[MCO – add cover sheet and taglines page]

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Section – 1

Welcome

Introduction

What is HealthChoices?

HealthChoices is Pennsylvania's Medical Assistance managed care program. The Office of Medical Assistance Programs (OMAP) in Pennsylvania's Department of Human Services (DHS) oversees the physical health portion of HealthChoices. Physical health services are provided through the physical health managed care organizations (PH-MCOs). Behavioral health services are provided through behavioral health managed care organizations (BH-MCOs). For more information on behavioral health services, see page **[MCO insert page number]**.

Welcome to [MCO Name]

[MCO Name] welcomes you as a member in HealthChoices and **[MCO Name]**! **[MCO to provide a brief description of plan including a map of counties where the plan operates.] [MCO Name]** has a network of contracted providers, facilities, and suppliers to provide covered physical health services to members. **[MCO to provide explanation of the need/importance to get services from network providers]**

Member Services

Staff at Member Services can help you with:

[MCO to provide list and description of things that Member Services can help with and services offered]

[MCO Name]'s Member Services are available:

[MCO to provide hours of operation]

And can be reached at **[MCO Member Services Phone Number and TTY]**

Member Services can also be contacted in writing at:

[MCO address]

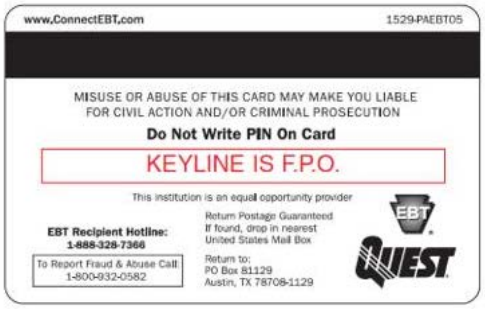
And

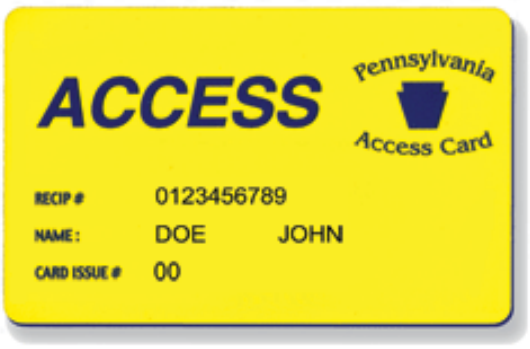
[MCO to provide any additional means of contact (email, website, etc.)]

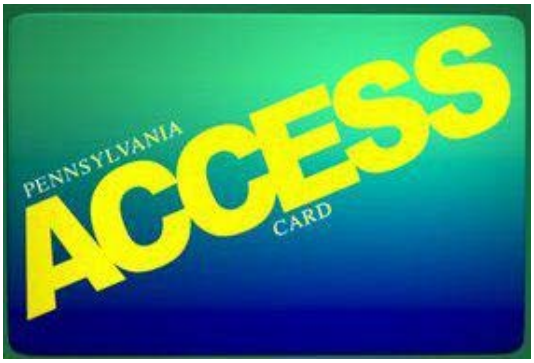
Member Identification Cards

[MCO to provide description of member ID card and pharmacy card, if it has one, and image(s). The MCO should explain what information is on the card(s) and how they are used. It should also explain what to do if a card is lost or stolen, with a statement that explains services the member is receiving will continue and all services will continue to be available while the member waits for a new card to be delivered.]

You will also get an ACCESS or EBT card. You will need to present this card along with your **[MCO Name] ID** card at all appointments. If you lose your ACCESS or EBT card, call your County Assistance Office (CAO). The phone number for the CAO is listed later in the **Important Contact Information** section. You will receive one of the following two cards.







Until you get your **[MCO Name]** ID card, use your ACCESS or EBT card for your health care services that you get through HealthChoices.

Important Contact Information

The following is a list of important phone numbers you may need. If you are not sure who to call, please contact Member Services for help: **[MCO Member Services Phone Number and TTY]**.

Emergencies

Please see Section 3, Covered Physical Health Services, beginning on page **[xx],** for more information about emergency services. If you have an emergency, you can get help by going to the nearest emergency department, calling 911, or calling your local ambulance service.

Important Contact Information – At a Glance

Name	Contact Information: Phone or Website	Support Provided
Pennsylvania Department of Human Services Phone Numbers		
County Assistance Office/COMPASS	1-877-395-8930 or 1-800-451-5886 (TTY/TTD) or www.compass.state.pa.us or myCOMPASS PA mobile app for smart phones	Change your personal information for Medical Assistance eligibility. See page **[page]** of this handbook for more information.
Fraud and Abuse Reporting Hotline, Department of Human Services	1-844-DHS-TIPS (1-844-347-8477)	Report member or provider fraud or abuse in the Medical Assistance Program. See page **[page]** of this handbook for more information.
Other Important Phone Numbers		
[MCO Name] Nurse Hotline	**[MCO Name Nurse Hotline Phone Number]**	Talk with a nurse 24 hours a day, 7 days a week, about urgent health matters. See page **[page]** of this handbook for information.
Enrollment Assistance Program	1-800-844-3989 1-800-618-4255 (TTY)	Pick or change a HealthChoices plan. See page **[page]** of this handbook for more information.

Insurance Department, Bureau of Consumer Services	1-877-881-6388	Ask for a Complaint form, file a Complaint, or talk to a consumer services representative.
Protective Services	1-800-490-8505	Report suspected abuse, neglect, exploitation, or abandonment of an adult over age 60 or an adult between age 18 and 59 who has a physical or mental disability.

Other Phone Numbers

[MCO to provide list of relevant phone numbers (CAOs, MATP, etc.) in counties of operation here or make reference to an appendix at the end of the manual.]
[The following is a list of resources as an example of what may be included, as appropriate. This is not an exhaustive list.]

Childline	1-800-932-0313
County Assistance Office	**[MCO to provide]**
Crisis Intervention Services	**[MCO to provide]**
Legal Aid	**[MCO to provide]**
Medical Assistance Transportation Program	**[MCO to provide]**
Mental Health/Intellectual Disability Services	**[MCO to provide]**
National Suicide Prevention Lifeline	1-800-273-8255

Communication Services

[MCO Name] can provide this Handbook and other information you need in languages other than English at no cost to you. **[MCO Name]** can also provide your Handbook and other information you need in other formats such as compact disc, Braille, large print, DVD, electronic communication, and other formats if you need them, at no cost to you. Please contact Member Services at **[MCO Member Services Phone Number and TTY]** to ask for any help you need. Depending on the information you need, it may take up to 5 business days for **[MCO Name]** to send you the information.

[MCO Name] will also provide an interpreter, including for American Sign Language or TTY services, if you do not speak or understand English or are deaf or hard of hearing. These services are available at no cost to you. If you need an interpreter, call Member

Services at **[MCO Member Services Phone Number and TTY]** and Member Services will connect you with the interpreter service that meets your needs. For TTY services, call our specialized number at **[MCO TTY Direct Number]** or call Member Services who will connect you to the next available TTY line.

If your PCP or other provider cannot provide an interpreter for your appointment, **[MCO Name]** will provide one for you. Call Member Services at **[MCO Member Services Phone Number and TTY]** if you need an interpreter for an appointment.

Enrollment

In order to get services in HealthChoices, you need to stay eligible for Medical Assistance. You will get paperwork or a phone call about renewing your eligibility. It is important that you follow instructions so that your Medical Assistance does not end. If you have questions about any paperwork you get or if you are unsure whether your eligibility for Medical Assistance is up to date, call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** or your CAO.

[MCO to add enrollment information as necessary]

Enrollment Services

The Medical Assistance Program works with the Enrollment Assistance Program (EAP) to help you enroll in HealthChoices. You received information about the EAP with the information you received about selecting a HealthChoices plan. Enrollment specialists can give you information about all of the HealthChoices plans available in your area so that you can decide which one is best for you. If you do not pick a HealthChoices plan, a HealthChoices plan will be chosen for you. Enrollment specialists can also help you if you want to change your HealthChoices plan or if you move to another county.

Enrollment specialists can help you:

- Pick a HealthChoices plan
- Change your HealthChoices plan
- Pick a PCP when you first enroll in a HealthChoices plan
- Answer questions about all of the HealthChoices plans
- Determine whether you have special needs, which could help you decide which HealthChoices plan to pick
- Give you more information about your HealthChoices plan

To contact the EAP, call 1-800-440-3989 or 1-800-618-4225 (TTY).

Changing Your HealthChoices Plan

You may change your HealthChoices plan at any time, for any reason. To change your HealthChoices plan, call the EAP at 1-800-440-3989 or 1-800-618-4225 (TTY). They will tell you when the change to your new HealthChoices plan will start, and you will stay in **[MCO Name]** until then. It can take up to 6 weeks for a change to your HealthChoices plan to take effect. Use your **[MCO Name]** ID card at your appointments until your new plan starts.

Changes in the Household

Call your CAO and Member Services at **[MCO Member Services Phone Number and TTY]** if there are any changes to your household.

For example:

- Someone in your household is pregnant or has a baby
- Your address or phone number changes
- You or a family member who lives with you gets other health insurance
- You or a family member who lives with you gets very sick or becomes disabled
- A family member moves in or out of your household
- There is a death in the family

A new baby is automatically assigned to the mother's current HealthChoices plan. You may change your baby's plan by calling the EAP at **1-800-440-3989**. Once the change is made you will receive a new HealthChoices member ID card for your baby.

Remember that it is important to call your CAO right away if you have any changes in your household because the change could affect your benefits.

What Happens if I Move?

If you move out of your county, you may need to choose a new HealthChoices plan. Contact your CAO if you move. If **[MCO Name]** also serves your new county, you can stay with **[MCO Name]**. If **[MCO Name]** does not serve your new county, the EAP can help you select a new plan.

If you move out of state, you will no longer be able to get services through HealthChoices. Your caseworker will end your benefits in Pennsylvania. You will need to apply for benefits in your new state.

Loss of Benefits

There are a few reasons why you may lose your benefits completely.

They include:

- Your Medical Assistance ends for any reason. If you are eligible for Medical Assistance again within 6 months, you will be re-enrolled in the same HealthChoices plan unless you pick a different HealthChoices plan.
- You go to a nursing home outside of Pennsylvania.
- You have committed Medical Assistance fraud and have finished all appeals.
- You go to prison or are placed in a youth development center.

There are also reasons why you may no longer be able to receive services through a physical health MCO and you will be placed in the fee-for service program.

They include:

- You are placed in a juvenile detention center for more than 35 days in a row.
- You are 21 years of age or older and begin receiving Medicare Part D (Prescription Drug Coverage).
- You go to a state mental health hospital

You may also become eligible for Community HealthChoices. If you become eligible for Medicare coverage or become eligible for nursing facility or home and community based services, you will be eligible for Community HealthChoices. For more information on Community HealthChoices visit www.healthchoices.pa.gov.

You will receive a notice from DHS if you lose your benefits or if you are no longer able to receive services through a physical health MCO and will begin to receive services through the fee-for-service system or Community HealthChoices.

Information About Providers

The **[MCO Name]**'s provider directory has information about the providers in **[MCO Name]**'s network. The provider directory is located online here: **[MCO Provider Directory Website link].** You may call Member Services at **[MCO Member Services Phone Number and TTY]** to ask that a copy of the provider directory be sent to you or to request information about where a doctor went to medical school or their residency program. You may also call Member Services to get help finding a provider. The

provider directory includes the following information about network providers:

- Name, address, website address, email address, telephone number
- Whether or not the provider is accepting new patients
- Days and hours of operation
- The provider's credentials and board certifications
- The provider's specialty and services offered by the provider
- Whether or not the provider speaks languages other than English and, if so, which languages
- Whether or not the provider locations are wheelchair accessible

*The information in the printed provider directory may change. You can call Member Services to check if the information in the provider directory is current. **[MCO Name]** updates the printed provider directory **[Frequency]**. The online directory is updated at least monthly.

Picking Your Primary Care Provider (PCP)

Your PCP is the doctor or doctors' group who provides and works with your other health care providers to make sure you get the health care services you need. Your PCP refers you to specialists you need and keeps track of the care you get by all of your providers.

A PCP may be a family doctor, a general practice doctor, a pediatrician (for children and teens), or an internist (internal medicine doctor). You may also pick a certified registered nurse practitioner (CRNP) as a PCP. A CRNP works under the direction of a doctor and can do many of the same things a doctor can do such as prescribing medicine and diagnosing illnesses.

Some doctors have other medical professionals who may see you and provide care and treatment under the supervision of your PCP.

Some of these medical professionals may be:

- Physician Assistants
- Medical Residents
- Certified Nurse-Midwives

If you have Medicare, you can stay with the PCP you have now even if your PCP is not in **[MCO Name]**'s network. If you do not have Medicare, your PCP must be in **[MCO Name]**'s network.

If you have special needs, you can ask for a specialist to be your PCP. The specialist needs to agree to be your PCP and must be in **[MCO Name]**'s network.

Enrollment specialists can help you pick your first PCP with **[MCO Name].** If you do not pick a PCP through the EAP within 14 days of when you picked **[MCO Name],** we will pick your PCP for you.

[MCO to provide any additional PCP information needed]

Changing Your PCP

If you want to change your PCP for any reason, call Member Services at **[MCO Member Services Phone Number and TTY]** to ask for a new PCP. If you need help finding a new PCP, you can go to **[MCO website address]**, which includes a provider directory, or ask Member Services to send you a printed provider directory.

[MCO Name] will send you a new ID card with the new PCP's name and phone number on it. The Member Services representative will tell you when you can start seeing your new PCP.

When you change your PCP, **[MCO Name]** can help coordinate sending your medical records from your old PCP to your new PCP. In emergencies, **[MCO Name]** will help to transfer your medical records as soon as possible.

If you have a pediatrician or pediatric specialist as a PCP, you may ask for help to change to a PCP who provides services for adults.

Office Visits

Making an Appointment with Your PCP

To make an appointment with your PCP, call your PCP's office. If you need help making an appointment, please call **[MCO Name]**'s Member Services at **[MCO Member Services Phone Number and TTY]**.

If you need help getting to your doctor's appointment, please see the Medical Assistance Transportation Program (MATP) section on page **[MCO insert page number of MATP information]**, of this Handbook or call **[MCO Name]**'s Member Services at the phone number above.

If you do not have your **[MCO Name]** ID card by the time of your appointment, take your ACCESS or EBT card with you. You should also tell your PCP that you selected **[MCO Name]** as your HealthChoices plan.

Appointment Standards

[MCO Name]'s providers must meet the following appointment standards:

- Your PCP should see you within 10 business days of when you call for a routine appointment.
- You should not have to wait in the waiting room longer than 30 minutes, unless the doctor has an emergency.
- If you have an urgent medical condition, your provider should see you within 24 hours of when you call for an appointment.
- If you have an emergency, the provider must see you immediately or refer you to an emergency room.
- If you are pregnant and
    - In your first trimester, your provider must see you within 10 business days of **[MCO Name]** learning you are pregnant.
    - In your second trimester, your provider must see you within 5 business days of **[MCO Name]** learning you are pregnant.
    - In your third trimester, your provider must see you within 4 business days of **[MCO Name]** learning you are pregnant.
    - Have a high-risk pregnancy, your provider must see you within 24 hours of **[MCO Name]** learning you are pregnant.

Referrals

A referral is when your PCP sends you to a specialist. A specialist is a doctor (or a doctor's group) or a CRNP who focuses his or her practice on treating one disease or medical condition or a specific part of the body. If you go to a specialist without a referral from your PCP, you may have to pay the bill.

If **[MCO Name]** does not have at least 2 specialists in your area and you do not want to see the one specialist in your area, **[MCO Name]** will work with you to see an out-of-network specialist at no cost to you. Your PCP must contact **[MCO Name]** to let **[MCO Name]** know you want to see an out-of-network specialist and get approval from **[MCO Name]** before you see the specialist.

Your PCP will help you make the appointment with the specialist. The PCP and the specialist will work with you and with each other to make sure you get the health care you need.

Sometimes you may have a special medical condition where you need to see the specialist often. When your PCP refers you for several visits to a specialist, this is called a standing referral.

For a list of specialists in **[MCO Name]**'s network, please see the provider directory on our website at **[MCO Provider Directory Website link]** or call Member Services to ask for help or a printed provider directory.

Self-Referrals

Self-referrals are services you arrange for yourself and do not require that your PCP arrange for you to receive the service. You must use a **[MCO Name]** network provider unless **[MCO Name]** approves an out-of-network provider.

The following services do not require referral from your PCP:

- Prenatal visits
- Routine obstetric (OB) care
- Routine gynecological (GYN) care
- Routine family planning services (may see out-of-network provider without approval)
- Routine dental services
- Routine eye exams
- Emergency services

You do not need a referral from your PCP for behavioral health services. You can call your behavioral health managed care organization for more information. Please see section 7 of the handbook, on page **[MCO to add page number]** for more information

After-Hours Care

You can call your PCP for non-emergency medical problems 24 hours a day, 7 days a week. On-call health care professionals will help you with any care and treatment you need.

[MCO Name] has a toll-free nurse hotline at **[MCO Nurse Hotline Phone Number]** that you can also call 24 hours a day, 7 days a week. A nurse will talk with you about your urgent health matters.

Member Engagement

Suggesting Changes to Policies and Services

[MCO Name] would like to hear from you about ways to make your experience with HealthChoices better. If you have suggestions for how to make the program better or how to deliver services differently, please contact **[MCO Contact].**

[MCO Name] Health Education Advisory Committee (HEAC)

[MCO Name] has a Health Education Advisory Committee (HEAC) that includes members and network providers. The Committee provides advice to **[MCO Name]** about the experiences and needs of members like you. For more information about the Committee, please call **[MCO phone number]** or visit the website at **[MCO Name website]**.

[MCO Name] Quality Improvement Program

[MCO to provide description of its quality improvement program including contact information]

Section – 2

Rights and Responsibilities

Member Rights and Responsibilities

[MCO Name] and its network of providers do not discriminate against members based on race, sex, religion, national origin, disability, age, sexual orientation, gender identity, or any other basis prohibited by law.

As a **[MCO Name]** member, you have the following rights and responsibilities.

Member Rights

You have the right:

1. To be treated with respect, recognizing your dignity and need for privacy, by **[MCO Name]** staff and network providers.

2. To get information in a way that you can easily understand and find help when you need it.

3. To get information that you can easily understand about **[MCO Name]**, its services, and the doctors and other providers that treat you.
4. To pick the network health care providers that you want to treat you.
5. To get emergency services when you need them from any provider without **[MCO Name]**'s approval.
6. To get information that you can easily understand and talk to your providers about your treatment options, risks of treatment, and tests that may be self-administered without any interference from **[MCO Name]**.
7. To make all decisions about your health care, including the right to refuse treatment. If you cannot make treatment decisions by yourself, you have the right to have someone else help you make decisions or make decisions for you.
8. To talk with providers in confidence and to have your health care information and records kept confidential.
9. To see and get a copy of your medical records and to ask for changes or corrections to your records.
10. To ask for a second opinion.

11. To file a Grievance if you disagree with **[MCO Name]**'s decision that a service is not medically necessary for you.
12. To file a Complaint if you are unhappy about the care or treatment you have received.
13. To ask for a DHS Fair Hearing.
14. To be free from any form of restraint or seclusion used to force you to do something, to discipline you, to make it easier for the provider, or to punish you.
15. To get information about services that **[MCO Name]** or a provider does not cover because of moral or religious objections and about how to get those services.
16. To exercise your rights without it negatively affecting the way DHS, **[MCO Name],** and network providers treat you.
17. To create an advance directive. See Section 6 on page **[MCO to add page number]** for more information.
18. To make recommendations about the rights and responsibilities of **[MCO name]**'s members.

Member Responsibilities

Members need to work with their health care service providers. **[MCO Name]** needs your help so that you get the services and supports you need.

These are the things you should do:

1. Provide, to the extent you can, information needed by your providers.
2. Follow instructions and guidelines given by your providers.
3. Be involved in decisions about your health care and treatment.
4. Work with your providers to create and carry out your treatment plans.
5. Tell your providers what you want and need.
6. Learn about **[MCO Name]** coverage, including all covered and non-covered benefits and limits.
7. Use only network providers unless **[MCO Name]** approves an out-of-network provider or you have Medicare.
8. Get a referral from your PCP to see a specialist.

9. Respect other patients, provider staff, and provider workers.
10. Make a good-faith effort to pay your co-payments.
11. Report fraud and abuse to the DHS Fraud and Abuse Reporting Hotline.

Privacy and Confidentiality

[MCO Name] must protect the privacy of your protected health information (PHI). **[MCO Name]** must tell you how your PHI may be used or shared with others. This includes sharing your PHI with providers who are treating you or so that **[MCO Name]** can pay your providers. It also includes sharing your PHI with DHS. This information is included in **[MCO Name]**'s Notice of Privacy Practices. To get a copy of **[MCO Name]**'s Notice of Privacy Practices, please call **[MCO Privacy Contact]** or visit **[MCO Website]**.

Co-payments

A co-payment is the amount you pay for some covered services. It is usually only a small amount. You will be asked to pay your co-payment when you get the service, but you cannot be denied a service if you are not able to pay a co-payment at that time. If you did not pay your co-payment at the time of the service, you may receive a bill from your provider for the co-payment.

Co-payment amounts can be found in the Covered Services chart starting on page **[MCO to insert page number]** of this Handbook.

The following members do not have to pay co-payments:

- Members under age 18
- Pregnant women (including 60 days after the child is born (the post-partum period))
- Members who live in a long-term care facility, including Intermediate Care Facilities for the Intellectually Disabled and Other Related Conditions or other medical institution
- Members who live in a personal care home or domiciliary care home
- Members eligible for benefits under the Breast and Cervical Cancer Prevention and Treatment Program

- Members eligible for benefits under Title IV-B Foster Care and Title IV-E Foster Care and Adoption Assistance

The following services do not require a co-payment:

- Emergency services
- Laboratory services
- Family planning services, including supplies
- Hospice services
- Home health services
- Tobacco cessation services
- **[MCO to identify any additional services exempt from co-payment]**

What if I Am Charged a Co-payment and I Disagree?

If you believe that a provider charged you the wrong amount for a co-payment or a co-payment you believe you should not have had to pay, you can file a Complaint with **[MCO Name]**. Please see Section 8, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint, or call Member Services at **[MCO Member Services Phone Number and TTY]**.

Billing Information

Providers in **[MCO Name]**'s network may not bill you for medically necessary services that **[MCO Name]** covers. Even if your provider has not received payment or the full amount of his or her charge from **[MCO Name]**, the provider may not bill you. This is called balance billing.

When Can a Provider Bill Me?

Providers may bill you if:

- You did not pay your co-payment.
- You received services from an out-of-network provider without approval from **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.
- You received services that are not covered by **[MCO Name]** and the provider told you before you received the service that the service would not be covered, and you agreed to pay for the service.

- You received a service from a provider that is not enrolled in the Medical Assistance Program.

What Do I Do if I Get a Bill?

If you get a bill from a **[MCO Name]** network provider and you think the provider should not have billed you, you can call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO may add additional steps it would like members to take (call provider, return bill with MCO ID number)]

If you get a bill from a provider for one of the above reasons that a provider is allowed to bill you, you should pay the bill or call the provider.

Third-Party Liability

You may have Medicare or other health insurance. Medicare or your other health insurance is your primary insurance. This other insurance is known as "third party liability" or TPL. Having other insurance does not affect your Medical Assistance eligibility. In most cases, your Medicare or other insurance will pay your PCP or other provider before **[MCO Name]** pays. **[MCO Name]** can only be billed for the amount that your Medicare or other health insurance does not pay.

You must tell both your CAO and Member Services at **[Member Services Phone Number and TTY]** if you have Medicare or other health insurance. When you go to a provider or to a pharmacy you must tell the provider or pharmacy about all forms of medical insurance you have and show the provider or pharmacy your Medicare card or other insurance card, ACCESS or EBT card, and your **[MCO Name]** ID card. This helps make sure your health care bills are paid timely and correctly.

Coordination of Benefits

If you have Medicare and the service or other care you need is covered by Medicare, you can get care from any Medicare provider you pick. The provider does not have to be in **[MCO Name]**'s network**.** You also do not have to get prior authorization from **[MCO Name]** or referrals from your Medicare PCP to see a specialist. **[MCO Name]** will work with Medicare to decide if it needs to pay the provider after Medicare pays first, if the provider is enrolled in the Medical Assistance Program.

If you need a service that is not covered by Medicare but is covered by **[MCO Name]**, you must get the service from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

If you do not have Medicare but you have other health insurance and you need a service or other care that is covered by your other insurance, you must get the service from a provider that is in both the network of your other insurance and **[MCO Name]**'s network. You need to follow the rules of your other insurance and **[MCO Name]**, such as prior authorization and specialist referrals. **[MCO Name]** will work with your other insurance to decide if it needs to pay for the services after your other insurance pays the provider first.

If you need a service that is not covered by your other insurance, you must get the services from a **[MCO Name]** network provider. All **[MCO Name]** rules, such as prior authorization and specialist referrals, apply to these services.

Recipient Restriction/Lock-in Program

The Recipient Restriction/Member Lock-In Program requires a member to use specific providers if the member has abused or overused his or her health care or prescription drug benefits. **[MCO Name]** works with DHS to decide whether to limit a member to a doctor, pharmacy, hospital, dentist, or other provider.

How Does it Work?

[MCO Name] reviews the health care and prescription drug services you have used. If **[MCO Name]** finds overuse or abuse of health care or prescription services, **[MCO Name]** asks DHS to approve putting a limit on the providers you can use. If approved by DHS, **[MCO Name]** will send you a written notice that explains the limit.

You can pick the providers, or **[MCO Name]** will pick them for you. If you want a different provider than the one **[MCO Name]** picked for you, call Member Services at **[Member Services Phone Number and TTY]**. The limit will last for 5 years even if you change HealthChoices plans.

If you disagree with the decision to limit your providers, you may appeal the decision by asking for a DHS Fair Hearing, within 30 days of the date of the letter telling you that **[MCO Name]** has limited your providers.

You must sign the **written** request for a Fair Hearing and send it to:

Department of Human Services
Office of Administration
Bureau of Program Integrity - DPPC
Recipient Restriction Section
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675

If you need help asking for a Fair Hearing, please call Member Services at **[MCO Member Services Phone Number and TTY]** or contact your local legal aid office.

If your appeal is postmarked within 10 days of the date on **[MCO Name]**'s notice, the limits will not apply until your appeal is decided. If your appeal is postmarked more than 10 days but within 30 days from the date on the notice, the limits will be in effect until your appeal is decided. The Bureau of Hearings and Appeals will let you know, in writing, of the date, time, and place of your hearing. You may not file a Grievance or Complaint through **[MCO Name]** about the decision to limit your providers.

After 5 years, **[MCO Name]** will review your services again to decide if the limits should be removed or continued and will send the results of its review to DHS. **[MCO Name]** will tell you the results of the review in writing.

Reporting Fraud or Abuse

How Do I Report Member Fraud or Abuse?

If you think that someone is using your or another member's **[MCO Name]** card to get services, equipment, or medicines, is forging or changing their prescriptions, or is getting services they do not need, you can call the **[MCO Name]** Fraud and Abuse Hotline at **[Insert Phone Number and TTY]** to give **[MCO Name]** this information. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

How Do I Report Provider Fraud or Abuse?

Provider fraud is when a provider bills for services, equipment, or medicines you did not get or bills for a different service than the service you received. Billing for the same service more than once or changing the date of the service are also examples of provider fraud. To report provider fraud you can call the **[MCO Name]**'s Fraud and Abuse Hotline at **[Insert Phone Number]**. You may also report this information to the DHS Fraud and Abuse Reporting Hotline at 1-844-DHS-TIPS (1-844-347-8477).

Section 3 –

Physical Health Services

Covered Services

The chart below lists the services that are covered by **[MCO Name]** when the services are medically necessary. Some of the services have limits or co-payments, or need a referral from your PCP or require prior authorization by **[MCO Name]**. If you need services beyond the limits listed below, your provider can ask for an exception, as explained later in this section. Limits do not apply if you are under age 21 or pregnant.

[MCO to complete table, including additional services that MCO covers]

Service		Children	Adults
Primary Care Provider	Limit		
	Co-payment		
	Prior Authorization / Referral		
Specialist	Limit		
	Co-payment		
	Prior Authorization / Referral		
Certified Registered Nurse Practitioner	Limit		
	Co-payment		
	Prior Authorization / Referral		
Federally Qualified Health Center / Rural Health Center	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Non-Hospital Clinic	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Hospital Clinic	Limit		
	Co-payment		
	Prior Authorization / Referral		
Podiatrist Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Chiropractor Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Optometrist Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Hospice Care	Limit		
	Co-payment		
	Prior Authorization / Referral		

Service		Children	Adults
Dental Care Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Radiology (ex. X-rays, MRIs, CTs)	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Hospital Short Procedure Unit	Limit		
	Co-payment		
	Prior Authorization / Referral		
Outpatient Ambulatory Surgical Center	Limit		
	Co-payment		
	Prior Authorization / Referral		
Non-Emergency Medical Transport	Limit		
	Co-payment		
	Prior Authorization / Referral		
Family Planning Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Renal Dialysis	Limit		
	Co-payment		
	Prior Authorization / Referral		
Emergency Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Urgent Care Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Ambulance Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Inpatient Hospital	Limit		
	Co-payment		
	Prior Authorization / Referral		
Inpatient Rehab Hospital	Limit		
	Co-payment		
	Prior Authorization / Referral		
Maternity Care	Limit		
	Co-payment		
	Prior Authorization / Referral		
Prescription Drugs	Limit		

Service		Children	Adults
	Co-payment		
	Prior Authorization / Referral		
Enteral/Parenteral Nutritional Supplements	Limit		
	Co-payment		
	Prior Authorization / Referral		
Nursing Facility Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Home Health Care including Nursing, Aide, and Therapy Services	Limit		
	Co-payment		
	Prior Authorization / Referral		
Durable Medical Equipment	Limit		
	Co-payment		
	Prior Authorization / Referral		
Prosthetics and Orthotics	Limit		
	Co-payment		
	Prior Authorization / Referral		
Eyeglass Lenses	Limit		
	Co-payment		
	Prior Authorization / Referral		
Eyeglass Frames	Limit		
	Co-payment		
	Prior Authorization / Referral		
Contact Lenses	Limit		
	Co-payment		
	Prior Authorization / Referral		
Medical Supplies	Limit		
	Co-payment		
	Prior Authorization / Referral		
Therapy (Physical, Occupational, Speech)	Limit		
	Co-payment		
	Prior Authorization / Referral		
Laboratory	Limit		
	Co-payment		
	Prior Authorization / Referral		
Tobacco Cessation	Limit		
	Co-payment		
	Prior Authorization / Referral		

[MCO to add any additional information regarding covered services as necessary]

Services That Are Not Covered

There are physical health services that **[MCO Name]** does not cover. If you have any questions about whether or not **[MCO Name]** covers a service for you, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

MCOs may not cover experimental medical procedures, medicines, and equipment**.**

Second Opinions

You have the right to ask for a second opinion if you are not sure about any medical treatment, service, or non-emergency surgery that is suggested for you. A second opinion may give you more information that can help you make important decisions about your treatment. A second opinion is available to you at no cost other than a co-pay.

Call your PCP to ask for the name of another **[MCO Name]** network provider to get a second opinion. If there are not any other providers in **[MCO Name]**'s network, you may ask **[MCO Name]** for approval to get a second opinion from an out-of-network provider.

What is Prior Authorization?

Some services or items need approval from **[MCO Name]** before you can get the service. This is called Prior Authorization. For services that need prior authorization, **[MCO Name]** decides whether a requested service is medically necessary before you get the service. You or your provider must make a request to **[MCO Name]** for approval before you get the service.

What Does Medically Necessary Mean?

Medically necessary means that a service, item, or medicine does one of the following:

- It will, or is reasonably expected to, prevent an illness, condition, or disability;
- It will, or is reasonably expected to, reduce or improve the physical, mental, or developmental effects of an illness, condition, injury or disability;

- It will help you to get or keep the ability to perform daily tasks, taking into consideration both your abilities and the abilities or someone of the same age.

If you need any help understanding when a service, item, or medicine is medically necessary or would like more information, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to add additional prior authorization information as necessary]

How to Ask for Prior Authorization

[Insert detailed steps that MCO requires for prior authorization here, including all contact information.]

If you need help to better understand the prior authorization process, talk to your PCP or specialist or call Member Services at **[MCO Member Services Phone Number and TTY]**.

If you or your provider would like a copy of the medical necessity guidelines or other rules that were used to decide your prior authorization request, **[Insert MCO information here on how to obtain the information.]**

What Services, Items, or Medicines Need Prior Authorization?

The following chart identifies some, but not all services, items, and medicines that require prior authorization.

[Insert chart of covered services, items, and medicines that require prior authorization]

[TO BE ADDED IF MCO DOES NOT HAVE SEPARATE PA AND PE PROCESSES:]

For those services that have limits, if you or your provider believes that you need more services than the limit on the service allows, you or your provider can ask for more services through the prior authorization process.

If you are or your provider is unsure about whether a service, item, or medicine requires prior authorization, call Member Services at **[MCO Member Services Phone Number and TTY].**

Prior Authorization of a Service or Item

[MCO Name] will review the prior authorization request and the information you or your provider submitted. **[MCO Name]** will tell you of its decision within 2 business days of the date **[MCO Name]** received the request if **[MCO Name]** has enough information to decide if the service or item is medically necessary.

If **[MCO Name]** does not have enough information to decide the request, we must tell your provider within 48 hours of receiving the request that we need more information to decide the request and allow 14 days for the provider to give us more information. **[MCO Name]** will tell you of our decision within 2 business days after **[MCO Name]** receives the additional information.

You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

Prior Authorization of Outpatient Drugs

[MCO Name] will review a prior authorization request for outpatient drugs, which are drugs that you do not get in the hospital, within 24 hours from when **[MCO Name]** gets the request. You and your provider will get a written notice telling you if the request is approved or denied and, if it was denied, the reason it was denied.

If you go to a pharmacy to fill a prescription and the prescription cannot be filled because it needs prior authorization, the pharmacist will give you a temporary supply unless the pharmacist thinks the medicine will harm you. If you have not already been taking the medicine, you will get a 72-hour supply. If you have already been taking the medicine, you will get a 15-day supply. Your provider will still need to ask **[MCO Name]** for prior authorization as soon as possible

The pharmacist will not give you the 15-day supply for a medicine that you have been taking if you get a denial notice from **[MCO Name]** 10 days before your prescription ends telling you that the medicine will not be approved again and you have not filed a Grievance.

What if I Receive a Denial Notice?

If **[MCO Name]** denies a request for a service, item, or drug or does not approve it as requested, you can file a Grievance or a Complaint. If you file a Complaint or a Grievance for denial of an ongoing medication, **[MCO Name]** must authorize the medication until the Complaint or Grievance is resolved. See Section 8, Complaints,

Grievances, and Fair Hearings, starting on page **[MCO to add page number]** of this Handbook for detailed information on Complaints and Grievances.

Program Exception Process

For those services that have limits, if you or your provider believes that you need more services than the limits on the service allows, you or your provider can ask for a program exception (PE). The PE process is different from the Dental Benefit Limit Exception process described on page **[MCO to insert page number]**.

To ask for a PE, **[MCO to add information on how to request a PE]**

[MCO to add additional Program Exception information as necessary]

Service Descriptions

Emergency Services

Emergency services are services needed to treat or evaluate an emergency medical condition. An emergency medical condition is an injury or illness that is so severe that a reasonable person with no medical training would believe that there is an immediate risk to a person's life or long-term health. If you have an emergency medical condition, go to the nearest emergency room, dial 911, or call your local ambulance provider. You do **not** have to get approval from **[MCO Name]** to get emergency services and you may use any hospital or other setting for emergency care.

Below are some examples of emergency medical conditions and non-emergency medical conditions:

<u>Emergency medical conditions</u>

- Heart attack
- Chest pain
- Severe bleeding
- Intense pain
- Unconsciousness
- Poisoning

<u>Non-emergency medical conditions</u>

- Sore throat
- Vomiting

- Cold or flu
- Backache
- Earache
- Bruises, swelling, or small cuts

If you are unsure if your condition requires emergency services, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline Phone Number]** 24 hours a day, 7 days a week.

[MCO to add any additional information about emergency services as necessary]

Emergency Medical Transportation

[MCO Name] covers emergency medical transportation by an ambulance for emergency medical conditions. If you need an ambulance, call 911 or your local ambulance provider. Do not call MATP (described on page **[MCO to insert page number]** of this Handbook) for emergency medical transportation.

Urgent Care

[MCO Name] covers urgent care for an illness, injury, or condition which if not treated within 24 hours, could rapidly become a crisis or an emergency medical condition. This is when you need attention from a doctor, but not in the emergency room.

If you need urgent care, but you are not sure if it is an emergency, call your PCP or the **[MCO Name]** Nurse Hotline at **[MCO Nurse Hotline phone number]** first. Your PCP or the hotline nurse will help you decide if you need to go to the emergency room, the PCP's office, or an urgent care center near you. In most cases if you need urgent care, your PCP will give you an appointment within 24 hours. If you are not able to reach your PCP or your PCP cannot see you within 24 hours and your medical condition is not an emergency, you may also visit an urgent care center or walk-in clinic within **[MCO Name]**'s network. Prior authorization is not required for services at an Urgent Care center.

Some examples of medical conditions that may need urgent care include:

- Vomiting
- Coughs and fever
- Sprains
- Rashes
- Earaches
- Diarrhea

- Sore throats
- Stomach aches

If you have any questions, please call Member Services at **[MCO Member Services Phone Number and TTY].**

[MCO to add any additional information about urgent care services as necessary]

Dental Care Services

[MCO to provide information on DBM if applicable]

Members Under 21 Years of Age

[MCO Name] provides all medically necessary dental services for children under 21 years of age. Children may go to a participating dentist within the **[DBM / MCO Name]** network.

Dental visits for children do not require a referral. If your child is 1 year old or older and does not have a dentist, you can ask your child's PCP to refer your child to a dentist for regular dental checkups. For more information on dental services, contact **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Members 21 Years of Age and Older

[MCO Name] covers some dental benefits for members 21 years of age and older through dentists in the **[DBM / MCO Name]** network. Some dental services have limits.

[MCO to include further details and specifics including process for choosing and changing a dentist, covered services, co-payments, and prior authorization and BLE requirements]

Dental Benefit Limit Exception

Some dental services are only covered with a Benefit Limit Exception (BLE). You or your dentist can also ask for a BLE if you or your dentist believes that you need more dental services than the limits allow.

[MCO Name] will approve a BLE if**:**

- You have a serious or chronic illness or health condition and without the additional service your life would be in danger; OR
- You have a serious or chronic illness or health condition and without the additional service your health would get much worse; OR
- You would need more expensive treatment if you do not get the requested service; OR
- It would be against federal law for **[MCO Name]** to deny the exception.

To ask for a BLE before you receive the service, you or your dentist can call **[MCO/DBM Name]** Member Services at **[MCO/DBM Member Services Phone Number and TTY]** or send the request to:

[MCO/DBM Contact Address].

BLE requests must include the following information:

- Your name
- Your address
- Your phone number
- The service you need
- The reason you need the service
- Your provider's name
- Your provider's phone number

Time Frames for Deciding a Benefit Limit Exception

If you or your provider asks for an exception before you get the service, **[MCO Name]** will let you know whether or not the BLE is approved within the same time frame as the time frame for prior authorization requests, described on page **[MCO to insert page number]**. **[or MCO can repeat the time frame]**.

If your dentist asks for an exception after you got the service, **[MCO Name]** will let you know whether or not the BLE request is approved within 30 days of the date **[MCO Name]** gets the request.

If you disagree with or are unhappy with **[MCO Name]**'s decision, you may file a Complaint or Grievance with **[MCO Name]**. For more information on the Complaint and Grievance process, please see Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings on page **[MCO to insert page number]**.

Vision Care Services

[MCO to provide information on Vision Benefit Manager if applicable]

Members Under 21 Years of Age

[MCO Name] covers all medically necessary vison services for children under 21 years of age. Children may go to a participating vision provider within the **[MCO/VBM Name]** network.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Members 21 Years of Age and Older

[MCO Name] covers some vision services for members 21 years of age and older through providers within the **[MCO/VBM Name]** network.

[MCO to include further details and specifics including covered service, co-payments, and prior authorization requirement]

Pharmacy Benefits

[MCO Name] covers pharmacy benefits that include prescription medicines and over-the-counter medicines and vitamins with a doctor's prescription.

Prescriptions

When a provider prescribes a medication for you, you can take it to any pharmacy that is in **[MCO Name]**'s network. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment if you are over the age of 18. **[MCO Name]** will pay for any medicine listed on the Statewide PDL and **[MCO Name]**'s supplemental formulary and may pay for other medicines if they are prior authorized. Either your prescription or the label on your medicine will tell you if your doctor ordered refills of the prescription and how many refills you may get. If your doctor ordered refills, you may only get 1 refill at a time. If you have questions about whether a prescription medicine is covered, need help finding a pharmacy in **[MCO Name]**'s network, or have

any other questions, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to add additional information on prescriptions as necessary]

Statewide Preferred Drug List (PDL) and [MCO Name] Supplemental Formulary

[MCO Name] covers medicines listed on the Statewide Preferred Drug List (PDL) and the **[MCO Name]** supplemental formulary. This is what your PCP or other doctor should use when deciding what medicines you should take. Both the Statewide PDL and [MCO Name] supplemental formulary cover both brand name and generic drugs. . Generic drugs contain the same active ingredients as brand name drugs. Any medicine prescribed by your doctor that is not on the Statewide PDL and **[MCO Name]**'s supplemental formulary needs prior authorization. The Statewide PDL and **[MCO Name]**'s supplemental formulary can change from time to time, so you should make sure that your provider has the latest information when prescribing a medicine for you.

If you have any questions or to get a copy of the the Statewide PDL and **[MCO Name]**'s supplemental formulary, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

[MCO to add any additional information on the drug formulary as necessary]

Reimbursement for Medication

[MCO to provide description of any potential reimbursement for medication]

Specialty Medicines

The Statewide PDL and **[MCO Name]**'s supplemental formulary includes medicines that are called specialty medicines. A prescription for these medicines needs to be prior authorized **[MCO may remove sentence if prior authorization is not required]**. You may have a co-payment for your medicine. To see the Statewide Preferred Drug List, the **[MCO Name]**'s supplemental formulary and a complete list of specialty medicines, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO to insert link to formulary on website]**.

You will need to get these medicines from a specialty pharmacy. A specialty pharmacy can mail your medicines directly to you and will not charge you for sending you your medicines. The specialty pharmacy will contact you before sending your medicine. The pharmacy can also answer any questions you have about the process. You can pick any specialty pharmacy that is in **[MCO Name]**'s network. For the list of network specialty pharmacies, please call Member Services at **[MCO Member Services Phone Number and TTY]** or see the provider directory on **[MCO Name]**'s website at **[MCO to insert link to provider directory on website].** For any other questions or more information please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Over-the-Counter Medicines

[MCO Name] covers over-the-counter medicines when you have a prescription from your provider. You will need to have your **[MCO Name]** prescription ID card with you and you may have a co-payment. The following are some examples of covered over-the-counter medicines:

- Sinus and allergy medicine
- Tylenol or aspirin
- Vitamins
- Cough medicine
- Heartburn medicine
- **[MCO may add additional items]**

You can find more information about covered over-the-counter medicines by visiting **[MCO Name]**'s website at **[MCO website]** or by calling Member Services at **[Member Services phone number and TTY]**.

Tobacco Cessation

Do you want to quit smoking? [MCO Name] wants to help you quit!

If you are ready to be smoke free, no matter how many times you have tried to quit smoking, we are here to help you.

Medicines

The Statewide PDL covers the following medicines to help you quit smoking.

[MCO to insert chart of tobacco medicines covered and whether they require prior authorization]

Contact your PCP for an appointment to get a prescription for a tobacco cessation medicine.

Counseling Services

Counseling support may also help you to quit smoking. **[MCO Name]** covers the following counseling services: **[MCO to insert specific information on what is covered & how to receive counseling services here.]**

Behavioral Health Treatment

Some people may be stressed, anxious, or depressed when they are trying to become smoke-free. **[MCO Name]** members are eligible for services to address these side effects, but these services are covered by your BH-MCO. You can find the BH-MCO in your county and its contact information on page **[xx]** in this Handbook. You can also call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY]** for help in contacting your BH-MCO.

[MCO to provide additional behavioral health treatment for tobacco cessation information as necessary]

Case Management Programs [If Applicable]

[If the MCO offers tobacco cessation as part of any case management programs insert that specific information here.]

Other Tobacco Cessation Resources

[Insert information on services provided by and contact information for tobacco cessation services offered by the PA Free Quit line, PA Cancer Society, and the American Heart Association and the American Lung Association.]

Remember **[MCO Name]** is here to help support you in becoming healthier by becoming smoke-free. Do not wait! Please call Member Services at **[MCO Member Services Phone Number and TTY]** so we can help to get you started.

Family Planning

[MCO Name] covers family planning services. You do not need a referral from your PCP for family planning services. These services include pregnancy testing, testing and treatment of sexually transmitted diseases, birth control supplies, and family planning education and counseling. You can see any doctor that is a Medical Assistance provider, including any out-of-network provider that offers family planning services. There is no co-payment for these services. When you go to a family planning provider that is not in the **[MCO Name]** network, you must show your **[MCO Name]** and ACCESS or EBT card.

For more information on covered family planning services or to get help finding a family planning provider, call Member Services at **[MCO Member Services Phone Number and TTY].**

Maternity Care

Care During Pregnancy

Prenatal care is the health care a woman receives through her pregnancy and delivery from a maternity care provider, such as an obstetrician (OB or OB/GYN) or a nurse-midwife. Early and regular prenatal care is very important for you and your baby's health. Even if you have been pregnant before, it is important to go to a maternity care provider regularly through each pregnancy.

If you think you are pregnant and need a pregnancy test, see your PCP or a family planning provider. If you are pregnant, you can:

- Call or visit your PCP, who can help you find a maternity care provider in the **[MCO Name]**'s network.
- Visit a network OB or OB/GYN or nurse-midwife on your own. You do not need a referral for maternity care.
- Visit a network health center that offers OB or OB/GYN services.
- Call Member Services at **[MCO Member Services Phone Number and TTY]** to find a maternity care provider.

You should see a doctor as soon as you find out you are pregnant. Your maternity care provider must schedule an appointment to see you

- If you are in your first trimester, within 10 business days of **[MCO Name]** learning you are pregnant.
- If you are in your second trimester, within 5 business days of **[MCO Name]** learning you are pregnant.

- If you are in your third trimester, within 4 business days of **[MCO Name]** learning you are pregnant.
- If you have a high-risk pregnancy, within 24 hours of **[MCO Name]** learning you are pregnant.

If you have an emergency, go to the nearest emergency room, dial 911, or call your local ambulance provider.

It is important that you stay with the same maternity care provider throughout your pregnancy and postpartum care (60 days after your baby is born). They will follow your health and the health of your growing baby closely. It is also a good idea to stay with the same HealthChoices plan during your entire pregnancy.

[MCO Name] has specially trained maternal health coordinators who know what services and resources are available for you.

If you are pregnant and are already seeing a maternity care provider when you enroll in **[MCO Name]**, you can continue to see that provider even if he or she is not in **[MCO Name]**'s network. The provider will need to be enrolled in the Medical Assistance Program and must call **[MCO Name]** for approval to treat you.

[MCO to add any additional information on maternity care as necessary]

Care for You and Your Baby After Your Baby is Born

You should visit your maternity care provider between **[MCO may choose preferred time frame]** after your baby is delivered for a check-up unless your maternity care provider wants to see you sooner.

Your baby should have an appointment with the baby's PCP when he or she is 3 to 5 days old, unless the doctor wants to see your baby sooner. It is best to pick a doctor for your baby while you are still pregnant. If you need help picking a doctor for your baby, please call Member Services at **[MCO Member Services Phone Number and TTY].**

MCO Maternity Program [If applicable]

[MCO Name] has a special program for pregnant women called **[Program Name]**.

[Insert information and details here about MCO Maternity Program if applicable].

Durable Medical Equipment and Medical Supplies

[MCO Name] covers Durable Medical Equipment (DME) and medical supplies, including home accessibility DME, DME is a medical item or device that can be used many times in your home or in any setting where normal life activities occur and is generally not used unless a person has an illness or injury. Medical supplies are usually disposable and are used for a medical purpose. Some of these items need prior authorization, and your physician must order them. DME suppliers must be in the **[MCO Name]** network. You may have a co-payment.

Examples of DME include:

- Oxygen tanks
- Wheelchairs
- Crutches
- Walkers
- Splints
- Special medical beds

Examples of home accessibility DME include:

- Wheelchair lifts
- Stair glides
- Ceiling lifts
- Metal accessibility ramps

[MCO Name] covers installation of the home accessibility DME, but not home modifications.

Examples of medical supplies include:

- Diabetic supplies (such as syringes, test strips)
- Gauze pads
- Dressing tape
- Incontinence supplies (such as pull ups, briefs, underpads)

If you have any questions about DME or medical supplies, or for a list of network suppliers, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Outpatient Services

[MCO Name] covers outpatient services such as physical, occupational, and speech therapy as well as x-rays and laboratory tests. Your PCP will arrange for these services with one of **[MCO Name]**'s network providers.

[MCO to include further details and specifics, including whether prior authorization is needed]

Nursing Facility Services

[**MCO Name]** covers up to 30 days of nursing facility services. If you need nursing facility services for more than 30 days and the Community HealthChoices Program is available in the area where you live, you will be evaluated to see if you are eligible for participation in the Community HealthChoices Program. If Community HealthChoices is not available in the area where you live you will be disenrolled from **[MCO Name]** and will receive your services through the Medical Assistance fee-for-service system.

Hospital Services

[MCO Name] covers inpatient and outpatient hospital services. If you need inpatient hospital services and it is not an emergency, your PCP or specialist will arrange for you to be admitted to a hospital in **[MCO Name]**'s network and will follow your care even if you need other doctors during your hospital stay. Inpatient hospital stays must be approved by **[MCO Name]**. To find out if a hospital is in the **[MCO Name]** network, please call Member Services at **[MCO Member Services Phone Number and TTY]** or check the provider directory on **[MCO Name]**'s website at **[website link to provider directory]**.

If you have an emergency and are admitted to the hospital, you or a family member or friend should let your PCP know as soon as possible but no later than 24 hours after you were admitted to the hospital. If you are admitted to a hospital that is not in **[MCO Name]**'s network, you may be transferred to a hospital in **[MCO Name]**'s network. You will not be moved to a new hospital until you are strong enough to be transferred to a new hospital.

It is very important to make an appointment to see your PCP within 7 days after you leave the hospital. Seeing your PCP right after your hospital stay will help you follow any instructions you got while you were in the hospital and prevent you from having to be readmitted to the hospital.

Sometimes you may need to see a doctor or receive treatment at a hospital without being admitted overnight. These services are called outpatient hospital services.

If you have any other questions about hospital services, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

[MCO to include further details and specifics including if prior authorization or referral from a PCP is required]

Preventive Services

[MCO Name] covers preventive services, which can help keep you healthy. Preventive services include more than just seeing your PCP once a year for a check-up. They also include immunizations (shots), lab tests, and other tests or screenings that let you and your PCP know if you are healthy or have any health problems. Visit your PCP for preventive services. He or she will guide your health care according to the latest recommendations for care.

Women can also go to a participating OB/GYN for their yearly Pap test and pelvic exam, and to get a prescription for a mammogram.

[MCO can include further details and specifics]

Physical Exam

You should have a physical exam by your PCP at least once a year. This will help your PCP find any problems that you may not know about. Your PCP may order tests based on your health history, age, and sex. Your PCP will also check if you are up to date on immunizations and preventive services to help keep you healthy.

If you are unsure about whether or not you are up to date with your health care needs, please call your PCP or Member Services at **[MCO Member Services Phone Number and TTY].** Member Services can also help you make an appointment with your PCP.

New Medical Technology

[MCO Name] may cover new medical technologies such as procedures and equipment if requested by your PCP or specialist**. [MCO Name]** wants to make sure that new medical technologies are safe, effective, and right for you before approving the service.

[Insert MCO information on how new technologies are reviewed and approved. If MCO does not have information, remove entire New Medical Technology section]

If you need more information on new medical technologies, please call **[MCO Name]** Member Services at **[MCO Member Services Phone Number and TTY].**

Home Health Care

[MCO Name] covers home health care provided by a home health agency. Home health care is care provided in your home and includes skilled nursing services; help with activities of daily living such as bathing, dressing, and eating; and physical, speech, and occupational therapy. Your physician must order home health care.

If you are over age 21, there are **[no-MCO to insert whatever is correct]** limits on the number of home health care visits that you can get **[MCO to add the following if has limits: unless you or your provider asks for an exception to the limits.]**

OR

[MCO Name] has a program that includes home health care visits directly relating to a special health care need such as **[MCO to identify programs]**.

OR BOTH

You should contact Member Services at **[MCO Member Services Phone Number and TTY]** if you have been approved for home health care and that care is not being provided as approved.

[MCO to add any additional information as necessary]

Patient Centered Medical Homes

A patient-centered medical home or health home is a team approach to providing care. It is not a building, house, or home health care service.

[MCO to add information on their Patient Centered Medical Home program]

Disease Management

[MCO Name] has voluntary programs to help you take better care of yourself if you have one of the health conditions listed below. **[MCO Name]** has care managers who will work with you and your providers to make sure you get the services you need. You do not need a referral from your PCP for these programs, and there is no co-payment.

[MCO should list and provide a brief description of each of their specific programs here, including HIV/AIDS programs].

By following your provider's plan of care and learning about your disease or condition, you can stay healthier. **[MCO Name]** care managers are here to help you understand how to take better care of yourself by following your doctor's orders, teaching you about your medicines, helping you to improve your health, and giving you information to use in your community. If you have any questions or need help, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Expanded Services

[MCO to provide list and description of any enhanced benefits offered to all members, including requirements for coverage and how to access.]

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

EPSDT services are available for children under the age of 21. They are sometimes also referred to as well-baby or well-child checkups. Your child may be seen by a pediatrician, family practice doctor, or CRNP. The provider you choose for your child will be your child's PCP. The purpose of this service is to detect potential health problems early and to make sure your child stays healthy. If you have questions or want more information, contact Member Services at **[MCO Member Services Phone Number and TTY]**.

When Should an EPSDT Exam be Completed?

Children and young adults should have their examinations completed based on the schedule listed below. It is important to follow this schedule even if your child is not sick. Your provider will tell you when these visits should occur. Infants and toddlers will need several visits per year, while children between the ages of 3 to 20 will need just 1 visit per year.

Recommended Screening Schedule			
3-5 Days	0-1 Months	2-3 Months	4-5 Months
6-8 Months	9-11 Months	12 Months	15 Months
18 Months	24 Months	30 Months	
Children ages 3-20 should be screened yearly			

What Will the Provider Do During the EPSDT Exam?

Your provider will ask you and your child questions, perform tests, and check how much your child has grown. The following services are some of the services that may be performed during an exam depending on the child's age and needs of the child:

- A complete physical exam
- Immunizations
- Vision test
- Hearing test
- Autism screening
- Tuberculosis screening
- Oral health examination
- Blood pressure check
- Health and safety education
- Check of the child's body mass index (BMI)
- Screen and/or counsel for tobacco and alcohol use and substance use starting at age 11
- Urinalysis screening
- Blood lead screening test
- Developmental screening
- Depression screening starting at age 12
- Maternal depression screening

[MCO Name] covers services that are needed to treat health problems that are identified during the EPSDT exam.

Additional services are available for children with special needs. Talk to your provider about whether or not your child may need these additional services.

Section 4 –

Out-of-Network
and
Out-of-Plan Services

Out-of-Network Providers

An out-of-network provider is a provider that does not have a contract with **[MCO Name]** to provide services to **[MCO Name]**'s members. There may be a time when you need to use a doctor or hospital that is not in the **[MCO Name]** network. If this happens, you can ask your PCP to help you. Your PCP has a special number to call to ask **[MCO Name]** that you be allowed to go to an out-of-network provider. **[MCO Name]** will check to see if there is another provider in your area that can give you the same type of care you or your PCP believes you need. If **[MCO Name]** cannot give you a choice of at least 2 providers in your area, **[MCO Name]** will cover medically necessary services provided by an out-of-network provider.

Getting Care While Outside of [MCO Name]'s Service Area

If you are outside of **[MCO Name]**'s service area and have a medical emergency, go to the nearest emergency room or call 911. For emergency medical conditions, you do not have to get approval from **[MCO Name]** to get care. If you need to be admitted to the hospital, you should let your PCP know.

If you need care for a non-emergency condition while outside of the service area, call your PCP or Member Services at **[MCO Member Services Phone Number and TTY]** who will help you to get the most appropriate care.

[MCO Name] will not pay for services received outside of the United States and its territories.

Out-of-Plan Services

You may be eligible to get services other than those provided by **[MCO Name]**. Below are some services that are available but are not covered by **[MCO Name]**. If you would like help in getting these services, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Non-Emergency Medical Transportation

[MCO Name] does not cover non-emergency medical transportation for most HealthChoices members. **[MCO Name]** can help you arrange transportation to covered service appointments through programs such as Shared Ride or the MATP described below.

[MCO Name] does cover non-emergency medical transportation if:

- You live in a nursing home, and need to go to any medical appointment or an urgent care center or a pharmacy for any Medical Assistance service, DME or medicine
- You need specialized non-emergency medical transportation, such as if you need to use a stretcher to get to your appointment

If you have questions about non-emergency medical transportation, please call Member Services at **[MCO Member Services Phone Number and TTY]**.

Medical Assistance Transportation Program

MATP provides non-emergency transportation to and from qualified MA-enrolled medical providers and pharmacies of your choice who are generally available and used by other residents of your community. This service is provided at no cost to you. The MATP in the county where you live will determine your need for the Program and provide the right type of transportation for you. Transportation services are typically provided in the following ways:

- Where public transportation such as buses, subways or trains are available, MATP provides tokens or passes or repays you for the public transportation fare if you live within ¼ mile of a fixed route service stop.
- If you or someone else has a car that you can use to get to your appointment, MATP may pay you an amount per mile plus parking and tolls with valid receipts.
- Where public transportation is not available or is not right for you, MATP provides rides in paratransit vehicles, which include vans, vans with lifts, or taxis. Usually, the vehicle will have more than 1 rider with different pick-up and drop-off times and locations.

If you need transportation to a medical appointment or to the pharmacy, contact your local MATP to get more information and to register for services. **[MCO to provide list of MATP contacts in counties served or direction to page of handbook were MATP contact list can be found]** A complete list of county MATP contact information can be found here: http://matp.pa.gov/CountyContact.aspx. **(OR)** Please see page _____of this handbook for a complete list of county MATP contact information.

MATP will confirm with **[MCO Name]** or your doctor's office that the medical appointment you need transportation for is a covered service. **[MCO Name]** works with MATP to help you arrange transportation. You can also call Member Services for more information at **[MCO Member Services Phone Number and TTY].**

Women, Infants, and Children Program

The Women, Infants, and Children Program (WIC) provides healthy foods and nutrition services to infants, children under the age of 5, and women who are pregnant, have given birth, or are breastfeeding. WIC helps you and your baby eat well by teaching you about good nutrition and giving you food vouchers to use at grocery stores. WIC helps babies and young children eat the right foods so they can grow up healthy. You can ask your maternity care provider for a WIC application at your next visit or call 1-800-WIC-WINS (1-800-942-9467). For more information visit the WIC website at www.pawic.com

Domestic Violence Crisis and Prevention

Domestic violence is a pattern of behavior where one person tries to gain power or control over another person in a family or intimate relationship.

There are many different types of domestic violence. Some examples include:

- Emotional abuse
- Physical violence
- Stalking
- Sexual violence
- Financial abuse
- Verbal abuse
- Elder Abuse
- Intimate partner violence later in life
- Intimate partner abuse
- Domestic Violence in the LGBTQ+ Community

There are many different names used to talk about domestic violence. It can be called: abuse; domestic violence; battery; intimate partner violence; or family, spousal, relationship or dating violence.

If any of these things are happening to you, or have happened, or you are afraid of your partner, you may be in an abusive relationship.

Domestic violence is a crime and legal protections are available to you. Leaving a violent relationship is not easy, but you can get help.

Where to get help:

National Domestic Violence Hotline

1-800-799-7233 (SAFE)
1-800-787-3224 (TTY)

Pennsylvania Coalition Against Domestic Violence

The services provided to domestic violence victims include: crisis intervention; counseling; going along to police, medical, and court appointments; and temporary emergency shelter for victims and their dependent children. Prevention and educational programs are also provided to lower the risk of domestic violence in the community.

1-800-932-4632 (in Pennsylvania)

Sexual Violence and Rape Crisis

Sexual violence includes any type of unwanted sexual contact, words or actions of a sexual nature that is against a person's will. A person may use force, threats, manipulation, or persuasion to commit sexual violence. Sexual violence can include:

- Rape
- Sexual assault
- Incest
- Child sexual assault
- Date and acquaintance rape
- Grabbing or groping
- Sexting without permission
- Ritual abuse
- Commercial sexual exploitation (for example: prostitution)
- Sexual harassment
- Anti-LGBTQ+ bullying
- Exposure and voyeurism (the act of being viewed, photographed, or filmed in a place where one would expect privacy)
- Forced participation in the production of pornography

Survivors of sexual violence can have physical, mental or emotional reactions to the experience. A survivor of sexual violence may feel alone, scared, ashamed, and fear that no one will believe them. Healing can take time, but healing can happen.

Where to get help:

Pennsylvania rape crisis centers serve all adults and children. Services include:

- Free and confidential crisis counseling 24 hours a day.
- Services for a survivor's family, friends, partners or spouses.
- Information and referrals to other services in your area and prevention education programs.

Call **1-888-772-7227** or visit the link below to reach your local rape crisis center.

Pennsylvania Coalition Against Rape (www.pcar.org/)

Early Intervention Services

While all children grow and develop in unique ways, some children experience delays in their development. Children with developmental delays and disabilities can benefit from the Early Intervention Program.

The Early Intervention Program provides support and services to families with children birth to the age of 5 who have developmental delays or disabilities. Services are provided in natural settings, which are settings where a child would be if the child did not have a developmental delay or disability.

Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family. These services and supports address the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

Parents who have questions about their child's development may contact the CONNECT Helpline at 1-800-692-7288 or visit www.papromiseforchildren.org. The CONNECT Helpline assists families in locating resources and providing information regarding child development for children from birth to age 5. In addition, CONNECT can help parents with contacting their county Early Intervention Program or local preschool Early Intervention Program.

Section 5 –

Special Needs

Special Needs Unit

[MCO Name] wants to make sure all of our members get the care they need. We have trained case managers in the **[MCO Name]** Special Needs Unit that help our members with special needs have access to the care they need. The case managers of the unit help members with physical or behavioral disabilities, complex or chronic illnesses, and other special needs. **[MCO Name]** understands that you and your family may need help with issues that may not be directly related to your health care needs. The Special Needs Unit is able to assist you with finding programs and agencies in the community that can help you and your family address these needs.

[MCO to add any additional information on its special needs unit as necessary]

If you think you or someone in your family has a special need, and you would like the Special Needs Unit to help you, please contact them by calling **[SNU Hotline #, please note if the member has to choose a specific menu option to reach the SNU].** The Special Needs Unit staff members are available **[days and hours of operation].** If you need assistance when the Special Needs Unit staff are not available you may call **[alternate MCO contact]**.

Coordination of Care

The **[MCO Name]** Special Needs Unit will help you coordinate care for you and your family who are members of **[MCO Name]**. In addition, **[MCO Name]** can assist in connecting you with other state and local programs.

If you need help with any part of your care, your child's care, or coordinating that care with another state, county, or local program, please contact the **[MCO Name]** Special Needs Unit for assistance.

The **[MCO Name]** Special Needs Unit will also assist members in transitioning care from services received in a hospital or temporary medical setting to care received at home. We want our members to be able to move back home as soon as possible. Please contact the **[MCO Name]** Special Needs Unit for assistance in help receiving care in your home.

Care Management

[MCO to add language specific to any Care Management]

Home and Community-Based Waivers and Long-Term Services and Supports

The Office of Developmental Programs (ODP) administers the Consolidated Waiver, Community Living Waiver, Person/Family Directed Supports Waiver, Adult Autism Waiver, and the Adult Community Autism Program (ACAP) for individuals with intellectual disabilities or autism. If you have questions regarding any of these programs, you may contact ODP's Customer Service Hotline at 1-888-565-9435, or request assistance from the Special Needs Unit at **[MCO Name].**

The Office of Long-Term Living (OLTL) administers programs for seniors and individuals with physical disabilities. This includes the Community HealthChoices Program (CHC). The CHC Program is a Medical Assistance managed care program for individuals who also have Medicare coverage or who need the services of a nursing facility or home-and community-based wavier.

If you have questions regarding what services are available and how to apply, you may contact OLTL's Participant Helpline at 1-800-757-5042 or request assistance from the **[MCO Name]** Special Needs Unit at **[SNU Contact Information]**.

Medical Foster Care

The Office of Children, Youth, and Families has oversight of medical foster care for children under the authority of county children and youth programs. If you have questions about this program, please contact the Special Needs Unit at **[SNU Contact Information]**.

Section 6 –

Advance Directives

Advance Directives

There are 2 types of advance directives: Living Wills and Health Care Powers of Attorney. These allow for your wishes to be respected if you are unable to decide or speak for yourself. If you have either a Living Will or a Health Care Power of Attorney, you should give it to your PCP, other providers, and a trusted family member or friend so that they know your wishes.

If the laws regarding advance directives are changed, **[MCO Name]** will tell you in writing what the change is within 90 days of the change. For information on **[MCO Name]**'s policies on advance directives, call Member Services at **[MCO Member Services Phone Number and TTY]** or visit **[MCO Name]**'s website at **[MCO Website]**.

Living Wills

A Living Will is a document that you create. It states what medical care you do, and do not, want to get if you cannot tell your doctor or other providers the type of care you want. Your doctor must have a copy and must decide that you are unable to make decisions for yourself for a Living Will to be used. You may revoke or change a Living Will at any time.

Health Care Power of Attorney

A Health Care Power of Attorney is also called a Durable Power of Attorney. A Health Care or Durable Power of Attorney is a document in which you give someone else the power to make medical treatment decisions for you if you are physically or mentally unable to make them yourself. It also states what must happen for the Power of Attorney to take effect. To create a Health Care Power of Attorney, you may but do not have to get legal help. You may contact **[MCO Contact]** for more information or direction to resources near you.

What to Do if a Provider Does Not Follow Your Advance Directive

Providers do not have to follow your advance directive if they disagree with it as a matter of conscience. If your PCP or other provider does not want to follow your advance directive, **[MCO Name]** will help you find a provider that will carry out your wishes. Please call Member Services at **[MCO Member Services Phone Number and TTY]** if you need help finding a new provider.

If a provider does not follow your advance directive, you may file a Complaint. Please see page **[xx]** in Section 8 of this Handbook, Complaints, Grievances, and Fair Hearings for information on how to file a Complaint; or call Member Services at **[MCO Member Services Phone Number and TTY]**.

Section 7 –

Behavioral Health Services

Behavioral Health Care

Behavioral health services include both, mental health services and substance use disorder services. These services are provided through behavioral health managed care organizations (BH-MCOs) that are overseen by the Department of Human Services' Office of Mental Health and Substance Abuse Services (OMHSAS).
Contact information for the BH-MCO is listed below **[MCO to insert BH-MCO contact list below]**. You can also call Member Services at **[MCO Member Services Phone Number and TTY]** to get contact information for your BH-MCO.

You can call your BH-MCO toll-free 24 hours a day, 7 days a week.

You do not need a referral from your PCP to get behavioral health services, but your PCP will work with your BH-MCO and behavioral health providers to help get you the care that best meets your needs. You should let your PCP know if you, or someone in your family, is having a mental health or drug and alcohol problem.

The following services are covered:

- Behavioral health rehabilitation services (BHRS) (children and adolescent)
- Clozapine (Clozaril) support services
- Drug and alcohol inpatient hospital-based detoxification services (adolescent and adult)
- Drug and alcohol inpatient hospital-based rehabilitation services (adolescent and adult)
- Drug and alcohol outpatient services
- Drug and alcohol methadone maintenance services
- Family based mental health services
- Laboratory (when related to a behavioral health diagnosis and prescribed by a behavioral health practitioner)
- Mental health crisis intervention services
- Mental health inpatient hospitalization
- Mental health outpatient services
- Mental health partial hospitalization services
- Peer support services
- Residential treatment facilities (children and adolescent)
- Targeted case management services

If you have questions about transportation to appointments for any of these services, contact your BH-MCO.

Section 8 –

Complaints, Grievances, and Fair Hearings

Complaints, Grievances, and Fair Hearings

If a provider or **[MCO Name]** does something that you are unhappy about or do not agree with, you can tell **[MCO Name]** or the Department of Human Services what you are unhappy about or that you disagree with what the provider or **[MCO Name]** has done. This section describes what you can do and what will happen.

Complaints

What is a Complaint?

A Complaint is when you tell **[MCO Name]** you are unhappy with **[MCO Name]** or your provider or do not agree with a decision by **[MCO Name]**.

Some things you may complain about:

- You are unhappy with the care you are getting.
- You cannot get the service or item you want because it is not a covered service or item.
- You have not gotten services that **[MCO Name]** has approved.
- You were denied a request to disagree with a decision that you have to pay your provider.

First Level Complaint

What Should I Do if I Have a Complaint?

To file a first level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax, or
- If you received a notice from **[MCO Name]** telling you **[MCO Name]**'s decision and the notice included a Complaint/Grievance Request Form, fill out the form and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Complaints:
[MCO address]
[MCO fax number]

Your provider can file a Complaint for you if you give the provider your consent in writing to do so.

When Should I File a First Level Complaint?

Some Complaints have a time limit on filing. You must file a Complaint within **60 days of getting a notice** telling you that

- **[MCO Name]** has decided that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]** will not pay a provider for a service or item you got.
- **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- **[MCO Name]** has denied your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must file a Complaint **within 60 days of the date you should have gotten a service or item** if you did not get a service or item. The time by which you should have received a service or item is listed below:

New member appointment for your first examination…	**We will make an appointment for you…**
members with HIV/AIDS	with PCP or specialist no later than 7 days after you become a member in **[MCO Name]** unless you are already being treated by a PCP or specialist.
members who receive Supplemental Security Income (SSI)	with PCP or specialist no later than 45 days after you become a member in **[MCO Name]**, unless you are already being treated by a PCP or specialist.
members under the age of 21	with PCP for an EPSDT exam no later than 45 days after you become a member in **[MCO Name],** unless you are already being treated by a PCP or specialist.

all other members	with PCP no later than 3 weeks after you become a member in **[MCO Name]**.
Members who are pregnant:	**We will make an appointment for you . . .**
pregnant women in their first trimester	with OB/GYN provider within 10 business days of **[MCO Name]** learning you are pregnant.
pregnant women in their second trimester	with OB/GYN provider within 5 business days of **[MCO Name]** learning you are pregnant.
pregnant women in their third trimester	with OB/GYN provider within 4 business days of **[MCO Name]** learning you are pregnant.
pregnant women with high-risk pregnancies	with OB/GYN provider within 24 hours of **[MCO Name]** learning you are pregnant.
Appointment with…	**An appointment must be scheduled . . . . .**
PCP	
urgent medical condition	within 24 hours.
routine appointment	within 10 business days.
health assessment/general physical examination	within 3 weeks.
Specialists (when referred by PCP)	
urgent medical condition	within 24 hours of referral.
routine appointment with one of the following specialists: • Otolaryngology • Dermatology • Pediatric Endocrinology	within 15 business days of referral

- Pediatric General Surgery
- Pediatric Infectious Disease
- Pediatric Neurology
- Pediatric Pulmonology
- Pediatric Rheumatology
- Dentist
- Orthopedic Surgery
- Pediatric Allergy & Immunology
- Pediatric Gastroenterology
- Pediatric Hematology
- Pediatric Nephrology
- Pediatric Oncology
- Pediatric Rehab Medicine
- Pediatric Urology
- Pediatric Dentistry

routine appointment with all other specialists	within 10 business days of referral

You may file **all other Complaints at any time.**

What Happens After I File a First Level Complaint?

After you file your Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the First Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 10 days before the day of the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 1 or more **[MCO Name]** staff who were not involved in and do not work for someone who was involved in the issue you filed your Complaint about will meet to make a decision about your Complaint. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Complaint]** days from the date you filed your First Level Complaint to tell you the decision on your First Level Complaint. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____ **[MCO to insert page number of help section]**.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you file a Complaint verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are not covered services or items for you, the services or items will continue until a decision is made.

What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Complaint review, a Fair Hearing, or an external Complaint review and a Fair Hearing if the Complaint is about one of the following:

- **[MCO Name]**'s decision that you cannot get a service or item you want because it is not a covered service or item.
- **[MCO Name]**'s decision to not pay a provider for a service or item you got.
- **[MCO Name]**'s failure to decide a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.
- You did not get a service or item within the time by which you should have received it
- **[MCO Name]**'s decision to deny your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.

You must ask for an external Complaint review within **15 days of the date you got the First Level Complaint decision notice**.

You must ask for a Fair Hearing within **120 days from the mail date on the notice** telling you the Complaint decision.

For all other Complaints, you may file a Second Level Complaint within **45 days of the date you got the Complaint decision notice**.

For information about Fair Hearings, see page _____
For information about external Complaint review, see page ___
If you need more information about help during the Complaint process, see page _____
[MCO to insert page number].

Second Level Complaint

What Should I Do if I Want to File a Second Level Complaint?

To file a Second Level Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Second Level Complaint, or
- Write down your Second Level Complaint and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint Request Form included in your Complaint decision notice and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Second Level Complaints
[MCO address]
[MCO fax number]

What Happens After I File a Second Level Complaint?

After you file your Second Level Complaint, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Complaint, and about the Second Level Complaint review process.

You may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint about at no cost to you. You may also send information that you have about your Complaint to **[MCO Name]**.

You may attend the Complaint review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Complaint review at least 15 days before the Complaint review. You may appear at the Complaint review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

A committee of 3 or more people, including at least 1 person who does not work for **[MCO Name]**, will meet to decide your Second Level Complaint. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about. If the Complaint is about a clinical issue, a licensed doctor will be on the committee. **[MCO Name]** will mail you a notice within **[date that is no more than 45 days from receipt of the Second Level Complaint]** days from the date your Second Level Complaint was received to tell you the decision on your Second Level Complaint. The letter will also tell you what you can do if you do not like the decision.

If you need more information about help during the Complaint process, see page _____ **[MCO to insert page number of help section]**.

What if I Do Not Like [MCO Name]'s Decision on My Second Level Complaint?

You may ask for an external review from the Pennsylvania Insurance Department's Bureau of Managed Care.

You must ask for an external review **within 15 days of the date you got the Second Level Complaint decision notice.**

External Complaint Review

How Do I Ask for an External Complaint Review?

Send your written request for an external review of your Complaint to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Telephone Number: 1-877-881-6388

You can also go to the "File a Complaint Page" at:

https://www.insurance.pa.gov/Consumers/insurance-complaint/Pages/default.aspx

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

If you ask, the Bureau of Consumer Services will help you put your Complaint in writing.

What Happens After I Ask for an External Complaint Review?

The Insurance Department will get your file from [MCO Name]. You may also send any other information that may help with the external review of your Complaint,

You may be represented by an attorney or another person such as your representative during the external review.

A decision letter will be sent to you after the decision is made. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you want to continue getting services, you must ask for an external Complaint review or a Fair Hearing within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision that you cannot get services or items you have been receiving because they are not covered services or items for you for the services or items to continue until a decision is made. If you will be asking for both an external Complaint review and a Fair Hearing, you must request both the external Complaint review and the Fair Hearing within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint decision. If you wait to request a Fair Hearing until after receiving a decision on your external Complaint, services will not continue.

GRIEVANCES

What is a Grievance?

When **[MCO Name]** denies, decreases, or approves a service or item different than the service or item you requested because it is not medically necessary, you will get a notice telling you **[MCO Name]**'s decision.

A Grievance is when you tell **[MCO Name]** you disagree with **[MCO Name]**'s decision.

What Should I Do if I Have a Grievance?

To file a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax, or
- Fill out the Complaint/Grievance Request Form included in the denial notice you got from **[MCO Name]** and send it to **[MCO Name]** by mail or fax.

[MCO Name]'s address and fax number for Grievances:
[MCO address]
[MCO fax number]

Your provider can file a Grievance for you if you give the provider your consent in writing to do so. If your provider files a Grievance for you, you cannot file a separate Grievance on your own.

When Should I File a Grievance?

You must file a Grievance within **60 days from the date you get the notice** telling you about the denial, decrease, or approval of a different service or item for you.

What Happens After I File a Grievance?

After you file your Grievance, you will get a letter from **[MCO Name]** telling you that **[MCO Name]** has received your Grievance, and about the Grievance review process.

You may ask **[MCO Name]** to see any information that **[MCO Name]** used to make the decision you filed your Grievance about at no cost to you. You may also send information that you have about your Grievance to **[MCO Name]**.

You may attend the Grievance review if you want to attend it. **[MCO Name]** will tell you the location, date, and time of the Grievance review at least 10 days before the day of the Grievance review. You may appear at the Grievance review in person, by phone, or by videoconference **[MCO to include videoconferencing only if available]**. If you decide that you do not want to attend the Grievance review, it will not affect the decision.

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the Grievance review committee will include a dentist. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about **[MCO Name]** will mail you a notice within **[date that is no more than 30 days from receipt of the Grievance]** days from the date your Grievance was received to tell you the decision on your Grievance. The notice will also tell you what you can do if you do not like the decision.

If you need more information about help during the Grievance process, see page _____ **[MCO to insert page number of help section]**.

What to do to continue getting services:

If you have been getting services or items that are being reduced, changed, or denied and you file a Grievance verbally, or that is faxed, postmarked, or hand-delivered within 10 days of the date on the notice telling you that the services or items you have been receiving are being reduced, changed, or denied, the services or items will continue until a decision is made.

What if I Do Not Like [MCO Name]'s Decision?

You may ask for an external Grievance review or a Fair Hearing or you may ask for both an external Grievance review and a Fair Hearing. An external Grievance review is a review by a doctor who does not work for **[MCO Name].**

You must ask for an external Grievance review within **15 days of the date you got the Grievance decision notice**.

You must ask for a Fair Hearing from the Department of Human Services **within 120 days from the date on the notice** telling you the Grievance decision.

For information about Fair Hearings, see page _____
For information about external Grievance reviews, see below
If you need more information about help during the Grievance process, see page _____ **[MCO to insert page number]**.

External Grievance Review

How Do I Ask for External Grievance Review?

To ask for an external Grievance review:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or
- Write down your Grievance and send it to **[MCO Name]** by mail to: **[MCO address]**.

[MCO Name] will send your request for external Grievance review to the Insurance Department.

What Happens After I Ask for an External Grievance Review?

[MCO Name] will notify you of the external Grievance reviewer's name, address and phone number. You will also be given information about the external Grievance review process.

[MCO Name] will send your Grievance file to the reviewer You may provide additional information that may help with the external review of your Grievance to the reviewer within 15 days of filing the request for an external Grievance review.

You will receive a decision letter within 60 days of the date you asked for an external Grievance review. This letter will tell you all the reason(s) for the decision and what you can do if you do not like the decision.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed, or denied and you want to continue getting services, you must ask for an external Grievance review within 10 days of the date on the notice telling you **[MCO Name]**'s Grievance decision for the services or items to continue until a decision is made. If you will be asking for both an external Grievance review and a Fair Hearing, you must request both the external Grievance review and the Fair Hearing within 10 days of the date on the notice telling you **[MCO Name]**'s Grievance decision. If you wait to request a Fair Hearing until after receiving a decision on your external Grievance, services will not continue.

Expedited Complaints and Grievances

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting **[30, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions or 45, unless the MCO will be using a shorter time frame to provide notice of 2nd Level Complaint decisions]** days to get a decision about your Complaint or Grievance, could harm your health, you or your doctor or dentist may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

- You must ask **[MCO Name]** for an early decision by calling **[MCO Name]** at **[Member Services Phone Number and TTY]**, faxing a letter or the Complaint/Grievance Request Form to **[MCO fax number],** or sending an email to **[PH-MCO e-mail]**.

- Your doctor or dentist should fax a signed letter to **[MCO fax number]** within 72 hours of your request for an early decision that explains why **[MCO Name]** taking **[30, unless the MCO will be using a shorter time frame for 1st Level Complaint or Grievance decisions or 45, unless the MCOS will be issuing a shorter time frame for 2nd level Complaint decisions]** days to tell you the decision about your Complaint or Grievance could harm your health.

If **[MCO Name]** does not receive a letter from your doctor or dentist and the information provided does not show that taking the usual amount of time to decide your Complaint or Grievance could harm your health, **[MCO Name]** will decide your Complaint or Grievance in the usual time frame of **[45, unless the MCO will be using a shorter time frame to provide notice of 1st Level Complaint or Grievance decisions]** days from when **[MCO Name]** first got your Complaint or Grievance.

Expedited Complaint and Expedited External Complaint

Your expedited Complaint will be reviewed by a committee that includes a licensed doctor. Members of the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Complaint about.

You may attend the expedited Complaint review if you want to attend it. You can attend the Complaint review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available]** because **[MCO Name]** has a short amount of time to decide an expedited Complaint. If you decide that you do not want to attend the Complaint review, it will not affect the decision.

[MCO Name] will tell you the decision about your Complaint within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Complaint will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Complaint. You can ask **[MCO Name]** to take up to 14 more days to decide your Complaint. You will also get a notice telling you the reason(s) for the decision and how to ask for expedited external Complaint review, if you do not like the decision.

If you did not like the expedited Complaint decision, you may ask for an expedited external Complaint review from the Insurance Department within **2 business days from**

the date you get the expedited Complaint decision notice. To ask for expedited external review of a Complaint:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Complaint, or
- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Complaint and send it to **[MCO Name]** by mail or fax: **[MCO Address and fax number for requesting expedited external review of a Complaint]**.

Expedited Grievance and Expedited External Grievance

A committee of 3 or more people, including a licensed doctor, will meet to decide your Grievance. If the Grievance is about dental services, the expedited Grievance review committee will include a dentist. The **[MCO Name]** staff on the committee will not have been involved in and will not have worked for someone who was involved in the issue you filed your Grievance about.

You may attend the expedited Grievance review if you want to attend it. You can attend the Grievance review in person, but may have to appear by phone or by videoconference **[MCO to include videoconferencing only if available**] because **[MCO Name]** has a short amount of time to decide the expedited Grievance. If you decide that you do not want to attend the Grievance review, it will not affect our decision.

[MCO Name] will tell you the decision about your Grievance within 48 hours of when **[MCO Name]** gets your doctor's or dentist's letter explaining why the usual time frame for deciding your Grievance will harm your health or within 72 hours from when **[MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[MCO Name]** to take more time to decide your Grievance. You can ask **[MCO Name]** to take up to 14 more days to decide your Grievance. You will also get a notice telling you the reason(s) for the decision and what to do if you do not like the decision.

If you do not like the expedited Grievance decision, you may ask for an expedited external Grievance review or an expedited Fair Hearing by the Department of Human Services or both an expedited external Grievance review and an expedited Fair Hearing. An expedited external Grievance review is a review by a doctor who does not work for **[MCO Name].**

You must ask for expedited external Grievance review within **2 business days from the date you get the expedited Grievance decision notic**e. To ask for expedited external review of a Grievance:

- Call **[MCO Name]** at **[Member Services Phone Number and TTY]** and tell **[MCO Name]** your Grievance, or

- Send an email to **[MCO Name]** at **[MCO email address]**, or
- Write down your Grievance and send it to **[MCO Name]** by mail or fax: **[MCO address and fax number for requesting expedited external review of a Grievance]**.

[MCO Name] will send your request to the Insurance Department within 24 hours after receiving it.

You must ask for a Fair Hearing within **120 days from the date on the notice** telling you the expedited Grievance decision.

What Kind of Help Can I Have with the Complaint and Grievance Processes?

If you need help filing your Complaint or Grievance, a staff member of **[MCO Name**] will help you. This person can also represent you during the Complaint or Grievance process. You do not have to pay for the help of a staff member. This staff member will not have been involved in any decision about your Complaint or Grievance.

You may also have a family member, friend, lawyer or other person help you file your Complaint or Grievance. This person can also help you if you decide you want to appear at the Complaint or Grievance review.

At any time during the Complaint or Grievance process, you can have someone you know represent you or act for you. If you decide to have someone represent or act for you, tell **[MCO Name]**, in writing, the name of that person and how **[MCO Name]** can reach him or her.

You or the person you choose to represent you may ask **[MCO Name]** to see any information **[MCO Name]** has about the issue you filed your Complaint or Grievance about at no cost to you.

You may call **[MCO Name]**'s toll-free telephone number at **[Member Services Phone Number and TTY]** if you need help or have questions about Complaints and Grievances, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.

Persons Whose Primary Language Is Not English

If you ask for language services, **[MCO Name]** will provide the services at no cost to you.

Persons with Disabilities

[MCO Name] will provide persons with disabilities with the following help in presenting Complaints or Grievances at no cost, if needed. This help includes:

- Providing sign language interpreters;
- Providing information submitted by **[MCO Name]** at the Complaint or Grievance review in an alternative format. The alternative format version will be given to you before the review; and
- Providing someone to help copy and present information.

DEPARTMENT OF HUMAN SERVICES FAIR HEARINGS

In some cases you can ask the Department of Human Services to hold a hearing because you are unhappy about or do not agree with something **[MCO Name]** did or did not do. These hearings are called "Fair Hearings." You can ask for a Fair Hearing after **[MCO Name]** decides your First Level Complaint or decides your Grievance.

What Can I Request a Fair Hearing About and By When Do I Have to Ask for a Fair Hearing?

Your request for a Fair Hearing must be postmarked within **120 days from the date on the notice** telling you **[MCO Name]**'s decision on your First Level Complaint or Grievance about the following:

- The denial of a service or item you want because it is not a covered service or item.
- The denial of payment to a provider for a service or item you got and the provider can bill you for the service or item.
- **[MCO Name]**'s failure to decide a First Level Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer days]** days from when **[MCO Name**] got your Complaint or Grievance.
- The denial of your request to disagree with **[MCO Name]**'s decision that you have to pay your provider.
- The denial of a service or item, decrease of a service or item, or approval of a service or item different from the service or item you requested because it was not medically necessary.
- You're not getting a service or item within the time by which you should have received a service or item.

You can also request a Fair Hearing within 120 days from the date on the notice telling you that **[MCO Name]** failed to decide a First Level Complaint or Grievance you told

[MCO Name] about within **[number that is 30 or fewer days]** days from when **[MCO Name]** got your Complaint or Grievance.

How Do I Ask for a Fair Hearing?

Your request for a Fair Hearing must be in writing. You can either fill out and sign the Fair Hearing Request Form included in the Complaint or the Grievance decision notice or write and sign a letter.

If you write a letter, it needs to include the following information:

- Your (the member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have the Fair Hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of any letter you received about the issue you are asking for a Fair Hearing about.

You must send your request for a Fair Hearing to the following address:

Department of Human Services
Office of Medical Assistance Programs – HealthChoices Program
Complaint, Grievance and Fair hearings
PO Box 2675
Harrisburg, PA 17105-2675

What Happens After I Ask for a Fair Hearing?

You will get a letter from the Department of Human Services' Bureau of Hearings and Appeals telling you where the hearing will be held and the date and time for the hearing. You will receive this letter at least 10 days before the date of the hearing.

You may come to where the Fair Hearing will be held or be included by phone. A family member, friend, lawyer or other person may help you during the Fair Hearing. You **MUST** participate in the Fair Hearing.

[MCO Name] will also go to your Fair Hearing to explain why **[MCO Name]** made the decision or explain what happened.

You may ask **[MCO Name]** to give you any records, reports and other information about the issue you requested your Fair Hearing about at no cost to you.

When Will the Fair Hearing Be Decided?

The Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the written notice of the **[MCO Name]**'s First Level Complaint decision or Grievance decision and the date you asked for a Fair Hearing.

If you requested a Fair Hearing because **[MCO Name]** did not tell you its decision about a Complaint or Grievance you told **[MCO Name]** about within **[number that is 30 or fewer]** days from when **[MCO Name]** got your Complaint or Grievance, your Fair Hearing will be decided within 90 days from when you filed your Complaint or Grievance with **[MCO Name]**, not including the number of days between the date on the notice telling you that **[MCO Name]** failed to timely decide your Complaint or Grievance and the date you asked for a Fair Hearing.

The Department of Human Services will send you the decision in writing and tell you what to do if you do not like the decision.

If your Fair Hearing is not decided within 90 days from the date the Department of Human Services receives your request, you may be able to get your services until your Fair Hearing is decided. You can call the Department of Human Services at 1-800-798-2339 to ask for your services.

What to do to continue getting services:

If you have been getting the services or items that are being reduced, changed or denied and you ask for a Fair Hearing and your request is postmarked or hand-delivered within 10 days of the date on the notice telling you **[MCO Name]**'s First Level Complaint or Grievance decision, the services or items will continue until a decision is made.

Expedited Fair Hearing

What Can I Do if My Health Is at Immediate Risk?

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. This is called an expedited Fair Hearing. You can ask for an early decision by calling the Department at 1-800-798-2339 or by faxing a letter or the Fair Hearing Request Form to 717-772-6328. Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or

dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your Fair Hearing could harm your health.

The Bureau of Hearings and Appeals will schedule a telephone hearing and will tell you its decision within 3 business days after you asked for a Fair Hearing.

If your doctor does not send a written statement and does not testify at the Fair Hearing, the Fair Hearing decision will not be expedited. Another hearing will be scheduled and the Fair Hearing will be decided using the usual time frame for deciding a Fair Hearing.

You may call **[MCO Name]**'s toll-free telephone number at **[MCO Number]** if you need help or have questions about Fair Hearings, you can contact your local legal aid office at **[MCO insert Phone Number]** or call the Pennsylvania Health Law Project at 1-800-274-3258.