



Kaiser Permanente MARYLAND HEALTHCHOICE PROGRAM

2023

MEMBER HANDBOOK

Greetings

Dear Member,

Welcome to Kaiser Permanente! Thank you for choosing us. We want to help you stay healthy. We're also here to serve you when you are sick or injured. This member handbook is a guide to Kaiser Permanente benefits and processes. It is written for members and/or their guardians.

There are a number of ways that Kaiser Permanente is special and different from other health plans.

First, most Kaiser Permanente members receive care from the doctors of the Mid-Atlantic Permanente Medical Group (MAPMG).

MAPMG doctors, including primary care doctors and specialists, have their offices in our medical centers and work together.

Most of our medical centers include a pharmacy, lab, and X-ray services, all under the same roof. This makes getting care simple and easy.

Second, our services are available 24 hours a day, 7 days a week (24/7).

We have Urgent Care available 24/7 at medical centers in Largo, South Baltimore, and Gaithersburg and have other Urgent Care centers as well.

We have advice nurses who work with MAPMG physicians and are also available 24/7. You can access advice by calling the Appointment and Advice Call Center at **855-632-8278** whenever you need to speak with an advice nurse.

Third, we have a website connected to your electronic medical record that lets you:

- Email your MAPMG doctor
- Make appointments at Kaiser Permanente centers
- Read many lab test results
- Order prescription refills from Kaiser Permanente pharmacies
- Read about medical conditions
- Do and learn much more

You can get these services on a computer or smartphone, day or night.

We're happy you've chosen us as your partner in health, and we look forward to helping you stay well, live well, and THRIVE.

Sincerely,



Ruth Williams-Brinkley

President, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Nondiscrimination Statement

It is the policy of Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. (Kaiser Health Plan) not to discriminate on the basis of race, color, national origin, sex, age or disability. Kaiser Health Plan has adopted an internal grievance procedure 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 Kaiser Civil Rights Coordinator, 2101 East Jefferson Street, Rockville, MD 20852, telephone number: 1-800-777- 7902, who has been designated to coordinate the efforts of the Kaiser Health Plan 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 Kaiser Health Plan 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 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 Coordinator will maintain the files and records of Kaiser Health Plan relating to such grievances. To the extent possible, and in accordance with applicable law, the Section 1557 Coordinator 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 Coordinator will issue a written decision on the grievance, based on a preponderance of the evidence, no later than 30 days after its filing, including a notice to the complainant of their right to pursue further administrative or legal remedies.

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

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.

Kaiser Health Plan 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 Coordinator will be responsible for such arrangements.

Interpreter Services Are Available for Free

ATTENTION: *Language assistance services, free of charge, are available to you.
Call 855-249-5019 (TTY: 711).*

Español/Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 855-249-5019 (TTY: 711).

አማርኛ/Amharic

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 855-249-5019 (መስማት ለተሳናቸው: 711)።

العربية/Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 855-249-5019 (رقم هاتف الصم والبكم: 711).

Bàsòò-wùdù-po-nyò /Bassa

Dè dɛ nià ke dyédé gbo: ɔ jũ ké m̩ [Bàsò ò -wùdù-po-nyò] jũ ní, n̩í, à wuɖu kà kò dò po-poò b̩é in̩ m̩ gbo kpáa. Đá 855-249-5019 (TTY: 711).

中文/Chinese

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855-249-5019 (TTY: 711)。

فارسی/Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما بگيريد تماس 855-249-5019 (TTY: 711) با. باشند می فر

Français/French

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 855-249-5019 (ATS : 711).

Gujarati

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે.

इोन करो

855-249-5019 (TTY: 711).

kreyòl ayisyen/Haitian Creole

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele - 855-249-5019 (TTY: 711).

Igbo

Ntị: Ọ bụrụ na asụ Ibo, asụsụ aka ọasụ n'efu, defu, aka. Call 855-249-5019 (TTY: 711).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 855-249-5019 (TTY: 711.)번으로 전화해 주십시오.

Português/Portuguese

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 855-249-5019 (TTY: 711).

Русский/Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 855-249-5019 (телетайп: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 855-249-5019 (TTY: 711).

اردو/Urdu

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال

کریں۔(855-249-5019 (TTY: 711).

Tiếng Việt/Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 855-249-5019 (TTY: 711).

Yorùbá/Yoruba

AKIYESI: Bi o ba nsọ èdè Yorùbú ọfẹ ni iranlọwọ lori èdè wa fun yin o. Ẹ pe ẹrọ-ibanisọrọ yi 1-855-249-5019 (TTY: 711).

Interpretation Services and Auxiliary Aids

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

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

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

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1. HealthChoice Overview

A. What Is Medicaid?

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

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

B. What Is HealthChoice?

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

MCOs are health care organizations that provide health care benefits to Medicaid recipients in Maryland. General health care benefits include (see pages 12-22 for a full listing of HealthChoice benefits):

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

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

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

C. How to Renew Medicaid Coverage

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

- **Maryland Health Connection**

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

- **myDHR**

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

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

- All individuals can apply
- To get connected with DSS, call **800-332-6347**
- To get connected with an LHD, see page 7

D. HealthChoice/MCO Enrollment

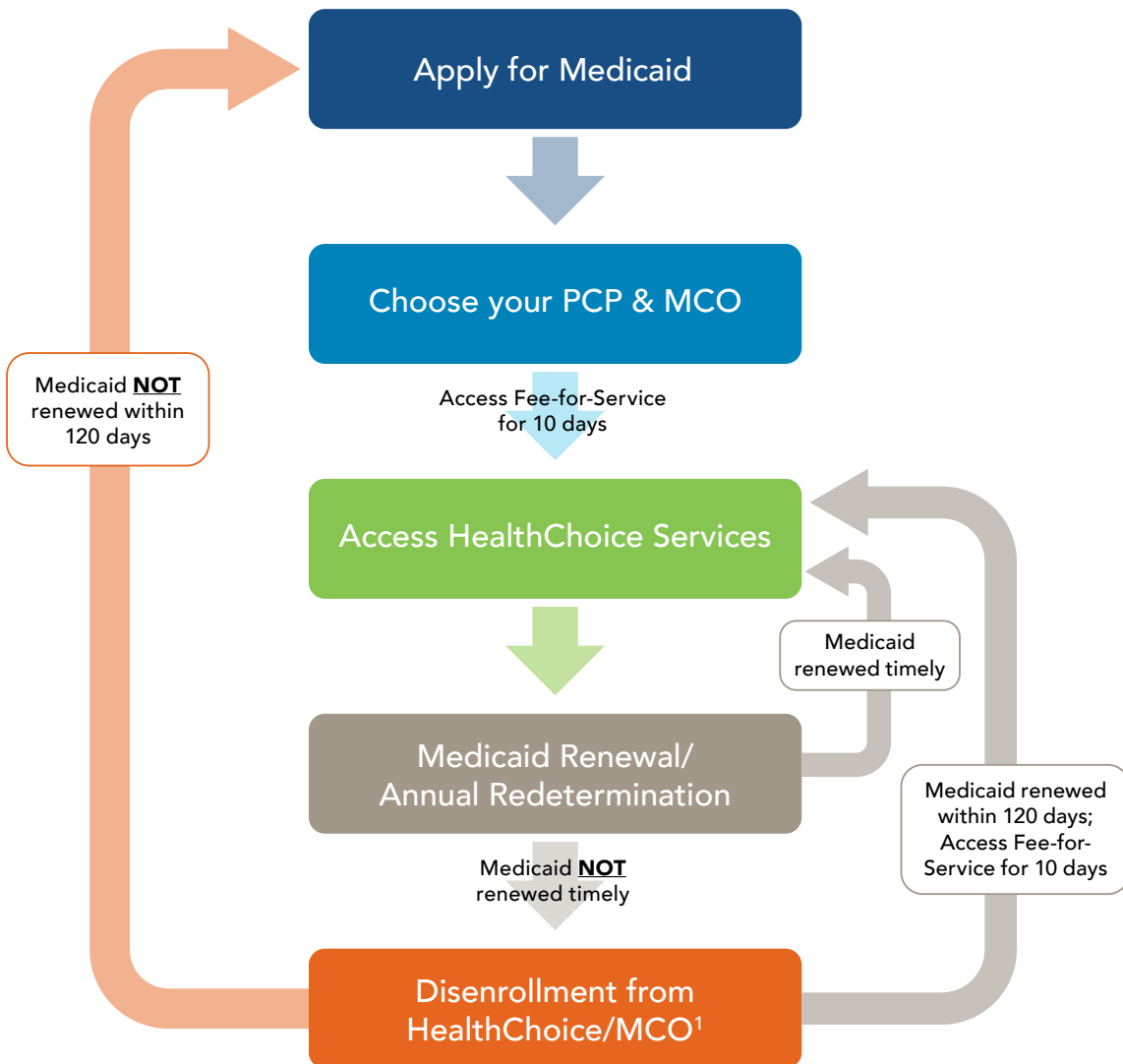
If you received this MCO Member Manual, you have been successfully enrolled in HealthChoice. The State sent you an enrollment packet explaining how to select an MCO. If you did not choose an MCO, the State automatically assigned you to an MCO in your area. It takes 10-15 days after you chose or were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

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

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

The MCO will assist you in receiving needed care and services. If you kept your same PCP but it has been 3 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.

E. HealthChoice Enrollment Process



¹ The State will disenroll you from HealthChoice and your MCO when Medicaid is **NOT** renewed timely.

F. HealthChoice Eligibility/Disenrollment

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

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

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

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

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

G. Updating Status and Personal Information

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

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



2. Important Information

A. HealthChoice and State Programs Contact Information

Help Information	Phone Number	Website
Enrollment into <i>HealthChoice</i>	855-642-8572 TDD (for hearing impaired)	www.marylandhealthconnection.gov
General Questions about <i>HealthChoice</i>	410-767-5800 (local) 800-492-5231 (rest of state) TDD (for hearing impaired) 800-735-2258	https://health.maryland.gov/mmcp/healthchoice/pages/home.aspx
<i>HealthChoice</i> Help Line – for problems and complaints about access, enrollment process, and quality of care.	800-284-4510	
Pregnant member and family planning	800-456-8900	
Healthy Kids, EPSDT	410-767-1903	https://mmcp.health.maryland.gov/epsdt/pages/Home.aspx
Healthy Smiles Dental Program	855-934-9812	https://health.maryland.gov/mmcp/Pages/maryland-healthy-smiles-dental-program.aspx
Rare and Expensive Case Management Program (REM) – for questions about referrals, eligibility, grievances, services	800-565-8190	https://health.maryland.gov/mmcp/longtermcare/Pages/REM-Program.aspx
Mental Health and substance use disorders – for referrals, provider information, grievances, preauthorization	800-888-1965	https://health.maryland.gov/bha/Pages/HELP.aspx
Maryland Health Connection Consumer Support Center	855-642-8572 TDD (for hearing impaired) 855-642-8573	www.marylandhealthconnection.gov

B. Local Health Department Contact Information

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Allegany	301-759-5000	301-759-5123	301-759-5094	www.alleganyhealthdept.com
Anne Arundel	410-222-7095	410-222-7152	410-222-7541	www.aahealth.org
Baltimore City	410-396-4398	410-396-6422	410-649-0521	http://health.baltimorecity.gov
Baltimore County	410-887-2243	410-887-2828	410-887-4381	www.baltimorecountymd.gov/agencies/health
Calvert	410-535-5400	410-414-2489	410-535-5400 ext. 360	www.calverthealth.org
Caroline	410-479-8000	410-479-8014	410-479-8023	http://dhmh.maryland.gov/carolinecounty
Carroll	410-876-2152	410-876-4813	410-876-4940	http://cchd.maryland.gov
Cecil	410-996-5550	410-996-5171	410-996-5145	www.cecilcountyhealth.org
Charles	301-609-6900	301-609-7917	301-609-6803	www.charlescountyhealth.org
Dorchester	410-228-3223	410-901-2426	410-228-3223	www.dorchesterhealth.org
Frederick	301-600-1029	301-600-1725	301-600-3341	http://health.frederickcountymd.gov
Garrett	301-334-7777	301-334-9431	301-334-7695	http://garretthealth.org
Harford	410-838-1500	410-638-1671	410-942-7999	http://harfordcountyhealth.com
Howard	410-313-6300	877-312-6571	410-313-7567	www.howardcountymd.gov/Departments/Health
Kent	410-778-1350	410-778-7025	410-778-7035	http://kenthd.org
Montgomery	311 or 240-777-0311	240-777-5899	240-777-1648	www.montgomerycountymd.gov/hhs

2. IMPORTANT INFORMATION

County	Main Phone Number	Transportation Phone Number	Administrative Care Coordination Unit (ACCU) Phone Number	Website
Prince George's	301-883-7879	301-856-9555	301-856-9550	www.princegeorgescountymd.gov/1588/Health-Services
Queen Anne's	410-758-0720	443-262-4462	443-262-4481	www.qahealth.org
St. Mary's	301-475-4330	301-475-4296	301-475-6772	www.smchd.org
Somerset	443-523-1700	443-523-1722	443-523-1766	http://somersehealth.org
Talbot	410-819-5600	410-819-5609	410-819-5654	http://talbothealth.org
Washington	240-313-3200	240-313-3264	240-313-3290	http://dhmh.maryland.gov/washhealth
Wicomico	410-749-1244	410-548-5142 Option # 1	410-543-6942	www.wicomicohealth.org
Worcester	410-632-1100	410-632-0092	410-632-9230	www.worcesterhealth.org

3. Rights and Responsibilities

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

- Receive health care and services that are culturally competent and free from discrimination.
- Be treated with respect to your dignity and privacy.
- Receive information, including information on treatment options and alternatives, regardless of cost or benefit coverage, in a manner you can understand.
- Participate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records and request that they be amended or corrected as allowed.
- Request copies of all documents, records, and other information, free of charge, that was used in an adverse benefit determination.
- Exercise your rights, and be assured that the exercise of those rights does not adversely affect the way the managed care organizations (MCOs), their providers, or the Maryland Department of Health treats 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.

3. RIGHTS AND RESPONSIBILITIES

- 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.
- 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 its 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.

C. Nondiscrimination Statement

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

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

Procedure:

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

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

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

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

D. Notice of Privacy Practices

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

To file a complaint, see contact information below:

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

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

4. Benefits and Services

A. HealthChoice Benefits

The table below lists the basic benefits that all MCOs must offer to HealthChoice members. Review the table carefully as some benefits have limits, you may have to be a certain age, or have a certain kind of problem. Except for pharmacy 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 <u>do not</u> 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 <u>do not</u> 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 There are no copays for children under age 21, pregnant members, or individuals in a nursing facility or hospice, or for birth control.	

4. BENEFITS AND SERVICES

Benefit	What it is	Who can get this benefit	What you <u>do not</u> 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.	<ol style="list-style-type: none"> 1. Children with special health care needs 2. Pregnant and postpartum members 3. Individuals with HIV/AIDS 4. Individuals who are homeless 5. Individuals with physical or developmental disabilities 6. Children in State-supervised care 7. Case management provided by MCO for other members as needed 	

Benefit	What it is	Who can get this benefit	What you <u>do not</u> 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	<p>Eye Exams Under 21: one exam every year. 21 and older: one exam every two years.</p> <p>Glasses Under 21 only. Contact lenses if there is a medical reason why glasses will not work.</p>	<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, 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.

4. BENEFITS AND SERVICES

Benefit	What it is	Who can get this benefit	What you <u>do not</u> 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 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 <u>do not</u> 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

4. BENEFITS AND SERVICES

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**).

4. BENEFITS AND SERVICES

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	<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 have serious physical or mental health problems, or could die, if the patient has the baby; • The patient is pregnant because of rape or incest, and reported the crime; or • The baby will have very serious health problems. <p>Members eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.</p>
Transportation Services	<p>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.</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 faraway 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 your MCO to see if they provide any transportation services.</p> <p>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.</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 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.

5. Information on Providers

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

Your PCP is the main coordinator of your care and assists you in managing your health care needs and services. Go to your PCP for routine checkups, medical advice, immunizations, and referrals to 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 who 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. Formembers, if your PCP is not a member health specialist, you have the right to see a member health specialist within your MCO network without a referral. Your providers will not be penalized for advising or advocating on your behalf.

B. Selecting or Changing Providers

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

If other members of your household 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 that HealthChoice members under 21 years of age select an Early Periodic Screening Diagnosis and Treatment (EPSDT) provider. EPSDT providers are trained and certified to identify and treat health problems before they become complex and costly. MCO Member Services will be able to tell you which providers are EPSDT certified.

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

C. Termination of a Provider

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

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

6. Getting into Care

A. Making or Canceling an Appointment

To make an appointment with your PCP or another provider, call the provider's office. Your PCP's name and number will be located on the front of the ID card the MCO provided you. You can also call MCO Member Services and they will provide you with your PCP's or other provider's name and number. To ensure that 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
- Inform staff if you think you need immediate attention

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



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

- Medicaid card
- MCO ID card
- Photo ID

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

B. Referral to a Specialist or Specialty Care

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

C. After Hours, Urgent Care, and Emergency Room Care

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



Doctor's Office

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



Urgent Care Center

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



Emergency Room

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

6. GETTING INTO CARE

After Hours

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

Urgent Care

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

Emergency Room Care

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

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

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

D. Out-of-Service Area Coverage

Not all MCOs operate in all areas of the State. If you need non-emergency care while out of the MCO's service area, call your PCP or MCO Member Services. Both numbers are on your MCO card. If you move and your new residence is in a different Maryland county that your MCO does not serve, 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 accepted only 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 required to cover only 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 19).

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

The table below shows the ages at which children need well-child visits. If your child's PCP recommends more visits, they will also be covered. During well-child visits, the PCP will check your child's health and all aspects of development. They will also check for problems through screening. Some screenings for health problems are done through blood work while others are done by asking questions. Additional screens may be required based on age and risk. The PCP will also offer advice and tell you what to expect. Make sure you keep appointments for well-child exams. Do not miss immunizations, and make sure children get their blood tested for lead. Lead in the blood causes serious problems, so testing is required for all children regardless of risk. This applies even if your child has both Medicaid and other insurance.

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

F. Wellness Care for Adults

Wellness visits with your doctor are important. Your PCP will examine you, provide or recommend screenings based on your age and needs, and 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 members, starting at age 20 if at increased risk
Diabetes	Adults aged 40 to 70 years who are overweight or obese
Colon Cancer Screening	Age 50–75, frequency depends on test used: stool-based yearly to every 3 years, flexsigmoid every 5 years, CT colonography every 5 years, or colonoscopy every 10 years
Sexually Transmitted Disease Screening	HIV – Once for all adults regardless of risk, additionally based on risk Hepatitis C (HCV) – Once for anyone born between 1945 and 1965, others based on risk Hepatitis B – Adults at increased risk Chlamydia/gonorrhea – Yearly for members with internal reproductive organs age 16 to 24 if sexually active, based on risk for age 25+ Syphilis – Adults at increased risk
Influenza Vaccine	Yearly
Tdap (tetanus, diphtheria, acellular pertussis) Vaccine	Once as an adult (if not received at age 11–12), during every pregnancy
Td (tetanus) Vaccine	Every 10 years, additional doses if dictated by risk
Shingles (zoster) Vaccine	Once for All adults age 60 and older
Pneumococcal Vaccine (PPSV23)	Once for everyone (age 2–64) with diabetes, lung disease, heart disease, smoking, alcoholism, or other risk factors (talk to your doctor to determine your risk)

Service	Frequency/Population
Breast Cancer Screening (via Mammogram)	Every 2 years age 50-75, risk based 40-50
Lung Cancer Screening	Yearly for adults age 55-80 with 30 pack-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 3 years for members with internal reproductive organs ages 21-29, every 5 years for members with internal reproductive organs ages 30-65
Substance Use/Misuse: Alcohol, Tobacco, Other	Adult 18 and older; yearly or more frequently depending on risk

¹All recommendations are based on recommendations by the U.S. Preventive Services Task Force (USPSTF). Excludes recommendations for patients 65 and older since not eligible for HealthChoice.

G. Case Management

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

H. Care for Members During Pregnancy and One Year After Delivery

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

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

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

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

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

I. Family Planning (Birth Control)

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

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

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

J. Dental Care

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

- Regular checkups
- Teeth cleaning
- Fluoride treatments
- X-rays
- Fillings
- Root canals
- Crowns
- Pulling teeth - extractions
- Anesthesia

Call Maryland Healthy Smiles Member Services at **855-934-9812** if you have questions or need help finding a dental provider.

K. Vision Care

- If you are under the age of 21, you are eligible for:
 - Eye exams
 - Glasses once a year
 - Contact lenses if medically necessary over glasses
- If you are age 21 and over, you are eligible for:
 - Eye exams every 2 years
 - See Attachment C for additional adult vision benefits offered by your MCO

Call MCO Member Services if you have questions or need help 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 MCO Member Services to find out what health education programs are available, when they occur, and how you can stay informed about them.

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

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

M. Behavioral Health Services

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

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



6. GETTING INTO CARE

- Residential treatment centers

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

7. Special Services

A. Services for Special-Needs Populations

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

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

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

Services Every Special-Needs Population Receives

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

- **A case manager** – A case manager will be a nurse or a social worker or other professional who may be assigned to your case soon after you join an 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 that the plan of care is updated at least every 12 months or as needed;
 - Keep track of the health care services; and
 - Help those who give you treatment to work together.
- **Specialists** – Having special needs requires you to see providers who have the most experience with your condition. Your PCP and your case manager will work together to be sure to send you to the right specialists. These 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.

7. SPECIAL SERVICES

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

1. Pregnant Members and Members Who Have Just Given Birth:

- **Appointments** – The MCO will assist in scheduling an appointment for prenatal care within 10 days of your request.
- **Prenatal Risk Assessment** – Pregnant members will have a prenatal risk assessment. At your first prenatal care visit, the provider will complete a risk assessment. This information will be shared with the local health department and the MCO. The MCO will offer a range of services to help you take care of yourself and to help make sure your baby is born healthy. The local health department may also contact you and offer help and advice. They will have information about local resources.
- **Link to a Pediatric Provider** – The MCO will assist you in choosing a pediatric care provider. This may be a pediatrician, family practitioner, or nurse practitioner.
- **Length of Hospital Stay** – The length of hospital stay after delivery is 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery. If you elect to be discharged earlier, a home visit will be offered within 24 hours after discharge. If you must remain in the hospital after childbirth for medical reasons, you may request that your newborn remain in the hospital while you are hospitalized. Additional hospitalization for up to four (4) days is covered for your newborn.



- **Follow-up** – The MCO will schedule the newborn for a follow-up visit 2 weeks after discharge if no home visit has occurred or within 30 days after discharge if there has been a home visit.
- **Dental** – Good oral health is important for a healthy pregnancy. All pregnant women HealthChoice recipients are eligible to receive dental services through the State’s Maryland Healthy Smiles Dental Program. Call Healthy Smiles (855-934-9812) if you have questions about your dental benefits.
- **Substance Use Disorder Services** – If you request treatment for a substance use disorder, you will be referred to the Public Behavioral Health System within 24 hours of your request.
- **HIV Testing and Counseling** – Pregnant members will be offered a test for HIV and will receive information on HIV infection and its effect on the unborn child.
- **Nutrition Counseling** – Pregnant members will be offered nutritional information to teach them to eat healthy.
- **Smoking Counseling** – Pregnant members will receive information and support on ways to stop smoking.
- **EPSDT Screening Appointments** – Pregnant adolescents (up to age 21) should receive all EPSDT screening services in addition to prenatal care.
- **See Attachment D for additional services the MCO offers for pregnant members.**

2. Children with Special Health Care Needs

- **Work with Schools** – The MCO will work closely with the schools that provide education and family services programs to children with special needs.
- **Access to Certain Non-Participating Providers** – Children with special 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 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 if specific conditions are satisfied.

3. Children in State-Supervised Care

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

4. Adults and Children with Physical and Developmental Disabilities

- **Materials Prepared in a Way You Can Understand** – The MCO has materials reviewed by people with experience in the needs of people with disabilities. This means that the information will be presented using the right methods so that people with disabilities can understand them, whether in writing or by voice translation.
- **DDA Services** – Members who currently receive services through the Developmental Disabilities Administration (DDA) or under the DDA waiver can continue to receive those services.
- **Medical Equipment and Assistive Technology** – MCO providers have the experience and training to provide medical equipment and assistive technology services to both adults and children.
- **Case Management** – Case managers are experienced in working with people with disabilities.

5. Adults and Children with HIV/AIDS

- **HIV/AIDS Case Management** – The MCO has special case managers trained in dealing with HIV/AIDS issues and in linking persons with the services that they need.
- **Diagnostic Evaluation Service (DES) Assessment Visits Once Every Year** – One annual diagnostic and evaluation service (DES) visit for any member diagnosed with HIV/AIDS, which the MCO is responsible for facilitating on the member's behalf.
- **Substance Use Disorder Services** – Individuals with HIV/AIDS who need treatment for a substance use disorder will be referred to the Public Behavioral Health System within 24 hours of request.

6. Adults and Children Who Are Homeless

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

B. Rare and Expensive Case Management Program (REM)

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

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

8. Utilization Management

A. Medical Necessity

You are eligible to receive HealthChoice benefits when needed as described in the Benefits and Services section of this manual (Section 4). Some benefits may have limitations or restrictions. **All HealthChoice benefits/services must 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
- Not primarily for the convenience of the member, the member's family, or the provider

B. Utilization Management Affirmative Statement

Kaiser Permanente practitioners and health care professionals make decisions about which care and services are provided based on the member's clinical needs, the appropriateness of care and service, and the existence of health plan coverage.

Kaiser Permanente does not make decisions regarding hiring, promoting, or terminating its practitioners or other individuals based upon the likelihood or perceived likelihood that the individual will support or tend to support the denial of benefits. The health plan does not specifically reward, hire, promote, or terminate practitioners or other individuals for issuing denials of coverage or benefits or care. No financial incentives exist that encourage decisions that specifically result in denials or create barriers to care and services or result in underutilization. In order to maintain and improve the health of our members, all practitioners and health professionals should be especially diligent in identifying any potential underutilization of care or service.

C. 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 by which a qualified health care professional reviews and determines if a service is medically necessary.

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

If the preauthorization is denied or reduced in amount, duration, or scope, then that service or medication will not be covered by the MCO. You will be notified in writing of the decision within 14 calendar days, or 28 calendar days if there was a request for an extension. You will be given the right to file an appeal for a denied preauthorization. (See Section 10, Complaints, Grievance, and Appeals.)

There may be times when 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.

Note: See Attachment F for the MCO's current policy.

D. Continuity of Care Notice

If you are currently receiving treatment and fit into 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 health care provider who is a participating provider with your old company or MCO, and that provider is a non-participating provider under your new plan, you 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 Health Care Services

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

Right to Use Non-Participating Providers

- If you have been receiving services from a health care provider who was a participating provider with your old company or MCO 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



8. UTILIZATION MANAGEMENT

- Examples of conditions listed above include bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS, and organ transplants.
- There is a time limit for how long you can continue to see a non-network provider. For all conditions other than pregnancy, the time limit is 90 days or until the course of treatment is completed, whichever is sooner. The 90-day limit is measured from the date your coverage starts under the new plan. For pregnancy, the time limit lasts through the pregnancy and the first visit to a health care provider after the baby is born.

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

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

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

- Limitation on use of non-participating providers: Your special right to use a non-participating provider does not apply to:
 - Dental services
 - Mental health services
 - Substance use disorder services
 - 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 MCO Member Services.
- If your current MCO denies your appeal, you may file a complaint with the Maryland Medicaid Program by calling the HealthChoice Help Line at **800-284-4510**.
- If you have any questions about this procedure, call MCO Member Services or the HealthChoice Help Line at **800-284-4510**.

E. Coordination of Benefits – What to Do If You Have Other Insurance

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

Medicaid/HealthChoice is not a supplemental health insurance plan. Your other health insurance will always be your primary insurance, which means participating providers must bill your other insurance first. It is likely that your primary insurance will have paid more than the MCO's allowed amount, and

therefore the provider cannot collect additional money from you or from the MCO. Talk with MCO Member Services to better understand your options. Since other insurers will likely have copays and deductibles, in most cases MCOs will require you to use participating providers.

F. Out-of-Network Services

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

G. Preferred Drug List

If you need medications, your PCP or specialist will use the MCO's 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 MCO's preferred drug list, call MCO Member Services or go online and access their website. Some medicines on the preferred drug list, as well as any medicine not on the list, will require preauthorization before the MCO will cover them. If the MCO denies the preauthorization for the medicine, then you will be given the right to file an appeal.

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

H. New Technology and Telehealth

As new and advanced health care technology emerges, MCOs have processes in place to review and determine if these innovations will be covered. Each MCO has its own policy on the review of new medical technology, treatments, procedures, and medications. To find out an MCO's policy and procedure on reviewing new technology for health care, contact MCO Member Services. MCOs are required to provide telehealth services as medically necessary. Telehealth services use 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

9. Billing

A. Explanation of Benefits or Denial of Payment Notices

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

Explanation of Benefits (EOB) or Denial of Payment notices are not bills. The notices may list the type of service, date of service, amount billed, and amount paid by the MCO on your behalf. The purpose of the notice is to summarize which provider charges are a covered service or benefit. If you believe that there is an error, like finding a service that you never received, contact MCO Member Services.

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

B. What to Do If You Receive a Bill

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

10. Complaints, Grievances, and Appeals

A. Adverse Benefit Determination, Complaints, and Grievances

Adverse Benefit Determination

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

- Denies or limits a requested service based on type or level of service, meeting medical necessity, appropriateness, setting, or effectiveness
- Reduces, suspends, or terminates a previously authorized service
- Denies partial or full payment of a service (a denial, in whole or in part, of a payment for a service because the claim is not “clean” is not an adverse benefit determination)
- Fails to make an authorization decision or to provide services in a timely manner
- Fails to resolve a grievance or appeal in a timely manner
- Does not allow members living in a rural area with only one MCO to obtain services outside the network
- Denies a member’s request to dispute a financial liability, including cost sharing, copayments, coinsurance, and other member financial liabilities

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

Complaints

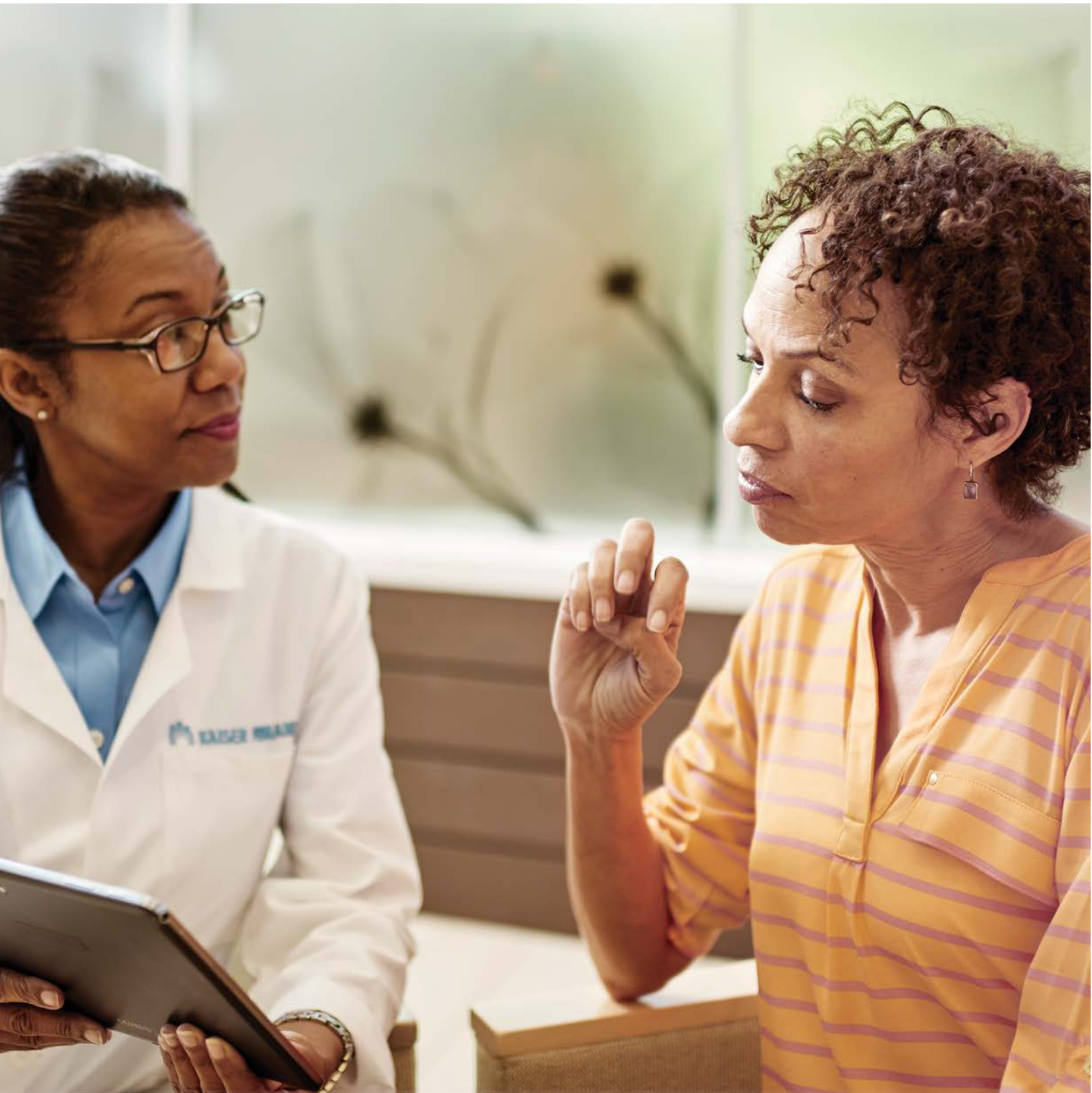
If you disagree with the MCO or provider about an adverse benefit determination, this is called a complaint. Examples of complaints include reducing or stopping a service you are receiving, being denied a medication not on the preferred drug list, or having a preauthorization for a procedure denied.

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 the MCO’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 on the letter saying the MCO would not cover the service you wanted.

Your doctor can also file an appeal for you if you sign a form giving them 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 you have that will help them make a decision. The MCO will send you a letter letting you know that they received your appeal within five business days. While your appeal is being reviewed, you can still send or deliver any additional information that you think will help the MCO decide.

When reviewing your appeal, the MCO reviewers:

- Will be different from the medical professionals who made the previous decision
- Will not be subordinates of the reviewers who made the previous decision
- Will have the appropriate clinical knowledge and expertise to perform the review
- Will review all information submitted by the member or representative, regardless of whether 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 it needs additional information.

If your doctor or MCO believes 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 the service, you may be able to keep getting the service while your appeal is under review. You will need to contact MCO Member Services and request to keep getting services while your appeal is reviewed. You will need to contact Member Services within 10 days from when the MCO sent the determination notice or before the intended effective date of the determination. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

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

If you file a grievance and it is:

- About an urgent medical problem you are having, it will be solved within 24 hours.
- About a medical problem but it is not urgent, it will be solved within 5 days.
- Not about a medical problem, it will be solved within 30 days.

Note: See Attachment F for the MCO's current policy.

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

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

You can request to file an appeal verbally or in writing. You can appeal verbally by calling Kaiser Permanente Member Services. To file the appeal in writing, the MCO can send you a simple form that you can complete, sign, and mail back. The MCO can also assist you in completing the form if you need help. You will also be given the opportunity to give the MCO your testimony and factual arguments prior to the appeal resolution.

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

D. The State's Complaint/Appeal Process

Getting Help from the HealthChoice Help Line

If you have a question or complaint about your health care and the MCO has not solved the issue to your satisfaction, you can ask the State for help. The HealthChoice Help Line 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; or
- Send your complaint to a Complaint Resolution Unit nurse, who may:
 - Ask the MCO to provide information about your case within 5 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.

Fair Hearings

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

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

Continuing Services During the Fair Hearing

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



E. Reversed Appeal Resolutions

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

If the MCO reverses a denial, termination reduction, or delay in services that a member was receiving during the appeal 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 the MCO's attention, call MCO Member Services. MCOs are interested in both hearing from you and ways to enhance your experience receiving health care.

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

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

11. Changing Your MCO

A. 90-Day Rules

- The first time you enroll in the **HealthChoice Program**, you have one opportunity to request to change your MCO. 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 your MCO. 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 parent was in at the time of delivery for the first 90 days.)
- If you have a foster child placed in your home and you or your family members receive care by a doctor in a different MCO than the foster child, the foster child being placed can switch to the foster family's MCO.
- If the MCO terminates your PCP contract for reasons other than listed below, then you will be notified by the state.
 - Your MCO has been purchased by another MCO;
 - The provider and the MCO cannot agree on a contract for certain financial reasons; or
 - Quality of care.

D. How to Change Your MCO

Contact Maryland Health Connection at **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, they may not allow you to change MCOs.
- If you lose Medicaid eligibility but are approved again within 120 days, you will automatically be enrolled with the same MCO that you had prior to losing eligibility.



12. Reporting Fraud, Waste, and Abuse

A. Types of Fraud, Waste, and Abuse

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

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

B. How to Report Fraud, Waste, and Abuse

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

- Call MCO Member Services or write the MCO a letter
- Contact the Maryland Department of Health, Office of the Inspector General:
 - **866-770-7175**
 - **http://dhmh.maryland.gov/oig/Pages/Report_Fraud.aspx**
- Contact the U.S. Department of Health and Human Services, Office of the Inspector General
 - **800-447-8477**
 - **<https://oig.hhs.gov/fraud/report-fraud/index.asp>**

13. Attachment A – Kaiser Permanente Contact Information



Member Services	855-249-5019
	TTY 711
24/7 Nurse Advice Line	800-777-7904
	TTY 711
Website	kp.org
Online Member Portal	kp.org
Nondiscrimination Coordinator	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Attn: Appeals and Correspondence Unit 2101 E. Jefferson St. Rockville, MD 20852 Fax: 866-640-9826
Complaint, Grievance, Appeals Address	Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Attn: Appeals and Correspondence Unit Nine Piedmont Center 3495 Piedmont Road NE Atlanta, GA 30305 Fax: 866-640-9826
Reporting Fraud and Abuse Address	Compliance Department Program Integrity Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. 2101 E. Jefferson St. Rockville, MD 20852

14. Attachment B – Notice of Privacy Practices

This section describes how patient medical information may be used and disclosed. It also describes how patients can access this information.

The privacy of patient information is important to us. That is true whether it is spoken, written, or in electronic format. Patient Protected Health Information (PHI) is information that contains certain personal identifiers such as name, Social Security number, medical record number, race, ethnicity, and language. Patient medical records are PHI because they include patient names and other identifiers.

New members receive the Kaiser Permanente Notice of Privacy Practices, as required by federal law. This notice describes how PHI may be used and disclosed. This Notice of Privacy Practices is posted in Kaiser Permanente medical centers. It is also on our website, kp.org. The Notice of Privacy Practices gives a full description of rights and protections. Below are highlights of that notice.

Members have the right to receive and request their PHI. They can request it from the medical records office where they are receiving care. Members can ask for information about our disclosures of PHI to third parties, like health departments and MDH, where we are required by law to share information and can do so without member written permission. Members can also ask us to update PHI if they believe there is a mistake or information is missing.

How much PHI is disclosed without member permission can vary. For example, Kaiser Permanente medical center staff need access to provide member treatment and services. In order to bill or pay for those services, our coders, claims, and billing staff need access to PHI. Because member protection and the quality of our care are very important to us, our quality, licensing, and compliance staff have limited access to PHI.

Call Member Services if you want a copy of Kaiser Permanente's full Notice of Privacy Practices or have questions about the notice. Kaiser Permanente's Notice of Privacy Practices is also available on kp.org/privacy.

15. Attachment C – Additional Services Offered by Kaiser Permanente

Benefit	What It Is	Who Can Get This Benefit	Limitations
Adult Vision Care	Eye examinations and eyeglasses	Adults 21 years of age or older	<ul style="list-style-type: none"> • One adult eye examination per year • One pair of glasses every 2 years • If your glasses are lost, stolen, or broken, or your eyesight has changed, you may be able to get new frames or lenses sooner, as needed • No contact lenses • Maximum allowance for frames: \$150
Healthy living classes and wellness coaching	<ul style="list-style-type: none"> • Classes on a large number of health topics, including newborn care, prenatal care, weight management, chronic pain, chronic kidney disease, diabetes, and many other topics. <p>These classes are held virtually.</p> <ul style="list-style-type: none"> • For more information about healthy living classes and programs in your area, please visit kp.org/healthyliving/mas or call 301-816-6565 or 800-444-6696 toll free 	Kaiser Permanente members	All classes and wellness coaching is offered to Kaiser Permanente members

Benefit	What It Is	Who Can Get This Benefit	Limitations
<p>Baby's first checkup before leaving hospital</p>	<p>If the Kaiser Permanente physician you selected does not see your newborn baby for a checkup before the baby is ready to go home from the hospital, we will pay for the oncall doctor to do the checkup in the hospital.</p>	<p>Pregnant members</p>	<p>Must have been pregnant when joining Kaiser Permanente and have been seen by a Kaiser Permanente provider</p>



16. Attachment D – Prenatal/ Postpartum Programs

Prenatal Class Descriptions and How to Register

Prenatal classes are held in Kaiser Permanente medical offices. There is no cost to attend any Kaiser Permanente prenatal class. You are encouraged to bring a partner or support person with you.

Prenatal 1: This one to one “class” usually happens the same day as the New OB visit with your ob-gyn. In the OB department, you’ll meet with an OB nurse. You’ll learn how to care for yourself during pregnancy. You and the nurse will complete a prenatal risk assessment together. We’ll offer a range of services to help you take care of yourself and to help make sure your baby is born healthy. You’ll learn when, where, and who to call if you have questions or problems during pregnancy and receive valuable information about community resources.

Prenatal 2: Preparing for Labor & Delivery. Participate in this program during your seventh or eighth month of pregnancy. This program will focus on how you can minimize discomforts of late pregnancy. You’ll learn how to tell when you’re in labor, when to go to the hospital, your options for pain management during labor, and much more. Prenatal 2 class is taught by registered nurses with experience in the obstetrics department.

Prenatal 3: Preparing for Your Newborn. Participate in this program during your last months of pregnancy. Practice or refresh your skills to care for your newborn baby, such as bathing, feeding, and soothing. You’ll learn more about Kaiser Permanente’s pediatric care services. If this is your first baby with Kaiser Permanente, we strongly encourage you to attend. Prenatal 3 class is taught by registered nurses

Prenatal 4: Breastfeeding Basics. Watch this on-demand class during your third trimester of pregnancy. You’ll learn how breastfeeding protects you and your baby. You’ll learn how to get breastfeeding off to a good start and where to get help if you need it. Prenatal 4 was recorded by registered nurses who are also certified lactation consultants.

Prenatal classes fill fast, so register early. You have two options to register for Prenatal 2 and 3 classes. You can either:

- Tell a receptionist, clinic assistant, or nurse in the ob-gyn department that you want to sign up for prenatal classes. They can schedule you for the class you would like to attend.
- Register on **kp.org**, then sign up for classes online. Visit **kp.org/appointments** and choose Schedule Appointments. You can view a list of scheduled classes at **kp.org/classes/mas**.
- Call an appointment representative at **703-359-7878** or **800-777-7904** (toll free). If you are deaf or hard of hearing, call **711**.

Comprehensive Perinatal Program

Kaiser Permanente’s Comprehensive Perinatal Program helps the pregnant member to have a healthy pregnancy and deliver a full-term, healthy baby. The program has three components:

CenteringPregnancy® and KP Connected Pregnancy

For members who qualify, CenteringPregnancy is a unique approach to prenatal care. Pregnant members who are due about the same time meet for prenatal appointments as a group in a relaxed setting. One-to-one visits with an OB doctor or certified midwife happen privately as usual. Then, the group gathers for lively discussions and learning activities. Since the OB doctor or midwife is part of the group, members have much more time with them. Studies show women who participate in CenteringPregnancy are more likely to have healthier babies.

The CenteringPregnancy model of care creates a community that empowers you to be actively involved in your own care.

For members who qualify, KP Connected Pregnancy is a maternity care option that offers a mix of in-person office visits and video visits. During important moments in pregnancy, members see their OB doctor or certified midwife in person and get labs and ultrasounds done. Members will receive a toolkit of devices including a blood pressure cuff, weight scale, and fetal doppler to support video visits during their pregnancy and postpartum period. Members send results of their at-home blood pressure and weight screenings to their digital health record via an app.

The KP Connected Pregnancy model of care allows you to stay connected with your care team throughout pregnancy from the comfort of home.

Early Start

All parents want to have a healthy baby, but quitting cigarettes, drugs, or alcohol can be really hard. This is a confidential (private) program for pregnant and postpartum members who want to quit or stay off substances. A counselor, called an Early Start specialist, can meet with you privately in person or by phone. You can discuss your concerns and get help if others in your family make it hard to quit. The Early Start specialist can help you manage stress and provide individual and family counseling. If you are using alcohol, cigarettes, or drugs, the Early Start specialist will reach out to you by phone or secure message. There is no cost to be in Early Start.

Perinatal Case Management

There are many things that help you have a safe and healthy pregnancy. You may need help with housing or food. You may be in an unhealthy relationship and need help staying safe. You may just need a ride to your doctor visit. Our social workers and nurses in the Perinatal Case Management program can help you with all those things. Since gum disease can cause problems in pregnancy, they can even help you find a dentist. At your first prenatal visit, we’ll ask about what kind of help you may need. A case manager will contact you by phone. There is no cost to you for case management.

Perinatal Service Center

When babies are born too early, they have a harder start in life. Certain medical issues in your past or current pregnancy may make you more likely to deliver early. The Perinatal Service Center (PSC) is staffed by registered nurses with a lot of experience caring for members with high-risk pregnancies. If you have diabetes, high blood pressure, or preterm labor, a PSC nurse will contact you by phone. Working closely with your ob-gyn, your nurse will be your guide throughout your pregnancy. The PSC nurses are available from 7 a.m. to 11 p.m. in case you have questions or concerns. There is no cost for being part of the Perinatal Service Center program.

Newborn Care Center

The Newborn Care Center is for all members who recently gave birth. It has two parts. The first is a checkup for your baby one to two days after hospital discharge. Registered nurses who are also certified lactation consultants do the checkups. You and your baby will be given an appointment in the Newborn Care Center before you leave the hospital. We want to make sure you're both thriving after leaving the hospital. The second part of the Newborn Care Center program is breastfeeding education and support from the lactation consultants. We want to help you reach your breastfeeding goals. Lactation consultants are available to help you in person or by phone. Also, you can leave a message on the Breastfeeding warmline and a lactation consultant will call you back. There is no cost to you for these services.

Gestational Age	Visit	Activities and Screenings
First Trimester	To 12 weeks	Visits every 4-6 weeks
6-8 weeks		Your ob-gyn will do a transvaginal sonogram to confirm your pregnancy and provide an estimated due date for your baby.
8-12 weeks	Before your first visit or at Prenatal 1 Class	<p>Your ob-gyn will order lab work, tests, and/or screenings including:</p> <ul style="list-style-type: none"> • Complete blood count, blood type, and Rh antibody screen, • Syphilis test and HIV screen, • Test for genetic diseases such as sickle cell, cystic fibrosis, or spinal muscular atrophy, • Immunity against Hepatitis B, rubella, and chicken pox, • Urine test for infections, including sexually transmitted infections and drugs, unless you decline. <p>If you have not done so already, we ask you to get your prenatal vitamins at the pharmacy.</p> <p>Share with us your medical history, including:</p> <ul style="list-style-type: none"> • All medications, past surgeries, and major illnesses • Major infectious diseases • Past pregnancies (were there any problems?) • Work status <p>Tell us if you, or someone in your family, have or have had:</p> <ul style="list-style-type: none"> • Any blood disorders, like Rh disease • Diabetes (high blood sugar) or high blood pressure • Any genetic disorders, like Tay-Sachs or sickle cell anemia • Problems learning or functioning • Multiple pregnancy (twins, triplets, or more)

16. ATTACHMENT D – PRENATAL/POSTPARTUM PROGRAMS

Gestational Age	Visit	Activities and Screenings
8-12 weeks	At your first visit	<p>Your ob-gyn:</p> <ul style="list-style-type: none"> • Gives you a complete physical examination and performs additional tests: cervical cancer screening, cervical cultures, TB screen • Checks your blood pressure, breathing, pulse, height, and weight, including weight before pregnancy • Offers you first-trimester prenatal screening and genetic counseling, if needed • Discusses your lab results and genetic screening, and answers your questions • Asks you questions to see if you may be at risk for problems with your pregnancy • Discusses with you whether low-dose aspirin is recommended • May order a blood glucose test if you are at higher risk for gestational diabetes
Second Trimester¹	13-27 weeks	Visits every 4-6 weeks
13-27 weeks	During each visit	<p>Your ob-gyn:</p> <ul style="list-style-type: none"> • Checks your weight and blood pressure • Checks to see how your baby is growing and listens to the heartbeat • Asks how you are doing between visits, including your baby's movement and any contractions you may be having • Answers your questions
15-20 weeks	During a visit	<ul style="list-style-type: none"> • If first-trimester screening was not performed, you will be offered a screen for certain birth defects using a blood test (AFP). If needed, we will refer you to a genetic counselor. • Options for having a vaginal birth after a cesarean section will be discussed with you
18-20 weeks	During a visit	<ul style="list-style-type: none"> • We will order a sonogram to check the length of your cervix, your baby's anatomy, and the placenta (afterbirth). This is done either by a Maternal-Fetal Medicine doctor or in a radiology department

¹Note: In the fall and winter, an influenza vaccine (flu shot) is recommended for all women who will be pregnant during flu season.

Gestational Age	Visit	Activities and Screenings
24-28 weeks	During a visit	Your ob-gyn will: <ul style="list-style-type: none"> • Order a 1-hour glucose tolerance test to screen for gestational diabetes. We will ask you to drink a very sweet drink. Your blood will be drawn one hour later. If the result is abnormal, further testing may be needed.
Third Trimester²	28-35 weeks 36+ weeks	Visits every 2-3 weeks Visit every week
28-40+ weeks	During each visit	Your ob-gyn: <ul style="list-style-type: none"> • Checks your weight and blood pressure • Checks to see how your baby is growing and listens to the heartbeat • Asks how you are doing between visits, including your baby's movements and any contractions you may be having • May perform pelvic exams occasionally to check your cervix for dilation (opening) and effacement (thinning) • Answers your questions
28 weeks	During a visit	<ul style="list-style-type: none"> • If you are Rh negative and your partner is Rh positive, we screen for Rh antibodies in your blood. If needed, we give you a Rhogam injection to protect the baby. • We encourage you—and other caretakers—to get a Tdap vaccination to protect your baby from pertussis (whooping cough).
28+ weeks	During Prenatal 2 Class	We talk with you about: <ul style="list-style-type: none"> • Your baby's growth and activity and what to expect during and after labor • How to recognize pre-term labor and what to do about it • How to recognize labor and what to do about it • What the birthing experience may be like You can: <ul style="list-style-type: none"> • Learn how to manage discomforts of late pregnancy • Learn how to time contractions • Learn the stages of labor and what to do in each stage • Receive an information packet • Watch and discuss a birth video

²Note: In the fall and winter, an influenza vaccine (flu shot) is recommended for all women who will be pregnant during flu season.

16. ATTACHMENT D – PRENATAL/POSTPARTUM PROGRAMS

Gestational Age	Visit	Activities and Screenings
28-37 weeks	During a visit	<ul style="list-style-type: none"> • We do a second screen for sexually transmitted infections, including HIV, and a Group B strep test for infection. If you are at risk, these tests may be done earlier
32+ weeks	During Prenatal 3 Class	<p>You can:</p> <ul style="list-style-type: none"> • Learn how to bathe, diaper, feed, and soothe your baby • Learn how to keep your baby safe • Watch an informative video on baby care • Receive a packet of information about how to care for yourself and your new baby
32+ weeks	During Prenatal 4 Class	<p>You can:</p> <ul style="list-style-type: none"> • Learn why breast milk is what your baby needs • Learn how to latch your baby to your breast • Learn how to tell if your baby is getting enough milk

Your ob-gyn will want to see you about 5 weeks after you have your baby. For more information, visit kp.org/pregnancy or kp.org/maternity.



17. Attachment E – Health Education Programs

Health Education Programs

Kaiser Permanente’s Health Education Program has many resources that you can use to help care for yourself and your family. Try to make it a goal to use one of these programs this month!

Classes

We offer lots of classes in an online format or OnDemand for times that work best for you. Some classes are as often as one time a month. Classes help you learn more about different topics so you can make healthy changes or manage your care. Some classes are offered online as well. To register for a class:

- Ask a member of your health care team to schedule you
- Call the appointment line at **800-777-7904**
- Schedule a class on **kp.org/appointment**

Below is a list of the types of classes we have for you.

PREVENTION

Weight Control
Pain Management

PRENATAL

Early Pregnancy
Labor and Delivery
Preparing for Your Newborn
Breastfeeding Basics
(OnDemand)

PHYSICAL THERAPY

Total Joint Replacement
Back Pain

ONGOING CONDITIONS

Diabetes
Chronic Kidney Disease
Cardiac Rehab
Cholesterol

OLDER ADULTS

Falls Prevention
Bladder Control

MENTAL HEALTH

Stress Management
Sleep and Mental Health
Exercise and Mental Health
Elements of Wellbeing

Health Education Materials

Health education materials may be provided at the end of a visit to your doctor, sent to you by your doctor through your **kp.org** account, or your health care team may direct you to online education content or videos. Handouts are meant to help with learning about a health topic, making a behavior change, or even how to manage a condition.

Healthy Lifestyle Programs

Healthy Lifestyle programs are online digital coaching tools to help you self-manage your health. There are nine programs available. The best program to start with is the Total Health Assessment. It allows you to get a snapshot of your health and then choose other programs that will help you. Those topics include:

- Healthy Eating
- Weight management
- Stress management
- Quitting tobacco
- Sleep

You must be registered on **kp.org** to use the programs. To get started today, go to **kp.org/healthylifestyles**.

Wellness Coaching

It's hard to talk about everything in a doctor's visit. That's why wellness coaches are available to help. Coaching sessions are done by phone for as many 20-minute sessions as you need. They can help you with:

- Weight management
- Nutrition
- Stress management
- Smoking cessation
- Physical activity

Information shared with you during a coaching session will be consistent with the care plans from your doctor. To sign up for wellness coaching, call **800-777-7904**. Appointments are available 7 days a week.

Emmi Video Programs

Emmi programs are online video tools to help you get ready for a procedure or manage a condition. The videos allow you to go at the speed you like. Your doctor or a member of your health care team may register you for the videos that relate to your health care needs. These video links will be sent to your **kp.org** or personal email account.

18. Attachment F – Kaiser Permanente Internal Complaints/Appeals Procedure

Kaiser Permanente Internal Grievance Procedures

Contact us directly, or you can have a representative or provider file a grievance. You can call, write, or come to one of our medical centers for assistance.

If you have a complaint, you can contact us at **855-249-5019** (TTY **711**).

If you need interpreter or translation services, call Member Services at **855-249-5019** (TTY **711**). Only you or someone with your written permission can act on your behalf. They can be family, friends, or your doctor. All we need is a letter from you with the name of that person, stating that you have given them permission to file an appeal on your behalf.

Appeals

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

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

To file an appeal or request help with filing an appeal, contact Member Services at **855-249-5019** (TTY **711**), or send us a letter to the address or fax number below.

You can call us to file your appeal, or you may also send your appeal in writing. We have a simple form you can use to file your appeal. Just call Kaiser Permanente at **855-249-5019** (TTY **711**) to get one. We will mail or fax the appeal form to you and provide assistance if you need help completing it.

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Attn: Appeals and Correspondence Unit Nine Piedmont Center 3495 Piedmont Road NE Atlanta, GA 30305 Fax: **866-640-9826**

Your doctor can also file an appeal for you if you sign a form giving them permission. 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 us know any new information that you have that will help us make our decision. We will send you a letter letting you know that we received your appeal within 5 business days. 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:

18. ATTACHMENT F – KAISER PERMANENTE INTERNAL COMPLAINTS/APEALS PROCEDURE

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

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

If your doctor or Kaiser Permanente believes 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 we do not believe that your appeal needs to be reviewed quickly, we will try to call you and send you a letter letting you know that your appeal will be reviewed within 30 days.

If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while we review your appeal. Contact us at **855-249-5019** if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

Once we complete our review, we will send you a letter letting you know our decision. If we decide that you should not receive the denied service, that letter will tell you how to file another appeal or ask for a State Fair Hearing.

Grievances

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

If your grievance is:

- About an urgent medical problem you are having, it will be solved within 24 hours
- About a medical problem but it is not urgent, it will be solved within 5 days
- Not about a medical problem, it will be solved within 30 days

Contact us directly, or you can have a representative or provider file a grievance. You can call, write, or come to one of our medical centers for assistance.

If you would like a copy of our official complaint procedure, or if you need help filing a complaint, please call us at **855-249-5019** (TTY **711**). We can tell you which medical centers to go to if you want help filling out forms.

Or write us at:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. Attn: Appeals and Correspondence Unit Nine
Piedmont Center 3495 Piedmont Road NE Atlanta, GA 30305 Fax: **866-640-9826**

19. Attachment G – Advance Directives

MARYLAND ADVANCE DIRECTIVE:
PLANNING FOR FUTURE HEALTH CARE DECISIONS



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

**STATE OF MARYLAND
OFFICE OF THE ATTORNEY GENERAL**

*Brian E. Frosh
Attorney General*



August 2019

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 for 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 durable

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

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

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

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

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

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

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

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

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

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

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 laws 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 Backup Agents

(Optional; form valid if left blank)

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

Name: _____

Address: _____

Telephone Numbers: _____
(home and cell)

2. If my primary agent and my first backup 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):
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

F. In Case of Pregnancy
 (Optional, for members 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.)

My agent's power is in effect:

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-stage 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. Pain Relief

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

F. In Case of Pregnancy


(Optional, for members 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

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

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

 _____

>>**OR**<<

This person:

Name: _____

Address: _____

Telephone Number(s): _____
(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 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 backup agents in case your first choice as health care agent is not available when needed?
- Talk to your agents and backup 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?

20. Attachment H – Quality Care at Kaiser Permanente

You can get a copy of our quality report. It's a summary of our quality goals, objectives, and activities. It explains how we improve care and service to our members, providers, and the community. For a complimentary copy of this year's report, call Member Services at **855-249-5025** (TTY **711**). You can also see the report online at kp.org/quality.



21. Attachment I – Kaiser Permanente Enrollment/Instructions on Getting into the System

Make the most of your Kaiser Permanente membership

As a new member, you need to make an appointment as soon as possible. The following “Simple steps to get started” will help you build a relationship with your doctor and learn ways to make full use of what Kaiser Permanente offers its members.

Simple steps to get started



Step 1: Register at kp.org

You can get many services online. With your Kaiser Permanente ID card handy, go to kp.org/register to set up a user ID and password. Once you’ve registered, you’ll have around-the-clock access to the time-saving features on kp.org. These services are available from a computer or smartphone.

If you get services at Kaiser Permanente medical centers, you can do the following through kp.org:

- Email your MAPMG doctor
- Schedule appointments with your MAPMG doctor
- Order most prescription refills
- View most lab test results performed at Kaiser Permanente medical facilities
- Learn about healthy living and more



Step 2: Choose your doctor

You can learn about our physicians at kp.org/doctors, by reading the *Provider Directory*, or by calling Member Services.

If you want to change your doctor, call Member Services. You may contact them Monday through Friday, 7:30 a.m. to 9 p.m., except holidays, at **855-249-5019**, (TTY **711**).



Step 3: Transfer your prescriptions

If you need to refill a current prescription before your first appointment, contact your Kaiser Permanente medical center pharmacy or visit kp.org/newmember. Please have your medical/health record number, prescription number(s), and the previous pharmacy’s name and phone number ready. Prescription transitions can take 2 or more working days to process, so please plan ahead. If you have a question about covered drugs, please visit thrive.kaiserpermanente.org/medicaid/maryland/new-members.

22. Attachment J – Kaiser Permanente Medical Facilities

Maryland

- 1 Abingdon Medical Center
- 2 Annapolis Medical Center
- 3 **FUTURE LOCATION**
Medical Center in Aspen Hill
- 4 Kaiser Permanente Baltimore Harbor Medical Center
- 5 Bowie Fairwood Medical Center
- 6 Camp Springs Medical Center
- 7 Columbia Gateway Medical Center
- 8 Kaiser Permanente Frederick Medical Center
- 9 Gaithersburg Medical Center
- 10 Kensington Medical Center
- 11 Largo Medical Center
- 12 Lutherville-Timonium Medical Center
- 13 Marlow Heights Medical Center
- 14 North Arundel Medical Center
- 15 Shady Grove Medical Center
- 16 Silver Spring Medical Center
- 17 South Baltimore County Medical Center
- 18 **FUTURE LOCATION**
Medical Center in Waldorf

- 19  Friendship Heights
by KAISER PERMANENTE.
- 20 West Hyattsville Medical Center
- 21 White Marsh Medical Center
- 22 Woodlawn Medical Center

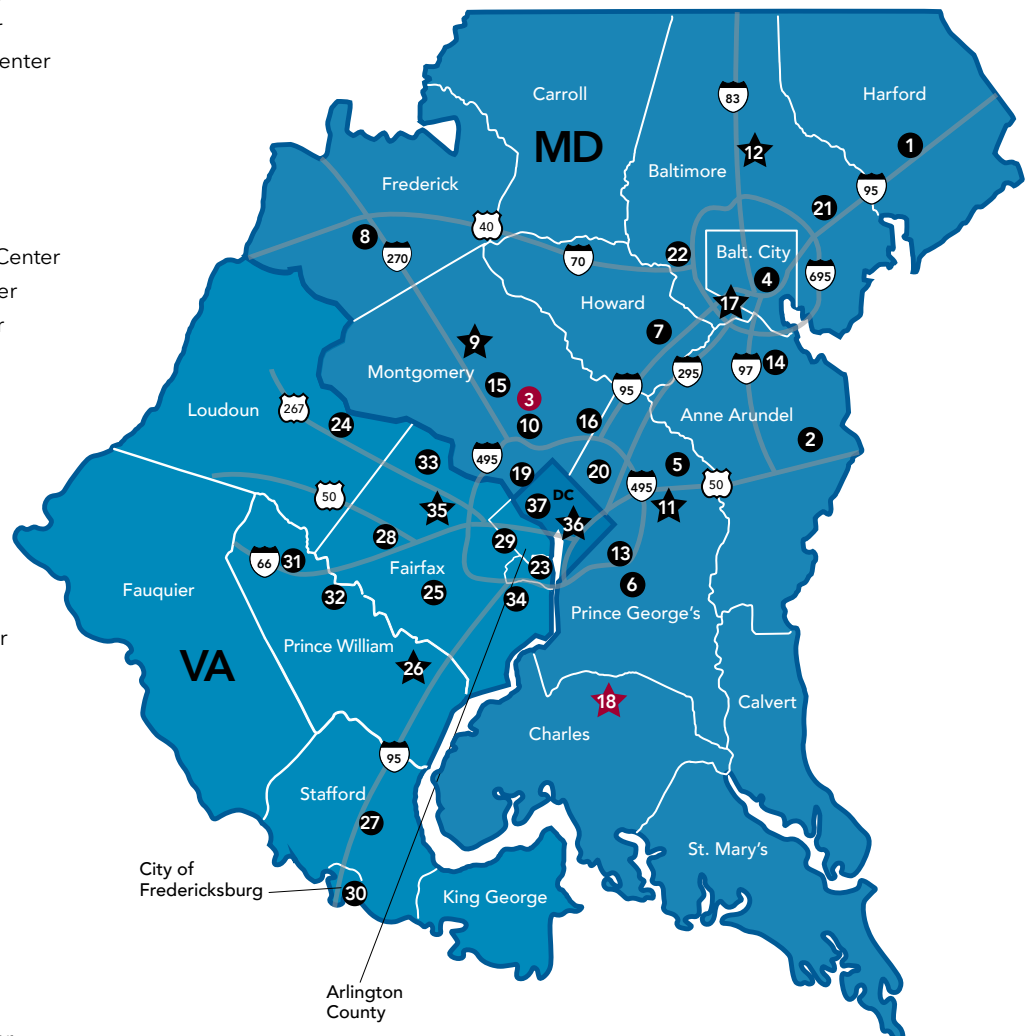
Virginia

- 23 Alexandria Medical Center
- 24 Ashburn Medical Center
- 25 Burke Medical Center
- 26 Caton Hill Medical Center
- 27 Colonial Forge Medical Center
- 28 Fair Oaks Medical Center
- 29 Falls Church Medical Center
- 30 Fredericksburg Medical Center
- 31 Haymarket Crossroads Medical Center
- 32 Manassas Medical Center

- 33 Reston Medical Center
- 34 Springfield Medical Center
- 35 Tysons Corner Medical Center

Washington, DC

- 36 Kaiser Permanente Capitol Hill Medical Center
- 37 Northwest DC Medical Office Building



- ★ These centers offer 24/7:
 - Advanced Urgent Care
 - Lab*
 - Pharmacy*
 - Radiology

*Extended pharmacy hours at Gaithersburg and Lutherville-Timonium and extended lab hours at Tysons Corner. For our most up-to-date listing of facilities and services available, please check kp.org/facilities.



23. Attachment K – Medicaid at Kaiser Permanente

Medicaid at Kaiser Permanente

<p>How does Kaiser Permanente provide the medical care you need?</p>	<p>HealthChoice is a program of the State of Maryland.</p> <p>As a managed care organization, Kaiser Permanente:</p> <ul style="list-style-type: none">• Provides your medical benefits through Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), a participating Medicaid managed care organization (MCO), and the Mid-Atlantic Permanente Medical Group, P.C. (MAPMG). We work together to give you the medical care you need.
<p>What makes Kaiser Permanente special?</p>	<ul style="list-style-type: none">• Large medical group of more than 1,500 doctors dedicated to serving just Kaiser Permanente members across our entire region.• Contracts with participating providers when we do not have offices in a particular area or do not have a particular kind of specialist.
<p>How does choosing a Kaiser Permanente physician make a difference in how your care is managed?</p>	<p>MAPMG doctors have access to very powerful tools to ensure that you get care when you need it. One of these tools is our electronic medical record system. This system allows all of our MAPMG doctors, who treat you, access to the same medical information whenever they see you.</p> <ul style="list-style-type: none">• Make referrals to specialists easily• Order your medications from the pharmacy, so you can pick them up before you leave a Kaiser Permanente medical center• Read your lab results and follow up on needed screenings• Make appointments, order medicines, and ask your doctor questions using our online member system at kp.org

24. Attachment L – Choosing Your Primary Care Provider

Thank you for choosing Kaiser Permanente. We are happy to have you as a member through the Maryland Medicaid HealthChoice program. Our goal is to help you be healthy and be there for you if you are sick.

To get the most out of your health care, choose a doctor who meets your needs and is close to where you live. However, we allow our members to see any of our providers, whether in Maryland, Washington, DC, or Virginia. If you are a new member, you should choose a primary care doctor as soon as you can. You can see the full list of doctors and make your choice at [kp.org](https://www.kp.org).

If you do not choose a doctor, we will assign one to you. You can call Member Services at **855-249-5025** (TTY **711**) or visit [kp.org](https://www.kp.org) to change your doctor at any time. Please contact us with any questions.



25. Attachment M – Additional Information on Member Rights and Responsibilities

Kaiser Permanente members have a right to a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.



26. Attachment N – Utilization Management Affirmative Statement

Utilization management describes the different ways to make sure that you receive the right care at the right time in the right place. Kaiser Permanente's Utilization Management Program uses advice and cooperation from your PCP and other caregivers. Utilization management activities happen across all health care settings where Kaiser Permanente provides care. Utilization management activities include hospital medical management, complex case management, and renal case management, among others.

If you want to find out more about our Utilization Management Program, contact a Member Services representative, who can give you:

- Information about the status of a referral or an approval
- A copy of our criteria, guidelines, or protocols used for decision making
- Answers to your questions about a denial decision

Member Services can also connect you with someone on the utilization management staff. Call Member Services representatives, Monday through Friday, 7:30 a.m. to 5:30 p.m., except holidays, at **855-249-5019** (TTY **711**).

A member's health care plan covers them for certain benefits. A member may be approved for or denied health care services based on their health care plan. Permanente doctors, nurses, and other health care staff decide what care is best for each member's needs. These decisions are based on each member's health and health care plan. Health care staff do not benefit from denying health care services to members. This does not make Kaiser Permanente more likely to hire, promote, or fire staff. All health care staff want members to have the best care possible.

27. Attachment O – Kaiser Permanente Case Management Self-Referral Line

301-321-5126 or **1-866-223-2347**

If you would like help obtaining additional resources or assistance in coordinating your care, please call us. You will need to leave your name, medical record number, telephone contact information, and what kind of assistance you need. You should expect a call back within 3-7 days by one of our professional case managers.

Please note this line is not for urgent medical needs and is responded to Monday through Friday, 8 a.m. to 4:30 p.m. (excluding holidays). If you need urgent medical assistance, please call **703-359-7878** or **1-800-777-7904**.



28. Attachment P – Selecting an Adult Primary Care Provider

Members who've turned 18 are of age to choose an adult primary care provider (PCP). Members can go to kp.org/doctor to choose a PCP or can contact Member Services at **855-249-5019** for assistance.



29. Attachment Q – Kaiser Permanente Member Voices Forum Meetings

What Is the Kaiser Permanente Member Forum?

It is a meeting for members to talk about their experiences with other members and Kaiser Permanente staff.

Why Should I Join?

If you join the meeting:

- You will be a key link between members and Kaiser Permanente.
- The comments you make to the group about your experiences as a member could affect all Kaiser Permanente members in this region.

What Happens to the Comments I Make at the Meeting?

After each meeting, Kaiser Permanente staff will make notes that include members' comments. Staff will then use these notes to create a report to send to the Appeals and Correspondence department, who will review the comments. Kaiser Permanente will use the comments to help us decide what we do in the future.

Who Can Join?

Kaiser Permanente members and/or their family members or caregivers. For example, the parent or caregiver of a child who is a member in the region can join.

We are looking for members from different backgrounds and locations, so we can have a diverse group.

What Do I Get for Joining?

We will give you a ride to and from the meetings, and a free dinner.

What Are My Next Steps?

If you would like to be a part of the meeting, email us at kpmembervoices@kp.org for more information.

30. Attachment R – Definitions

Health Plan (also referred to as “Kaiser Permanente”): Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., a nonprofit company that operates a managed care organization (MCO). Health Plan is sometimes referred to as “Kaiser Permanente.”

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Also referred to as “Health Plan” or “Kaiser Permanente”): The MCO contracted with DHMH to provide health care services to you.

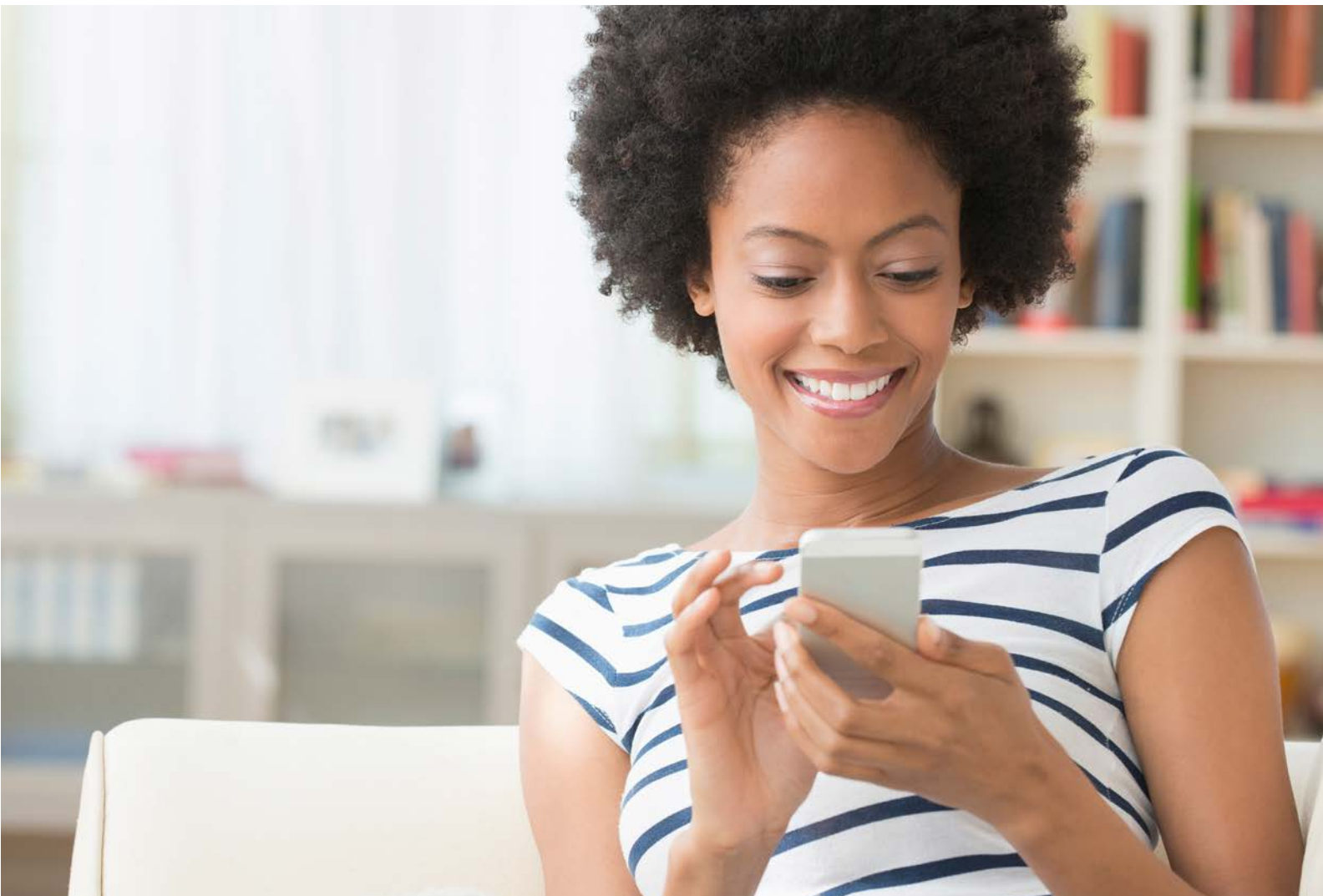
Kaiser Permanente: Medical care program that is operated by the following entities in the Mid-Atlantic States: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. (Health Plan), Kaiser Foundation Hospitals (KFH), and Mid-Atlantic Permanente Medical Group, P.C. (MAPMG). Health Plan is sometimes referred to as “Kaiser Permanente.”

Mid-Atlantic Permanente Medical Group, P.C. (MAPMG): Multi-specialty physician group practice that contracts with the Health Plan to provide and arrange for provision of medical services to Kaiser Permanente members. It may also contract with other professional medical services providers to render covered services that it cannot provide through its employees.

Provider Directory/Provider panel or network: A list of providers who have contracted with Kaiser Permanente to provide care to members. This list changes, and you will be sent an updated printed list at least once each year. The online list is updated more often.

31. Attachment S – Non-Formulary Exception Request Process

If you think you need a medication that is not on the formulary, speak with your doctor in person by making an appointment, call Member Services, or email your Kaiser Permanents doctor's care team using My Health Manager on kp.org to request the non-formulary exception process. This process is available so patients and doctors can access medically necessary medications under the prescription benefit, even if the medication is not on the formulary. These non-formulary prescriptions are covered by your prescription benefit only if your doctor requests an exception to the formulary and provides specific information on why no formulary medications are acceptable.



32. Attachment T – Create your online account on **kp.org**

Registering is very easy. Go to **kp.org/newmember** from a computer or mobile device and follow the sign-on instructions. You'll need your medical record number, which you can find on your member ID card. Next, take a few minutes to complete the Kaiser Permanente Medicare Total Health Assessment, which provides us an overview of your medical history and allows us to provide the best care for you.

Start using our secure website, **kp.org**, to manage your health on your time¹

Visit **kp.org** anytime, from anywhere, to:

- View most lab results
- Refill most prescriptions
- Email your doctor's office with nonurgent questions
- Schedule and cancel routine appointments
- Print vaccination records for school, sports, and camp
- Manage a family member's health care
- And much more

Caregiver access

Caregivers can have access to certain features of **kp.org** for their loved ones who are Kaiser Permanente members. Non-members can be caregivers on **kp.org** as long as they are at least 18 years old and have either:

1. Permission from you.
2. Legal rights to make health care decisions on your behalf, or legal rights to access your health care information.

To set up an account, go to **kp.org/register** and follow the prompts for caregiver access.

Download the Kaiser Permanente app

Now you can download the Kaiser Permanente app to your smartphone.

1. From your smartphone, go to your preferred app site: App StoreSM (iOS) or Google Play[®] (Android[™]).²
2. Search for the Kaiser Permanente app, then download it to your smartphone.
3. Use your **kp.org** user ID and password to activate the app, and you'll be ready to go.

¹These features are available when you get care at Kaiser Permanente facilities.

²Apple is a trademark of Apple, Inc., registered in the U.S. and other countries. App Store is a service mark of Apple, Inc. Google Play and Android are trademarks of Google, Inc.



Your guide to better health

Keep this book handy as a quick reference to getting the most out of your new plan



Register at
kp.org



Choose your
doctor



Transfer your
prescriptions