



MedStar Family
Choice



MedStar Family Choice
Maryland HealthChoice
Member Handbook

2021

It's how we **treat people.**

Important Phone Numbers



For questions about how to find a doctor, change your primary care provider, order a new ID card, or other questions about your benefits and/or MedStar Family Choice:

Member Services

888-404-3549

Monday through Friday, 8:30 a.m. to 5 p.m.

TTY/TDD Member Services

711 or 800-508-6975

Monday through Friday, 8:30 a.m. to 5 p.m.



If you need care after your doctor's office closes or have a question you need to ask a nurse:

After Hours Nurse Helpline

855-210-6204

24 hours a day, seven days a week

TTY/TDD After Hours Nurse Helpline

711 or 800-508-6975

24 hours a day, seven days a week



If you need to see a doctor within 24 hours for urgent care:

Your primary care provider's office

_____ - _____ - _____

(Check your member ID card for the phone number)

After Hours Nurse Helpline

855-210-6204

24 hours a day, seven days a week

TTY/TDD After Hours Nurse Helpline

711 or 800-508-6975

24 hours a day, seven days a week



For behavioral health questions:

Maryland Public Behavioral Health System

800-888-1965

TTY/TDD

866-835-2755



For dental questions:

Maryland Healthy Smiles—children and pregnant women

888-696-9596

Monday through Friday, 7:30 a.m. to 6 p.m.

TTY/TDD: **800-466-7566**

Avesis—adult dental

844-478-0512

Monday through Friday, 8:30 a.m. to 5 p.m.

TTY/TDD: **711**



For vision questions:

Avesis

844-478-0512

Monday through Friday, 8:30 a.m. to 5 p.m.

TTY/TDD: **711**

FOR AN EMERGENCY, DIAL 911 OR GO TO THE NEAREST EMERGENCY ROOM.

Language Accessibility

Language Accessibility Statement

Interpreter Services Are Available for Free

Help is available in your language: 1-800-905-1722 (TTY: 711).

These services are available for free.

Español/Spanish

Hay ayuda disponible en su idioma: 1-800-905-1722 (TTY: 711). Estos servicios están disponibles gratis.

አማርኛ/Amharic

እገዛ በ ቋንቋዎ ማግኘት ይችላሉ:-: 1-800-905-1722 (TTY: 711) :: እነዚህ አገልግሎቶች ያለክፍያ የሚገኙ ነጻ ናቸው

العربية /Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-905-1722 (رقم هاتف الصم والبكم) - (TTY: 711)

Bàsòò-wùdù-po-nyò /Bassa

Dè dɛ nìà kɛ dyédé gbo: ɔ jù ké m̀ [Bàsò ò -wùdù-po-nyò] jù ní, nìí, à wuɖu kà kò d̀ò po-poò b́é in m̀ gbo kpáa. Dá 1-800-905-1722 (TTY: 711).

中文/Chinese

用您的语言为您提供帮助：1-800-905-1722 (TTY: 711)。 这些服务都是免费的

فارسی /Farsi

خط تلفن کمک به زبانی که شما صحبت می کنید : 1-800-905-1722 (خط تماس افراد ناشنوا) (TTY:711)
این خدمات به صورت رایگان در دسترس هستند

Français/French

Vous pouvez disposer d'une assistance dans votre langue : 1-800-905-1722 (TTY: 711). Ces services sont disponibles pour gratuitement.

ગુજરાતી/Gujarati

તમારી ભાષામાં મદદ ઉપલબ્ધ છે: 1-800-905-1722 (ટીટીવાય: (TTY:711)). સેવાઓ મફત ઉપલબ્ધ છે

kreyòl ayisyen/Haitian Creole

Gen èd ki disponib nan lang ou: 1-800-905-1722 (TTY: 711). Sèvis sa yo disponib gratis.

Language Accessibility

Igbo

Enyemaka di na asusu gi: 1-800-905-1722 (TTY: 711). Ọrụ ndị a dị na enweghi ugwo i ga akwu maka ya.

한국어/Korean

사용하시는 언어로 지원해드립니다: 1-800-905-1722 (TTY: 711). 무료로 제공 됩니다

Português/Portuguese

A ajuda está disponível em seu idioma: 1-800-905-1722 (TTY: 711). Estes serviços são oferecidos de graça.

Русский/Russian

Помощь доступна на вашем языке: 1-800-905-1722 (TTY: 711). Эти услуги предоставляются бесплатно.

Tagalog

Makakakuha kayo ng tulong sa iyong wika: 1-800-905-1722 (TTY: 711). Ang mga serbisyong ito ay libre.

اردو/Urdu).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کر 1-800-905-1722 (TTY: 711).

Tiếng Việt/Vietnamese

Hỗ trợ là có sẵn trong ngôn ngữ của quý vị 1-800-905-1722 (TTY: 711). Những dịch vụ này có sẵn miễn phí.

Yorùbá/Yoruba

Ìrànlọwọ wà ní àrọwọtó ní èdè rẹ: 1-800-905-1722 (TTY: 711). Awon ise yi wa fun o free.

Interpretation Services and Auxiliary Aids

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

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

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

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I. HealthChoice Overview

A. What is Medicaid

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

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

B. What is HealthChoice

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

MCOs are healthcare organizations that provide health care benefits to Medicaid recipients in Maryland. General healthcare benefits include (see pages 16 to 21 for a full listing of HealthChoice benefits):

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

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

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

C. How to Renew Medicaid Coverage

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

- Maryland Health Connection
 - Individuals eligible to apply/renew through Maryland Health Connection:

- Adults under age of 65;
- Parent/caretaker relatives;
- Pregnant women; and
- Children, and former foster care children.
- Online: **MarylandHealthConnection.gov**
- Calling: **855-642-8572 (TTY: 855-642-8573)**
- myDHR
 - Individuals eligible to apply/renew through myDHR:
 - Aged, blind, or disabled (ABD);
 - Current foster care children or juvenile justice; Parent/caretaker relatives;
 - Receiving Supplemental Security Income (SSI); and
 - Qualified Medicare Beneficiaries (QMB) or Specified Low-income Medicare Beneficiaries (SLMB).
 - Online: **MyDHRBenefits.DHR.State.MD.us**
- Department of Social Services (DSS) or Local Health Department (LHD)
 - All individuals can apply
 - To get connected with DSS call **800-332-6347**
 - To get connected with a LHD see page 12

D. HealthChoice/MCO Enrollment

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

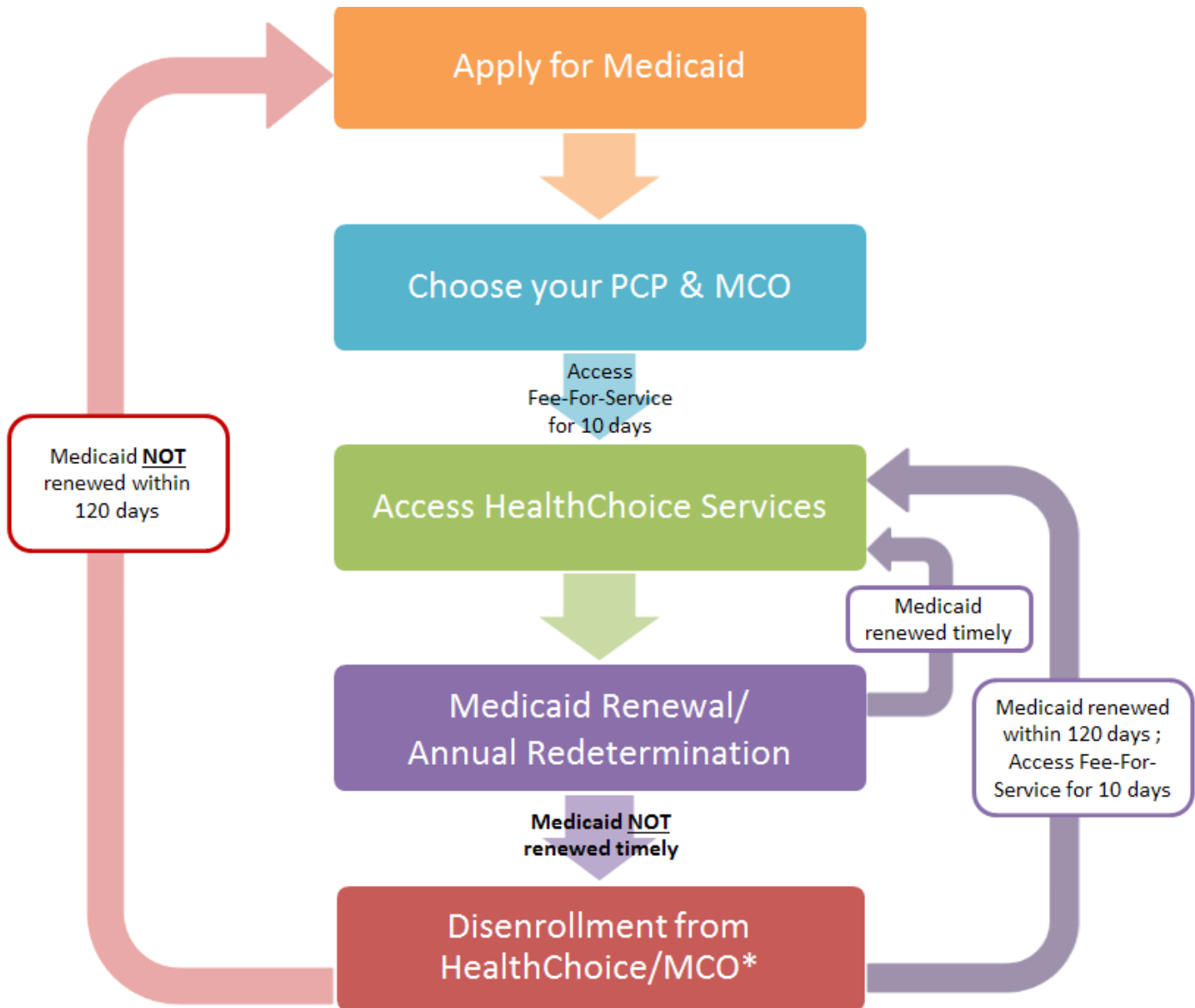
You must now use your MedStar Family Choice ID card when you get services. If MFC assigned you a different ID number, your Medicaid ID will also be on the MedStar Family Choice ID card. The phone number for MFC Member Services and the HealthChoice Help Line (**800-284-4510**) are both on your card. If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

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

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

I. HealthChoice Overview

E. HealthChoice Enrollment Process



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

F. HealthChoice Eligibility/Disenrollment

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

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

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

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

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

G. Updating Status and Personal Information

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

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

II. Important Information

A. HealthChoice and State Programs Contact Information

HELP INFORMATION	PHONE NUMBER	WEBSITE
Enrollment into HealthChoice	855-642-8572 TDD (for hearing impaired) 800-977-7389	MarylandHealthConnection.gov
General Questions about HealthChoice	410-767-5800 (local) 800-492-5231 (rest of state) TDD (for hearing impaired) 800-735-2258	MMCP.Health.Maryland.gov/HealthChoice
HealthChoice Help Line - for problems and complaints about access, enrollment process, and quality of care	800-284-4510	
Pregnant women and family planning	800-456-8900	MMCP.Health.Maryland.gov/CHP
Healthy Kids, EPSDT	410-767-1903	MMCP.Health.Maryland.gov/EPSDT
Healthy Smiles Dental Program	855-934-9812	MMCP.Health.Maryland.gov/Pages/maryland-healthy-smiles-dental-program.aspx
Rare and Expensive Case Management Program (REM) - for questions about referrals, eligibility, grievances, services	800-565-8190	MMCP.Health.Maryland.gov/LongTermCare/Pages/REM-Program.aspx
Mental Health and substance use disorders- for referrals, provider information, grievances, preauthorization	800-888-1965	BHA.Health.Maryland.gov/Pages/HELP.aspx
Maryland Health Connection Consumer Support Center	855-642-8572 TDD (for hearing impaired) 855-642-8573	MarylandHealthConnection.gov

B. Local Health Department Contact Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	AlleganyHealthDept.com
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	AAHealth.org
Baltimore City	410-396-3835	410-396-6422	410-649-0521	Health.BaltimoreCity.gov
Baltimore County	410-887-2243	410-887-2828	410-887-4381	BaltimoreCountyMD.gov/Agencies/Health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext.360	CalvertHealth.org
Caroline	410-479-8000	410-479-8014	410-479-8023	Health.Maryland.gov/CarolineCounty
Carroll	410-876-2152	410-876-4813	410-876-4940	CCHD.Maryland.gov
Cecil	410-996-5550	410-996-5171	410-996-5145	CecilCountyHealth.org
Charles	301-609-6900	301-609-7917	301-609-6803	CharlesCountyHealth.org
Dorchester	410-228-3223	410-901-2426	410-228-3223	DorchesterHealth.org
Frederick	301-600-1029	301-600-1725	301-600-3341	Health.FrederickCountyMD.gov
Garrett	301-334-7777	301-334-9431	301-334-7695	GarrettHealth.org
Harford	410-838-1500	410-638-1671	410-942-7999	HarfordCountyHealth.com
Howard	410-313-6300	877-312-6571	410-313-7567	HowardCountyMD.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	KentHD.org
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1648	MontgomeryCountyMD.gov/HHS
Prince George's	301-883-7879	301-856-9555	301-856-9550	PrinceGeorgesCountyMD.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4481	QAHealth.org
St. Mary's	301-475-4330	301-475-4296	301-475-6772	SMCHD.org
Somerset	443-523-1700	443-523-1722	443-523-1766	SomersetHealth.org
Talbot	410-819-5600	410-819-5609	410-819-5654	TalbotHealth.org
Washington	240-313-3200	240-313-3264	240-313-3290	Health.Maryland.gov/WashHealth
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	WicomicoHealth.org
Worcester	410-632-1100	410-632-0092	410-632-9230	WorcesterHealth.org

III. Rights and Responsibilities

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

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

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

- Inform your provider and MCO if you have any other health insurance coverage.
- Treat HealthChoice staff, MCO staff, and health care providers and staff, with respect and dignity.
- Be on time for appointments and notify providers as soon as possible if you need to cancel an appointment.
- Show your membership card when you check in for every appointment. Never allow anyone else to use your Medicaid or MCO card. Report lost or stolen member ID cards to the MCO.
- Call your MCO if you have a problem or a complaint.

- Work with your Primary Care Provider (PCP) to create and follow a plan of care that you and your PCP agree on.
- Ask questions about your care and let your provider know if there is something you do not understand.
- To understand your health problems and to work with your provider to create mutually agreed upon treatment goals that you will follow.
- Update the State if there has been a change in your status.
- Provide the MCO and their providers with accurate health information in order to provide proper care.
- Use the emergency department for emergencies only.
- Tell your PCP as soon as possible after you receive emergency care.
- Inform your caregivers about any changes to your Advance Directive.

C. Non-Discrimination Statement

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

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

Procedure:

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

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

OCRPortal.HHS.gov/OCR/Smartscreen, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, **800-368-1019** - TDD: **800-537-7697**.

Complaint forms are available at: **HHS.gov/OCR/Filing-With-OCR**. Such complaints must be filed within 180 days of the date of the alleged discrimination.

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

D. Notice of Privacy Practices

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

To file a complaint, see contact information below:

- Provider: call your provider's office
- MCO: call MedStar Health's Privacy Officer at **410-772-6606** or email **PrivacyOfficer@MedStar.net**.
- U.S. Department of Health and Human Services
 - Online at: **OCRPortal.HHS.gov/OCR/Smartscreen**
 - Email: **ocrcomplaint@hhs.gov**
 - In Writing at:
 - Centralized Case Management Operations
 - U.S. Department of Health and Human Services
 - 200 Independence Avenue, S.W.
 - Room 509F HHH Bldg.
 - Washington, D.C. 20201

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

IV. Benefits and Services

A. HealthChoice Benefits

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



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

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DON'T GET WITH THIS BENEFIT
Primary Care Services	These are all of the basic health services you need to take care of your general health needs, and are usually provided by your primary care provider (PCP). A PCP can be a doctor, advanced practice nurse, or physician assistant.	All members	
EPSDT Services for Children (MMCP. Health. Maryland. gov/EPSDT)	Regular well-child check-ups, immunizations (shots), developmental screens and wellness advice. These services provide whatever is needed to take care of sick children and to keep healthy children well.	Under age 21	
Pregnancy-Related Services	Medical care during and after pregnancy, including hospital stays and, when needed, home visits after delivery	Women who are pregnant, and for two months after the birth.	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DON'T GET WITH THIS BENEFIT
Family Planning	Family planning office visits, lab tests, birth control pills and devices (includes latex condoms and emergency contraceptives from the pharmacy, without a doctor's order), and permanent sterilizations	All members	
Primary Mental Health Services	Primary mental health services are basic mental health services provided by your PCP or another provider within the MCO. If more than just basic mental health services are needed, your PCP will refer you to or you can call the Public Behavioral Health System at 800-888-1965 for specialty mental health services.	All members	You do not get specialty mental health services from the MCO. For treatment of serious emotional problems your PCP or specialist will refer you or you can call the Public Behavioral Health System at: 800-888-1965 .
Prescription Drug Coverage (Pharmacy Services)	Prescription drug coverage includes prescription drugs (drug dispensed only with a prescription from an authorized prescriber) insulin, needles and syringes, birth control pills and devices, coated aspirin for arthritis, iron pills (ferrous sulfate), and chewable vitamins for children younger than age 12. You can get latex condoms and emergency contraceptives from the pharmacy without a doctor's order.	All members There are no copays for children under age 21, pregnant women, and for birth control.	
Specialist Services	Healthcare services provided by specially trained doctors, advanced practice nurses or physicians assistants. You may need a referral from your PCP before you can see a specialist.	All members	
Laboratory and Diagnostic Services	Lab tests and X-rays to help find out the cause of an illness	All members	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DON'T GET WITH THIS BENEFIT
Home Health Care	Healthcare services received in-home that includes nursing and home health aide care	Those who need skilled nursing care (care provided by or under the supervision of a registered nurse) in their home, usually after being in a hospital	No personal care services (help with daily living)
Case Management	A case manager may be assigned to help you plan for and receive health care services. The case manager also keeps track of what services are needed and what has been provided. You must communicate with case manager to receive effective case management.	<ul style="list-style-type: none"> (1) Children with special health care needs (2) Pregnant and postpartum women (3) Individuals with HIV/AIDS (4) Individuals who are Homeless; (5) Individuals with physical or developmental disabilities (6) Children in State-supervised care (7) Case management provided by MCO for other members as needed 	
Diabetes Care	Special services, medical equipment and supplies for enrollees with diabetes	Members who have been diagnosed with diabetes	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DON'T GET WITH THIS BENEFIT
Diabetes Prevention Program	A program to prevent diabetes in members who are at risk.	Members 18 to 64 years old who are overweight and have elevated blood glucose level or a history of diabetes during pregnancy.	Not eligible if previously diagnosed with diabetes or if pregnant.
Podiatry	Foot care when medically needed.	All members	Routine foot care; unless you are under 21 years of age or have diabetes or vascular disease affecting the lower extremities
Vision Care	<p>Eye Exams</p> <ul style="list-style-type: none"> • <u>Under 21</u>: One exam every year • <u>21 and Older</u>: One exam every two years <p>Glasses</p> <ul style="list-style-type: none"> • Under 21 only • Contact lenses if there is a medical reason why glasses will not work 	<p>Exams - all members</p> <p>Glasses and Contact Lenses - Members under age 21</p>	More than one pair of glasses per year unless lost, stolen, broken, or new prescription needed
Oxygen and Respiratory Equipment	Treatment to help breathing problems.	All members	
Hospital Inpatient Services	Services and care received for scheduled and unscheduled admittance for inpatient hospital stays (hospitalization)	All members with authorization or as an emergency	
Hospital Outpatient Care	Services and care received from an outpatient hospital setting that does not require inpatient admittance to the hospital. Services would include diagnostic and laboratory services, physician visit, and authorized outpatient procedures.	All members	MCOs are not required to cover hospital observation services beyond 24 hours.

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DON'T GET WITH THIS BENEFIT
Emergency Care	Services and care received from a hospital emergency facility to treat and stabilize an emergent medical condition	All members	
Urgent Care	Services and care received from an urgent care facility to treat and stabilize an urgent medical need	All members	
Hospice Services	Home or inpatient services designed to meet the physical, psychological, spiritual, and social needs for people who are terminally ill	All members	
Nursing Facility/ Chronic Hospital	Skilled nursing care or rehab care up to 90 days	All members	
Rehabilitation Services/ Devices	Outpatient services/devices that help a member function for daily living. Services include: Physical, Occupational, and Speech Therapy.	Members age 21 and older Members under 21 are eligible under EPSDT (see section 6 E)	
Habilitation Services/ Devices	Services/devices that help a member function for daily living. Services include Physical Therapy, Occupational Therapy, and Speech Therapy.	Eligible members; benefits may be limited.	
Audiology	Assessment and treatment of hearing loss	All members	Members over 21 must meet certain criteria for hearing devices.
Blood and Blood Products	Blood used during an operation, etc.	All members	
Dialysis	Treatment for kidney disease	All members	

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	WHAT YOU DON'T GET WITH THIS BENEFIT
Durable Medical Equipment (DME) & Disposable Medical Supplies (DMS)	DME (can use repeatedly) are things like crutches, walkers, and wheelchairs) DMS (cannot use repeatedly) are equipment and supplies that have no practical use in the absence of illness, injury, disability or health condition. DMS are things like finger stick supplies, dressings for wounds, and incontinence supplies.	All members	
Transplants	Medically necessary transplants	All members	No experimental transplants
Clinical Trials	Members costs for studies to test the effectiveness of new treatments or drugs	Members with little threatening conditions, when authorized	
Plastic and Restorative Surgery	Surgery to correct a deformity from disease, trauma, congenital or development abnormalities, or to restore body functions	All members	Cosmetic surgery to make you look better

B. Self-Referral Services

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

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

Emergency Services

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

Family Planning Services (Birth Control)

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

Pregnancy Services

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

Birthing Centers

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

Baby's first check-up before leaving hospital

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

School-Based Health center services

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

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

Check-up for children entering State custody

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

Certain providers for children with special health care needs

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



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

Diagnostic Evaluation Service (DES)

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

Renal Dialysis

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

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

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

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

BENEFIT	DESCRIPTION
Dental Services for Children Under 21, former foster care youth up to age 26, and Pregnant Women	General dentistry including regular and emergency treatment is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program administered by Scion. If you are eligible for the Dental Services Program, you will receive information and a dental card from Scion. If you have not received your dental ID card or have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at 855-934-9812 .
Occupational, Physical, & Speech Therapies for Children Under the Age of 21	The State pays for these services if medically needed. For help in finding a provider, you can call the State's Hotline at 800-492-5231 .
Speech Augmenting Devices	Equipment that helps people with speech impairments to communicate
Behavioral Health	Substance use disorder and specialty mental health services are provided through the Public Behavioral Health System. You can reach them by calling 800-888-1965 .
Intermediate Care Facility (ICF) - Mental Retardation (MR) Services	This is treatment in a care facility for people who have an intellectual disability and need this level of care.

BENEFIT	DESCRIPTION
Skilled Personal Care Services	This is skilled help with daily living activities.
Medical Day Care Services	This is help to improve daily living skills in a center licensed by the state or local health department, which includes medical and social services.
Nursing Facility & Long Term Care Services	The MCO does not cover care in a nursing home, chronic rehabilitation hospital, or chronic hospital after the first 90 days. If you lose Medicaid coverage while you are in a nursing facility you will not be re-enrolled in the MCO. If this happens you will need to apply for Medicaid under long term care coverage rules. If you still meet the State's requirements after you are disenrolled from the MCO or after the MCO has paid the first 90 days, the State would be responsible.
HIV/AIDS	Certain diagnostic services for HIV/AIDS are paid for by the State (Viral load testing, genotypic, phenotypic, or other HIV/AIDS resistance testing).
Abortion Services	<p>This medical procedure to end certain kinds of pregnancies is covered by the State only if:</p> <ul style="list-style-type: none"> • The patient will probably have serious physical or mental health problems, or could die, if she has the baby; • She is pregnant because of rape or incest, and reported the crime; or • The baby will have very serious health problems. <p>Women eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.</p>

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

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

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

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

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

Benefits and Services NOT Covered:

- Dental services for adults (Except for pregnant women and former foster care youth up to age 26)
- Orthodontist services for people 21 years and older or children who do not have a serious problem that makes it difficult for them to speak or eat
- Non-prescription drugs (Except coated aspirin for arthritis, insulin, iron pills, and chewable vitamins for children younger than age 12)
- Routine foot care for adults 21 years and older who do not have diabetes or vascular problems
- Special (orthopedic) shoes and supports for people who do not have diabetes or vascular problems
- Shots for travel outside the continental United States or medical care outside the United States
- Diet and exercise programs, to help you lose weight
- Cosmetic surgery to make you look better, but you do not need for any medical reason
- Fertility treatment services, including services to reverse a voluntary sterilization
- Private hospital room for people without a medical reason such as having a contagious disease
- Private duty nursing for people 21 years and older
- Autopsies
- Anything experimental unless part of an approved clinical trial
- Anything that you do not have a medical need for

F. Change of Benefits and Service Locations

Change of Benefits

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

Loss of Benefits

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

Change of Healthcare Locations

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

V. Information on Providers

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

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

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

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

B. Selecting or Changing Providers

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

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



To view a list of participating providers within MedStar Family Choice, provider directories are available on MFC's website. If you would like a paper copy of the provider directory mailed to you, contact MFC Member Services. If you would like to know more about your PCP, specialists, midwives, physical therapists, speech therapists, audiologists, or any other type of provider that will be caring for you, you may call MedStar Family Choice Member Services toll-free at **888-404-3549**.

The member services representative will give you information about your provider or will transfer your call to someone who can help you. You may also view our website at **MedStarFamilyChoice.com**. There is detailed information on the website regarding each of our providers, including information regarding hospital privileges, education and certifications. If you would like to obtain this type of information on your provider, but do not have access to our website, you may contact Member Services to receive this information over the phone, or we can send you the information on specific providers.

C. Termination of a Provider

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

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

VI. Getting Into Care

A. Making or Canceling an Appointment

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

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

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

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

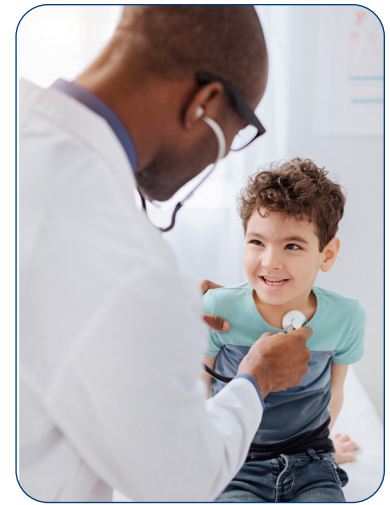
- Medicaid card
- MFC ID card
- A photo ID

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

B. Referral to a Specialist or Specialty Care




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

Call MFC Member Services for their referral requirements.



C. After Hours, Urgent Care and Emergency Room Care

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

		
Doctor's Office	Urgent Care Center	Emergency Room
<ul style="list-style-type: none"> • Check-ups • Health screenings • If something causes you concern • Cough/cold • Fever • Lingering pain • Unexplained weight loss 	<ul style="list-style-type: none"> • Minor illness/injury • Flu/fever • Vomiting/diarrhea • Sore throats, earaches, or eye infection • Sprains/strains • Possible broken bones • Sports injuries 	<ul style="list-style-type: none"> • Unconsciousness • Difficulty breathing • Serious head, neck, or back injury • Chest pain/pressure • Severe bleeding • Poisons • Severe Burns • Convulsions/seizures • Severely broken bone • Sexual Assault

After Hours

If you need non-emergency care after normal business hours, contact your PCP's office, call MFC's 24-hour Nurse Advice Line, or use MedStar eVisit. The phone numbers for your PCP and the Nurse Advice Line are on your MFC member ID card. Your doctor or their answering service will be able to answer your questions, provide you instructions, and arrange any necessary services. The Nurse Advice Line is always open to answer your questions. They will help guide you to the right place so you get the best care and so you don't get billed unnecessarily. **See below for more information on MedStar eVisit.**

Urgent Care

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

MedStar eVisit is another urgent care option with 24/7 video access to trusted medical providers from your tablet, smartphone, or computer. To learn more or sign up, please visit **MedStarFamilyChoice.com/eVisit.**

Emergency Room Care

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

If you are unsure if you should go to the emergency department, contact your PCP, call the MFC 24-hour Nurse Advice Line, or use MedStar eVisit. After you are treated for an emergency medical condition you may need additional services to make sure the emergency medical condition does not return. These are called post-stabilization services. MFC will work with the hospital staff to decide if you need these services. If you would like additional information about how this is decided, contact MFC.

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

D. Out-of-Service Area Coverage

Not all MCOs operate in all areas of the State. If you need non-emergency care while out of MFC's service area call your PCP or MFC Member Services. Both numbers are on your MFC card. If you move and your new residence is in a different Maryland county that MFC does not service, you can change MCOs by calling Maryland Health Connection (**855-642-8572**). If you decide to stay with your MCO you may need to provide your own transportation to an in-network provider in another county.

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

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

It is important for infants, children, and adolescents up to age 21 to receive regular checkups. The Healthy Kids/EPSDT program helps to identify, treat, and prevent health problems before they become complex and costly. EPSDT is a comprehensive benefit that covers medically necessary medical, dental, vision, and hearing services. Many of the EPSDT services will be covered by the MCO, but services such as dental, behavioral health, and therapies will be covered through fee-for-service Medicaid (**see page 24**).

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

The table below shows the ages that children need well child visits. If your child's PCP recommends more visits they will also be covered. During well child visits the PCP will check your child's health and all aspects of development. They will also check for problems through screening. Some screenings for health

problems are done through blood work while others are done by asking questions. Additional screens may be required based on age and risk. The PCP will also offer advice and tell you what to expect. Make sure you keep appointments for well-child exams. Do not miss immunizations and make sure children get their blood tested for lead. Lead in the blood causes serious problems so testing is required for all children regardless of risk. This applies even if your child has both Medicaid and other insurance.

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

F. Wellness Care for Adults

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

Adult Preventive Care Recommendations

Service	Frequency - Population
Blood Pressure Check	Yearly
Cholesterol	Every 5 years starting at age 35 for men and 45 for women, starting at age 20 if at increased risk
Diabetes	Adults aged 40 to 70 years who are overweight or obese

Service	Frequency - Population
Colon Cancer Screening	Age 50 to 75, frequency depends on test used: stool based - yearly to every three years, flexsigmoid every five years, CT colonography every five years, or colonoscopy every 10 years
Sexually Transmitted Disease Screening	HIV - once for all adults regardless of risk, additionally based on risk Hepatitis C (HCV) - once for anyone born between 1945 and 1965, others based on risk Hepatitis B - adults at increased risk Chlamydia/Gonorrhea - yearly for women age 16 to 24 if sexually active, based on risk for age 25+ Syphilis - adults at increased risk
Influenza Vaccine	Yearly
Tdap (tetanus, diphtheria, acellular Pertussis) Vaccine	Once as an adult (if didn't receive at age 11 to 12), during every pregnancy
Td (tetanus) Vaccine	Every 10 years, additional doses if dictated by risk
Shingles (zoster) Vaccine	Once for All adults age 60 and older
Pneumococcal Vaccine (PPSV23)	Once for Everyone (age 2 to 64) with diabetes, lung disease, heart disease, smokers, alcoholism, or other risk factors (talk to your doctor to determine your risk)
Breast Cancer Screening (via Mammogram)	Every two years age 50 to 75, risk based 40 to 50
Lung Cancer Screening	Yearly for adults age 55 to 80 with 30 pack per year smoking history who are actively smoking or quit smoking less than 15 years ago, screening done using Low Dose CT (LDCT) scan
Cervical Cancer Screening	Every three years for women ages 21 to 29, every five years for women ages 30 to 65
Substance Use/Misuse: Alcohol, Tobacco, Other	Adult 18 and older; Yearly or more frequently depending on risk

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

G. Case Management

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

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

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

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

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

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

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

I. Family Planning (Birth Control)

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

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

Call MFC Member Services or the State's Help Line (**800-456-8900**) for additional information on family planning and self-referral services.

J. Dental Care

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

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

K. Vision Care

- If you are under the age of 21, you are eligible for:
 - Eye exams
 - Glasses once a year
 - Eye contact lenses if medically necessary over glasses
- If you are age 21 and over, you are eligible for:
 - Eye exams every two years
 - See Attachment C for additional adult vision benefits offered by MFC
- Call MFC Member Services if you have questions need finding a vision care provider.

L. Health Education/Outreach

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

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

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

M. Behavioral Health Services

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

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

- Residential Treatment Centers

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

VII. Special Services

A. Services for Special Needs Populations

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

1. Pregnant women and women who have just given birth
2. Children with special health care needs
3. Children in State-supervised care
4. Adults or children with a physical disability or developmental disability
5. Adults and children with HIV/AIDS
6. Adults and children who are homeless



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

Services Every Special Needs Population Receives

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

- **Case Manager** – A case manager will be a nurse or a social worker or other professional that may be assigned to your case soon after you join a MCO. This person will help you and your PCP develop a patient centered plan that addresses the treatment and services you need. The case manager will:
 - Help develop the plan of care
 - Ensure the plan of care is updated at least every 12 months or as needed
 - Keep track of the health care services
 - Help those who give you treatment work together.
- **Specialists** – Having special needs requires you to see providers who have the most experience with your condition. Your PCP and your case manager will work together to be sure to send you to the right specialists. This will include specialists for supplies and equipment you might need.

- **Follow-up When Visits Are Missed** - If your PCP or specialist finds that you keep missing appointments, they will let us know and someone will try to get in touch with you by mail, by telephone, or by a visit to your home to remind you to call for another appointment. If you still miss appointments, you may be visited by someone from the local health department near where you live.
- **Special Needs Coordinator** - MCOs are required to have a Special Needs Coordinator on staff. The Special Needs Coordinator will educate you about your condition and will suggest places in your area where you can get support from people who know about your needs.

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

1. Pregnant Women and Women Who Have Just Given Birth

a. Appointments - MFC will assist in scheduling an appointment for prenatal care within 10 days of your request.

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



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

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

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

f. Dental - Good oral health is important for a healthy pregnancy. All pregnant women are eligible to receive dental services through the State's Maryland Healthy Smiles Dental Program. Call Healthy Smiles (**855-934-9812**) if you have questions about your dental benefits. After delivery members age 21 and over will no longer be eligible for dental benefits through Healthy Smiles. MFC may offer adult dental benefits. See Attachment C.

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

- h. HIV Testing and Counseling** – Pregnant women will be offered a test for HIV and will receive information on HIV infection and its effect on the unborn child.
- i. Nutrition Counseling** – Pregnant women will be offered nutritional information to teach them to eat healthy.
- j. Smoking Counseling** – Pregnant women will receive information and support on ways to stop smoking.
- k. EPSDT Screening Appointments** – Pregnant adolescents (up to age 21) should receive all EPSDT screening services in addition to prenatal care.
- l. See Attachment D** for additional services MFC offers for pregnant women.

2. Children with Special Healthcare Needs

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

3. Children in State-Supervised Care

- a. State-Supervised Care (Foster and Kinship Care)** – MFC will ensure that children in State supervised care (foster care or kinship care) get the services that they need from providers by having one person at the MCO be responsible for organizing all services. If a child in State supervised care moves out of the area and needs another MCO, the State and the current MCO will work together to quickly find the child new providers close to where the child has moved, or if needed, the child can change to another MCO.
- b. Screening for Abuse or Neglect** – Any child thought to have been abused physically, mentally, or sexually will be referred to a specialist who is able to determine if abuse has occurred. In the case of possible sexual abuse, MFC will ensure that the child is examined by someone who knows how to find and keep important evidence.

4. Adults and Children with Physical and Developmental Disabilities

- a. Materials Prepared in a way You Can Understand** – MFC has materials reviewed by people with experience in the needs of people with disabilities. This means that the information will be presented using the right methods so that people with disabilities can understand, whether in writing or by voice translation.
- b. DDA Services** – Members that currently receive services through the Developmental Disabilities Administration (DDA) or under the DDA waiver can continue to receive those services.

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

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

5. Adults and Children with HIV/AIDS

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

b. **Diagnostic Evaluation Service (DES) Assessment Visits Once Every Year** - One annual diagnostic and evaluation service (DES) visit for any member diagnosed with HIV/AIDS, which MFC is responsible for facilitating on the member's behalf.

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

6. Adults and Children Who Are Homeless

MFC will attempt to identify individuals who are homeless and link them with a case manager and appropriate healthcare services. It can be difficult for MCOs to identify when members become homeless. If you find yourself in this situation, contact MFC Member Services.

B. Rare and Expensive Case Management Program (REM)

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

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

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

VIII. Utilization Management

A. Medical Necessity

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

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

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

B. Preauthorization/Prior Approval

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

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

If the preauthorization is denied or reduced in amount, duration or scope, then that service or medication will not be covered by MFC. You will be notified in writing of the decision within 14 calendar days, or 28 calendars if there was a request for an extension. You will be given the right to file an appeal for the denied preauthorization (see Complaints, Grievance, and Appeals section on page 44).

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

See Attachment F for MFC's current policy.

C. Continuity of Care Notice

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

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

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

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

Preauthorization for Healthcare Services

- If you previously were covered under another company's plan, a preauthorization for services that you received under your old plan may be used to satisfy a preauthorization requirement for those services if they are covered under your new plan with MedStar Family Choice.
- To be able to use the old preauthorization under MedStar Family Choice, you will need to contact MedStar Family Choice Member Services to let us know that you have a preauthorization for the services and provide us with a copy of the preauthorization. Your parent, guardian, designee, or healthcare provider may also contact us on your behalf about the preauthorization.
- There is a time limit for how long you can rely on this preauthorization. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health practitioner after the baby is born.
- Limitation on Use of Preauthorization - Your special right to use a preauthorization does not apply to:
 - Dental Services
 - Mental Health Services
 - Substance Use Disorder Services
 - Benefits or services provided through the Maryland Medicaid fee-for-service program



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

Right to Use Non-Participating Providers

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

This right applies only if you are being treated by the non-participating provider for covered services for one or more of the following types of conditions:

1. Acute conditions
2. Serious chronic conditions
3. Pregnancy
4. Any other condition upon which we and the out-of-network provider agree

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

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

Example of How the Right to Use Non-Participating Providers Works

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

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

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

Appeal Rights

- If your current MCO denies your right to use a preauthorization from your old company or your right to continue to see a provider who was a participating provider with your old company, you may appeal this denial by contacting the MCO Member Services.
- If your current MCO denies your appeal, you may file a complaint with the Maryland Medicaid Program by calling the HealthChoice Help Line at **800-284-4510**.
- If you have any questions about this procedure call MFC Member Services or the HealthChoice Help Line at **800-284-4510**.

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

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

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

E. Out-of-Network Services

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

F. Preferred Drug List

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

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

G. New Technology and Telehealth

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

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

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

IX. Billing

A. Explanation of Benefits or Denial of Payment Notices

From time to time you may receive a notice from MFC that your provider's claim has been paid or denied. Explanation of Benefits (EOB) or Denial of Payment notices are not a bill. The notices may list the

type of service, date of service, amount billed, and amount paid by MFC on your behalf. The purpose of the notice is to summarize which provider charges are a covered service or benefit. If you feel that there is an error, like finding a service that you never received, contact MFC Member Services.

If you are copied on a notice that your provider was not paid, you are not responsible for payment. Your provider should not charge you. If you have questions call MFC Member Services.

B. What to Do if you Receive a Bill

- Do not pay for a service that is not your responsibility as you may not be reimbursed. Only providers can receive payment from Medicaid or MCOs. If you receive a medical bill for a covered benefit:
 - First contact the provider who sent the bill.
 - If you are told you did not have coverage on the date you received care or that MFC did not pay, call MFC Member Services.
 - MFC will determine if there has been an error or what needs to be done to resolve the problem.
 - If MFC does not resolve the problem contact the HealthChoice Help Line (**800-284-4510**).
- Providers are required to verify eligibility. Providers must bill the MCO. (If the service is covered by the State and not the MCO, the Eligibility Verification System (EVS) will tell them where to send the bill.)
- With few exceptions Medicaid and HealthChoice providers are not allowed to bill members. Small pharmacy copays and copays for optional services, such as adult dental and eyeglasses for adults are examples of services you could be billed for.

X. Complaints, Grievances, and Appeals

A. Adverse Benefit Determination, Complaints, and Grievances

Adverse Benefit Determination

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

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

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

Complaints

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

Grievances

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

B. Appeals

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

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

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

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

When reviewing your appeal, the MCO reviewers:

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

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

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

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

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

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

If you file a grievance and it is:

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

See Attachment F for MFC's current policy.

C. How to File a Complaint, Grievance, or Appeal

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

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

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

D. The State's Complaint/Appeal Process

Getting Help From the HealthChoice Help Line

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

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

Asking the State to Review the MCO's Decision

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

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

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

- If the State thinks the MCO should provide the requested service, it can order the MCO to give you the service.
- If the State thinks that the MCO does not have to give you the service, you will be told that the State agrees with the MCO.
- If you do not agree with the State's decision, which you will receive in writing, you will again be given the opportunity to request a State Fair Hearing.

Types of State Decisions You Can Appeal

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

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

Continuing Services During the Appeal

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

Fair Hearings

To appeal one of the State's decisions, you must request that the State file a notice of appeal with the Office of Administrative Hearings on your behalf. The request for a State Fair Hearing must be submitted no later than 120 days from the date of the MCO's notice of resolution.

The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

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

E. Reversed Appeal Resolutions

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

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

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

F. Making Suggestions for Changes in Policies and Procedures

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

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

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

XI. Changing Your MCO

A. 90 Day Rules

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

B. Once Every 12 Months

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

C. When There is an Approved Reason to Change MCOs

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

- If you move to another county where your current MCO does not offer care
- If you become homeless and find that there is another MCO closer to where you live or have shelter which would make getting to appointments easier
- If you or any of your family has a doctor in a different MCO and the adult member wishes to keep all family members together in the same MCO. (This does not apply to newborns. Newborns must remain in the MCO that the mother was in at the time of delivery for the first 90 days.)
- If you have a foster child placed in your home and you or your family members receive care by a doctor in a different MCO than the foster child, the foster child being placed can switch to the foster family's MCO.
- If the MCO terminates your PCP contract for reasons other than listed below, you will be notified by the state.
 - Your MCO has been purchased by another MCO.
 - The provider and the MCO cannot agree on a contract for certain financial reasons.
 - Quality of care

D. How to Change Your MCO

Contact Maryland HealthChoice (**855-642-8572**). Note that:

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

XII. Reporting Fraud, Waste, and Abuse

A. Types of Fraud, Waste, and Abuse

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

Member Examples

- Falsely reporting your income and or assets to qualify for Medicaid
- Permanently living in another state while receiving Maryland Medicaid benefits
- Lending your member ID card or using another member's ID card to obtain health services
- Selling or making changes to a prescription medicine

Provider Examples

- Providing services that are not medically necessary
- Billing for services that were not provided
- Billing multiple times for the same service
- Altering medical records to cover up fraudulent activity

When someone is reported for possible fraud and abuse, MedStar Family Choice will perform an investigation. The results are reported to the Maryland Department of Health (MDH). MDH may perform its own investigation too. People who perform these activities or any other dishonest activity on purpose may lose their health benefits, be fined, or jailed.

B. How to Report Fraud, Waste, and Abuse

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

- Call MFC Member Services at **888-404-3549** or write a letter to MedStar Family Choice, Attention: Director of Medicaid Contract Oversight, 5233 King Ave., Ste 400, Baltimore, MD 21237).
- Contact the Maryland Department of Health, Office of the Inspector General:
 - **866-770-7175**
 - **[Health.Maryland.gov/OIG/Pages/Report_Fraud.aspx](https://www.health.maryland.gov/OIG/Pages/Report_Fraud.aspx)**
- Contact the U.S. Department of Health and Human Services, Office of the Inspector General
 - **800-447-8477**
 - **[OIG.HHS.gov/Fraud/Report-Fraud/Index.asp](https://www.OIG.HHS.gov/Fraud/Report-Fraud/Index.asp)**

ATTACHMENT A - Managed Care Organization Contact Information

MEDSTAR FAMILY CHOICE	
Member Services	888-404-3549
	TTY/TDD MEMBER SERVICES: 711 or 800-508-6975
24/7 Nurse Advice Line	855-210-6204
	TTY/TDD: 711
MedStar eVisit - 24/7 video access to doctors	MedStarHealth.org/eVisit
Online Member Portal / Website	MedStarFamilyChoice.com
Online Health and Wellness Portal	MedStarFamilyChoiceHealthyLife.com
Non-Discrimination Coordinator	Section 1557 Coordinator 5233 King Avenue, Suite 400 Baltimore, MD 21237 888-404-3549 MFC1557Coordinator@medstar.net
Complaints, Grievance, Appeals Address	MedStar Family Choice Attn: Appeals Department 5233 King Ave., Suite 400 Baltimore, MD 21237 888-404-3549
Reporting Fraud and Abuse Address	MedStar Family Choice Attn: Director of Medicaid Contract Oversight 5233 King Ave., Suite 400 Baltimore, MD 21237 888-404-3549
Dental and Vision Benefits	Avesis Monday through Friday 8:30 a.m. - 5 p.m. 844-478-0512 TTY/TDD 711

ATTACHMENT B - Notice of Privacy Practices

Notice of Privacy Practices for MedStar Health Inc.

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

Who will Follow This Notice

MedStar Health, Inc., and its affiliated entities and subsidiaries are separate legal entities. However, they are under common ownership and control, and thus have organized themselves as a single Affiliated Covered Entity (ACE) for the purposes of the HIPAA Privacy Rule. This status permits MedStarHealth, its affiliated entities and subsidiaries to maintain a single Notice of Privacy Practices. This notice describes the health information practices of the MedStar Health Inc., organization. All entities, sites, and locations will follow the terms of this notice. In addition, these entities, sites, and locations may share medical information with each other for treatment, payment and healthcare operations as described in this notice.

Our Obligation to You

We value the privacy of your medical information as an important part of our “patient first” pledge. We view the protection of patient privacy as an essential component of our vision to be the Trusted Leader in Caring for People and Advancing Health and our mission to serve our patients. We strive to use only the minimum amount of your health information necessary for the purposes described in this Notice of Privacy Practice (“notice”).

We collect information from you and use it to provide you with quality care, and to comply with certain legal requirements. We are required by law to maintain the privacy of your health information, and to give you this notice of our legal duties, our privacy practices and your rights. We are required to follow the terms of our most current notice. When we disclose information to other persons and companies to perform services for us, we will require them to protect your privacy. There are other laws we will follow that may provide additional protections, such as laws related to mental health, alcohol and other substance abuse, and communicable disease or other health conditions.

This notice covers the following sites and people: all healthcare professionals authorized to enter information into your chart, all volunteers authorized to help you while you are here, all of our associates and on-site contractors, all departments and units within the hospital, all healthcare students, all healthcare delivery facilities and providers within the MedStar Health system, and your personal doctor and others while they are providing care at this site. Your doctor may have different policies or notices about the health information that was created in his or her private office or clinic.

How We May Use and Disclose Health Information

Treatment: We may use and disclose your health information to provide treatment or services, to coordinate or manage your health care, or for medical consultations or referrals. We may use and disclose your health information among doctors, nurses, technicians, medical students and other personnel who are involved in taking care of you at our facilities or with such persons outside our facilities. We may use or share information about you to coordinate the different services you need, such as prescriptions, lab work, and X-rays. We may disclose information about you to people outside

our facility who may be involved in your care after you leave, such as family members, home health agencies, therapists, nursing homes, clergy, and others. We may give information to your health plan or another provider to arrange a referral or consultation.

Payment: We may use and disclose your health information so that we can receive payment for the treatment and services that were provided. We may share this information with your insurance company or a third party used to process billing information. (As described below, if you pay for your health care in full and out-of-pocket, you may request that we not share your information with your insurance company.) We may contact your insurance company to verify what benefits you are eligible for, to obtain prior authorization, and to tell them about your treatment to make sure that they will pay for your care. We may disclose information to third parties who may be responsible for payment, such as family members, or to bill you. We may disclose information to third parties that help us process payments, such as billing companies, claims processing companies, and collection companies.

Healthcare Operations: We may use and disclose your health information as necessary to operate our facility and make sure that all of our patients receive quality care. We may use health information to evaluate the quality of services that you received, or the performance of our staff in caring for you. We may use health information to improve our performance or to find better ways to provide care. We may use health information to grant medical staff privileges or to evaluate the competence of our healthcare professionals. We may use your health information to decide what additional services we should offer and whether new treatments are effective. We may disclose information to students and professionals for review and learning purposes. We may combine our health information with information from other health care facilities to compare how we are doing and see where we can make improvements. We may use health information for business planning, or disclose it to attorneys, accountants, consultants, and others in order to make sure we are complying with the law. We may remove health information that identifies you so that others may use the de-identified information to study health care and healthcare delivery without learning who you are. If operating as a health plan, we will not use or disclose genetic information for underwriting purposes (this does not apply to long term care plans).

Business Associates: There are some services provided in MedStar Health through contracts with business associates. Examples include a copy service we use when making copies of your health record, consultants, accountants, lawyers, medical transcriptionists, and third party billing companies. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Certain Marketing Activities: We may use your medical information to forward promotional gifts of nominal value, to communicate with you about products, services and educational programs offered by MedStar Health, to communicate with you about case management and care coordination, and to communicate with you about treatment alternatives. We do not sell your health information to any third party for their marketing activities unless you sign an authorization allowing us to do this.

Health Information Exchanges: We may participate in health information exchanges (HIEs) to facilitate the secure exchange of your electronic health information between and among several health care providers or other health care entities for your treatment, payment, or other health care operations purposes. This means we may share information we obtain or create about you with outside entities (such as hospitals, doctors' offices, pharmacies, or insurance companies) or we may receive information they create or obtain about you (such as medication history, medical history, or insurance information)

so each of us can provide better treatment and coordination of your healthcare services. In addition, if you visit any MedStar Health facility, your health information may be available to other clinicians and staff who may use it to care for you, to coordinate your health services or for other permitted purposes.

The Chesapeake Regional Information System for our Patients (CRISP) is a regional HIE serving Maryland and Washington, D.C., in which we participate. We may share information about you through CRISP for treatment, payment, healthcare operations, or research purposes.

You may “opt-out” and disable access to your health information available through CRISP by calling **877-952-7477** or completing and submitting an Opt-Out form to CRISP by mail, fax or through their website at **CrispHealth.org**. As permitted by law, even if you opt-out of CRISP, public health reporting and Controlled Dangerous Substances information, as part of the Maryland Prescription Drug Monitoring Program (PDMP), will still be available to providers through CRISP.

Appointment Reminders and Service Information: We may use or disclose your health information to contact you to provide appointment reminders, or to let you know about treatment alternatives or other health related services or benefits that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may give your health information to people involved in your care, such as family members or friends, unless you ask us not to. We may give your information to someone who helps pay for your care. We may share your information with other healthcare professionals, government representatives, or disaster-relief organizations, such as the Red Cross, in emergency or disaster-relief situations so they can contact your family or friends or coordinate disaster-relief efforts.

Patient Directories: We may keep your name, location in the facility, and your general condition in a directory to give to anyone who asks for you by name. We may give this information and your religious affiliation to clergy, even if they do not know your name. You may ask us to keep your information out of the directory, but you should know that if you do, visitors and florists will not be able to find your room. Even if you ask us to keep your information out of the directory, we may share your information for disaster-relief efforts or in declared emergency situations.

Fundraising Activities: We depend extensively on philanthropy to support our healthcare missions. We may use your name and other limited information to contact you, including the dates of your care, the name of the department where you were treated and the name of your treating physician so that we may provide you with an opportunity to make a donation to our programs. We may collaborate with a third party, including Georgetown University, to manage our fundraising activities. If we or any of our agents contact you for fundraising or philanthropy purposes, you will be told how you may ask us not to contact you in the future.

Research: We may use or disclose your health information for research that has been approved by one of our official research review boards, which has evaluated the research proposal and established standards to protect the privacy of your health information. We may use or disclose your health information to a researcher preparing to conduct a research project.

Organ and Tissue Donation: We may use or disclose your health information in connection with organ donations, eye or tissue transplants, or organ donation banks, as necessary to facilitate these activities.

Public Health Activities: We may disclose your health information to public health or legal authorities whose official activities include preventing or controlling disease, injury, or disability. For example, we must report certain information about births, deaths, and various diseases to government agencies.

We may disclose health information to coroners, medical examiners, and funeral directors as allowed by the law to carry out their duties. We may use or disclose health information to report reactions to medications, problems with products, or to notify people of recalls of products they may be using. We may use or disclose health information to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease.

Serious Threat to Health and Safety: We may use or disclose your health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. We will only disclose health information to someone reasonably able to help prevent or lessen the threat, such as law enforcement or government officials.

Required by Law, Legal Proceedings, Health Oversight Activities and Law Enforcement: We will disclose your health information when we are required to do so by federal, state, and other law. For example, we may be required to report victims of abuse, neglect or domestic violence, as well as patients with gunshot and other wounds. We will disclose your health information when ordered in a legal or administrative proceeding, such as a subpoena, discovery request, warrant, summons, or other lawful process. We may disclose health information to a law enforcement official to identify or locate suspects, fugitives, witnesses, victims of crime, or missing persons. We may disclose health information to a law enforcement official about a death we believe may be the result of criminal conduct, or about criminal conduct that may have occurred at our facility. We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure.

Specialized Government Functions: If you are in the military or a veteran, we will disclose your health information as required by command authorities. We may disclose health information to authorized federal officials for national security purposes, such as protecting the President of the United States or the conduct of authorized intelligence operations. We may disclose health information to make medical suitability determinations for Foreign Service.

Correctional Facilities: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your health information to the correctional institution or law enforcement official. We may release your health information for your health and safety, for the health and safety of others, or for the safety and security of the correctional institution.

Workers Compensation: We may disclose your health information as required by applicable workers compensation and similar laws.

Health Plan: When MedStar Health operates as a health plan, we will not use or disclose your genetic information for underwriting purposes.

Your Written Authorization: Other uses and disclosures of your health information not covered by this notice, or the laws that govern us, will be made only with your written authorization. These include the sale of your health information, use of your health information for marketing purposes, and certain disclosures of psychotherapy notes. You may revoke your authorization in writing at any time, and we will discontinue future uses and disclosures of your health information for the reasons covered by your authorization. We are unable to take back any disclosures that were already made with your authorization, and we are required to retain the records of the care that we provided to you.

Your Privacy Rights Regarding Your Health Information

Right to Obtain a Copy of This Notice of Privacy Practices

We will post a copy of our current Notice in our facilities and on our website, **MedStarHealth.org**. A copy of our current notice will be available at our registration areas or upon request. To request a copy of our current Notice of Privacy Practices, please call **410-772-6606**.

Right to See and Copy Your Health Record

You have the right to look at and receive a copy of your health record or your billing record. To do so, please contact the facility where you received treatment, or the Privacy Office listed below. You may be required to make your request in writing.

You may request an electronic copy of this information, and we will provide access in the electronic form and format requested if it is readily reproducible in the requested format. If not, we will discuss the issue with you and provide a copy in a readable electronic form and format upon which we mutually agree, depending on the information and our capabilities at the time of the request. You may also request that we send your health information directly to a person you designate if your written request is signed, in writing and clearly identifies both the person designated and an address to send the requested information.

If you would like a copy of your health record, a fee may be charged for the cost of copying or mailing your record (and the electronic media if the request is to provide the information on portable electronic media), as permitted by law.

We will provide a copy of your health record usually within 30 days. In certain situations, we may deny your request. If we do, we will tell you, in writing, our reasons for the denial and explain your right to have the denial reviewed.

Right to Update Your Health Record

If you believe that a piece of important information is missing from your health record, you have the right to request that we add an amendment to your record. Your request must be in writing, and it must contain the reason for your request. To submit your request, please contact the facility where you received treatment, or the Privacy Office listed below. We will make every effort to fulfill your request usually within 60 days. We may deny your request to amend your record if the information being amended was not created by us, if we believe that the information is already accurate and complete, or if the information is not contained in records that you would be permitted by law to see and copy. If we deny your request, you will be notified in writing usually within 60 days. Even if we accept your amendment, we will not delete any information already in your records.

Right to Get a List of the Disclosures We Have Made

You have the right to request a list of the disclosures that we have made of your health information. This list is not required to include disclosures made for treatment, payment and healthcare operations, and certain other disclosure exceptions. Your request must be in writing and indicate in what form you want the list (for example, on paper, electronically). To request a list of disclosures, please contact the facility where you received treatment, or the Privacy Office listed below. The first list you request in a 12-month period is free. For additional lists, we may charge a fee, as permitted by law.

Right to Request a Restriction on Certain Uses or Disclosures

You have a right to request a restriction on how we use and disclose your medical information for treatment, payment and healthcare operations, and to certain family members or friends identified by

you who are involved in your care or the payment of your care. We are not required to agree to your request, and will notify you if we are unable to agree. Your request must be in writing and it must (1) describe what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. In some instances, you may choose to pay for a healthcare item or service out-of-pocket rather than submit a claim to your insurance company. You may request that we not submit your medical information to a health plan or your insurance company, if you, or someone on your behalf, pays for the treatment or service out-of-pocket in full. To request this restriction, you must make your request in writing prior to the treatment or service. In your request you must tell us (1) what information you want to restrict and (2) and to what health plan the restriction applies.

Right to Breach Notification

You have the right under HIPAA, or as required by law, to be notified if there is a breach of your unsecured medical information. If requested, this notification may be provided to you electronically.

Right to Choose a Representative

You have the right to choose someone to act on your behalf. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make efforts to verify the person you designate has this authority and can act for you before we take any action.

Right to Choose How You Receive Your Health Information

You have the right to request that we communicate with you in a certain way, such as by mail or fax, or at a certain location, such as a home address or post office box. We will try to honor your request if we reasonably can. Your request must be in writing, and it must specify how or where you wish to be contacted. To submit a request, please contact the facility where you received treatment, or the Privacy Office listed below.

Contact Person

If you believe your privacy rights have been violated, you may call or file a complaint in writing with the MedStar Health Privacy Office or the Department of Health and Human Services (please reference the contact information below). We will take no retaliatory action against you if you file a complaint about our privacy practices.

Privacy Officer • MedStar Health Inc.
10980 Grantchester Way, Columbia, MD 21044

410-772-6606 PHONE

privacyofficer@medstar.net

U.S. Department of Health and Human Services
Office for Civil Rights
200 Independence Ave., S.W., Washington, DC 20201

877-696-6775 TOLL FREE

HHS.gov/OCR/Privacy/HIPAA/Complaints

If you have questions about this notice or would like to exercise your privacy rights, please contact the facility where you received treatment or the MedStar Privacy Office.

Changes to this Notice of Privacy Practices

We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in each MedStar Health facility and on our website. In addition, each time you register at, or are admitted to, the hospital for treatment or healthcare services as an inpatient or outpatient, we will offer you a copy of our current notice in effect.

El Aviso sobre Prácticas de Privacidad está disponible en español.

개인 정보 보호 정책 관행의 공지 사항 한글로 사용할 수 있습니다.

آبى برع الة لالاب حاتم ةيصوصرل الة كذم

通知隱私做法是可以在简体中文。

Các thông báo về việc bảo mật Thực tiễn hiện có sẵn tại Việt Nam

Уведомление о конфиденциальности доступна на русском языке.

Footnote: MedStar Health, Inc., located in Columbia, Maryland, is a non-profit community-based healthcare organization serving the greater Baltimore/Washington region. The health system is made up of a number of distinguished health care providers and other diversified health care entities. While these entities operate independently of one another and as separate employers, they also work toward common missions and values. The mission of MedStar Health is to serve our patients, those who care for them, and our communities and our vision is to be the trusted leader in caring for people and advancing health. In working to achieve this goal, it is the responsibility of each MedStar Health entity to enforce its privacy policies and to take appropriate disciplinary or other actions for employee violations. Please note that for purposes of this Notice of Privacy Practices, the MedStar Health parent company and all of its subsidiaries will be referred to collectively as "MedStar Health." For privacy purposes only, MedStar Health is organized as an Affiliated Covered Entity, as described in 45 CFR §164.504(d)(1); legally separate entities that are affiliated may designate themselves as a single covered entity.

MedStar Health complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

注意：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 888-404-3549。

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 888-404-3549.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-404-3549 번으로 전화해 주십시오.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-404-3549.

ATTACHMENT C - Additional Services Offered By MedStar Family Choice

The healthcare services and benefits you have read about in Attachment A are given to you by all MCOs. MedStar Family Choice will give you some other services. The following table shows the extra healthcare services and benefits that MedStar Family Choice members can get when they need them. If you have a question or are confused about these extra benefits, you can call MedStar Family Choice Member Services toll-free at **888-404-3549**. Currently, there are no copays for services provided by MedStar Family Choice.

BENEFIT	WHAT IT IS	WHO CAN GET THIS BENEFIT	LIMITATIONS
Vision Care	Eye exam once a year. Eyeglasses once a year.	21 years and older	Contact lenses that are not medically necessary.
Over the counter medications	Some medications that are available over-the-counter will be paid for by MedStar Family Choice. Your doctor has a list of these medicines.	All enrollees	Not all over-the-counter medications are covered. Your doctor has a complete list.
Transportation	Transportation to receive care is provided as appropriate when medically necessary.	All enrollees	Transportation that is not medically necessary.
Adult Dental	Cleanings and examinations two times a year as well as fillings and x-rays. Simple extractions are covered.	Enrollees 21 and over who are not pregnant women	Maximum benefit limitation is \$1,000 per calendar year. Contact Avesis for specific exclusions.
MedStar eVisit	Access to board-certified medical doctors available 24/7 via secured video from a tablet, smart phone, or computer for non-urgent medical conditions.	All enrollees	None

ATTACHMENT D - Prenatal/Postpartum Programs

If you were pregnant when you joined MedStar Family Choice and had already seen a provider, who is not in MedStar Family Choice network, for at least one complete prenatal check-up, then you can choose to keep seeing that provider all through your pregnancy, delivery, and for two months after the baby is born for follow-up, as long as the provider agrees to continue to see you.

Baby's first check-up before leaving hospital

It is best to select your baby's doctor before you deliver. If the MedStar Family Choice doctor you selected or another MedStar Family Choice doctor does not see your newborn baby for a check-up before the baby is ready to go home from the hospital, we will pay for the on-call doctor to do the check-up in the hospital.

Pregnancy care is the healthcare you receive during pregnancy from a specially trained doctor called an obstetrician or OB doctor. **Seeing your OB doctor is very important to you and your baby. You will need regular check-ups the whole time you are pregnant and even after your baby is born.**

Please call MedStar Family Choice as soon as you know you are pregnant. We have a special program for pregnant women that helps encourage good prenatal care. If you are less than 28 weeks pregnant, you are eligible to join the MedStar Family Choice "Momma and Me" incentive program. This program offers gift certificates for every prenatal visit with the OB, for educational classes and for your baby's first pediatric visit. As a "Momma and Me" participant, you will also receive educational materials. For additional information about the program, please call **800-905-1722 (prompt #1)**.

For those moms that do not enroll in the MedStar Family Choice "Momma and Me" incentive program, we have a postpartum program called "We Care." For participating in this program, you are eligible for gift certificates if you receive your postpartum exam and for taking your newborn to his or her first two-week well-child visit. For additional information about the "We Care" program, please call **800-905-1722 (prompt #1)**.

You may have been pregnant when you signed up with MedStar Family Choice. If you already had an OB doctor, you may keep seeing him or her as long as he or she agrees to keep seeing you. If you become pregnant after you signed up, your PCP will help you pick a MedStar Family Choice OB doctor. Please tell your PCP when you think you might be pregnant so that you can start seeing an OB doctor right away. If you believe that you might be pregnant and do not have an Ob/Gyn doctor, you can call your PCP to get a pregnancy test.

Your OB doctor will want to see you at regular times. It is important for your health and your baby's health that you do not miss these appointments.

During the first seven months that you are pregnant, your OB doctor will want to see you every month. After seven months, your OB doctor will want to see you every two weeks. As you get close to the time to have your baby, your OB doctor will want to see you every week.

Your OB doctor will also want to see you about six weeks after you have your baby. After this visit, you can go back to your PCP. Remember to choose a pediatrician before your baby is born. Once your baby is born it is important to call the pediatrician immediately to schedule an appointment.

Appointments - The provider must schedule an appointment within 10 days of your request. If you cannot get an appointment call us at **888-404-3549** or the Enrollee Help Line at **800-284-4510**.

Link to a Pediatric Provider - Every pregnant woman will be linked with a children's doctor that she chooses before giving birth. A children's doctor may be a family practice doctor, pediatrician, or nurse practitioner.

Prenatal Risk Evaluation - Every pregnant woman should have a prenatal risk evaluation at the time of the first visit with the prenatal provider. If there is a risk that may affect the pregnancy and a healthy baby, someone from the Local Health Department or MedStar Family Choice will contact the pregnant woman and offer to visit her.

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

Follow-up - We are required to schedule the newborn for a follow-up visit two weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.

Dental - Pregnant women receive diagnostic, emergency, preventive, and therapeutic dental services for oral diseases. These services are provided by the Maryland Healthy Smiles Dental Program. Contact them at **888-696-9596** if you have questions about your dental benefits.

Substance Use Disorder Services - Any pregnant or postpartum (two months after delivery) woman, who needs treatment for a substance use disorder will immediately be referred to the Specialty Behavioral Health System.

HIV Testing and Counseling - All pregnant women will be offered a test for HIV and will receive information on HIV infection and its affect on the unborn child.

Nutrition Counseling - All pregnant women will be offered nutritional information to teach them to eat healthy.

Smoking Counseling - All pregnant women will be provided information and support on ways to stop smoking.

EPSDT Screening Appointments - Adolescents who are pregnant should receive EPSDT screening services in addition to prenatal care.

ATTACHMENT E - Health Education Programs

MedStar Family Choice wants you to learn about your health and how to stay well. We have many classes, support groups, and events in your community. We offer classes on subjects such as prenatal care, baby care, and many others. We encourage you to attend as many of these as you can. For a listing of these classes, call Member Services at **888-404-3549**. You may also view our website for a listing at **MedStarFamilyChoice.com**. All classes and events will be free of charge. Please bring your member identification card and photo ID with you when you attend.

MedStar Family Choice also offers our members an online program to help them establish and reach their wellness goals. If you are ready to get motivated and improve your health, all you need to do is log in and create an account at **MedStarFamilyChoiceHealthyLife.com** today. This secure online portal is easy to use. You can get started on your wellness journey by completing a health survey, exploring the health library, enrolling in a wellness workshop, or starting an exercise plan.

There are many different tools you can use to monitor your progress:

- weight log
- blood pressure log
- blood glucose log
- cholesterol log
- body measurement log
- health overview log
- food log
- meal planner
- explore healthy recipes
- water tracker
- cardio log
- step log

ATTACHMENT F - MCO Internal Complaints/Grievances/Appeals Procedure

A. MCO Enrollee Services and Hotline Information

MedStar Family Choice wants you to get the healthcare services you need in the best way possible. We want to know what you think about the services we provide. So please call Member Services toll-free at **888-404-3549** if you think we are not meeting your needs or if you have any questions about the care you are getting. We may also be calling you from time to time to ask you if you are happy with your care.

We have a Consumer Advisory Board (CAB) made up of members and MedStar Family Choice employees. They meet six times a year to talk about the care our members are getting and to make suggestions on how MedStar Family Choice can improve the services we provide. You may be asked to serve on this board. If you are, we hope that you would accept the offer and join the CAB. We hope that your participation will help us take care of your health and the health of all the members of MedStar Family Choice.

B. MedStar Family Choice Internal Grievance Procedures

Internal Grievance Procedure

If you have a grievance (also called a complaint) about your healthcare services, such as not being able to get an appointment, the way in which you were treated or having to travel too far to get healthcare services, call Member Services toll-free at **888-404-3549** Monday through Friday from 8:30 a.m. to 5 p.m. and tell us your concern. See page **4** for information about interpreter services and TTY/TDD services) The member service representative will:

1. Take your grievance;
2. Answer any questions; and
3. Forward your grievance to the appropriate person, who will:
 - a. Investigate your grievance;
 - b. Decide what steps will be taken; and
 - c. Respond to your grievance (within 24 hours for emergency medically related issues, five days for non-emergency medically related issues and 30 days for administrative issues)

Grievance Appeal

If you are not happy with the answer you get from MedStar Family Choice and the grievance is regarding issues such as quality of care, access, attitude/service, the quality of a provider's office location, or payment of services, you may be allowed to file a grievance appeal. Call Member Services toll-free at **888-404-3549**. A staff member who is different from the staff member that initially resolved your grievance will:

1. Investigate your grievance appeal;
2. Answer any questions;
3. Decide what steps will be taken; and

4. Respond to your grievance appeal (72 hours for urgent and 30 days for routine issues)

If you are still not satisfied with the outcome, you may at anytime during the grievance process contact the HealthChoice Enrollee Help Line at **800-284-4510** Monday through Friday between 7:30 a.m. and 5:30 p.m.

C. Medical Coverage Appeals

MedStar Family Choice approves or denies services based upon whether or not the service is medically needed and a covered benefit. We do not financially reward our providers, staff, or anyone contracted with MedStar Family Choice for denying services. In addition, we do not financially reward anyone involved in the decision process in such a way that would encourage them to deny services.

When you do not agree with our decision to deny, or stop or reduce a service that has been requested by your provider, you or your provider can ask us to review our decision again. This is called an appeal.

You may appeal MedStar Family Choice's decision to not cover a service once you receive a denial (adverse determination) letter from us. You have 60 days from the date on the denial letter to appeal our decision. The letter provides the details of why the medical services were denied. It also gives instructions on the appeals process. If your provider is appealing on your behalf, you must give him/her permission in writing, as required by the regulations.

Medical appeals are either urgent or non-urgent. Appeals are considered to be urgent if your life, physical health, or mental health are in jeopardy or if there could be a loss in the ability to attain, maintain, or regain maximum functioning.

The appeal, verbal or written, must include the specific reason for reconsidering the denial. You may file the appeal on your own. We have an appeal form you can use to file your appeal. Please call **410-933-2200** or **800-905-1722** to ask for the form. We will mail, fax, or email the appeal form to you and provide assistance if you need help completing it. Other people can also help you file an appeal, like a family member or a lawyer. With permission in writing from you, you may have your provider or an authorized representative file the appeal on your behalf. All requests for appeals can be submitted verbally or in writing to the MedStar Family Choice Denial and Appeal Division. Written appeals must be sent to the following address:

MedStar Family Choice
P.O. Box 43790
Baltimore, MD 21236
Attn: Denial and Appeal Division

We will send you a letter to notify you know that we have received your appeal within five business days of receiving your appeal request. If you prefer to verbally request an appeal, please call **410-933-2200** or **800-905-1722** Monday through Friday between 8:30 a.m. and 5 p.m.

When you file an appeal, be sure to let us know any new information that you have that will help us make our decision. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help us make our decision.

When reviewing your appeal we will:

- Use doctors who know about the type of illness you have
- Not use the same medical professionals who denied your request for a service

- Not use medical professionals who are subordinates of those who made the previous decision
- Make a decision about your appeal within 72 hours for urgent appeals, and within 30 calendar days for non-urgent appeals.

Urgent Appeals

Urgent appeals must be requested within 60 days from the date on the denial (adverse determination) letter from MedStar Family Choice. Urgent appeals may not be requested for services that have already been received. In addition to the specific reason for the appeal, you, your authorized representative, or your provider are given the chance to provide any additional information that you want considered during the appeal process.

MedStar Family Choice will resolve an urgent appeal within 72 hours of receiving the urgent request. Once a decision has been reached we will mail you our decision within two calendar days. We will also attempt to reach you or your representative over the phone so that you have our decision within 24 hours of making the decision. If we believe that your appeal is not urgent, MedStar Family Choice will change this to a non-urgent appeal and follow the time requirements for a non-urgent appeal.

If you are not satisfied with the outcome of your appeal, you may contact the HealthChoice Enrollee Help Line at **800-284-4510** Monday through Friday between 7:30 a.m. and 5:30 p.m. In addition, you may contact the Enrollee Help Line at any point during the appeal process.

Non-Urgent Appeals

Non-urgent appeals must be requested within 60 days from the date on the denial (adverse determination) letter from MedStar Family Choice. In addition to the specific reason for the appeal, you, your authorized representative or your provider are given the chance to provide any additional documentation that you want considered during the appeal process. Non-urgent appeals can be for services that have not yet occurred or for services that have already occurred. MedStar Family Choice will notify you, your authorized representative, and your provider of our decision within 30 calendar days from receipt of your appeal request.

The response time may be extended by no more than 14 days if you ask for more time to submit information or we need to get additional information from other sources. We will contact you in writing and attempt to contact you over the phone if more time is needed.

If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while we review your appeal. Contact us within 10 days from the date on the denial letter or within 10 days of the date your services are scheduled to end at **410-933-2200** or **800-905-1722** Monday through Friday between 8:30 a.m. and 5 p.m. if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

If you are not satisfied with the outcome of your appeal, you may contact the HealthChoice Enrollee Help Line at **800-284-4510** Monday through Friday between 7:30 a.m. and 5:30 p.m. In addition, you may contact the Enrollee Help Line at any time through the appeal process.

ATTACHMENT G - Other Important Information

A. MedStar Family Choice Website (MedStarFamilyChoice.com)

MedStar Family Choice has developed a website to provide you with access to up-to-date information about your health plan. On the website, you will find the following:

- Appeal process
- Benefit information
- Out of network services
- Second opinions
- Self referral services
- What services are covered or not covered
- Added services under MedStar Family Choice
- Whether or not there are co-pays
- What to do if you are billed for a covered service
- Out of area coverage
- Case management/disease management services
- Contact information for our company
- Find-A-Provider (searchable provider directory)
- Formulary (Medication List)
- Hours of operation and after hours instructions
- Interpreter services
- Member handbook
- Member rights and responsibilities
- New technology policies
- Notice of privacy practices
- Outreach program

B. How to Make Suggestions for Changes in Policies or Procedures

MedStar Family Choice welcomes your comments and ideas. If you have suggestions for changes to be made in how we provide healthcare or give you service, call Member Services toll-free at **888-404-3549**. Your ideas will be taken seriously. They will be brought before the Consumer Advisory Board, and you will receive a response from us. We want you to be happy with your healthcare and we want you to help us to take care of you. We hope you will let us know what we are doing right, as well as what we could do better.

C. New Technology

MedStar Family Choice evaluates new technology on an as needed basis. Providers will contact the MedStar Family Choice Care Management Department to request authorization for the new technology. The MedStar Family Choice Medical Director will review the request and make sure that it has been approved by the Food and Drug Administration. In addition, we will determine if Medicaid covers the service at this time. If Medicaid determines that the new technology should be a covered service, the request will be approved if it is medically necessary. If Medicaid does not currently cover the new technology, we will review industry standards in considering whether or not to cover the new technology.

D. Out-of-Pocket Expenses

You should always be sure to show your MedStar Family Choice identification card when you need medical care. All MedStar Family Choice providers are aware that they may not charge members for covered services. If, however, you were asked to pay for a covered service, please contact Member Services as soon as possible. We will contact the provider to determine why you were charged. In addition, if you were incorrectly charged for a service that is covered by MedStar Family Choice, we will assist you in getting reimbursed for this expense. In order to review the issue, we will request documentation, such as a receipt from the provider office.

E. Fraud, Waste, and Abuse

While MedStar Family Choice looks for possible fraud, waste, and abuse activities, we need your help to stop fraud, waste, and abuse. MedStar Family Choice has a strict non-retaliation policy. You do not need to give your name. However if you choose to give us your name, you don't have to worry about anyone denying you service, removing you from the managed care organization, or treating you in any way that would cause you or a family member from feeling that you did something wrong for reporting any incident. In addition to the ways listed in Section XII of this handbook, you may call MedStar Family Choice's Director of Medicaid Contract Oversight at **888-404-3549** or the MedStar Health Corporate Integrity Hotline at **877-811-3411**.

ATTACHMENT H - Advanced Directive

MARYLAND ADVANCE DIRECTIVE: PLANNING FOR FUTURE HEALTH CARE DECISIONS



A Guide to
Maryland Law on
Health Care Decisions
(Forms Included)

STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL

Brian E. Frosh
Attorney General



August 2019

Dear Fellow Marylander:

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

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

Here is some related, important information:

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

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

<http://www.oag.state.md.us/healthpol/advancedirectives.htm>.

Brian E. Frosh
Attorney General

*HEALTH CARE PLANNING
USING ADVANCE DIRECTIVES
Optional Form Included*

Your Right To Decide

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

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

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

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

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

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

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

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

If you already have a prior Maryland advance directive, living will, or a durable power of attorney for health care, that

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

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

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

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

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

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

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

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

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

**FREQUENTLY ASKED QUESTIONS ABOUT
ADVANCE DIRECTIVES IN MARYLAND**

1. Must I use any particular form?

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

2. Who can be picked as a health care agent?

Anyone who is 18 or older except, in general, an owner, operator, or employee of a health care facility where a patient is receiving care.

3. Who can witness an advance directive?

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

4. Do the forms have to be notarized?

No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

5. Do any of these documents deal with financial matters?

No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

6. When using these forms to make a decision, how do I show the choices that I have made?

Write your initials next to the statement that says what you want. Don't use checkmarks or X's. If you want, you can also draw lines all the way through other statements that do not say what you want.

7. Should I fill out both Parts I and II of the advance directive form?

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

8. Are these forms valid in another state?

It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

9. How can I get advance directive forms for another state?

Contact the National Hospice and Palliative Care Organization (NHPCO) at 1-800-658-8898 or on the Internet at:

<https://www.nhpc.org/patients-and-caregivers/advance-care-planning/advance-directives/downloading-your-states-advance-directive>

10. To whom should I give copies of my advance directive?

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

11. Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?

Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the form.

12. Can my health care agent or my family decide treatment issues differently from what I wrote?

It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

13. Is an advance directive the same as a “Patient’s Plan of Care”, “Instructions on Current Life-Sustaining Treatment Options” form, or Medical Orders for Life-Sustaining Treatment (MOLST) form?

No. These are forms used in health care facilities to document discussions about current life-sustaining treatment issues. These forms are not meant for use as anyone’s advance directive. Instead, they are medical records, to be done only when a doctor or other health care professional presents and discusses the issues. A MOLST form contains medical orders regarding life-sustaining treatments relating to a patient’s medical condition.

14. Can my doctor override my living will?

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

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

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

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

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

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

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

18. What about donating my body for medical education or research?

Part II of the “After My Death” form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-800-879-2728 for that form and additional information.

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

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

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

REVISED AUGUST 2019

IF YOU HAVE OTHER QUESTIONS, PLEASE TALK TO YOUR DOCTOR OR YOUR LAWYER. OR, IF YOU HAVE A QUESTION ABOUT THE FORMS THAT IS NOT ANSWERED IN THIS PAMPHLET, YOU CAN CALL THE HEALTH POLICY DIVISION OF THE ATTORNEY GENERAL’S OFFICE AT (410) 767-6918 OR E-MAIL US AT ADFORMS@OAG.STATE.MD.US.

MORE INFORMATION ABOUT ADVANCE DIRECTIVES CAN BE OBTAINED FROM OUR WEBSITE AT:

<http://www.marylandattorneygeneral.gov/Pages/HealthPolicy/advancedirectives.aspx>

**MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS**

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

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

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

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

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

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

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

Name: _____

Address: _____

Telephone Numbers: _____

(home and cell)

B. Selection of Back-up Agents

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

Name: _____

Address: _____

Telephone Numbers: _____

(home and cell)

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

Name: _____

Address: _____

Telephone Numbers: _____

(home and cell)

C. Powers and Rights of Health Care Agent

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

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

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

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

D. How my Agent is to Decide Specific Issues

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

E. People My Agent Should Consult

(Optional; form valid if left blank)

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

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

F. In Case of Pregnancy

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

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

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

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

H. Effectiveness of this Part

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

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

>>OR<<

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

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

PART II: TREATMENT PREFERENCES (“LIVING WILL”)

A. Statement of Goals and Values

(Optional: Form valid if left blank)

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

B. Preference in Case of Terminal Condition

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

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

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

>>**OR**<<

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

>>**OR**<<

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

C. Preference in Case of Persistent Vegetative State

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

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

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

>>OR<<

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

>>OR<<

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

D. Preference in Case of End-Stage Condition

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

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

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

>>OR<<

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

>>OR<<

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

E. People My Agent Should Consult

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

F. In Case of Pregnancy

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

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

G. Effect of Stated Preferences

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

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

>>OR<<

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

PART III: SIGNATURE AND WITNESSES

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

(Signature of Declarant)

(Date)

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

(Signature of Witness)

(Date)

Telephone Number(s):

(Signature of Witness)

(Date)

Telephone Number(s):

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

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

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

PART I: ORGAN DONATION

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

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

I authorize the use of my organs, tissues, or eyes:
For transplantation _____
For therapy _____
For research _____
For medical education _____
For any purpose authorized by law _____

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

PART II: DONATION OF BODY

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

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

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

>>**OR**<<

This person:

Name: _____

Address: _____

Telephone Number(s): _____

(Home and Cell)

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

PART IV: SIGNATURE AND WITNESSES

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

(Signature of Donor)

(Date)

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

(Signature of Witness)

(Date)

Telephone Number(s):

(Signature of Witness)

(Date)

Telephone Number(s):

AFTER MY DEATH

Part II: Donation of Body

The State Anatomy Board, a unit of the Department of Health administers a statewide Body Donation Program. Anatomical Donation allows individuals to dedicate the use of their bodies upon death to advance medical education, clinical and allied-health training and research study to Maryland's medical study institutions. The Anatomy Board requires individuals to pre-register prior to death as an anatomical donor to the state Body Donation Program. There are no medical restrictions or qualifications to becoming an a "Body Donor". At death the Board will assume the custody and control of the body for study use. It is truly a legacy left behind for others to have healthier lives. For donation information and forms you can contact the Board toll-free at 800.879.2728.

Did You Remember To ...

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

ATTACHMENT I - MedStar Family Choice Nondiscrimination Statement

Nondiscrimination Statement

It is MedStar Family Choice's policy not to discriminate based on race, color, national origin, sex, age or disability. MedStar Family Choice will provide free aids and services to people with disabilities to communicate effectively with us (this includes qualified sign language interpreters, written information in accessible formats, and free language services to those whose primary language is not English, including qualified interpreters and information written in other languages). If you need these services, contact Member Services at **888-404-3549**.

We have an internal grievance procedure to help quickly and fairly resolve complaints alleging illegal discrimination under Section 1557 of the Affordable Care Act (42 U.S.C. 18116) and its implementing regulations at 45 CFR part 92, issued by the U.S. Department of Health and Human Services. This section of law prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. This section of law can be reviewed in the Compliance Department of MedStar Family Choice. MedStar Family Choice has a specific person who assists us in complying with issues that involve Section 1557:

Section 1557 Coordinator
5233 King Avenue, Suite 400
Baltimore, MD 21237
888-404-3549
MFC1557Coordinator@medstar.net

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

Procedure:

- Grievances must be sent to the Section 1557 Coordinator within (60 days) of the date the person filing the grievance becomes aware of the alleged discriminatory action.
- A complaint must be in writing and include the name and address of the person filing it. The complaint must state the problem or action alleged to be discriminatory and the desired resolution.
- The Section 1557 Coordinator (or her/his designee) will investigate the complaint. This investigation may be informal, but it will be thorough. There is an opportunity to submit evidence regarding the complaint. MFC will maintain the records regarding these grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator will keep the files confidential and will only share with those who have a need to know.
- The Section 1557 Coordinator will send a written decision on the grievance, based on what we found during our investigation within 30 days of receiving the complaint. The notice will include what to do if you do not agree with the decision, including but not limited to the ability to appeal to the President of MedStar Family Choice.

The availability and use of this grievance procedure do not prevent a person from pursuing other legal or administrative remedies, including filing a complaint of discrimination based on race, color, national origin, sex, age or disability in court or with the U.S. Department of Health and Human Services, Office for Civil Rights. A person can file a complaint of discrimination electronically through the Office for Civil Rights Complaint Portal, which is available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: **U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201. 1-800-368-1019, 800-537-7697 (TDD)**

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

MedStar Family Choice will ensure that individuals with disabilities and individuals with limited English proficiency are provided with any needed auxiliary aids and services or language assistance services free of charge and in a timely manner to participate in this grievance process. This may include assistance in the form of qualified interpreters, providing taped cassettes of material for individuals with low vision, or assuring a barrier-free location for the proceedings. We can also provide you with written materials in the prevalent non-English languages identified in Maryland and in alternative formats. If you need these aids or services, contact Member Services at **888-404-3549 (TTY: 7-1-1)**.



MedStarFamilyChoice.com



**MedStar Family
Choice**

5233 King Ave.
Suite 400
Baltimore, MD 21237
888-404-3549 **PHONE**