# 4. Benefits and Services

## A. HealthChoice Benefits

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

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

| Benefit | What it is | Who can get this benefit | What you do not get with this benefit |
|---|---|---|---|
| **Primary Care Services** | These are all of the basic health services you need to take care of your general health needs, and are usually provided by your primary care provider (PCP). A PCP can be a doctor, advanced practice nurse, or physician assistant. | All members | |
| **Early Periodic Screening Diagnosis Treatment (EPSDT) Services for Children** | Regular well-child checkups, immunizations (shots), and checkups to look for developmental problems and to provide wellness advice. These services provide whatever is needed to take care of sick children and to keep healthy children well. | Under age 21 | |
| **Pregnancy-related Services** | Medical care during and after pregnancy, including hospital stays, doula support, and, when needed, home visits after delivery. | Members who are pregnant, and for one year after the birth | |

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

| Benefit | What it is | Who can get this benefit | What you do not get with this benefit |
|---|---|---|---|
| **Specialist Services** | Health care services provided by specially trained doctors, advanced practice nurses, or physician's 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 | |
| **Home Health Care** | Health care services received in-home that include 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 the case manager to receive effective case management. | 1. Children with special health care needs<br>2. Pregnant and postpartum members<br>3. Individuals with HIV/AIDS<br>4. Individuals who are homeless<br>5. Individuals with physical or developmental disabilities<br>6. Children in State-supervised care<br>7. Case management provided by MCO for other members as needed | |

| Benefit | What it is | Who can get this benefit | What you do not get with this benefit |
|---|---|---|---|
| **Diabetes Care** | Special services, medical equipment, and supplies for members with diabetes. | Members who have been diagnosed with diabetes | |
| **Diabetes Prevention Program** | A program to prevent diabetes in members who are at risk. | Members 18 to 64 years old who are overweight and have elevated blood glucose levels or a history of diabetes during pregnancy | Not eligible if previously diagnosed with diabetes or if pregnant. |
| **Podiatry** | Foot care when medically needed. | All members | Routine foot care, unless you are under 21 years of age or have diabetes or vascular disease affecting the lower extremities |
| **Vision Care** | **Eye Exams**<br>Under 21: one exam every year.<br>21 and older: one exam every two years.<br>**Glasses**<br>Under 21 only.<br>Contact lenses if there is a medical reason why glasses will not work. | **Exams** – all members<br>**Glasses and contact lenses** – Members under age 21 | More than one pair of glasses per year unless lost, stolen, or broken, or a new prescription needed. |
| **Oxygen and Respiratory Equipment** | Treatment to help breathing problems. | All members | |
| **Hospital Inpatient Care** | Services and care received for scheduled and unscheduled admittance for inpatient hospital stays (hospitalization). | All members with authorization or as an emergency | |
| **Hospital Outpatient Care** | Services and care received from an outpatient hospital setting that does not require inpatient admittance to the hospital. Services would include diagnostic and laboratory services, physician visits, and authorized outpatient procedures. | All members | MCOs are not required to cover hospital observation services beyond 24 hours. |

| Benefit | What it is | Who can get this benefit | What you do not get with this benefit |
|---|---|---|---|
| **Emergency Care** | Services and care received from a hospital emergency facility to treat and stabilize an emergency 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 of 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<br><br>Members under 21 are eligible under EPSDT (see Section 6 E) | |
| **Habilitation Services/Devices** | Services/devices that help a member function for daily living. Services include physical therapy, occupational therapy, and speech therapy. | Eligible members (benefits may be limited) | |
| **Audiology** | Assessment and treatment of hearing loss | All members | Members over 21 must meet certain criteria for hearing devices. |
| **Blood and Blood Products** | Blood used during an operation, etc. | All members | |
| **Dialysis** | Treatment for kidney disease. | All members | |

| Benefit | What it is | Who can get this benefit | What you do not get with this benefit |
|---|---|---|---|
| **Durable Medical Equipment (DME) and 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, or congenital or development abnormalities, or to restore body functions. | All members | Cosmetic surgery to make you look better. |

## B. Self-Referral Services

You will go to your PCP for most of your health care, or your PCP will send you to a specialist who works with the same MCO. For some types of services, you can choose a local provider who does not participate with your MCO. The MCO will still pay the non-participating provider for services as long as the provider agrees to see you and accepts 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 where you receive the self-referral visit. The following services are self-referral services.

- Emergency services
- Family planning
- Pregnancy, under certain conditions, and birthing centers
- Doctor's check of newborn baby
- School-based health centers
- Assessment for placement in foster care
- Certain specialists for children
- Diagnostic evaluation for people with HIV/AIDS
- Renal dialysis
- Laboratory tests to detect COVID-19 infection

### Emergency Services

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

### Family Planning Services (Birth Control)

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

### Pregnancy Services

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

Doula support is available for prenatal visits, attendance at labor and delivery, and postpartum visits. You also have access to home visiting services. Home visiting services include prenatal home visits, postpartum home visits, and infant home visits up to 2 or 3 years.

### Birthing Centers

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

### Baby's First Checkup Before Leaving the Hospital

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

### School-Based Health Center Services

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

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

### Checkup for Children Entering State Custody

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

### Certain Providers for Children with Special Health Care Needs

Children with special health care needs may self-refer to providers outside of the MCO network (non-participating provider) under certain conditions. Self-referral for children with special needs is intended to ensure continuity of care, and ensure that appropriate plans of care are in place. Self-referral for children with special health care needs will depend on whether the condition that is the basis for the child's special health care needs is diagnosed before or after the child's initial enrollment in an MCO. Medical services directly related to a special-needs child's medical condition may be accessed out of network only if the following specific conditions are satisfied:

- **New Member:** A child who at the time of initial enrollment was receiving these services as part of a current plan of care may continue to receive these specialty services, provided the pre-existing non-participating provider submits the plan of care for review and approval within 30 days of the child's effective date of enrollment. The approved services must be medically necessary.
- **Established Member:** A child who is already enrolled in an 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 can receive one annual diagnostic and evaluation service (DES) visit. The DES will consist of a medical and psychosocial assessment. You must select the DES provider from an approved list of sites, but the provider does not have to participate with your MCO. The MCO is responsible to assist you with this service. The State and not your MCO will pay for your HIV/AIDS-related blood tests.

### Renal Dialysis

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

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

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

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

| Benefit | Description |
|---|---|
| **Dental Services** | General dentistry, including regular and emergency treatment, is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program administered by SKYGEN USA. If you are eligible for the Dental Services Program, you will receive information and a dental card from SKYGEN USA. If you have not received your dental ID card or have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at **855-934-9812.** |
| **Occupational, Physical and Speech Therapies for Children Under the Age of 21** | The State pays for these services if medically needed. For help in finding a provider, you can call the State's Hotline at **800-492-5231.** |
| **Speech Augmenting Devices** | Equipment that helps people with speech impairments to communicate. |
| **Behavioral Health** | Substance use disorder and specialty mental health services are provided through the Public Behavioral Health System. You can reach them by calling **800-888-1965.** |
| **Intermediate Care Facility (ICF) – Mental Retardation (MR) Services** | This is treatment in a care facility for people who have an intellectual disability and need this level of care. |
| **Skilled Personal Care Services** | This is skilled help with daily living activities. |
| **Medical Day Care Services** | This is help to improve daily living skills in a center licensed by the state or local health department, which includes medical and social services. |
| **Nursing Facility and 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). |

| Benefit | Description |
|---|---|
| **Abortion Services** | This medical procedure to end certain kinds of pregnancies is covered by the State only if:<br>• The patient will have serious physical or mental health problems, or could die, if the patient has the baby;<br>• The patient is pregnant because of rape or incest, and reported the crime; or<br>• The baby will have very serious health problems.<br>Members eligible for HealthChoice only because of their pregnancy are not eligible for abortion services. |
| **Transportation Services** | **Emergency Medical Transportation:** Medical services while transporting the member to a health care facility in response to a 911 call. This service is provided by local fire companies. If you are having an emergency medical condition, call 911.<br>**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 faraway county to get treatment that you could get in a closer county.<br>Certain MCOs may provide some transportation services, such as bus tokens, van services, and taxis, to medical appointments. Call your MCO to see if they provide any transportation services.<br>Local health departments (LHDs) 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 an MCO that is not offered within your service area, neither the LHD nor the MCO is required to provide non-emergency medical transportation services.<br>For assistance with transportation from your local health department, call the local health department's transportation program. |

## D. Additional Services Offered by MCOs and Not by the State

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

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

Below are the benefits and services that MCOs and the State are not required to cover (excluded services). The State requires MCOs to exclude most of these services. See Attachment C or call MCO Member Services to find out your MCO's additional benefits and services.

**Benefits and Services Not Covered:**

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

## F. Change of Benefits and Service Locations

### Change of Benefits

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

### Loss of Benefits

Loss of HealthChoice benefits will depend on your Medicaid eligibility. Failure to submit necessary Medicaid redetermination paperwork or to meet Medicaid eligibility criteria is a cause for disenrollment from HealthChoice. If you become ineligible for Medicaid, the State will disenroll you from the MCO and you will lose your HealthChoice benefits. If you regain eligibility within 120 days, you will automatically be re-enrolled with the same MCO.

### Change of Health Care Locations

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