Dear Member:

Welcome to University of Maryland Health Partners. We are happy to be your HealthChoice Managed Care Organization.

UM Health Partners will work with you and your doctors to help you get the health care you need. If you want help finding a doctor or have questions about your health care, call us. We can provide you with contact information, details and professional qualifications, such as medical school attended, residency completed and board certification status for all of our participating doctors. We are here to help.

This Member Manual has important information about your health care benefits. It also has important phone numbers that you may need.

If you have any questions, please call us at 410-779-9369 or 1-800-730-8530. TTY users should call 711. A Member Services Representative can explain this handbook to you or answer any questions you have. Also, we offer interpretation services for our members who speak a language other than English. You can call the Member Services team and ask for an interpreter.

Please view our website at www.umhealthpartners.com for information on benefits, providers, preventive health schedules, health education.

We look forward to serving you.

Sincerely,

Mark Puente
President and Chief Executive Officer

Si necesita una copia de este manual en español, llámenos
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I. **RIGHTS AND RESPONSIBILITIES**

You have the right to:

- Be treated with respect to your dignity and privacy by health care providers, their staff and all individuals employed by UM Health Partners.
- Receive information, including information on treatment options and alternatives regardless of cost or benefit coverage, in a manner you can understand.
- Take part in decisions about your health care; including the right to refuse treatment. If you are under 18 and married, pregnant or have a child, you can expect that you will be able to participate in and make decisions about your and/or your child’s health care.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Talk to your Primary Care Provider about your medical record, request and get a copy of your medical records; or ask that these records be amended or changed as allowed.
- Have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Exercise your rights and to know that the use of those rights will not badly affect the way that UM Health Partners or our providers treat you.
- File appeals and grievances with us about our organization or the care we provide, including requesting an independent review of a decision to deny or limit coverage (see the section on Grievances and Appeals).
- File appeals and grievances with the State (see page 39, the section on The State’s Complaint Process).
- Receive a State fair hearing (see the section on The State’s Appeal Process).
- Request that ongoing benefits be continued during an appeal or state fair hearing however, you may have to pay for the continued benefits if our decision is upheld in the appeal or hearing. (See page 40).
- Know you or your provider cannot be penalized for filing a grievance or appeal.
- Get a second opinion from a UM Health Partners’ provider or arrange for a second opinion from a doctor outside the network if you do not agree with your doctor’s opinion about the services that you need. Call us at 410-779-9369 or 1-800-730-8530 for help with this. TTY users should call 711.
- Have information about how UM Health Partners is managed, including our services, policies and procedures, providers, and member rights and responsibilities, and any changes made. Call us at 410-779-9369 or 1-800-730-8530 for help with this. TTY users should call 711.
- Make recommendations regarding our member rights and responsibilities.
- Expect that your records and communications will be treated confidentially and not released without your permission.
- Choose your own Primary Care Provider, choose a new Primary Care Provider and have privacy during a visit with your Primary Care Provider.
- Get help from someone who speaks your language.
You have the responsibility to:

- Be involved in your health care and work with your doctors about recommended care.
- Understand your health problems and participate in developing mutually agreed upon treatment goals.
- Call UM Health Partners if you have a problem or concern with your health care services and need help.
- Tell your doctor as soon as possible after you get emergency treatment.
- Treat your providers, their staff and UM Health Partners employees with respect and dignity.
- Tell your doctor about your symptoms and problems and ask questions when you do not understand.
- Follow the instructions and plan of care agreed upon by you and your provider(s).
- Talk to your providers about any problems you may have in following their directions.
- Cooperate with your doctors and UM Health Partners to the extent possible, supply the information needed in order to provide care.
- Call UM Health Partners before seeing a new Primary Care Provider and let us know that you would like to change your Primary Care Provider.
- Make and keep appointments and be on time. Always call if you need to cancel an appointment or if you will be late.

UM Health Partners provides health coverage to our members on a nondiscriminatory basis, according to state and federal law, regardless of gender, race, age, religion, national origin, physical or mental disability, or type of illness or condition.
## II. BENEFITS AND SERVICES

### A. HEALTHCHOICE BENEFITS

This table shows the health care services and benefits that all HealthChoice enrollees can get when they need them. We offer other services not listed here. (See page 11) for a few special benefits, you have to be certain ages or have a certain kind of problem. This table lists the basic benefits that you can get through UM Health Partners when you need them.

UM Health Partners makes utilization management decisions solely on the appropriateness of care and services, and the existence of coverage. UM Health Partners does not specifically reward providers or other individuals for issuing denials of coverage. Financial incentives for utilization management decision makers do not encourage decisions that result in underutilization. UM Health Partners does not use incentives to encourage barriers to care and service.

There are no costs to HealthChoice and MCHP members for covered medical services. Please call us at 1-800-730-8530 if you receive a bill for services.

If you have a question or are confused about whether we offer a certain benefit, you can call the Enrollee Help Line at 1-800-284-4510 or UM Health Partners at 410-779-9369 or 1-800-730-8530 for help.

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>WHAT IT IS</th>
<th>WHO CAN GET THIS BENEFIT</th>
<th>WHAT YOU DON’T GET WITH THIS BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood &amp; Blood Products</td>
<td>Blood used during an operation, etc.</td>
<td>All members</td>
<td></td>
</tr>
</tbody>
</table>
| 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. | Special Populations:  
(1) Children with special health care needs;  
(2) Pregnant and postpartum women;  
(3) Individuals with HIV/AIDS;  
(4) Individuals who are Homeless;  
(5) Individuals with physical or developmental disabilities;  
(6) Individuals in need of substance abuse care; and  
(7) Children in State-supervised care |                                      |
<p>| Chronic Hospital         | Full-time hospital care for long-term illness                              | Available to all members. After 30 days, the State pays, instead of UM Health Partners. |                                      |</p>
<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>WHAT IT IS</th>
<th>WHO CAN GET THIS BENEFIT</th>
<th>WHAT YOU DON’T GET WITH THIS BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Trials</td>
<td>Member costs for studies to test the effectiveness of new treatments or drugs</td>
<td>Members with life threatening conditions, when authorized</td>
<td></td>
</tr>
<tr>
<td>Diabetes Care</td>
<td>Special services, medical equipment, and supplies for members with diabetes</td>
<td>Members who have been diagnosed with diabetes</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td>Treatment for kidney disease</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>DME &amp; DMS</td>
<td>Durable medical equipment (DME) and disposable medical supplies (DMS) are things like crutches, walkers, wheelchairs, and finger stick supplies (for people who do blood testing at home).</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>EPSDT Services for Children</td>
<td>Regular well-child check-ups, immunizations (shots), and check-ups to look for illness. Whatever is needed to take care of sick children and to keep healthy children well.</td>
<td>Members under age 21</td>
<td></td>
</tr>
<tr>
<td>Family Planning</td>
<td>Family planning office visits, lab tests, birth control pills and devices (includes latex condoms from the pharmacy, without a doctor’s order) and permanent sterilizations.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>Home Health Services</td>
<td>In-home health care services, including nursing and home health aide care.</td>
<td>Those who need skilled nursing care in their home, usually after being in a hospital</td>
<td>Personal care services (help with daily living)</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>Support services for people who are terminally ill.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>Hospital Services</td>
<td>Inpatient and outpatient services are covered.</td>
<td>All members with authorization or as an emergency</td>
<td></td>
</tr>
<tr>
<td>Laboratory &amp; Diagnostic Services</td>
<td>Lab tests and X-rays to help find out the cause of an illness.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>WHAT IT IS</td>
<td>WHO CAN GET THIS BENEFIT</td>
<td>WHAT YOU DON’T GET WITH THIS BENEFIT</td>
</tr>
<tr>
<td>-------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>Full-time nursing care in a nursing home</td>
<td>Available to all members. After 30 days, State pays, instead of UM Health Partners</td>
<td></td>
</tr>
<tr>
<td>Out of Network Services</td>
<td>Access to a necessary and covered service by an out of network provider, only when these services are unable to be provided in network</td>
<td>All members only with prior approval</td>
<td>Unlimited access outside of UM Health Partners’ provider network</td>
</tr>
<tr>
<td>Oxygen &amp; Respiratory Equipment</td>
<td>Treatment to help breathing problems.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>Pharmacy Services</td>
<td>Prescription drugs, 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. A current list of covered drugs and formulary updates is available at <a href="http://www.umhealthpartners.com">www.umhealthpartners.com</a>.</td>
<td>All members</td>
<td>Non-prescription drugs except for coated aspirin, iron pills, and chewable vitamins for children under age 12</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Foot care when medically needed and authorized by UM Health Partners. Includes special shoes, supports, and routine foot care.</td>
<td>Available to members under age 21 or individuals with diabetes and circulatory problems</td>
<td></td>
</tr>
<tr>
<td>Pregnancy-related Services</td>
<td>Medical care during and after pregnancy, including hospital stays and, when needed, home visits after delivery</td>
<td>Women who are pregnant, and for two months after the birth</td>
<td></td>
</tr>
<tr>
<td>Primary Care Services</td>
<td>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”, or “PCP”, a doctor or advanced practice nurse.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>BENEFIT</td>
<td>WHAT IT IS</td>
<td>WHO CAN GET THIS BENEFIT</td>
<td>WHAT YOU DON'T GET WITH THIS BENEFIT</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Primary Mental Health</td>
<td>Primary mental health services are basic mental health services provided by your PCP or another provider in UM Health Partners. If more than just basic mental health services are needed, your PCP will refer you to or you can call the <em>Public Behavioral Health System at 1-800-888-1965</em> for specialty mental health services.</td>
<td>All members</td>
<td>You do not get specialty mental health services from UM Health Partners. For treatment of serious emotional problems like schizophrenia, your PCP or specialist will refer you or you can call the <em>Public Mental Health System at 1-800-888-1965</em>.</td>
</tr>
<tr>
<td>Rehabilitation Outpatient</td>
<td>Rehabilitation services, including physical therapy, occupational therapy and speech therapy (without a hospital stay).</td>
<td>All members (See Section II C for members under age 21)</td>
<td></td>
</tr>
<tr>
<td>Second Opinions</td>
<td>A visit to an in network provider other than the one a member has previously seen for the purpose of obtaining additional information concerning a medical condition or diagnosis, or to hear a differing point-of-view.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>Specialist Services</td>
<td>Health care services provided by specially trained doctors or advanced practice nurses. You might have to get a referral from your PCP before you can see a specialist.</td>
<td>All members</td>
<td></td>
</tr>
<tr>
<td>Transplants</td>
<td>Medically necessary transplants</td>
<td>All members</td>
<td>Experimental transplants</td>
</tr>
</tbody>
</table>
| Vision Care                | **Eye Exams**  
**Under 21:** one routine exam every year  
**21 and older:** one routine exam every two years  
**Glasses**  
**Under 21:** one pair of glasses every year (Contact lenses if there is a medical reason why glasses will not work)  
Maximum benefit for frames OR contacts is $125  
No limit for contacts when medically needed  
Exams – all members  
Glasses and contact lenses – every year for members under age 21.  
– every two years for members 21 and older | All members | More than one pair of glasses per year unless lost, stolen, broken or new prescription needed |
## B. OPTIONAL BENEFITS AND APPLICABLE TERMS AND CONDITIONS

<table>
<thead>
<tr>
<th>BENEFIT</th>
<th>WHAT IT IS</th>
<th>HOW WILL THE SERVICE BE PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>UM Health Partners will provide acupuncture services to members diagnosed with a substance abuse addiction. The benefit will be limited to 2 treatments per week up to 70 treatments per year.</td>
<td>The service will be provided by a limited number of contracted providers within Baltimore City only.</td>
</tr>
<tr>
<td>Adult Dental</td>
<td>UM Health Partners will provide preventative and restorative dental benefits to all adult eligible members with an annual cap of $250 per member. The benefit will include exams, x-rays, and extractions.</td>
<td>The service will be administered through DentaQuest, a national dental benefits administrator and its statewide network of dentists.</td>
</tr>
<tr>
<td>Adult Vision</td>
<td>The mandatory HealthChoice benefit allows for adults to receive a vision exam every two years. UM Health Partners will provide one pair of glasses every two years to all adult members in the event the exam outlines the needed for glasses.</td>
<td>The service will be administered through Superior Vision, a national vision services administrator and its statewide network of optometrists and ophthalmologists.</td>
</tr>
<tr>
<td>24 Hour Nurse Line</td>
<td>UM Health Partners offers free service that provides real time access to a registered nurse who can give medical advice 24 hours a day 7 days a week.</td>
<td>Members can connect directly with a nurse by calling 1-844-685-8379.</td>
</tr>
<tr>
<td>Over the Counter Medications and Supplies (OTC)</td>
<td>UM Health Partners will provide members with a $15 per quarter OTC benefit for such items such as aspirin, cold suppressants, ointments, vitamins and herbal supplements. These items must be prescribed by a physician.</td>
<td>The service will be provided by UM Health Partners’ pharmacy benefit manager, CVS Caremark, a national PBM. All members will present their prescription for service to the participating network pharmacy to receive their OTC item(s). CVS Caremark will reimburse the pharmacy for services and will track each member’s quarterly expenditure, not to exceed $15.</td>
</tr>
<tr>
<td>Home Delivered Meals Post-Discharge from a Hospital Stay</td>
<td>UM Health Partners will provide members with up to 18 nutritious meals to eligible members recovering from an inpatient stay in a hospital who have no support at home upon discharge.</td>
<td>The service will be provided by Moveable Feast. Members will need their physicians or facility discharge planners to obtain prior authorization for meals from UM Health Partners case managers.</td>
</tr>
</tbody>
</table>
Pharmaceutical Management Procedures

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

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

UM Health Partners may also use additional pharmaceutical management procedures to manage the use of pharmaceuticals:

- **Generic Substitution**
  UM Health Partners is required by state rules to dispense generic versions of drugs and products rather than brand-name drugs and products unless a provider requests otherwise.

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

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

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

- **Age Limits**
  UM Health Partners may require prior approval of certain drugs and products based on age. (A CVS clinical reviewer will provide drug or product specific age limits upon request during the call.)

- **Therapeutic Interchange**
  UM Health Partners prohibits a pharmacist from switching a prescribed drug or product to an alternative drug or product within the same therapeutic drug class except when the
pharmacist is servicing patients of a hospital, resident of a comprehensive care or extended care facility with an established procedure for therapeutic interchange.

**Medication Exceptions**

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

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

**Evaluation of New Technologies**

UM Health Partners researches and evaluates new medical technology and new applications of existing technology. New technologies can include medical procedures, medical devices, behavioral healthcare procedures and drugs. Before approving the use of new technologies for our members, we conduct research and ask the opinion of experts. Our Provider Advisory Committee evaluates the new technology to see if it would be a good benefit to add for our members. If the new technology meets the standards listed below, then we ask the Maryland HealthChoice program if it can be included in the UM Health Partners benefit package for members. The Maryland HealthChoice program makes final benefit coverage decisions on whether we may offer the new technology to our members.

**Standards for offering new technologies:**

- The appropriate governmental regulatory bodies have approved the technology for use
- Scientific evidence concludes what the effects of the technology are on health outcomes
- The technology improves net health outcomes
- The technology is as beneficial as any established alternatives
- The technology is affordable

**C. BENEFITS AND SERVICES NOT OFFERED BY UM HEALTH PARTNERS BUT OFFERED BY THE STATE**

These are benefits and services that we do not provide. People who need these services can get them through the State using their red and white Medical Assistance or dental card.

**Dental Services for Children under 21 and pregnant women** - General dentistry including regular and emergency treatment is offered. Dental services are provided by the Maryland Healthy Smiles Dental Program administered by Scion Dental, INC. If you are eligible for the Dental Services Program, you will receive information and a dental card from Scion Dental. If you have not received your dental ID card or you have questions about your dental benefits, call the Maryland Healthy Smiles Dental Program at 1-855-934-9812.

**Specialty mental health services** - We offer only the basic primary mental health services that your PCP can provide. If these services are not enough to take care of your problem, you, your PCP, or your
specialist doctor can request specialty mental health services through the Public Behavioral Health System by calling 1-800-888-1965.

**ICF-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.

**Transportation services** – We do not have to pay for your transportation to medical services, unless we send you to a far-away county to get treatment that you could get in a closer county. We will help you arrange non-emergency transportation, if needed for a medical visit or treatment, through your city or county government (usually the county health department). Emergency transportation is provided by local fire companies (“911” emergency service), but this is only for real emergencies.

**Nursing home & long-term care services** – We do not have to pay for your care in a nursing home, chronic rehabilitation hospital, or chronic hospital after the first 30 days. After that, the services are considered “long-term care”. After the first 30 days, you will not have to leave the nursing home or long-term hospital; you just will not be in UM Health Partners anymore. Once you are out of UM Health Partners, the State will pay for the medical treatment you need, including nursing home and other long-term care.

**Abortion Services** - This medical procedure to end certain kinds of pregnancies is covered by the State only if:

1. The patient will probably have serious physical or mental health problems, or could die, if she has the baby;
2. She is pregnant because of rape or incest, and reported the crime; or
3. The baby will have very serious health problems.

Women eligible for HealthChoice only because of their pregnancy are not eligible for abortion services.

**Occupational, Physical, and Speech Therapy, and Audiology for Children Under the Age of 21** - The State pays for these services if medically needed. For help in finding a provider, you can call the State’s Hotline at 1-800-492-5231.

**Speech Augmentation Devices** - Equipment that helps people with speech impairments to communicate.

**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). Most HIV/AIDS drugs are also paid for by the State.

**Substance Use Disorder Services** – Comprehensive assessments, individual and group counseling, methadone treatment, detox treatment, intensive outpatient, partial hospitalization and opioid maintenance. These services can be requested through the Public Behavioral Health System by calling 1-800-888-1965.
D. BENEFITS AND SERVICES NOT OFFERED BY UM HEALTH PARTNERS OR THE STATE

These are benefits and services that we are not required to offer. However, we offer a few of them anyway (see page 11). The State will not offer any of the benefits on this list.

- Anything that you do not have a medical need for
- Care received outside of our provider and hospital network, unless it is an emergency
- Anything experimental unless part of an approved clinical trial
- Autopsies
- Shots for travel outside the continental United States or medical care outside the United States
- Diet and exercise programs, to help you lose weight.
- Fertility treatment services, including services to reverse a voluntary sterilization.
- Cosmetic surgery. Operations to make you look better, but you do not need for any medical reason.
- Private hospital room. For people without a medical reason such as having a contagious disease.
- Private duty nursing. For people over 21 years old
- Orthodontist services. Braces to straighten teeth, for people 21 years old and older or children who do not have a serious problem that makes it difficult for them to speak or eat.
- Special (orthopedic) shoes and supports. For people who do not have diabetes or circulation problems or are older than age 21.
- Routine foot care. For people who do not have diabetes or circulation problems or are older than age 21.
- Non-prescription drugs. (Except coated aspirin for arthritis, insulin, iron pills, and chewable vitamins for children younger than age 12.)
- Hearing aids. For people over age 21.
- Dental services for adults. (Except for pregnant women, UM Health Partners provides limited dental coverage for adults as an optional benefit, see page 11)

E. SELF-REFERRAL SERVICES

What are 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 belongs to UM Health Partners. For some types of services, you can choose a health care provider who is not part of our network, and we will still pay for the service as long as the provider agrees to see you and accept payment from us. These are called “self-referral services.” We will also pay for any related lab work and medicine received at the same site that you receive the self-referral visit. The following are self-referred services.
**Family Planning Services**

If you choose to do so, you can go to a provider who is not a part of UM Health Partners for any of these family planning services:

- Family planning office visit
- Pap smear
- Special contraceptive supplies
- Diaphragm fitting
- IUD insertion and removal
- FDA approved contraceptives including emergency contraceptives

**Emergency Services**

If you have a real medical emergency, you do not need a referral from your PCP to go to the emergency department (ED). If you’re not sure if you should go to the ER, call your PCP for advice. After you are treated for an emergency condition you may need additional services to make sure the emergency condition does not return. These are called post stabilization services. We 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 us at 410-779-9369 or 1-800-730-8530.

**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.

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

**Pregnancy services**

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

**Baby’s first check-up before leaving hospital**

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

**Check-up for children entering State custody**

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

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

- **New Enrollee:** 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 out-of-network provider submits the plan of care to us for review and approval within 30 days of the child’s effective date of enrollment in UM Health Partners, and we approve the services as medically necessary.

- **Established Enrollee:** A child who is already enrolled in UM Health Partners when diagnosed as having a special health care need requiring a plan of care that includes specific types of services may request a specific out-of-network provider. We must grant the request unless we have a local in-network specialty provider with the same professional training and expertise who is reasonably available and provides the same services.

If we deny, reduce, or terminate the services, you can file an appeal (see page 37 for information about appeals).

**Diagnostic Evaluation Service (DES)**

One annual diagnostic and evaluation service (DES) visit for any enrollee diagnosed with HIV/AIDS, which we are responsible for facilitating on your behalf.

**Renal Dialysis**

Some people with kidney disease need to have their blood cleaned. This is called "renal dialysis." A person who needs renal dialysis does not have to go to a UM Health Partners provider for this treatment, but can choose any provider, either inside or outside of our MCO. People needing this service may be eligible for the Rare and Expensive Case Management Program (REM) (see page 23).

**Birthing Centers**

- Services performed at a birthing center, including an out-of-state center located in a contiguous (a state that borders Maryland) state.
F. NOTICE OF STOPPING OR CHANGING BENEFITS, SERVICES, OR HEALTH CARE LOCATIONS

If your medical office or other provider moves or closes, UM Health Partners will send you a letter telling you to choose another provider near you. Once you have chosen a new provider, UM Health Partners will send you a new member ID card within 10 business days.

If your benefits change for any reason, UM Health Partners will send you a letter telling you about the change before it happens.

If you become ineligible for Medical Assistance, you will be automatically dis-enrolled. If you regain eligibility within 120 days, you will automatically be re-enrolled with UM Health Partners.

Please call us member services at call at 410-779-9369, or 1-800-730-8530, if you have any questions.

III. INFORMATION ON PROVIDERS

A. What is a PCP, a Specialist, and What is Specialty Care?

There are different kinds of providers who will give you certain types of care when you need it. These providers are:

Primary Care Provider (PCP) - PCPs, also called family doctors, are general or family practitioners. Also, they can be internists, pediatricians, OB/GYNs, certified nurse midwives, and nurse practitioners.

He or she will give checkups, medical advice, immunizations and referrals to specialists, when needed.

Specialist – A provider who has specific training beyond PCP training and can treat you for special medical conditions. Examples of specialists are obstetricians, dermatologists and podiatrists.

Specialty Care – Any care that is provided by a specialist. These services may or may not need a referral from your PCP. Specialty care services that do not need a referral are called “self-referral” services (see page 15).

B. Information About Your PCP and Specialists

If you need more information about your PCP, specialist or other UM Health Partners provider please call Member Services at 410-779-9369 or 1-800-730-8530. Member Services Representatives can give you information about your practitioner including:

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

For female enrollees, if your PCP is not a women’s health specialist, you have the right to see a women’s health specialist within the UM Health Partners network without a referral for covered routine and preventive health care services.
C. Selecting or Changing Providers

If you need to choose a primary care provider or change the one you already have, call Member Services at 410-779-9369, or 1-800-730-8530. A new UM Health Partners ID Card will be mailed to you within 10 business days.

D. List of Primary and Specialty Care Providers

If you would like to view a list of our participating providers, the provider directory is available on our website at www.umhealthpartners.com. If you would like a paper copy of the provider directory mailed to you, contact member services at 410-779-9369, or 1-800-730-8530.

IV. SPECIAL SERVICES

A. Interpreter for Those Who Do Not Speak English

For members who do not speak English, we are able to help by talking with you in many different languages and dialects. This service is also available for visits with your PCP or specialist at no cost to you. Please let us know if you need an interpreter at least 24 hours before your appointment. Call us at 410-779-9369 or 1-800-730-8530 for more information. Or, you can tell your provider you need an interpreter before you go to your appointment. He or she can arrange to have one for you when you get there.

B. Interpreter for Those Who are Hearing Impaired

If you have any questions about your UM Health Partners benefits, please call our Member Services Department. UM Health Partners can also set up and pay for you to have a person who knows sign language to help you during your PCP or specialist visits. Please let UM Health Partners know if you need an interpreter at least 24 hours before your appointment by calling our Member Services Department at 410-779-9369 or 1-800-730-8530, TTY users can call us through the National Relay Services 711. UM Health Partners’ Member Services Department is available from 8:00 am to 5:00 pm Monday through Friday. You can also tell your provider you need an interpreter before you go to your appointment. He or she can arrange to have one for you when you get there at no cost to you.

C. Transportation Services

You are responsible to arrange your own transportation to and from your medical appointments. However, if you cannot get a ride, your local health department may be able to arrange one for you. For the local health department to assist you, you will need to have:

- Your UM Health Partners ID card
- A scheduled medical visit at a physician’s office, hospital or clinic

Transportation is for nonemergency medical appointments only. Please schedule transportation the week before your scheduled appointment.
For transportation in your county call:

- Allegany County 301-722-2770 or 301-689-1113
- Anne Arundel County 410-222-7152
- Baltimore City 410-396-7007 or 410-396-6422
- Baltimore County 410-887-2828 or 410-783-2465
- Calvert County 410-535-5400
- Caroline County 410-479-8030
- Carroll County 888-602-4007 or 410-602-4007
- Cecil County 410-996-5550
- Charles County 301-609-7917
- Dorchester County 410-901-2426
- Frederick County 301-600-1725
- Garrett County 301-334-9431
- Harford County 410-638-1671
- Howard County 410-313-6300
- Kent County 410-778-7025
- Montgomery County 240-777-5899
- Prince George’s County 301-856-9555
- Queen Anne’s County 410-758-0720
- Somerset County 443-523-1722
- St. Mary’s County 301-475-4296
- Talbot County 410-819-5600
- Washington County 240-313-3264
- Wicomico County 410-548-5142
- Worcester County 410-632-0092 or 410-632-0093

Make sure you are ready and waiting for your ride 45 minutes early. The driver may not wait for you. If you call for a ride and find out later that you do not need it, please call back at least an hour before they are supposed to pick you up and cancel the ride.

D. 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:

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

We have a process to let you know if you are in a special needs population. If you have a question about your special needs, contact Member Services at 410-779-9369 or 1-800-730-8530.
Services Every Special Needs Population Receives

If you are in one or more of these special needs populations, you are eligible to receive the services below to help you get the right amount and the right kind of care:

Case Manager - A case manager will be a nurse or a social worker or other professional that may be assigned to your case soon after you join UM Health Partners. This person will help you and your primary care provider (PCP) plan the treatment and services you need. The case manager will not only help plan the care, but will help keep track of the health care services you receive during the year 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. This will include specialists for supplies and equipment you might need.

Follow-up when visits are missed - If your PCP or specialist finds that you keep missing appointments, they will let us know and someone will try to get in touch with you by mail, by telephone or by a visit to your home to remind you to call for another appointment. If you still miss appointments, you may be visited by someone from the local health department near where you live.

Special Needs Coordinator – We 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. To speak to our Special Needs Coordinator, call 410-779-9371.

As a member of a special needs population, you will receive all of the services above. Some groups will receive other special services. These are listed below:

Adults and Children with HIV/AIDS

HIV/AIDS Case Management - We have 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 enrollee diagnosed with HIV/AIDS, which we are responsible for facilitating on the enrollee’s behalf.

Substance Use Disorder Services - Anyone with HIV/AIDS who needs treatment for substance use disorder will be immediately referred to the Behavioral Health System.

Adults and Children with Physical and Developmental Disabilities

Materials Prepared in a Way You Can Understand - We have our materials reviewed by people with experience in the needs of people with disabilities. This means that the information will be presented using the right methods so that people with disabilities can understand, whether in writing or by voice translation. Our staff is trained on the special communications needs of individuals with developmental disabilities.

DDA Services - Enrollees that currently receive services through the Developmental Disabilities Administration (DDA) or under the DDA waiver can continue to receive those services.
Medical Equipment and Assistive Technology - Our providers have the experience and training for both adults and children to provide medical equipment and assistive technology services.

Case Management - Case Managers are experienced in working with people with disabilities.

Pregnant Women and Women Who Have Just Given Birth

Appointments - The provider must schedule an appointment within 10 days of your request. If you cannot get an appointment call us at 410-779-9369, or 1-800-730-8530. Or, you can call the Enrollee Help Line at 1-800-284-4510.

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

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

Length of Hospital Stay - The length of hospital stay after delivery is 48 hours for an uncomplicated vaginal delivery or 96 hours for an uncomplicated cesarean delivery. If you elect to be discharged earlier, a home visit must be provided within 24 hours after discharge. If you must remain in the hospital after childbirth for medical reasons, you may request that your newborn remain in the hospital while you are hospitalized, additional hospitalization up to four (4) days is covered for your newborn.

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

Dental - Pregnant women receive diagnostic, emergency, preventive, and therapeutic dental services for oral diseases. These services are provided by the Maryland Healthy Smiles Dental Program. Contact them at 855-934-9812 if you have questions about your dental benefits.

Substance Use Disorder Services - Any pregnant or postpartum (2 months after delivery) woman, who need treatment for substance use disorder will immediately be referred to the Specialty Behavioral Health System.

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

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

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

EPSDT Screening Appointments - Adolescents who are pregnant should receive EPSDT screening services in addition to prenatal care.
Children with Special Health Care Needs

Work with Schools - We will work closely with the schools that provide education and family services programs to children with special needs.

Keeping Certain Non-UM Health Partners Providers - Children with special healthcare needs may self-refer to providers outside of our network under certain conditions. Self-referral for children with special needs is intended to insure continuity of care, and assure that appropriate plans of care are in place. Self-referral for children with special health care needs will depend on whether or not the condition that is the basis for the child’s special health care needs is diagnosed before or after the child’s initial enrollment in an MCO. Medical services directly related to a special needs child’s medical condition, may be accessed out-of-network only if conditions are satisfied (see page 17).

State Supervised Care - Foster and Kinship Care - We 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 UM Health Partners responsible for organizing all services. If a child in State supervised care moves out of the area and needs another MCO, the State and UM Health Partners 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, we will be sure that the child is examined by someone who knows how to find and keep important evidence.

Individuals Who Are Homeless

If you are homeless, we will provide a Case Manager to coordinate your health care services.

E. RARE AND EXPENSIVE CASE MANAGEMENT PROGRAM (REM)

What is the Rare and Expensive Case Management Program?

The Rare and Expensive Case Management Program, REM for short, is a program provided by the State for people who have very expensive and very unusual medical problems. To enter the REM program, you must have one of the problems (diagnoses) on the REM diagnosis list. Most of the REM diagnoses are found in children under the age of 21, however, a few are found in adults as well.

How do I know if I belong in this program?

Your Primary Care Provider (PCP) and the UM Health Partners 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. You will be informed by telephone, by mail, or by a visit from a REM case manager. If you do not want to join the REM program, you can stay in UM Health Partners.

Will I keep the same benefits?

The REM program offers Medicaid benefits plus other specialty services needed for your special medical problem. The State will pay for this care instead of us.
Do REM enrollees keep their MCO and their PCP?

Entering the REM program means not being in an MCO anymore. This change will happen automatically. You will work with a REM Case Manager who will become very familiar with the care you or your child needs and will help you select the right provider. The REM Case Manager will work with you or your child to see that you continue with the same PCP and specialists if possible, even though you will no longer be in UM Health Partners. If your child under age 21 was getting medical care from a specialty clinic or other setting before going into the REM program, you can choose for your child to keep getting services there after joining the REM program, as long as your provider takes Maryland Medicaid fee-for-service.

How Do I Get More Information About the REM Program?

Call the REM Program at 1-800-565-8190.

V. GETTING INTO CARE

A. Making or cancelling an appointment

As soon as possible, pick a primary care doctor (PCP). Your PCP is your family doctor, or the doctor you regularly see. This is your medical home. Your PCP takes care of your health care and will help you get care from other health care providers when needed. This is called “coordination of care.” Coordination of care makes sure you get the care you need when you need it. This is why having a medical home is so important.

You can choose the same PCP for your whole family or you can have a different PCP for each family member. There are different kinds of practitioners who can be PCPs, including:

- Family Practice and General Practice doctors, who treat adults and children,
- Internal Medicine doctors or Internists, who treat members older than the age of 18,
- Pediatricians, who treat children from birth to age 21, or
- Certified Registered Nurse Practitioners (Nurse Practitioners). Under the guidance of a doctor, the Nurse Practitioner can be your PCP.

The State of Maryland issues an EPSDT certification to primary care providers (PCPs) who are trained to follow the EPSDT (Early, Periodic, Screening, Diagnostic and Treatment) standards during well visits. UM Health Partners encourages all members to select EPSDT certified PCPs to care for members who are less than 21 years old. If you select a non-certified EPSDT provider, UM Health Partners will notify you about your options of keeping that doctor or changing to a certified provider. Our Member Services Department can tell you which PCPs are EPSDT certified.

To choose a PCP and see the addresses of all our doctors, go to www.umhealthpartners.com or call our Member Services Department at 410-779-9369 or 1-800-730-8530, and they will help you find a doctor near you. TTY users should dial 711. When you get the doctor’s telephone number, just call to make an appointment. The sooner you see your PCP, the better.
B. Referral to a specialist or specialty care

If you think you need specialty care, please call your Primary Care Provider. You can also call UM Health Partners’ Member Services Department at 410-779-9369 or 1-800-730-8530. TTY users should call 711. We can help you get the care you need.

C. After Hours Care

Because you never know when you will need medical care, your Primary Care Provider is available 24 hours a day. If you call the office when it is closed, leave a message with your name and a telephone number where you can be reached. You may also contact UM Health Partners’ after hours Case Manager by calling 410-779-9369 or 1-800-730-8530. TTY users can call 711.

D. Urgent Care

There are illnesses and injuries that can turn into an emergency if they are not treated within 48 hours. These conditions may require urgent care. Some examples are:

- Ear infections
- Urinary tract infections
- Coughs and congestion
- Diarrhea
- Sore throats
- Insect bites
- Rashes

Members may go to their doctor or a UM Health Partners network Urgent Care Center.

E. Emergency Care

If you have a medical emergency, you do not need a referral from your PCP to go to the emergency room (ER). If you think you need emergency care, call 911 or go to the nearest emergency room right away (see section on Emergency Care).

If you are not sure if you should go to the ER, call your PCP for advice. Except for emergencies and urgently needed care when you are traveling outside the service area, UM Health Partners will not pay for services you receive from non-UM Health Partners doctors and facilities.

What is an emergency?

An emergency is when not seeing a provider right away to get care could result in death or very serious bodily harm. The problem is so severe that someone with an average knowledge of health can tell the problem may be life threatening or cause serious damage to your body (or, with respect to pregnant women, the health of the woman or her unborn child).
Some examples of problems that are most likely an emergency are:

- Trouble breathing
- Chest pains
- Loss of consciousness
- Very bad bleeding
- Very bad burns
- Severe pain

You should call your Primary Care Provider within 24 hours after you visit the emergency room. If you cannot call, have someone else call for you. Your Primary Care Provider will provide or arrange any follow-up care you may need.

F. Out-of-Service-Area Coverage

If you need urgent or emergency care when you are out of town, go to the nearest urgent care center, hospital emergency room or call 911. If you need routine care like a checkup or prescription refill when you are out of town, call your Primary Care Provider or our Member Services Department at 410-779-9369, or 1-800-730-8530. TTY users should call 711. UM Health Partners’ Member Services Department is available from 8:00 am to 5:00 pm, Monday through Friday.

G. Wellness Care

ROUTINE CARE
In most cases when you need medical care, you call your Primary Care Provider to make an appointment. Then you go to see the Primary Care Provider. This will cover most minor illnesses and injuries, as well as regular checkups. This type of care is known as routine care.

WELLNESS CARE FOR CHILDREN AND ADULTS
Your Primary Care Provider is someone you see when you are not feeling well, but that is only part of your family Primary Care Provider’s job. He or she helps take care of you before you ever get sick. It is important that Adults and Children receive at least annual appointments for a routine exam or physical. Children under 2 years old, need more frequent well child exams.

THE HEALTHY KIDS PROGRAM
Babies need to see their PCP at least 7 times in their first year and more times if they get sick. At the 7 well-child visits, the PCP will:

- Make sure your baby is growing well;
- Help you care for your baby;
- Talk to you about what to feed your baby;
- Tell you how to help your baby go to sleep;
- Answer questions you have about your baby;
- Find problems that may need more health care; and
- Give your baby shots that will help protect him or her from illnesses.
The first well-child visit will happen in the hospital right after the baby is born. For the next 7 visits, you must take your baby to his or her PCP’s office. You must set up a well-child visit with the PCP when the baby is:

- 0-1 month old
- 2-3 months old
- 4-5 months old
- 6-8 months old
- 9-11 months old
- 12 months old

It is also very important for your child to see the PCP at least 3 more times in his or her second year of life. Please schedule an appointment for your baby at:

- 15 months old
- 18 months old
- 24 months old

Beginning at age 3, your child should see his or her PCP at least one time each year up to age 20 for well-child checkups.

**BLOOD LEAD SCREEN**
During every well-child checkup between age 6 months and 6 years, your PCP will screen you child’s risk for lead poisoning. In addition, all children should have a blood test for lead and anemia at:

- 12 months
- 24 months

Blood lead tests may be done sooner or more frequently if your child is at high risk or has previously had a positive blood lead test.

Your child’s doctor will take a blood sample by pricking the child’s finger or taking blood from the vein. You may also be referred to a laboratory to have blood drawn. This test will tell if your child has lead in his or her blood.

**EYE AND HEARING SCREENINGS**
Your child will have eye and hearing checkups from birth through age 20 during certain well-child checkups.

Eye exams are done at each well-child visit from birth through age 2. Standard tests are also given each year at ages 3, 4, 5, 6, 8, 12, 14 and 20. Hearing exams are done at each well child visit from birth through age 3. They are also done each year at age 6, 8, 10, 14, 16 and 20. Standard tests are given each year age 4, 5, 12 and 18.

**DENTAL CARE**
Your child will have his or her teeth and gums checked by his or her PCP from birth through age 20 as a part of his or her well-child checkup. At age 1, your child should begin seeing a dentist. Please call the Maryland Healthy Smiles Program at 855-934-9812 to help find a dentist.
Immunizations, also called Vaccines, protect your children and those around them against serious diseases. Most vaccines, but not all, are given in the form an injection or shot and are sometimes referred to as “shots”. You can use the chart below to tell you if your child is up-to-date on his or her vaccines. If your child is not up-to-date on his or her vaccines, call your PCP or our Member Services Department, if you need help with scheduling an appointment.

### Immunization Schedule Birth through 6 years old

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>2 Months</th>
<th>4 Months</th>
<th>6 Months</th>
<th>9 Months</th>
<th>12 Months</th>
<th>15 Months</th>
<th>18 Months</th>
<th>2-3 Years</th>
<th>4-6 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hepatitis B</td>
<td>Hep B</td>
<td>Hep B</td>
<td>Hep B</td>
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<td>Rotavirus</td>
<td>RV</td>
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<td></td>
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<tr>
<td>Diphtheria, Tetanus, Pertussis</td>
<td>DTaP</td>
<td>DTaP</td>
<td>DTaP</td>
<td>DTaP</td>
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<tr>
<td>Haemophilus Influenza type b</td>
<td>Hib</td>
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<td>Hib</td>
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<tr>
<td>Pneumococcal</td>
<td>PCV13</td>
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<td>PCV13</td>
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<tr>
<td>Polio</td>
<td>IPV</td>
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<tr>
<td>Influenza</td>
<td>IPV</td>
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<tr>
<td>Measles, Mumps, Rubella</td>
<td>MMR</td>
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<td>Varicella</td>
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<tr>
<td>Hepatitis A</td>
<td>HepA</td>
<td>HepA</td>
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</tbody>
</table>

### Immunization Schedule 7-18 years old

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>7-10 Years</th>
<th>11-12 Years</th>
<th>13-18 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tetanus, Diphtheria, Pertussis</td>
<td>Tdap</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Papillomavirus</td>
<td>HPV (3 Doses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Meningococcal</td>
<td>MCV4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Influenza</td>
<td>INFLUENZA (YEARLY)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The above vaccine schedule may require adjustment depending on individual risk and previous vaccine timing. Talk to your Primary Care Provider (PCP) about what is best for your child.*
WELLNESS CARE FOR ADULTS

Staying healthy means getting regular medical check-ups from your PCP. The chart below is a guide to make sure that you are up-to-date with your yearly wellness visits.

<table>
<thead>
<tr>
<th>EXAM TYPE</th>
<th>WHO NEEDS IT</th>
<th>HOW OFTEN?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Visit</td>
<td>All members</td>
<td>Every year**</td>
</tr>
<tr>
<td>Obesity Screening Body Mass Index (BMI)</td>
<td>All members</td>
<td>Every wellness visit</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>All members</td>
<td>Every wellness visit</td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Age 50 – 75 years old</td>
<td>(frequency depends on type of test used)</td>
</tr>
<tr>
<td>Fecal Blood Occult Test or Colonoscopy or Sigmoidoscopy</td>
<td>(frequency depends on type of test used)</td>
<td>Every year</td>
</tr>
<tr>
<td>Tobacco Use Screening</td>
<td>All members</td>
<td>Every opportunity</td>
</tr>
<tr>
<td>Breast Cancer Screening</td>
<td>Females 40+ years old</td>
<td>Every 2 years</td>
</tr>
<tr>
<td>Mammograms (Breast X-ray)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-woman Exam</td>
<td>Females 21+ years old</td>
<td>Every year</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>Females 21-65 years old</td>
<td>Every 3 years depending on risk</td>
</tr>
<tr>
<td>Chlamydia screening</td>
<td>Sexually active females younger than 25</td>
<td>Every year</td>
</tr>
<tr>
<td>Cholesterol /Lipid Disorders in Adults</td>
<td>Males 35 years and over</td>
<td>Males-frequency depends on risk</td>
</tr>
<tr>
<td></td>
<td>Females 45 years and over</td>
<td>Females - Only if high risk</td>
</tr>
</tbody>
</table>

Based on U.S. Preventive Services Task Force A + B Recommendations

**based on high risk guidelines

WHEN YOU OR YOUR CHILD MISSES A WELLNESS VISIT

Please make your appointment with your PCP for a well visit as soon possible when you have a new PCP. This is very important weather you were up to date on well care or not. If vaccines or well care exams have not been on time, your PCP will make a plan to get you caught up. If you need help setting up the appointment, call Member Services at 410-779-9369, or 1-800-730-8530 and we will assist you in scheduling an appointment. TTY users should call 711.

UM Health Partners or your provider sends reminders for certain due dates of wellness visits and may contact you by phone, text or letter if wellness services are not completed on time. It’s our way of helping you stay healthy.
H. Care for Women During Pregnancy and Two Months After Delivery

UM Health Partners has special services for all pregnant members. It’s very important to see your PCP or OB/GYN for care when you are pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Early and regularly scheduled prenatal care is always important even if you have already had a baby.

UM Health Partners Case Managers are there to help pregnant members with complex health care needs. Our Case Managers work closely with pregnant members who have a complex medical need and teach them about how to manage their pregnancy to improve the chances of having a healthy baby. They also give emotional support and help members to follow their PCP’s care plan.

Our Case Managers also work with PCPs and OB/GYNs to make certain that members get the services they may need. UM Health Partners’ goal is to support better health for members and the birth of healthy babies.

WHEN YOU BECOME PREGNANT

If you think you are pregnant, call your PCP or OB/GYN doctor right away. You do not need a referral from your PCP to see an OB/GYN provider. Please call our Member Services Department at 410-779-9369 or 1-800-730-8530 if you need help finding an OB/GYN. TTY users should call 711. If you become pregnant and have special needs or medical problems, ask to speak to UM Health Partners’ OB Case Manager.

If you are a new UM Health Partners member who is pregnant and have been seen by a non-UM Health Partners provider for at least one complete prenatal checkup before you joined UM Health Partners, then you may be able to keep seeing that provider throughout your pregnancy, delivery and up to two months after your baby is born as long as your provider is willing to continue treating you.

When you are pregnant, UM Health Partners will send you a pregnancy education package. It will include:

- A letter welcoming you
- Self-care information

The self-care book gives you information about your pregnancy. You can also use the book to write down things that happen during your pregnancy. When you are pregnant, you must go to your PCP or OB/GYN at least:

- Every 4 weeks for the first 6 months,
- Every 2 weeks for the 7th and 8th months, and
- Every week during the last month

Your PCP or OB/GYN may want you to visit more than this based on your health needs.
While you are pregnant, you need to take good care of your health. You may be able to get healthy food from the Women, Infants and Children Program (WIC). For a list of WIC sites near you, you can call the WIC phone number for your county or city below:

<table>
<thead>
<tr>
<th>County</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegany County</td>
<td>301-724-3750</td>
</tr>
<tr>
<td>Anne Arundel County</td>
<td>410-222-6797</td>
</tr>
<tr>
<td>Baltimore City</td>
<td>410-396-9427</td>
</tr>
<tr>
<td>Baltimore County</td>
<td>410-887-6000</td>
</tr>
<tr>
<td>Calvert County</td>
<td>877-631-6182</td>
</tr>
<tr>
<td>Caroline County</td>
<td>410-479-8060</td>
</tr>
<tr>
<td>Carroll County</td>
<td>410-876-4898</td>
</tr>
<tr>
<td>Cecil County</td>
<td>410-996-5255</td>
</tr>
<tr>
<td>Charles County</td>
<td>301-609-6857</td>
</tr>
<tr>
<td>Dorchester County</td>
<td>410-228-3968</td>
</tr>
<tr>
<td>Frederick County</td>
<td>301-694-2507</td>
</tr>
<tr>
<td>Garrett County</td>
<td>301-334-7710</td>
</tr>
<tr>
<td>Harford County</td>
<td>410-273-5656</td>
</tr>
<tr>
<td>Howard County</td>
<td>410-313-7510</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kent County</td>
<td>410-810-0125</td>
</tr>
<tr>
<td>Montgomery County</td>
<td>301-762-9426</td>
</tr>
<tr>
<td>Prince George’s County</td>
<td>301-856-9600</td>
</tr>
<tr>
<td>Queen Anne’s County</td>
<td>410-758-0720</td>
</tr>
<tr>
<td>Somerset County</td>
<td>410-749-2488</td>
</tr>
<tr>
<td>St. Mary’s County</td>
<td>877-631-6182</td>
</tr>
<tr>
<td>Talbot County</td>
<td>410-822-0441</td>
</tr>
<tr>
<td>Washington County</td>
<td>301-791-3310</td>
</tr>
<tr>
<td>Wicomico County</td>
<td>410-749-2488</td>
</tr>
<tr>
<td>Worcester County</td>
<td>410-749-2488</td>
</tr>
</tbody>
</table>

WHEN YOU HAVE A NEW BABY

When you deliver your baby, you and your baby may stay in the hospital:

- 48 hours after a normal vaginal delivery
- 96 hours after a normal cesarean section (C-section)

You may stay in the hospital less time if your PCP or OB/GYN and the baby’s PCP see that you and your baby are doing well. You and your baby should stay in the hospital until your PCP or OB/GYN says you can leave. You and your baby can leave the hospital before your PCP or OB/GYN releases you but it is best not to do this. If you and your baby leave the hospital early, the PCP or OB/GYN may ask you to have an office or in-home nurse visit within 48 hours.

After you have your baby, you must call UM Health Partners Member Services as soon as you can to let us know you had your baby. We will need to get information about your baby. You may have already picked a PCP for your baby before he or she was born. If not, we will try to help you pick a PCP for your baby and get your baby enrolled in Medical Assistance. If you do not know who your baby’s PCP is, call Member Services.

After you have your baby, UM Health Partners will send you a postpartum education package. It will include:

- Baby-care information
- Wellness visit schedule for baby
- A brochure about postpartum depression
- A brochure about the importance of postpartum follow-up care

I. Family Planning

See sections, “BENEFITS AND SERVICES” and “SELF-REFERRAL SERVICES” See pages 7 and 15.
J. Adult Dental Care

UM Health Partners offers dental benefits to our adult members. Dental services are provided by DentaQuest. You can call us at 1-800-730-8530 to learn more about this benefit. Dental services do not require a referral from your PCP.

Coverage for adult members age 21 and over may include:

- Oral exams and cleanings
- X-rays
- Simple extractions
- Anesthesia when needed

K. Health Education Programs

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

Below are some examples of education topics:

- Diabetes Education
- Childbirth Preparation
- Infant care
- Quitting cigarette smoking
- Protecting yourself from violence
- Care for people with special needs
- Care for chronic conditions
- Other health topics

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

UM Health Partners’ website, www.umhealthpartners.com has member education you can view online or print off. The Community Calendar of Health Education Events is also posted on the website. UM Health Partners may periodically reach out to you by phone, text message or mailing to give you health education tips and materials. You will also receive a UM Health Partners Member Newsletter in the mail that includes health education information about wellness care, managing your illness, parenting and many other topics. The newsletter is also posted on UM Health Partners’ website, www.umhealthpartners.com.

L. Disease Management

UM Health Partners has Disease Management programs and a 24-hour nurse advice line to help you better understand and manage your chronic health problem. Together with your PCP our Health Coaches will help you to understand what health care services you may need to manage your disease and will work with you to create a plan of care. Disease management services are designed to be provided both telephonically and via a web portal. The web portal provides extensive life, health and wellness
resources including a health risk assessment, online health lessons, personalized reports, wellness plan, wellness tools, and a comprehensive Health & Life Reference Library.

UM Health Partners offers five Disease Management Programs: Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Chronic Heart Failure (CHF), Diabetes and Asthma. More information on our Disease Management Programs can be found on our website at www.umhealthpartners.com. If you have any of these conditions, we encourage you to contact UM Health Partners and ask to speak to a Health Coach. Our Health Coaches may also reach out to you by phone, letter or text. Call 1-844-685-8379 to reach the 24-hour nurse advise line.

M. Case Management

Individualized Complex Case Management Programs are provided to members who have experienced a critical medical event, been diagnosed with a chronic illness, and have multiple illnesses or complications. These programs are designed to help you get the services, resources and one-on-one coaching you may need to better manage your medical situation.

The goal of UM Health Partners’ Individualized Complex Case Management program is to help our members regain health or improve functional ability. Our case management services are provided to you over the phone or in your home upon request.

N. Referral for Case or Disease Management

UM Health Partners’ Case/Disease Management Programs are voluntary and are provided at no cost to you. Members identified with certain needs may be automatically enrolled, but are under no obligation to participate in these programs. Members and/or their caregivers wishing to initiate case management services can either call us at 410-779-9369 or 1-800-730-8530 (TTY users should call 711), or email us at healthservices@umhealthpartners.com. We are available Monday through Friday from 8 am to 5 pm. Any voicemail messages received after normal business hours will be addressed the following business day. UM Health Partners also provides after-hour services to answer any questions that a member may have about case management programs/services.

O. Medicines

UM Health Partners has a list of commonly prescribed drugs you or your child’s PCP or specialist can choose from to help you get well. This list is called a Preferred Drug List (PDL). The covered medicines include prescriptions and certain over-the-counter medicines. All UM Health Partners network providers have access to this drug list. Your/your child’s PCP or specialist should use this list when he or she writes a prescription. Certain medicines on the PDL and all medicines that are not listed on the UM Health Partners PDL will require prior authorization.

You can get your prescriptions and medicines from approved pharmacies in the UM Health Partners network. A list of UM Health Partners’ network pharmacies is in the Provider Directory that you got in your new member packet.

If you do not know if a pharmacy is in UM Health Partners’ network, you can call our Member Services Department at 410-779-9368 or 1-800-730-8530 and a representative will help you. TTY users should call 711.
It is better for you to use the same pharmacy in the UM Health Partners network. This way your pharmacist will know about problems that may occur when you are taking more than one medicine. If you use another pharmacy, you should tell the pharmacist about any other medicines you are taking. To get your medicines:

- Show your UM Health Partners member ID card. If your doctor has written a prescription for a mental health medicine, you will need to show your Medical Assistance card. Mental health medicines may be prescribed by your PCP or behavioral health provider.

UM Health Partners does not charge copays for either brand-name or generic drugs.

UM Health Partners also gives you an extra benefit for certain over-the-counter medicines. Each member can get up to $15 worth of these drugs each quarter. Some restrictions apply. Quarters begin on the 1st day of January, April, July and October. In order for you to get an over-the-counter medicine, your provider must give you a prescription. Give the prescription to the pharmacist at a UM Health Partners network pharmacy to be filled. You will need to show your UM Health Partners member ID card. Some restrictions may apply.

P. Services for Victims of Domestic Violence

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

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

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

If you have questions or need help, please call our Member Services Department at 1-800-730-8530 or call the National Domestic Violence hotline number at 1-800-799-7233.

Q. Access to Utilization Management (UM) Department

Business hours at UM Health Partners are 8:00 am – 5:00 pm, Monday through Friday, excluding holidays.

- UM Department staff are available at least 8 hours a day during normal business hours for inbound calls regarding UM issues. Staff can receive inbound communication regarding UM issues after normal business hours and can also send outbound communication during normal business hours to respond to inquiries about UM issues.
- UM staff can receive inbound communication regarding UM issues after normal business hours.
- UM Health Partners staff always identify themselves by name, title and name of the organization when initiating or returning calls regarding UM issues.
- If you would like to contact the UM Department, please call our toll free number at 1-800-730-8530.
• Language assistance is available for members to discuss UM issues. UM Health Partners also offers TDD/TTY services for members who are hard of hearing, deaf, and/or speech disabled.

R. Continuity of Health Care Notice

If you are a new enrollee you may be moving from another managed care organization ("MCO") or another company’s health benefit plan to University of Maryland Health Partners coverage. If you are currently receiving treatment, you have special rights in Maryland.

For example, if your old company gave you pre-approval to have surgery or to receive other services, you may not need to receive new approval from us 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 an in-network provider with your old company, and that provider is not an in-network provider under your new plan, you may continue to see your provider for a limited period of time as though the provider were an in-network provider with us.

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

Prior approval for health care services:

• If you previously were covered under another company’s plan, a prior approval (also called “preauthorization”) for services that you received under your old plan may be used to satisfy a prior approval requirement for those services if they are covered under your new plan with us.

• To be able to use the old prior approval under this new plan, you will need to contact us at 410-779-9369 or 1-800-730-8530 to let us know that you have a prior approval for the services and provide us with a copy of the prior approval. Your parent, guardian, designee, or health care provider may also contact us on your behalf about the prior approval.

• There is a time limit for how long you can rely on this prior approval. 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 Prior Approvals: Your special right to use a prior approval does not apply to:

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

• If you do not have a copy of the prior approval, contact your old company and request a copy. Under Maryland law, your old company must provide a copy of the prior approval within 10 days of your request.
**Right to use non-network providers:**

- If you have been receiving services from a health care provider who was an in-network provider with your old company, and that provider is a non-network provider under your new health plan with us, you may be able to continue to see your provider as though the provider were an in-network provider. You must contact us at 410-779-9369 or 1-800-730-8530 to request the right to continue to see the non-network provider as if the provider were an in-network provider with us. Your parent, guardian, designee, or health care provider may also contact us on your behalf to request the right for your continue to see the non-network provider.

- This right applies only if you are being treated by the non-network provider for covered services for one or more of the following types of conditions:
  1. Acute conditions;
  2. Serious chronic conditions;
  3. Pregnancy; or
  4. Any other condition upon which we and the out-of-network provider agree.

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

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

**Example of how the right to use non-network providers works:**

You broke your arm while covered under Company A’s health plan and saw a Company A network doctor to set your arm. You changed health plans and are now covered under Company B’s plan. Your doctor is not a network provider with Company B. You now need to have the cast removed and want to see the original doctor who put on the cast.

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

- **Limitation on Use of Non-Network Providers:** Your special right to use a non-network provider does not apply to:
  
  - Dental Services;
  - Mental health services;
  - Substance use disorder services; or
  - Benefits or services provided through the Maryland Medical Assistance fee-for-service program.
Appeal Rights:

- If we deny your right to use a prior approval from your old company or your right to continue to see a provider who was an in-network provider with your old company, you may appeal this denial by contacting us at 410-779-9369 or 1-800-730-8530.

- If we deny your appeal, you may file a complaint with the Maryland Medical Assistance Program by calling the HealthChoice Help Line at 1-800-284-4510.

- If you have any questions about this notice, please contact us at 410-779-9369 or 1-800-730-8530.

VI. BEHAVIORAL HEALTH SERVICES

How Do I Get Specialty Mental Health or Substance Use Disorder Services?

If you think you have mental health or substance use problems and need help, call the Public Behavioral Health System (PBHS), at 1-800-888-1965, or call our Member Services hotline, or speak with your PCP. Your PCP may help refer you to the PBHS. Their toll-free help line is open 24-hours a day, 7 days a week. The staff members are trained to handle your call and will help you get the services you need.

If you have received mental health or substance use disorder services in the past, and would like to see the same provider, let the staff know and every effort will be made to get you to the same provider.

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

VII. GRIEVANCES AND APPEALS

A. UM Health Partners’ Member Services and Hotline Information:

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

B. UM Health Partners’ Internal Grievance Procedures

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

Appeals

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

If you want to file an appeal you have to file it within 90 days for a Level I Appeal, from the date that you received the letter saying that we would not cover the service you wanted; and 15 days for a Level II Appeal, from the date on the Level I Appeal outcome letter.
You may file your appeal in writing. We have a simple form you can use to file your appeal. Please call Member Services at 410-779-9369 or 1-800-730-8530 to get one. We will mail or fax the appeal form to you and provide assistance if you need help completing it. This form can also be found on our website at www.umhealthpartners.com.

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

University of Maryland Health Partners  
Attention: Appeals & Grievance Department  
1966 Greenspring Drive, Suite 100  
Timonium, MD 21093

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

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

When reviewing your appeal we will:

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

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

If your doctor or UM Health Partners feels that your appeal should be reviewed quickly due to the seriousness of your condition, this is called an expedited appeal. A UM Health Partners Medical Director will review the request and determine if your issue is life threatening. You will receive a decision about your appeal within 72 hours. When you ask for an expedited appeal, you may do so by calling us, or asking us in writing.

If we do not feel that your appeal needs to be reviewed quickly, we will try to call you and send you a letter letting you know that your appeal will be reviewed within 30 days.

If your appeal is about a service that was already authorized and you were already receiving, you may be able to keep getting the service while we review your appeal. Contact us at 1-800-730-8530 if you would like to keep getting services while your appeal is reviewed. If you do not win your appeal, you may have to pay for the services that you received while the appeal was being reviewed.

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

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

If your grievance is:

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

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

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

University of Maryland Health Partners  
Attention: Appeals & Grievance Department  
1966 Greenspring Drive, Suite 100  
Timonium, MD 21093

C. THE STATE’S COMPLAINT PROCESS

Getting Help From the Enrollee Help Line

If you have a question or complaint about your health care and we have not solved the issue to your satisfaction, you can ask for help from the State’s Enrollee Help Line. To reach the Enrollee Help Line, call 1-800-284-4510 Monday through Friday between 7:30 am and 5:30 pm (or you can leave a recorded message at any other time).

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 us to discuss what you need; or
- Send your complaint to the Complaint Resolution Unit nurses who may:
  - Ask us to provide information about your case within five days;
  - Work with your provider and us to assist you in getting what you need;
  - Help you to get more community services, if needed; or
  - Help you to appeal denials and send you the fair hearing process in writing.
D. THE STATE’S APPEAL PROCESS

**Asking the State to Review Our Decision**

When you do not agree with our decision to deny, stop, or reduce a service, you can ask the State to review the decision. This is called an appeal.

You can contact the Enrollee Help Line at 1-800-284-4510 and tell the representative that you would like to appeal our 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 a choice to request a fair hearing or wait until the Complaint Resolution Unit has finished its review.

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

- If the State thinks we should provide the requested service, it can order us to give you the service; or
- If the State thinks that we do not have to give you the service, you will be told that the State agrees with us.

If you do not agree with the State’s decision, which you will receive in writing, you will again be given the opportunity to request a State Fair Hearing.

**Types of State Decisions You Can Appeal**

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

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

**Continuing Services During the Appeal**

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 the State reviews your appeal. Contact the Enrollee Help Line at 1-800-284-4510 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.

**Fair Hearings**

To appeal one of the State’s decisions, you must request that the State file a notice of appeal with the Office of Administrative Hearings on your behalf. This will be your appeal against the State. We usually will not be involved in the appeal, but our providers and staff members may appear as witnesses for the State at the appeal hearing.
The Office of Administrative Hearings will set a date for the hearing based on the type of decision being appealed.

- If the appeal is about us reducing or not giving you a service because both the State and UM Health Partners thinks you do not have a medical need for the service, the Office of Administrative Hearings will set a hearing date within 20 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.
- For all other appeals, the Office of Administrative Hearings will set a hearing date within 30 days of the day you file your appeal with the Office of Administrative Hearings. The Office of Administrative Hearings will make its decision on the case within 30 days of the date of the hearing.

You can ask for an expedited appeal. If the State thinks your hearing should be held more quickly due to the seriousness of your health condition, a hearing will be held and a decision will be made within 3 days.

**The Board of Review**

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

**Judicial Appeal**

If the Board of Review decides against you, you may appeal to the Circuit Court.

**E. How to Make Suggestions for Changes in Policies or Procedures**

If you would like to make a suggestion to change UM Health Partners’ policies or procedures, please call UM Health Partners’ Member Services Department at 410-779-9369 or 1-800-730-8530. TTY users should call 711. Also, you can send a letter to:

University of Maryland Health Partners  
1966 Greenspring Drive, Suite 100  
Timonium, MD 21093
Use this form if you want to tell us you have a complaint or when you don’t agree with a decision we made about your health care (an appeal). For help with this form, please call us at 410-779-9369 or 1-800-730-8530. TTY users should call 711. Our Member Services staff can talk to you Monday to Friday from 8:00 am to 5:00 pm.

Member Name: _______________________  Member ID: _______________  Today’s Date: _________

Member ID Number: ________________________________

Phone Number:  Home: _______________  Cell: _________________  Other: ________________

Please tell us why you are filing this complaint:

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

□ You have a complaint (grievance)

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Name of Member’s Primary Care Provider Name (if applicable): ________________________________

Date(s) of Service (if needed): ___________________________________________________________

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

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

□ Yes  □ No

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

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Signature of UM Health Partners Member:

____________________________________________________________________________________
Please fax the form to 410-779-9389 or mail it to:

University of Maryland Health Partners
Appeals & Grievances Department
1966 Greenspring Drive, Suite 100
Lutherville-Timonium, MD 21093

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

Signature of Representative: _________________________
Your Name: _________________________

Relationship to Member: ____________________________________________________________

Phone Number: Home: ____________________ Cell: __________________ Other: ____________________
VIII. CHANGING YOUR MCO

When Can I Change My MCO?

(1) During the first 90 days of Enrollment

You can request to change your MCO one time during the first 90 days if you are new to the HealthChoice Program as long as you are not hospitalized at the time of the request. You can also make this request within 90 days if you are automatically assigned to an MCO.

(2) Once a Year

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

(3) 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 we do 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 member 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
- If a child is placed in foster care and the foster care children or the family members receive care by a doctor in a different MCO than the child being placed, the child being placed can switch to the foster family’s MCO
- You desire to continue to receive care from your primary care provider (PCP) and the MCO terminated the PCP’s contract for one of the following reasons:
  - For reasons other than quality of care;
  - The provider and the MCO cannot agree on a contract for certain financial reasons; or
  - Your MCO has been purchased by another MCO.

Reasons the State will disenroll you from an MCO

The State will remove you (disenroll you) from an MCO if you:

- Are placed in a long term care facility for more than 30 days straight;
- Are admitted into an intermediate facility for persons with intellectual disabilities;
- Are approved for the Rare and Expensive Case Management Program;
- Are no longer qualified for State benefits;
- Are no longer qualified to be in an MCO because you are now in another State program which does not enroll its members in MCOs;
- Are in an MCO that no longer has a contract to provide care in the State of Maryland;
- Should not have been enrolled in an MCO;
- Are 65 or older;
- Are eligible for Medicare; or
- Are incarcerated
How Do I Change My MCO?

If you decide to change your MCO, you should contact the State’s Enrollment Broker at: 1-800-977-7388.

NOTE: If you temporarily lose your Medicaid eligibility but are approved again within 120 days, you will automatically be enrolled in UM Health Partners.

IX. NOTICE OF PRIVACY PRACTICES

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

What is this Notice?

This Notice tells you:

• How UM Health Partners handles your protected health information
• How UM Health Partners uses and gives out your protected health information
• Your rights about your protected health information
• Responsibilities UM Health Partners has in protecting your protected health information

This Notice follows what is known as the HIPAA Privacy Regulations. These regulations were given out by the federal government. The federal government requires companies such as UM Health Partners to follow the terms of the regulations and of this Notice.

This Notice is also available on the UM Health Partners website at www.umhealthpartners.com.

NOTE: You may also get a Notice of Privacy Practices from the State and other organizations.

What is Protected Health Information?

In this Notice, protected health information will be written as PHI. The HIPAA Privacy Regulations define protected health information as:

• Information that identifies you or can be used to identify you
• Information that either comes from you or has been created or received by a health care provider, a health plan, your employer, or a health care clearinghouse
• Information that has to do with your physical or mental health or condition, providing health care to you, or paying for providing health care to you

What are UM Health Partners’ Responsibilities to You about Your Protected Health Information?

Your/your family’s PHI is personal. We have rules about keeping this information private. These rules are designed to follow state and federal requirements. UM Health Partners must:

• We are required by law to maintain the privacy and security of your protected health information.
• We are required to keep your protected health information private and secure in all forms, including: hardcopy files, electronic files, as well as verbal communications. UM Health Partners is required by law to enable security and privacy features to ensure that these
protections are met. Entry into buildings and offices is kept secure and monitored; electronic access to PHI is provided based on the role of the staff member. Staff are trained annually on how to keep your information private during verbal communication.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

How does UM Health Partners Use Your Protected Health Information?

The sections that follow tell some of the ways we can use and share PHI without your written authorization.

For Payment — UM Health Partners may use PHI about you so that the treatment services you get may be looked at for payment. For example, a bill that your provider sends us may be paid using information that identifies you, your diagnosis, the procedures or tests, and supplies that were used.

For Health Care Operations — UM Health Partners may use PHI about you for health care operations. For example, we may use the information in your record to review the care and results in your case and other cases like it. This information will then be used to improve the quality and success of the health care you get. Another example of this is using information to help enroll you for health care coverage.

UM Health Partners may use PHI about you to help provide coverage for medical treatment or services. For example, information we get from a provider (nurse, PCP, or other member of a health care team) will be logged and used to help decide the coverage for the treatment you need. UM Health Partners may also use or share your PHI to:

- Send you information about one of our disease or case management programs
- Send reminder cards that let you know that it is time to make an appointment or get services like EPSDT or Child Health Checkup services
- Answer a customer service request from you
- Make decisions about claims requests and Administrative Reviews for services you received
- Look into any fraud or abuse cases and make sure required rules are followed
- We are not allowed to use genetic information to decide whether we will give you coverage

Other Uses of Protected Health Information

Business Associates — UM Health Partners may contract with business associates that will provide services to UM Health Partners using your PHI. Services our business associates may provide include dental services for members, a copy service that makes copies of your record, and computer software vendors. They will use your PHI to do the job we have asked them to do. The business associate must sign a contract to agree to protect the privacy of your PHI.

People Involved with Your Care or with Payment for Your Care — UM Health Partners may make your PHI known to a family member, other relative, close friend or other personal representative that you choose. This will be based on how involved the person is in your care, or payment that relates to your
care. We may share information with parents or guardians, if allowed by law.

**Law Enforcement** — UM Health Partners may share PHI if law enforcement officials ask us to. We will share PHI about you as required by law or in response to subpoenas, discovery requests, and other court or legal orders. Some requests made by a court may require us to notify you.

**Other Covered Entities** — UM Health Partners may use or share your PHI to help health care providers that relate to health care treatment, payment or operations. For example, we may share your PHI with a health care provider so that the provider can treat you.

**Public Health Activities** — UM Health Partners may use or share your PHI for public health activities allowed or required by law. For example, we may use or share information to help prevent or control disease, injury or disability. We also may share information to assist with product recalls, and reporting of adverse reactions to medication. We also may share information with a public health authority allowed to get reports of child abuse, neglect or domestic violence.

**Health Oversight Activities** — UM Health Partners may share your PHI with a health oversight agency for activities approved by law, such as audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies include government agencies that look after the health care system; benefit programs, including Medicaid, SCHIP or Healthy Kids, and other government regulation programs.

**Research** — UM Health Partners may share your PHI with researchers when an institutional review board or privacy board has followed the HIPAA information requirements.

**Coroners, Medical Examiners, Funeral Directors and Organ Donation** — UM Health Partners may share your PHI to identify a deceased person, determine a cause of death, or to do other coroner or medical examiner duties allowed by law. We also may share information with funeral directors, as allowed by law. We may also share PHI with organizations that handle organ, eye or tissue donation and transplants.

**To Prevent a Serious Threat to Health or Safety** — UM Health Partners may share your PHI if we feel it is needed to prevent or reduce a serious and likely threat to the health or safety of a person or the public.

**Military Activity and National Security** — Under certain conditions, UM Health Partners may share your PHI if you are or were in the Armed Forces. This may happen for activities believed necessary by appropriate military command authorities.

**Disclosures to the Secretary of the U.S. Department of Health and Human Services** — UM Health Partners is required to share your PHI with the Secretary of the U.S. Department of Health and Human Services. This happens when the Secretary looks into or decides if we are in compliance with the HIPAA Privacy Regulations.

**What are Your Rights Regarding Your Protected Health Information?**

**Right to Get the UM Health Partners Notice of Privacy Practices**

We are required to send each UM Health Partners’ head of case or head of household a printed copy of this Notice on or before (date needed). After that, each head of case or head of household will get a printed copy of the Notice in the New Member Welcome package.
We have the right to change this Notice. Once the change happens, it will apply to PHI that we have at the time we make the change and to the PHI we had before we made the change. A new Notice that includes the changes and the dates they are in effect will be mailed to you at the address we have for you.

The changes to our Notice will also be included on our website. You may ask for a paper copy of the Notice of Privacy Practices at any time. Call Member Services toll free at 410-779-9369 or 1-800-730-8530. TTY users should call 711. Our Member Services staff can talk with you Monday to Friday from 8:00 am to 5:00 pm.

Right to Access

You have the right to look at and get a copy of your enrollment, claims, payment, and case management information on file with UM Health Partners. This file of information is called a designated record set. We will provide the first copy to you in any 12-month period without charge.

If you would like a copy of your PHI, you must send a written request to UM Health Partners’ Director of Compliance. The address is at the end of this Notice. We will answer your written request in 30 calendar days. We may ask for an extra 30 calendar days to process your request if needed. We will let you know if we need the extra time.

We do not keep complete copies of your medical records. If you would like a copy of your medical record, contact your PCP or other provider. Follow the PCP’s or provider’s instructions to get a copy. Your PCP or other provider may charge a fee for the cost of copying and/or mailing the record.

We have the right to keep you from having or seeing all or part of your PHI for certain reasons. For example, if the release of the information could cause harm to you or other persons. Or, if the information was gathered or created for research or as part of a civil or criminal proceeding. We will tell you the reason in writing. We will also give you information about how you can file an Administrative Review if you do not agree with us.

Right to Amend

You have the right to ask that the information in your health record be changed if you think it is not correct. To ask for a change, send your request in writing to UM Health Partners’ Director of Compliance. We can send you a form to complete. You can also call Member Services to request a form. The address and phone number are at the end of this Notice.

- State the reason why you are asking for a change.
- If the change you ask for is in your medical record, get in touch with the provider who wrote the record. The provider will tell you what you need to do to have the medical record changed.

We will answer your request within 30 days of when we receive it. We may ask for an extra 30 days to process your request if needed. We will let you know if we need the extra time.

We may deny the request for change. We will send you a written reason for the denial if:

- The information was not created or entered by UM Health Partners
- The information is not kept by UM Health Partners
• You are not allowed, by law, to see and copy that information
• The information is already correct and complete

Right to an Accounting of Certain Disclosures of Your Protected Health Information

You have the right to get an accounting of certain disclosures of your PHI. This is a list of times we shared your information when it was not part of treatment, payment and health care operations.

Most disclosures of your PHI by our business associates or us will be for treatment, payment or health care operations.

To ask for a list of disclosures, please send a request in writing to UM Health Partners' Member Privacy Unit. We can send you a form to complete. For a copy of the form, contact Member Services. The address and phone number are at the end of this Notice. Your request must give a time-period that you want to know about.

Right to Request Restrictions

You have the right to ask that your PHI not be used or shared. You do not have the right to ask for limits when we share your PHI if we are asked to do so by law enforcement officials, court officials, or State and Federal agencies in keeping with the law. We have the right to deny a request for restriction of your PHI.

To ask for a limit on the use of your PHI, send a written request to UM Health Partners' Member Privacy Unit. We can send you a form to fill out. You can contact Member Services for a copy of the form. The address and phone number are at the end of this Notice. The request should include:

• The information you want to limit and why you want to restrict access
• Whether you want to limit when the information is used, when the information is given out, or both
• The person or persons that you want the limits to apply to

We will look at your request and decide if we will allow or deny the request within 30 days. If we deny the request, we will send you a letter and tell you why.

Right to Choose Someone to Act for You

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

Right to Cancel a Privacy Authorization for the Use or Disclosure of Protected Health Information

We must have your written permission (authorization) to use or give out your PHI for any reason other than treatment, payment and health care operations or other uses and disclosures listed under Other Uses of Protected Health Information. If we need your authorization, we will send you an authorization form explaining the use for that information.
You can cancel your authorization at any time by following the instructions below.

Send your request in writing to UM Health Partners' Member Privacy Unit. We can send you a form to complete. You can contact Member Services for a copy of the form. The address and phone number are at the end of this Notice. This cancellation will only apply to requests to use and share information asked for after we get your Notice.

**Right to Request Confidential Communications**

You have the right to ask that we communicate with you about your PHI in a certain way or in a certain location. For example, you may ask that we send mail to an address that is different from your home address.

Requests to change how we communicate with you should be submitted in writing to UM Health Partners' Member Privacy Unit. We can send you a form to complete. For a copy of the form, contact Member Services. The address and phone number are at the end of this Notice. Your request should state how and where you want us to contact you.

**What should you do if you have a complaint about the way that your protected health information is handled by UM Health Partners or our business associates?**

If you believe that your privacy rights have been violated, you may file a complaint with UM Health Partners or with the Secretary of Health and Human Services.

To file a complaint with UM Health Partners or to ask for an Administrative Review of a decision about your PHI, send a written request to UM Health Partners’ Member Privacy Unit or call Member Services. The address and phone number are at the end of this Notice.

To file a complaint with the Secretary of Health and Human Services, send your written request to:

Office for Civil Rights  
U.S. Department of Health and Human Services  
150 S. Independence Mall West, Suite 372  
Philadelphia, PA 19106-3499

OR

[www.hhs.gov/ocr/privacy/hipaa/complaints](http://www.hhs.gov/ocr/privacy/hipaa/complaints)

You will not lose your UM Health Partners membership or health care benefits if you file a complaint. Even if you file a complaint, you will still get health care coverage from UM Health Partners as long as you are a member. We will not retaliate against you for filing a complaint.

**Where should you call or send requests or questions about your protected health information?**

You may call us toll free at 410-779-9369 or 1-800-730-8530. TTY users call 711.
Or, you may send questions or requests, such as the examples listed in this Notice, to the address below:

University of Maryland Health Partners  
Director of Compliance  
1966 Greenspring Drive, Suite 100  
Timonium, MD 21093

Send your request to this address so that we can process it timely. Requests sent to persons, offices or addresses other than the address listed above might be delayed.

X. REPORTING FRAUD AND ABUSE

If you know someone who is misusing (through fraud, abuse and/or overpayment) the Medicaid Program, you can report him or her. Examples of fraud and abuse include:

- For Members:
  ▪  Using another member’s member ID card, or letting someone use your member ID card  
  ▪  Selling or giving your prescriptions to anyone else
- For Doctors, Hospitals, and Clinics:
  ▪  Billing for services that were not provided  
  ▪  Overcharging for services, or billing for the same service more than once

Please report all suspected incidents of member, provider, hospital, clinic, or other fraud and abuse to:

Director of Compliance  
University of Maryland Health Partners  
1966 Greenspring Drive, Suite 100  
Timonium, MD 21093  
410-779-9323

**Reports may be made anonymously**

**UM Health Partners maintains a policy that its employees will not harass, threaten, coerce, or retaliate against a person who reports fraud or abuse**

You may also report incidents of fraud and abuse to the Department of Health and Mental Hygiene (DHMH), Office of the Inspector General:

Fraud Hotline: 866-770-7175

http://dhmh.maryland.gov/oig

Reports of fraud and abuse are investigated by UM Health Partners and submitted to DHMH, or other necessary departments or agencies, including law enforcement, which may conduct a separate investigation. Credible reports of fraud and abuse may result in loss of Medicaid eligibility for members, sanctions for UM Health Partners providers, and/or fines or other penalties permitted by law.
XI. ADVANCE DIRECTIVES

You have the right to make an advance directive (a living will). Please see the information on the following pages. You can also call Member Services for more information.

MARYLAND ADVANCE DIRECTIVE

PLANNING FOR FUTURE HEALTH CARE DECISIONS

A guide to Maryland Law on Health Care Decisions

(Forms Included)
Dear Fellow Marylander:

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

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

Here is some related, important information:

If you want information about Emergency Medical Services (EMS) Palliative Care/Do Not Resuscitate (DNR) Orders, please contact the Maryland Institute for Emergency Medical Services Systems directly at (410) 706-4367. An EMS/DNR Order is a physician’s instruction to emergency medical personnel (911 responders) to provide comfort care instead of resuscitation. The EMS/DNR Order can be found on the Internet at: [http://www.miemss.org](http://www.miemss.org). From that page, click on “EMS Forms.”

The Maryland Department of Health and Mental Hygiene makes available an advance directive focused on preferences about mental health treatment. This can be found on the Internet at: [www.dhmh.state.md.us/mha](http://www.dhmh.state.md.us/mha). From that page, click on “MHA Forms.”

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: [www.oag.state.md.us/healthpol/advancedirectives.htm](http://www.oag.state.md.us/healthpol/advancedirectives.htm).

**HEALTH CARE PLANNING USING ADVANCE DIRECTIVES**

Optional Form Included

**Your Right To Decide**

Adults can decide for themselves whether they want medical treatment. This right (to decide to say yes or no to proposed treatment) applies to treatments that extend life, like a breathing machine or a feeding tube. Tragically, accident or illness can take away a person's ability to make health care decisions. But decisions still have to be made. If you cannot do so, someone else will. These decisions should reflect your own values and priorities.
A Maryland law called the Health Care Decisions Act says that you can do health care planning through “advance directives.” An advance directive can be used to name a health care agent. This is someone you trust to make health care decisions for you. An advance directive can also be used to say what your preferences are about treatments that might be used to sustain your life.

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

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

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

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

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

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

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

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

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

We have a helpful booklet that you can give to your health care agent. It is called “Making Medical Decisions for Someone Else: A Maryland Handbook.” You or your agent can get a copy on the Internet by visiting to the Attorney General’s home page at: http://www.oag.state.md.us, then clicking on “Guidance for Health Care Proxies.” You can also 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 healthcare facility where a patient is receiving care.

3. **Who can witness an advance directive?**

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

4. **Do the forms have to be notarized?**

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

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

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

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

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

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

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

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

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

Contact Caring Connections (NHPCO) at 1-800-658-8898 or on the Internet at: http://www.caringinfo.org.

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. **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.

14. **If I have an advance directive, do I also need an Emergency Medical Services Palliative Care/Do Not Resuscitate Order?**

Yes. If you don't want ambulance personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have an EMS Palliative Care/DNR Order signed by your doctor.

15. **Does the EMS Palliative Care/DNR Order have to be in a particular form?**

Yes. Ambulance 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, a standardized order form has been developed. Have your doctor or health care facility contact the Maryland Institute for Emergency Medical Services System at (410) 706-4367 to obtain information on EMS Palliative Care/DNR Orders.
16. **Can I fill out a form to become an organ donor?**

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

17. **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 1-877-463-3464 for that form and additional information.
Maryland Advance Directives

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: _____________________________________________________

B. Selection of Back-up Agents

(Optional; form valid if left blank)

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

   Name: ________________________________________________________________

   Address: ______________________________________________________________

   Telephone Numbers: _____________________________________________________

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

   Name: ________________________________________________________________

   Address: ______________________________________________________________

   Telephone Numbers: _____________________________________________________
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.

<table>
<thead>
<tr>
<th>Name(s)</th>
<th>Telephone Number(s):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
F. In Case of Pregnancy
(Optional, for women of child-bearing years only; form valid if left blank)

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

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

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

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.

2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

H. Effectiveness of this Part
(Read both of these statements carefully. Then, initial one only.)

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. __________
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 women of child-bearing years only; form valid if left blank)

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

G. **Effect of Stated Preferences** (Read both of these statements carefully. Then, initial one only.)

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

>>>OR<<

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

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

_________________________________________________________________         _____________________
(Signature of Declarant)                                          (Date)

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

_________________________________________________________________         _____________________
(Signature of Witness)                                           (Date)

_________________________________________________________________
(Telephone Numbers)

_________________________________________________________________         _____________________
(Signature of Witness)                                           (Date)

_________________________________________________________________
(Telephone Numbers)

(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.)

BY: ____________________________________ Date of Birth: __________
(Print Name)                                                       (Month/Day/Year)
AFTER MY DEATH
(This document is optional. Do only what reflects your wishes)

By: __________________________________________
(Print Name)
Date of Birth: __________________________
(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 Numbers:_______________________________________________

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 No:________________________________________

______________________________________________________   ___________________
(Signature of Witness)                                                                         (Date)

Telephone No: __________________________________________
Advance Directives
Information Sheet

What You Should Know About Advance Directives?
Everyone has the right to make personal decisions about health care. Doctors ask whether you will accept a treatment by discussing the risks and benefits and working with you to decide. But what if you can no longer make your own decisions? Anyone can wind up hurt or sick and unable to make decisions about medical treatments. An advance directive speaks for you if you are unable to and helps make sure your religious and personal beliefs will be respected. It is a useful legal document for an adult of any age to plan for future health care needs. While no one is required to have an advance directive, it is smart to think ahead and make a plan now. If you don’t have an advance directive and later you can’t speak for yourself, then usually your next of kin will make health care decisions for you. But even if you want your next of kin to make decisions for you, an advance directive can make things easier for your loved ones by helping to prevent misunderstandings or arguments about your care.

What can you do in an advance directive?
An advance directive allows you to decide who you want to make health care decisions for you if you are unable to do so yourself. You can also use it to say what kinds of treatments you do or do not want, especially the treatments often used in a medical emergency or near the end of a person’s life.

1. Health Care Agent. Someone you name to make decisions about your health care is called a “health care agent” (sometimes also called a “durable power of attorney for health care,” but, unlike other powers of attorney, this is not about money). You can name a family member or someone else. This person has the authority to see that doctors and other health care providers give you the type of care you want, and that they do not give you treatment against your wishes. Pick someone you trust to make these kinds of serious decisions and talk to this person, to make sure he or she understands and is willing to accept this responsibility.

2. Health Care Instructions. You can let providers know what treatments you want to have or not to have. (Sometimes this is called a “living will,” but it has nothing to do with an ordinary will about property.) Examples of the types of treatment you might decide about are:
   a. Life support – such as breathing with a ventilator
   b. Efforts to revive a stopped heart or breathing (CPR)
   c. Feeding through tubes inserted into the body
   d. Medicine for pain relief

Ask your doctor for more information about these treatments. Think about how, if you become badly injured or seriously ill, treatments like these fit in with your goals, beliefs, and values.
How do you prepare an advance directive?
Begin by talking things over, if you want, with family members, close friends, your doctor, or a religious
advisor. Many people go to a lawyer to have an advance directive prepared. You can also get sample
forms yourself from many places, including the ones given as examples at the end of this information
sheet. There is no one form that must be used. You can even make up your own advance directive
document.

To make your advance directive valid, it must be signed by you in the presence of two witnesses, who
will also sign. If you name a health care agent, make sure that person is not a witness. Maryland law
does not require the document to be notarized. You should give a copy of your advance directive to your
doctor, who will keep it in your medical file, and to others you trust to have it available when needed.
Copies are just as valid as the originals. You can also make a valid advance directive by talking to your
doctor in front of a witness.

When would your advance directive take effect?
Usually, your advance directive would take effect when your doctor certifies in writing that you are not
capable of making a decision about your care. If your advance directive contains health care instructions,
they will take effect depending on your medical condition at the time. If you name a health care agent,
you should make clear in the advance directive when you want the agent to be able to make decisions
for you.

Can you change your advance directive?
Yes, you can change or take back your advance directive at any time. The most recent one will count.

Where can you get forms and more information about advance directives?
There are many places to get forms, including medical, religious, aging assistance, and legal organizations.
Three places are shown below, but these are just examples. Any of these forms are valid in Maryland,
but not all may be in keeping with your beliefs and values. Your advance directive does not have to be
on any particular form.

Call The Maryland Attorney General’s Office
410-576-7000 or 1-888-734-0023
www.oag.state.md.us/healthpol/adirective.pdf

Call Caring Connections (NHPCO)
1-800-658-8898
www.caringinfo.org

Call Aging with Dignity
1-800-594-7437
www.agingwithdignity.org
Notice of Non-Discrimination

University of Maryland Health Partners complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. University of Maryland Health Partners does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

University of Maryland Health Partners

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Member Services at 410-779-9369, or toll-free at 1-800-730-8530 from 8 AM to 5 PM EST Monday through Friday. TTY users should call 711.

If you believe that University of Maryland Health Partners has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

University of Maryland Health Partners
c/o Appeals and Grievance Department
1966 Greenspring Drive, Suite 100
Timonium, MD 21093

Phone: 410-779-9369, or toll-free at 1-800-730-8530. TTY users should call 711.
Fax: 410-779-9367

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Appeals and Grievance Department is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html