long term care services are the medical and support services that you need over a long time in a long-term care facility. A long-term care facility can be:

- A chronic hospital
- A chronic rehabilitation hospital
- A nursing facility
    - A nursing facility is state-certified to offer 24-hour medical and skilled nursing care, rehabilitation, or health-related services to people who do not need hospital care.
    - If you lose Medicaid coverage while you are in a nursing facility, you may not be re-enrolled in <MCO NAME>. If this happens, you will need to apply for Medicaid under long-term care coverage rules.

For more information or questions, call member services at <MCO Phone Number> or the HealthChoice Helpline at 800-284-4510.

Essential Benefits: Long Term Care

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit.

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization. See Self-Referral.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCO Phone Number>.

Habilitation Services/Devices

These are health care services that help you keep, learn or improve daily living skills and functions. Services may include:

- Physical therapy
- Occupational therapy
- Speech pathology
- For members 21 years old and younger, see EPSDT.

Home Health Services

These are health care services and supplies you get in your home under your doctor's orders. Services are on a part-time or an as-needed basis. Home health care does not include help with non-medical tasks, such as cooking and cleaning. Services may include:

- Skilled nursing services
- Home health aide services
    - Physical therapy
    - Occupational therapy
    - Speech therapy
- Medical supplies used during the visit. See Durable Medical Supplies and Disposable Medical Supplies.

Hospice Services

Home or inpatient services provide comfort and support for people in the last stages of a terminal illness and their families.

Outpatient Rehabilitation Service and Devices

Health care services that help a person keep, restore, or improve skills and functioning for daily living that they lost or were impaired because a person was sick, hurt or disabled. Services may include:

- Physical therapy
- Occupational therapy
- Speech pathology
- If you are under 21 years old, see EPSDT.

Other Covered Benefits: Long Term Care

<MCO Name> does not cover some benefits that Maryland Medicaid covers directly if they are medically necessary. You will use your red and white Medicaid card when you get these services.

For more information, call the HealthChoice Helpline at 800-284-4510.

Intermediate Care Facilities for Individuals with Intellectual Disabilities or Persons with Related Conditions (ICF/IID) services

An intermediate care facility (ICF) is a place that provides long-term care for people who need more help than residential care but less care than a skilled nursing facility. The goal of these services is to help people recover and increase their independence.

Medical Day Care Services

Medical Day Care Services are structured group programs that provide health, social, and related support services to functionally disabled adults, age 16 and older.

The program provides care in a community-based setting, offering people an alternative to nursing facility care. These are state licensed centers.

Skilled Personal Care Services

Skilled personal care services are medical services that only a licensed healthcare professional can give – like a nurse or therapist. These services go beyond the basic daily living help that a non-medical caregiver can provide. Examples of skilled personal care that your doctor may order are wound care, feeding tube changes, and physical therapy.

Pharmacy and Prescription Drug Services

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit.

You will use your <MCOName> card when you get these services.

Prescription drugs are drugs and medications that by law require a prescription also known as a doctor's order. Your doctor, nurse, or physician assistant who writes your prescription is known as the authorized prescriber.

Prescription drug coverage includes:

- Birth control pills and devices
- Chewable vitamins for children 12 years old and younger
- Coated aspirin for arthritis
- Insulin
- Iron pills (ferrous sulfate)
- Needles and syringes

There is a $1 or $3 co-pay for most prescriptions. There is no co-pay for covered family planning drugs or vaccines. There is no prescription co-pay for those who are younger than 21, pregnant, Native American, or living in long term care.

You can get latex condoms and emergency contraceptives from a pharmacy without a prescription.

Preferred Drug List

The preferred drug list (PDL) is also known as a formulary. It is a list of generic and brand name prescription drugs that we cover. The drugs on this list are the best in terms of safety, effectiveness and cost. Your prescriber will use this list to prescribe your medicine. Some medicines may require preauthorization. Some may have quantity or age limits.

To view our formulary, visit <MCO FORMULARY LINK>. If you would like us to mail you a copy of the formulary, call member services at <MCO MEMBER SERVICE NUMER>.

Call member services at <MCOPHONENUMBER> if you have any questions about a prescription or co-pay.

Telehealth and New Technology

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit.

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization. See Self-Referral.

A telehealth service is subject to the same coverage rules and preauthorizations as an in-person service. See Self-Referral.

Synchronous telehealth is a two-way, real-time visit where you and your provider interact with each other. You can meet your provider face-to-face during an online video meeting. You can meet from almost anywhere using your computer, phone or tablet. Your provider must meet with you from a private space like they would for an in-person visit. Some telehealth visits may be a phone conversation between you and your provider depending on the service.

A health care service provided by telehealth must:

- Be a service that the provider can offer.
- Be the right service for your medical needs.
- Meet the same standard of care as a service provided in person.

There are some health care services that are not eligible for telehealth.

A telehealth service does not include an email, a fax, or some telephone conversations between a health care provider and a patient.

Other covered telehealth services include remote patient monitoring and store-and-forward technology used in dermatology, ophthalmology, or radiology services. This is known as asynchronous telehealth and does not involve real-time interaction between you and your provider.

For more information or questions, call member services at <MCOPhoneNumber> or the HealthChoice Helpline at 800-284-4510.

New Technology and Other Advances

<MCOName> has a review process in place to decide how and when to cover advances in medicine. We regularly review new:

- Medical technology.
- Medications.
- Procedures.
- Treatments.

For more information or questions, call member services at <MCOPhoneNumber>.

Vision Care Services

Eye Care

All Maryland Medicaid HealthChoice managed care organizations must cover this essential medical benefit.

Maryland Medicaid only covers a benefit if it is medically necessary. You should not pay out of your pocket for a medically necessary covered benefit except for prescriptions.

You will use your <MCOName> card when you get these services. Some services may require a referral or preauthorization. See Self-Referral.

Use the <MCOProviderDirectory> to search for a <MCOName> Medicaid provider to get the care you need near you. For more information or questions, call member services at <MCOPhoneNumber>.

Adults Aged 21 +

- One eye exam every two years.
- For more vision benefit information, see <MCO NAME> Value Added Benefits.

Children and Young Adults Under Age 21

- One eye exam every year.
- One pair of eyeglasses per year.
- Contact lenses if medically necessary.
- See Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

Members with Diabetes

- One eye exam every year.
- One pair of eyeglasses per year.

Call member services at <MCO NUMBER> if you have questions or need help to find a vision care provider.

Rare and Expensive Case Management (REM) Program

The Rare and Expensive Case Management (REM) program provides medical case management and other services for eligible people with specific medical conditions. **This is a voluntary program.**

If you enroll in the REM Program, you will no longer get your health care coverage from <MCO name> or any other HealthChoice managed care organization. You will get all your health care benefits directly through Maryland Medicaid.

To be eligible for the REM Program, you must:

- Be eligible for the HealthChoice managed care program.
- Have at least one rare and expensive condition for your age group.
- Choose to be in the REM program.

Talk to your primary care provider to learn more about the medical conditions that will qualify you for this program. You may also call member services at <MCO Number > or our special needs coordinator at <MCO SNC NUMBER> for more information.

REM benefits include:

- Case management assessment and services
- Certified Nursing Assistant (CNA) and CNA Certified Medication Technician (CMT) services
- Chiropractic services
- Home Health Aide (HHA) and HHA Certified Medication Technician (CMT) services
- Nutrition counseling and supplements
- Occupational therapy
- Private duty nursing, shift nursing services
- Speech-language pathology

You must apply for the REM Program and Maryland Medicaid must approve you for it. If approved, the program will assign you a REM case manager. Your REM case manager will work with you to transition your coverage from <MCO Name>. They will work with you to make a care plan to meet your healthcare needs.

For more information and to learn how to apply, call the REM Program at 800-565-8190.
Go to the REM web page now. Type this link exactly as it appears into your phone or computer's address bar: bit.ly/4dnz45Q or scan the QR code.

Self-Referral

You can get certain healthcare services from a provider who is not part of the <MCO Name> network. You will not need a referral from your primary care provider. <MCO name> will cover these services even if the provider is out-of-network. However, the provider must be a participating Medicaid provider.

Self-referral services include:

- Birthing centers
- COVID-19 testing
- Dialysis
- Doula services
- Emergency Care, Emergency Services

- Family planning
- Foster care placement assessment
- HIV/AIDS diagnostic evaluation
- Newborn baby checkup
- Pregnancy, certain conditions
- School-based health centers
- Specialist, children with special needs

Continuity of Care

You may have the right to transfer a preauthorization or keep seeing an out-of-network provider if you are currently getting medical care and

- Are new to HealthChoice
- Changed your HealthChoice managed care organization
- Moved to HealthChoice from another health plan

Time Limit

These rights usually last 90 days from when your new coverage starts or until your treatment ends—whichever is first. If you are pregnant, these rights extend through pregnancy up to the first doctor's visit after birth.

Limitations

These rights do not apply to:

- Dental services
- Mental health services
- Substance use disorder services
- Services provided by Maryland Medicaid fee-for-service, see Other Covered Benefits.

Transferring a Preauthorization

If your former health plan approved surgery or other service, you may not need to get new approval from <MCO name>. Call member services at <MCO Customer Service phone number> if you want to use that approval. We will need a copy of the preauthorization. If you don't have a copy, contact your prior health plan. They must give you a copy within 10 days.

If you were getting care from a doctor who was in your prior health plan's network but is out of <MCO Name's> network, you might be able to keep seeing them temporarily. You must contact us to request this. This right only applies to specific conditions like:

- An acute condition, for example a broken bone
- A serious chronic condition, for example cancer
- Pregnancy
- Other conditions agreed upon by you and your provider

For questions, call member services at <MCO Member Services> or the HealthChoice Helpline at 800-284-4510.

You have the right to appeal a denial to transfer a preauthorization or to see your prior provider. See File a Complaint, Grievance or Appeal.

Out-of-Service Area Coverage

<MCO NAME>'s provider network offers many care options throughout our service area, which includes <MCO FILL IN SERVICE AREAS>.

We also cover care in a nearby state only if the provider is in our network or if we arrange your care. See Continuity of Care for exceptions.

We only cover emergency care and post-stabilization care services when you are outside of Maryland.

If you need non-emergency care outside our service area, call your primary care provider or member services at <MCO MEMBER CARE NUMBER> for help.

If you move outside our service area, you can change to another managed care plan. See Changing Managed Care Plans. <MCO TO REMOVE THIS IF NOT APPLICABLE>

Other Insurance

Coordination of Benefits

Medicaid coordinates benefits with other insurers as a secondary payer to all other payers. This means that if an insurer and Medicaid both cover a benefit, the other payer is first responsible for making payment. By law, Medicaid is the payer of last resort.

This is known as third party liability. Other sources of coverage, or a third party, may include

- Employer-sponsored health insurance
- Long term care insurance
- Medicare

- Other state and federal programs
- Private health insurance
- Settlement from a liability insurer
- Workers' compensation

Report Other Insurance

You must report if you have other coverage. Call member services at <MCO Customer Service phone number> to report any other insurance plans or coverage.

Always tell your provider about your other insurance. List your non-Medicaid insurance as your primary insurance.

Third-Party Liability and Work-Related Injury

You must inform <MCO NAME> if you receive care for an injury from an auto accident or a work-related injury. A third-party insurer is usually responsible for payment. Call member services at <MCO Customer Service number> to make a report.

Changing Managed Care Plans

New Medicaid Members 90 Day Rule

You have 90 days to choose a different managed care health plan for any reason when you first join Medicaid. You may only change your plan once during this time. You must stay with your plan for 12 months before you can make a change except for certain reasons.

Re-Enrolled Medicaid Members

If you lose your Medicaid coverage and re-apply within 120 days, and are eligible, Medicaid will automatically re-enroll you in the same plan.

Change Exceptions

You can change your plan at **any time** if

- You move
    - If you move to a county where your current health plan does not offer care.
- You become homeless
    - If another plan offers care closer to where you stay, making it easier to get to appointments.

- Family in different plans
    - A family with one or more household members in one plan and one or more members in a different plan can move everyone to the same plan. You will use the "family unification" change reason to do this. There is one exception. A newborn must stay with their parent's plan for the first 90 days after birth.
- Foster child placement
    - If a foster child joins your family, you can switch the child to your plan if you or other family members are in a different plan.
- Your primary care provider's contract ends
    - If your plan ends its contract with your primary care provider. You will get a notice to let you know if this happens. You will need to pick a new primary care provider. See Pick Your Primary Care Provider (PCP) for more information.

You may be able to change your plan **if Medicaid approves** when

- You experience poor quality of care.
- You cannot access the services you need with <MCO Name>.
- You want to see a provider with experience with your health care needs who is not in <MCO Name>'s provider network.

You **cannot change** your plan when

- You are in a hospital.
- You are in a nursing facility.

How to Change Your Plan

You must contact the Maryland Health Connection at 855-642-8572 to make a change. **Please note that <MCO NAME> cannot change your plan.**

Disenrollment

Disenrollment means your coverage ends.

Medicaid Disenrollment

Your Medicaid coverage can end, that is, terminate, for several reasons. Reasons include:

- You are no longer eligible for Medicaid.
- You do not renew your Medicaid coverage.

Medicaid will also disenroll a member at the time of their death.

If you lose your Medicaid coverage and re-apply within 120 days, and are eligible, Medicaid will automatically re-enroll you with <MCO NAME>. It will take 10 days for your <MCO NAME> coverage to be active again.

<MCO Name> Disenrollment Only

There are also reasons that Medicaid can disenroll you from <MCO Name> without disenrolling you from Medicaid.

- You have been in a nursing facility for more than 90 days in a row.
- You are now in an intermediate care facility for people with intellectual disabilities.
- You join the Rare and Expensive Case Management (REM) Program.
- You turn 65 years old.
- You enroll in Medicare before age 65 because of a disability.
- You are in jail or prison.

Explanation of Benefits or Denial of Payment Notice

An Explanation of Benefits (EOB) or Denial of Payment notice shows a summary of the services your doctor billed. It lists the type of service, the date, the amount billed, and the amount paid by <MCO Name>. **This is not a bill**. It just tells you what <MCO Name> has paid for. If you see a mistake, like a service you didn't get, call member services at <MCO NUMBER> right away.

Medicaid Billing Rights and Protections

A Medicaid provider may not bill you for a medically necessary Medicaid covered benefit. You should not pay out of your pocket for these except for prescriptions.

Make sure you see a participating Medicaid provider for your health care. Otherwise, you may have to pay for the service.

Use our <MCO NAME> provider directory> to search by provider name to find a participating Medicaid provider in our network.

Remember you may have to pay for the care that you get from a provider who is not part of Medicaid.

If you get a bill for a covered service, **do not pay it**. Contact the provider who sent the bill for help. If the provider says you did not have coverage on date of the service date or that < MCO Name> did not pay, call member services at <MCO NUMBER> for help.

If you still need help, call the HealthChoice Helpline at 800-284-4510.

You may also be able to file a complaint with the Maryland Attorney General. To learn more, visit their Health Education and Advocacy Unit webpage.

Preventive Care for Adults

What is preventive care? It is things that you can do to help keep you well, such as getting a flu shot each year or eating healthy foods. It includes preventive screenings. These are health care services to check your health and well-being. Getting routine preventive care can help you stay well and catch problems early - when they may be easier to treat.

Preventive screening and procedures are based on your age, gender, health condition, family history and other factors. Talk to your primary care provider about the screening and procedures you may need and how often you may need them.

Women can see an OB-GYN or a certified nurse midwife without a referral. This includes routine and preventive care such as a check-up, breast exam, mammogram, and Pap test. Staying up to date on your vaccines is one of the best things you can do to protect your health. If you are pregnant or have a medical condition that puts you at higher risk for infections, talk to your primary care provider about which vaccines are right for you.

Always let your primary care provider know if anything has changed since your last office visit. 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

General Health Care

Routine Checkup	Every year
Anxiety and Depression screening	Every year
Dental Checkup and cleanings	See Dental.
Intimate Partner Violence screening	Women of reproductive age
Substance Use/Misuse: Alcohol, Tobacco, Other	18+. Every year, more based on risk.

Screenings and Procedures*

Blood Pressure Monitoring – hypertension	Every year
BRCA-Related Cancer	Women with a personal or family history of breast, ovarian, tubal, or peritoneal cancer
Breast Cancer Screening	Every other year starting at 40, and continuing through age 75
Cervical Cancer Screening	Every 3 years for members with internal reproductive organs ages 21-29, every 5 years for women ages 30- 65
Cholesterol	Every 5 years starting at age 35 for men and 45 for women, starting at age 20 if at increased risk
Colon Cancer Screening	Age 50-75, frequency depends on test used: stool based – yearly to every 3 years, flexible sigmoidoscopy every 5 years, CT colonography every 5 years, or colonoscopy every 10 years
Prediabetes and Type 2 Diabetes	Adults aged 35 to 70 years who are overweight or obese
Latent Tuberculosis Infection	18+ at increased risk
Lung Cancer Screening	Yearly for adults aged 50-80 with a 20 pack-year smoking history who are actively smoking or quit smoking less than 15 years ago, screening done using Low Dose CT (LDCT) scan
HIV Human Immunodeficiency Virus (HIV)	Based on risk category
Hepatitis B	adults at increased risk
Hepatitis C	18+ once, more often for those at increased risk
Chlamydia and Gonorrhea	Sexually active women 24 years or younger, and in women 25 years or older who are at increased risk of infection
Syphilis Infection	Adults at increased risk

Recommended vaccinations for adults aged 19 years and Older

Immunizations**

COVID-19	At least one dose of the current COVID-19 vaccine or based on your doctor's advice.
Influenza/Flu	Every year
RSV	One dose ages 60+ or pregnant
Tdap/Td	One booster every 10 years and every pregnancy.
MMR	If aged 66 years or younger, one or two doses
Chickenpox	If U.S. born and aged 43 years or younger, two doses

Shingles	Age 50+, two doses, younger based on your doctor's advice.
HPV	26 years old and younger two or three doses, if 27–45 years based on your doctor's advice.
Pneumonia	Based on risk
Hepatitis A	Based on risk or your doctor's advice.
Hepatitis B	19 to 59 years old, after based on risk or your doctor's advice.
Meningitis	Based on risk or your doctor's advice.
Hib	For adults with certain medical conditions based on your doctor's advice.
Mpox	Based on risk or your doctor's advice.

*Recommendations for screening and procedure are based on the United States Preventive Services Task Force (USPSTF) guidance. For the latest recommendations, visit USPSTF.

**Recommendations for immunizations are based on the U.S. Centers for Disease Control and Prevention (CDC) guidelines. For the latest information, visit the CDC Recommended Vaccinations for Adults.

Know Your Family History

Talk to your family, then your doctor. You can use the CDC's My Family Health Portrait to keep track of your information. Be sure to update this information regularly and share what you've learned with your family and your doctor. Learn more about My Family Health Portrait.

Access Your Official Immunization Records

You can see and print your official immunization record online. It is free, simple and secure. To register or to sign in go to myirmobile.com.

Well Child Care

What is a well-child visit? A well-child visit (also called a checkup) is when you take your child to the doctor to make sure they're healthy and developing normally. This is different from visits for sickness or injury.

Taking your child to their regularly scheduled well-child visit can help them stay well and help catch problems early - when they may be easier to treat.

At a well-child visit, you can talk to your provider and ask questions about how your child is growing and developing. Your child will also get their shots, also called vaccines or immunizations, during their well child visit. Staying up to date on your child's vaccines is one of the best things you can do to protect their health.

If you're worried about your child's health, call your provider right away. Do not wait until your next scheduled visit.

Blood Lead Poisoning Test

A blood lead test is the best way to find out if a child has lead poisoning. Your provider will take a small amount of blood from your child's finger, heel, or arm to test.

Medicaid requires lead testing for all children at ages 12 and 24 months. Medicaid also requires testing for children ages 24–72 months if there is no record of testing.

Well-Child Visit Schedule

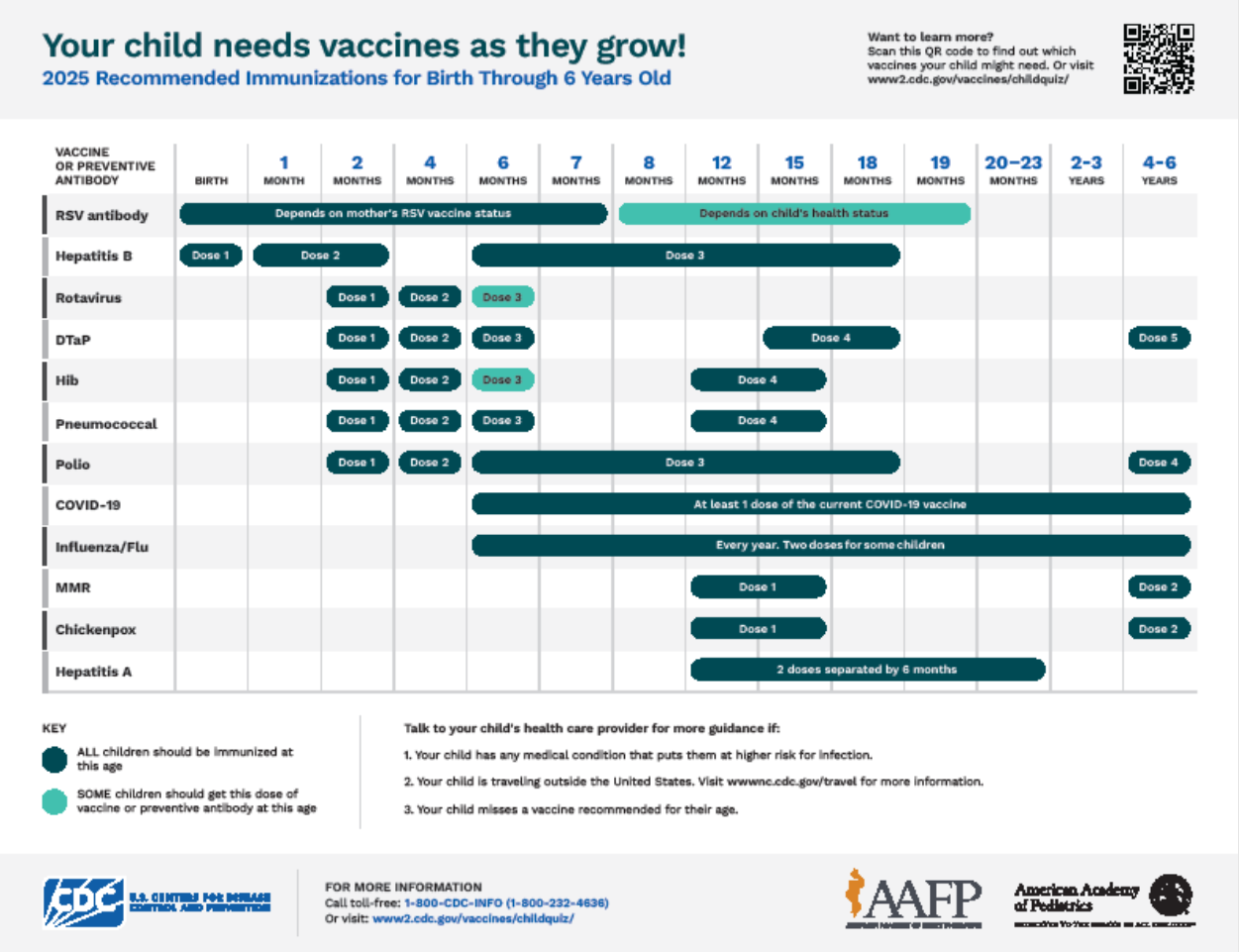
How often you will see the doctor, get services, screenings and immunizations depends on what your provider thinks is right for your child.

Recommend visits:

- 3 to 5 days old
- 1 month old
- 2 months old
- 4 months old
- 6 months old
- 9 months old
- 12 months old
- 15 months old
- 18 months old
- 2 years old (24 months)
- 2 ½ years old (30 months)
- 3 years old
- 4 years old
- 5 years old
- 6 years old

After the age of six, your child will continue to have a well-child visit once a year. They will get any shots they need for their age group during their visit.

CDC Recommend Vaccines for Birth to Age Six



Source: CDC; Materials developed by CDC.

The Maryland Department of Health and <MCO NAME>'s use of this material does not imply endorsement by CDC, ATSDR, HHS or the United States Government. The material is otherwise available on the CDC website for no charge.

<MCOName> Practice Guidelines

<MCOName> uses practice guidelines to help make sure you get safe, high-quality care. These guidelines are based on medical research and expert advice. They help doctors and other providers know the best ways to treat certain health conditions. The guidelines also consider your needs. <MCOName> uses them when deciding what services to cover, how to manage your care, and how to help you understand your treatment options. We update our practice guidelines as needed. You can ask for a copy of the guidelines at any time. Call member services at <MCO Member Services Number>.

Rights and Responsibilities

HealthChoice Managed Care Member Rights

- Receive respectful treatment and have your dignity and privacy considered.
- Get candid and easy-to-understand information about your treatment options – even if they cost more or your plan does not cover them.
- Take part in decisions about your healthcare, including the right to refuse treatment.
- Be free from any form of physical or mental control or left alone to make you agree to something, punish you, or because it is easier for someone else.
- Ask for and get a copy of your medical records. You can also ask for corrections to your record.
- Exercise your rights and to know that the exercise of those rights will not adversely affect the way that the Maryland Department of Health, <MCO NAME> or our providers treat you.
- File a complaint, grievance or appeal with <MCO NAME>.
- Request to continue Medicaid benefits while your appeal or State fair hearing is pending. NOTE: You may have to pay for any care you receive during this time if the original decision stands.
- Get a second opinion from another provider in <MCO NAME>'s network if you disagree with your provider's opinion about a service that you need. Call member services at <MCO customer service number > for help with finding another provider.
- Make, or refuse to make, an advance directive for healthcare decisions. For more information, see the Maryland Attorney General's advanced directives web page.
- Ask for and get information about how <MCO NAME> manages the organization. For more information, call member services at <MCO customer service number >.
- Ask for and get information about the health plan's services, practitioners, providers and member rights and responsibilities.
- Make recommendations about the member rights and responsibilities policy.

HealthChoice Managed Care Member Responsibilities

- Treat all those who work with you with respect and dignity.
- Be on time for your appointment.
- Cancel your appointment right away if you cannot keep it.
- Always Carry your Medicaid and <MCO NAME> member card with you.
- Never allow anyone else to use your Medicaid or <MCO Name > member card.
- Report a lost or stolen member ID card to <MCO Name> and get a new card.
- Report other health insurance coverage to your provider and to <MCO NAME>.
- Work with your primary care provider to create a care plan together.
- Work with your providers and follow plans and instructions for care that you have agreed to with them.

- Ask questions about your care and let your provider know if you do not understand something.
- Give honest, current health information to your providers.
- Use the emergency room only for a medical emergency. Let your primary care provider know as soon as possible after you receive emergency care.
- Tell your caregivers about any change to your advance directive.
- Call member services at <MCO NUMBER> if you have a problem or a complaint.
- Report required changes to your status within 10 days to the Maryland Health Connection.

Privacy and Confidentially

MCO TO INSERT. Formerly attachment B.

Utilization Management Affirmative Statement

MCO TO INSERT STATEMENT.

File a Complaint, Grievance or Appeal

If you are unhappy with a decision about your care, or if you have an issue with a service or provider, you have the right to take action.

<MCO NAME> has a process for filing a complaint, grievance, or an appeal to address your concern.

Complaint: File a complaint if you have a concern about the quality of your care, the behavior of a provider, or a service-related issue.

Grievance: File a grievance if you are unhappy with how <MCO NAME> handled your complaint.

Appeal: File an appeal if <MCO NAME> has denied, reduced, or ended a service you think you need. This is known as an adverse benefits determination. You or your authorized representative can file an appeal on your behalf. You must file an appeal within **60 days** from the date on your denial notice.

How to Keep Getting Services While Your Appeal or State Fair Hearing Is Pending

If <MCO Name> notifies you that we plan to reduce or end a service, you may still be able to get that service if:

- You filed an appeal or asked for a state fair hearing by the filing deadline.
- It is a service we previously approved for you.
- The original coverage period for services has not expired.

However, you may have to pay back the cost for any service you got while your appeal or fair hearing is pending if <MCO Name> or the administrative law judge upholds the denial. For more information, see When Your Appeal Decision Is in Your Favor.

Request Deadline

The deadline to ask to keep getting services is on or before the latest of these dates:

- Within 10 calendar days of when we sent the denial notice, or
- Before the date when <MCOName> will reduce or end your service.

You can ask to keep services when you file an appeal or ask for a State fair hearing. You can also call member services at <MCO Customer Service Number>.

How to File a Complaint, Grievance or Appeal

Be sure to act quickly, as there are specific timelines for filing. If you need help with filing, call member services at <MCO Customer Service Number>.

MCO TO INSERT PROCEDURE – FORMERLY ATTACHMENT F.

More Help with a Complaint, Grievance or Appeal

Get Help from the HealthChoice Helpline

If you have a question or complaint about your healthcare that <MCO NAME> has not solved to your satisfaction, you can ask Maryland Medicaid for help. They can help by:

- Working with <MCO NAME> to resolve your problem.
- Sending your complaint to a Maryland Medicaid nurse consultant to help solve the issue.
- Answering questions about the appeal process and when you can ask for a state fair hearing.

Call the HealthChoice Helpline at 800-284-4510.

Ask Maryland Medicaid to Review <MCO Name>'s Appeal Decision

If you filed an appeal and <MCO NAME> upheld our decision, that is not find in your favor, you may ask Maryland Medicaid to review our decision.

Call the HealthChoice Helpline at 800-284-4510 to ask for a review. If they uphold <MCO Name>'s decision, you can ask for a state fair hearing.

Ask for a State Fair Hearing

A fair hearing is also known as an appeal. You must first go through <MCO NAME>'s appeal process before asking for a state fair hearing.

You have **120 days** from the date on your <MCO NAME> appeal decision notice to file for a state fair hearing. If you want to keep getting services while your state fair hearing is pending, see How to Keep Getting Services While Your Appeal or State Fair Hearing Is Pending. You can request a state fair hearing online. Go to the online appeals form now. Type this link exactly as it appears into your phone or computer's address bar: https://bit.ly/3C7ThQO or scan the QR code.

An administrative law judge will hear your case. The judge will either find in your favor, that is overturn <MCO Name>'s decision or uphold our decision, which is not find in your favor.

Call the HealthChoice Helpline at 800-284-4510 for more information.

You can also visit the Office of Administrative Hearings website for more information about a state fair hearing.

When Your Appeal Decision Is in Your Favor

When you win your appeal, <MCOName> must provide you with the denied, limited, or delayed service you asked for. We must provide the service within 72 hours of receiving notice of the decision.

Member Feedback

Call Us

<MCOName> wants to hear from you. Do you have an idea about how to improve a process? Or want to bring something to our attention? Call member services at <MCOPhoneNumber>.

Join <MCOName>'s Consumer Advisory Board

The Consumer Advisory Board consists of members, members' families, guardians, caregivers, and member representatives. The group meets regularly throughout the year. The consumer advisory board provides us with member input. For more information about the board, call member services at <MCOPhoneNumber>.

Member Feedback Call

We may contact you about a service you received from us. If we do, share detailed information about your experience. This helps us know how we are doing and how we can improve our members' care.

Non-Discrimination

[**Name of covered entity**] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity). [**Name of covered entity**] does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity).

[Name of covered entity]:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages
- If you need these services, contact [**Name of Civil Rights Coordinator**]

If you believe that [**Name of covered entity**] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with:

- [**Name and Title of Civil Rights Coordinator**],
- [**Mailing Address**],
- [**Telephone number**],
- [**TTY number** —if covered entity has one],
- [**Fax**],
- [**Email**].

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, [**Name and Title of Civil Rights Coordinator**] is available to help you.

You can also file a complaint with the Maryland Department of Health, Office of Equal Opportunity Programs, Equal Access Compliance Unit (EACU) by:

- Mail: Maryland Department of Health, Office of Equal Opportunity Programs, Equal Access Compliance Unit (EACU) 201 West Preston Street, Room 422, Baltimore, Maryland 21201.
- Phone: 410-767-6600, TTY users call 711
- Fax: 410-333-5337
- Email: mdh.oeop@maryland.gov

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://bit.ly/3OEZVAy, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TDD)

Limited English Proficiency (LEP)

Language Accessibility Statement.

We have translated this statement into each language below: If you speak _____, language assistance services, free of charge, are available to you. Call: 877-463-3464 (TTY: 7-1-1).

Español/Spanish

Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al: 877-463-3464 (TTY: 7-1-1).

አማርኛ/Amharic

የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 877-463-3464 (መስማትለተሳናቸው: TTY: 7-1-1).

Arabic/ العربية

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. برقم اتصل 877-463-3464 (والبكم الصم هاتف رقم: (7-1-1: TTY).

Ɓàsɔ̀ɔ̂ -wùɖù-po-nyɔ̀(Bassa)

Dè ɖɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ [Ɓàsɔ̀ɔ̂ -wùɖù-po-nyɔ̀] jǔ ní, nìí, à wuɖu kà kò ɖò po-poɔ̀bɛ̀ìń m̀ gbo kpáa. Đá 877-463-3464 (TTY: 7-1-1)

中文/Chinese

如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 877-463-3464 (TTY: 7-1-1)

Farsi/ فارسی

توجه: اگر بهـ زبان فارس ی گفتگو می کن ی د، تسهی لات زبان ی بصورت رای گان برای شما

دا ری بگی تماس 877-463-3464 (TTY: 7-1-1) با .باشد ی م فراهم

Français/French

Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le: 877-463-3464 (ATS: 7-1-1).

kreyòl ayisyen/Haitian Creole

Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 877-463-3464 (TTY: 7-1-1).

Igbo

O buru na asu Ibo asusu, enyemaka diri gi site na call 877-463-3464 (TTY: 7-1-1)

한국어/Korean

한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-463-3464 (TTY: 7-1-1) 번으로 전화해 주십시오.

Português/Portuguese

Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 877-463-3464 (TTY: 7-1-1)

Русский/Russian

Помощь доступна на вашем языке: 877-463-3464 (TTY: 7-1-1). Эти услуги предоставляются бесплатно.

Tagalog

Makakakuha kayo ng tulong sa iyong wika: 877-463-3464 (TTY: 7-1-1). Ang mga serbisyong ito ay libre.

Urdu/اردو

خبردار: اگر آپ اردو بولتے ہیں تو، آپ کو زبان کی مدد کی مفت خدمات دستیاب ہیں۔ کال کریں 877-463-3464. (7-1-1: TTY)

Tiếng Việt/Vietnamese

Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-463-3464 (TTY: 7-1-1).

Yorùbá/Yoruba

Ti o ba nso ede Yoruba ofe ni iranlowo lori ede wa fun yin o. E pe ero ibanisoro yi 877-463-3464 (TTY: 7-1-1)

Fraud, Waste and Abuse

We are committed to finding and stopping fraud, waste, and abuse. You can help by reporting a potential issue right away. Know what to look for so you can spot a problem.

Fraud happens when someone lies or cheats Medicaid on purpose to get a benefit or service they should not have.

Waste is when people use Medicaid resources in the wrong way or too much.

Abuse is when someone causes extra costs for Medicaid.

Member Examples

- Lying about your income or property to qualify for Medicaid
- Living in another state but still using Maryland Medicaid

- Letting someone else use your member ID or using someone else's ID to get health services
- Selling or changing a prescription medicine

Provider Examples

- Giving services that the patient did not need
- Charging for services that they did not provide
- Charging for the same service more than once
- Changing medical records to hide fraud

Knowing if something is fraud, waste or abuse depends on the situation, intent, and knowledge. I can be hard to tell the difference between fraud and a mistake. If you are not sure, make a report so the proper agency can investigate it. Not all complaints result in an investigation. Keep in mind that the more information you provide the better.

Reporting will not change how we treat you. You can decide whether you want to give your name or not. Making a report is easy.

Contact <MCO NAME>
MCO to insert information.

Contact the Maryland Department of Health, Office of the Inspector General

- Submit a MDH OIG Report Fraud online form.
- Call 866-770-7175

Contact the U.S. Department of Health and Human Services, Office of the Inspector General

- Submit a OIG hotline complaint online form
- Call 800-447-8477

Glossary of Terms

Health insurance can be complicated. Our glossary can help simplify it. Find the definitions you need to help better understand your health care.

Appeal: To ask your health plan to review and change a decision to deny a benefit. This process allows you to challenge a decision and have it reviewed to ensure it is fair and correct.

Authorized Representative: Someone who you choose to speak and act on your behalf to make health care-related decisions. An authorized representative can be a family member, a friend, a provider, or a lawyer.

Complaint: To tell your health plan when you are unhappy or have a concern. A complaint may lead to a grievance or an appeal.

Co-pay or Co-payment: A small set amount you pay out of your pocket for a covered benefit. Usually paid at the time of the visit.

Disposable Medical Supplies (DMS): Medically needed items that are for one time use then thrown away.

Durable Medical Equipment (DME): Medically needed items ordered by a provider. Items that can withstand daily or long-term use.

Emergency Medical Condition: Also known as medical emergency. A sudden illness, injury, severe pain, symptom, or condition is so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance service for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: Any health care service to evaluate or treat an emergency medical condition to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan does not pay for or cover.

Formulary: Also known as preferred drug list or prescription drug list. A list of the prescription drugs that your health plan covers.

Grievance: A formal complaint to your health plan when you are unhappy with how they handled an initial complaint.

Habilitation Services and Devices: health care services that help you keep, learn or improve daily living skills and functions.

Health Insurance: A contract or policy between the insurer and you to cover some or all the cost of your health care. Some people buy health insurance directly from a health insurance company. Others buy or get it through an employer as part of a benefits package. Public health insurance is insurance through the government. It is free or at a low cost for eligible people.

Home Health Care: Health care services and supplies you get in your home under your doctor's orders.

Hospice Services: Services that provide comfort and support for people in the last stages of terminal illness and their families.

Hospital Outpatient Care: medical care or treatment in a hospital but with no overnight stay.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

In-network: Also known as a participating provider**.** Doctors, hospitals, and other health care providers who work with your health care plan to give you the care you need. See your health plan's provider directory to find their in-network providers.

Inpatient: Medical care or treatment in a hospital for one or more nights.

Medically Necessary: The most cost-efficient health care services or supplies needed to diagnose or treat an illness, injury, condition, disease. Must meet accepted standards of medical practice.

Network: The facilities, providers, and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Participating Provider: Also known as out-of-area, or out-of-plan.

Out-of-network: Also known as out-of-area, out-of-plan, or non-participating provider. Doctors, hospitals, and other health care providers who are not part of your health care plan.

Participating Provider: Also known as in-network. A health care provider who has a contract with an insurance company to provide your care.

Physician Services: Health care services a licensed medical physician provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: Also known as prior approval or prior authorization. Approval that Medicaid or your health plan requires before you receive certain services or medications to ensure they are medically necessary. Emergency care does not require preauthorization.

Preferred Drug List: Also known as prescription drug list or formulary. A list of the prescription drugs that your health plan covers.

Premium: The amount you pay for your health insurance every month to keep your coverage. HealthChoice does not charge any premiums.

Prescription Drug Coverage: A health plan benefit that helps pay for covered prescription drugs and medications.

Prescription Drugs: A type of medication that by law you can only get with a doctor's order.

Primary Care Physician: A Medical Doctor (M.D.) or a Doctor of Osteopathic Medicine (D.O.) who is your main health care provider who you see for routine care. They help you stay healthy and get better when you are sick. A PCP helps you find and get other health care services.

Primary Care Provider: A Primary Care Provider (PCP) is your main health care provider who you see for routine care. They help you stay healthy and get better when you are sick. A PCP helps you find and get other health care services. A PCP can be a doctor, a nurse practitioner, clinical nurse specialist, or a physician assistant.

Provider: A doctor, other health care professional, hospital, or other health care facility licensed, certified, or accredited as required by Maryland law who takes care of your health.

Rehabilitation Services and Devices: Health care services that help you keep, get back, or improve skills and functioning for daily living that you lost or were impaired because you were sick, hurt, or disabled.

Skilled Nursing Care: Services from a licensed nurse in your own home or in a nursing home.

Specialist: A health care provider who treats a specific type of illness or a specific area of the body. A specialist has training in a specific area of medicine. Some specialists only treat a certain group of patients.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe it requires emergency room care.

MCO TO INSERT BACK COVER

<MCO NAME> is your Maryland Medicaid HealthChoice managed care plan.

Maryland
DEPARTMENT OF HEALTH