McLaren

MEDICARE

Annual Notice of Changes
Inspire Flex (HMO-POS)

Region 1: Bay, Charlevoix, Cheboygan, Clinton, Emmet, Genesee, Ingham, Isabella, Lapeer, Macomb, Oakland, and St. Clair counties.

H6322_InspireFlexReg12024ANOC_M

McLaren Medicare Inspire Flex (HMO-POS) offered by McLaren Health Plan, Inc.

Annual Notice of Changes for 2024

You are currently enrolled as a member of McLaren Medicare Inspire Flex. Next year, there will be changes to the plan's costs and benefits. ***Please see page 4 for a Summary of Important Costs, including Premium.***

This document tells about the changes to your plan. To get more information about costs, benefits, or rules please review the *Evidence of Coverage*, which is located on our website at www.mclarenhealthplan.org/mclarenmedicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

- **You have from October 15 until December 7 to make changes to your Medicare coverage for next year.**

What to do now

1. ASK: Which changes apply to you

☐ Check the changes to our benefits and costs to see if they affect you.

- Review the changes to Medical care costs (doctor, hospital).
- Review the changes to our drug coverage, including authorization requirements and costs.
- Think about how much you will spend on premiums, deductibles, and cost sharing.

☐ Check the changes in the 2024 "Drug List" to make sure the drugs you currently take are still covered.

☐ Check to see if your primary care doctors, specialists, hospitals, and other providers, including pharmacies will be in our network next year.

☐ Think about whether you are happy with our plan.

2. COMPARE: Learn about other plan choices

☐ Check coverage and costs of plans in your area. Use the Medicare Plan Finder at www.medicare.gov/plan-compare website or review the list in the back of your *Medicare & You 2024* handbook.

☐ Once you narrow your choice to a preferred plan, confirm your costs and coverage on the plan's website.

3. **CHOOSE:** Decide whether you want to change your plan
   - If you don't join another plan by December 7, 2023, you will stay in McLaren Medicare Inspire Flex.
   - To change to a **different plan**, you can switch plans between October 15 and December 7. Your new coverage will start on **January 1, 2024.** This will end your enrollment with McLaren Medicare Inspire Flex.
   - If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can switch plans or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

Additional Resources

- Please contact our Member Services number at 833-358-2404 for additional information. (TTY users should call 711) Hours are April 1-Sept. 30: Monday through Friday, 8 a.m. to 8 p.m. Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p.m. (except Thanksgiving and Christmas days). This call is free.
- This document is available in alternate formats such as Braille and large print.
- **Coverage under this Plan qualifies as Qualifying Health Coverage (QHC)** and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information.

About McLaren Medicare Inspire Flex

- McLaren Medicare is an HMO-POS plan with a Medicare contract. Enrollment in McLaren Medicare depends on contract renewal.
- When this document says "we," "us," or "our", it means McLaren Health Plan, Inc. When it says "plan" or "our plan," it means McLaren Medicare Inspire Flex.

Annual Notice of Changes for 2024
Table of Contents

Summary of Important Costs for 2024

The table below compares the 2023 costs and 2024 costs for McLaren Medicare Inspire Flex in several important areas. **Please note this is only a summary of costs**.

Cost	2023 (this year)	2024 (next year)
Monthly plan premium* * Your premium may be higher than this amount. See Section 1.1 for details.	$0	$0
Maximum out-of-pocket amount This is the most you will pay out-of-pocket for your covered Part A and Part B services. (See Section 1.2 for details.)	$3,800	$3,800
Doctor office visits	Primary care visits: $0 per visit Specialist visits: $30 per visit	Primary care visits: $0 per visit Specialist visits: $30 per visit
Inpatient hospital stays	Per admission: $200 copay per day for days 1 – 7 $0 copay per day for days 8 – 90 $0 copay for additional covered hospital days.	Per admission: $200 copay per day for days 1 – 7 $0 copay per day for days 8 – 90 $0 copay for additional covered hospital days.

Cost	2023 (this year)	2024 (next year)
Part D prescription drug coverage (See Section 1.5 for details.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $12 o You pay $10 per month supply of each covered insulin product on this tier. • Drug Tier 3: $47 o You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 o You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% o You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, the plan pays most of the cost for your covered drugs. • For each prescription, you pay whichever of these is larger: a payment equal to 5% of the cost of the drug (this is called **coinsurance**), or a copayment ($4.15 for a generic drug or a drug that is treated like a generic, and $10.35 for all other drugs.)	Deductible: $0 Copayment/Coinsurance during the Initial Coverage Stage: • Drug Tier 1: $0 • Drug Tier 2: $12 o You pay $10 per month supply of each covered insulin product on this tier. • Drug Tier 3: $47 o You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 4: $100 o You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 5: 33% o You pay $35 per month supply of each covered insulin product on this tier. • Drug Tier 6: $0 Catastrophic Coverage: • During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

SECTION 1 Changes to Benefits and Costs for Next Year

Section 1.1 – Changes to the Monthly Premium

Cost	2023 (this year)	2024 (next year)
Monthly premium (You must also continue to pay your Medicare Part B premium.)	$0	$0 There is no change to your monthly premium for 2024.
Optional dental plan monthly premium	Delta Dental Option 1 $24.50 per month Delta Dental Option 2 $38 per month	Delta Dental Option 1 $20.50 per month Delta Dental Option 2 $36 per month

- Your monthly plan premium will be *more* if you are required to pay a lifetime Part D late enrollment penalty for going without other drug coverage that is at least as good as Medicare drug coverage (also referred to as creditable coverage) for 63 days or more.
- If you have a higher income, you may have to pay an additional amount each month directly to the government for your Medicare prescription drug coverage.

Section 1.2 – Changes to Your Maximum Out-of-Pocket Amount

Medicare requires all health plans to limit how much you pay out-of-pocket for the year. This limit is called the maximum out-of-pocket amount. Once you reach this amount, you generally pay nothing for covered Part A and Part B services for the rest of the year.

Cost	2023 (this year)	2024 (next year)
Maximum out-of-pocket amount Your costs for covered medical services (such as copays) count toward your maximum out-of-pocket amount. Your costs for prescription drugs do not count toward your maximum out-of-pocket amount.	$3,800	$3,800 Once you have paid $3,800 out-of-pocket for covered Part A and Part B services, you will pay nothing for your covered Part A and Part B services for the rest of the calendar year. There is no change to your maximum out-of-pocket for 2024.

Section 1.3 – Changes to the Provider and Pharmacy Networks

Updated directories are located on our website at www.mclarenhealthplan.org/mclarenmedicare. You may also call Member Services for updated provider and/or pharmacy information or to ask us to mail you a directory, which we will mail within three business days.

There are changes to our network of providers for next year. **Please review the 2024 Provider/Pharmacy Directory to see if your providers (primary care provider, specialists, hospitals, etc.) are in our network**.

There are changes to our network of pharmacies for next year. **Please review the 2024 Provider/Pharmacy Directory to see which pharmacies are in our network**.

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers), and pharmacies that are part of your plan during the year. If a mid-year change in our providers affects you, please contact Member Services so we may assist.

Section 1.4 – Changes to Benefits and Costs for Medical Services

We are making changes to costs and benefits for certain medical services next year. The information below describes these changes.

Cost	2023 (this year)	2024 (next year)
Diagnostic Procedures/Tests	Prior authorization is required for genetic testing.	Prior authorization is required for genetic and molecular testing.
Dialysis Services	Prior authorization is required.	Prior authorization is not required.

Cost	2023 (this year)	2024 (next year)
Diabetes self-management training, diabetic services, and supplies	Prior authorization is not required.	Prior authorization is required for non-Abbott brand blood glucose monitors and test strips when obtained at the pharmacy.
Durable Medical Equipment (DME)	Prior authorization is required for items over $1000, insulin pumps & bone stimulators.	Prior authorization is required for items over $1000, insulin pumps, bone stimulators & neurostimulators.
Emergency Care	You pay a $95 copay for each Medicare-covered emergency room visit in the United States and its territories. You pay a $95 copay for each covered worldwide emergency room visit. There is a $50,000 combined emergency/ urgent care benefit limit.	You pay a $100 copay for each Medicare-covered emergency room visit in the United States and its territories. You pay a $100 copay for each covered worldwide emergency room visit. There is a $50,000 combined emergency/urgent care benefit limit.
Lab Services	Prior authorization is required for genetic testing.	Prior authorization is required for genetic and molecular testing.
Observation Services	Prior authorization is required.	Prior authorization is not required in-network.
Occupational Therapy	Prior authorization is required.	Prior authorization is not required.
Outpatient surgery	Prior authorization is required.	Prior authorization is required for cosmetic procedures, oral/ orthognathic and TMJ procedures, procedures to correct obstructive sleep apnea (OSA) and procedures to treat asthma

Cost	2023 (this year)	2024 (next year)
Over the Counter (OTC) Items	You will receive $60 a quarter with no rollover for the purchase of OTC health and wellness products.	You will receive $100 a quarter with no rollover for the purchase of OTC health and wellness products.
Partial Hospitalization	You pay a $70 copay per day.	You pay a $80 copay per day.
Physical Therapy and Speech-language Pathology	Prior authorization is required.	Prior authorization is not required.

Cost	2023 (this year)	2024 (next year)
Readmission Prevention		
Meals After Discharge	Benefit covers 28 meals (2 meals per day for 14 days) delivered directly to your home after each discharge from an inpatient acute or a skilled nursing facility stay. Annual limit of 5 discharges for a total of 140 meals per year. You must use GA Foods.	Benefit covers 28 meals (2 meals per day for 14 days) delivered directly to your home after each discharge from an inpatient acute or a skilled nursing facility stay. Annual limit of 5 discharges for a total of 140 meals per year. You must use GA Foods
In-home Medication Reconciliation	Not covered	Immediately following a discharge from a hospital or skilled nursing facility, a qualified health care provider, in cooperation with your physician, will review your complete medication regime in place prior to admission and reconcile it with medications prescribed at discharge to ensure new prescriptions are obtained and discontinued medications are discarded.
In-home Safety Assessment	Not covered	Immediately following a discharge from a hospital or skilled nursing facility, a qualified health care provider will complete an in-home safety assessment if you do not qualify for one under original Medicare's home health benefit. The assessment will focus on both medical and behavioral hazards, your risk for falls or injuries and how to prevent them and identify potential hazards throughout your home.
Skilled Nursing Facility (Days 21-100)	You pay $196 copay per day.	You pay $203 copay per day.

Cost	2023 (this year)	2024 (next year)
Special Supplemental Benefits for the Chronically Ill (SSBCI) **Healthy Groceries**	SSBCI is not a covered benefit.	Available to members who meet certain criteria. To be eligible, you must have one or more qualifying comorbid and medically complex chronic conditions, be at high risk for hospitalization or other adverse health outcomes and require intensive care coordination. Please see your 2024 Evidence of Coverage for additional information on how to qualify. If you qualify, you will receive a Mastercard® Prepaid Card with a $50 monthly healthy grocery allowance to be used to purchase qualifying healthy foods and produce at participating retail locations or online through NationsBenefits with free home delivery. The monthly allowance does not rollover from month to month. If you believe you qualify, please call Member Services to learn more about this benefit.
Therapeutic Radiology Services	Prior authorization is not required.	Prior authorization is required for Proton Beam Treatment and high-intensity focused ultrasounds (HIFU).

Section 1.5 – Changes to Part D Prescription Drug Coverage

Changes to Our "Drug List"

Our list of covered drugs is called a Formulary or "Drug List." A copy of our "Drug List" is provided electronically.

We made changes to our "Drug List," which could include removing or adding drugs, changing the restrictions that apply to our coverage for certain drugs or moving them to a different cost-sharing tier. **Review the "Drug List" to make sure your drugs will be covered next year and to see if there will be any restrictions, or if your drug has been moved to a different cost-sharing tier.**

Most of the changes in the "Drug List" are new for the beginning of each year. However, during the year, we might make other changes that are allowed by Medicare rules. For instance, we can immediately remove drugs considered unsafe by the FDA or withdrawn from the market by a product manufacturer. We update our online "Drug List" to provide the most up to date list of drugs.

If you are affected by a change in drug coverage at the beginning of the year or during the year, please review Chapter 9 of your Evidence of Coverage and talk to your doctor to find out your options, such as asking for a temporary supply, applying for an exception and/or working to find a new drug. You can also contact Member Services for more information.

Changes to Prescription Drug Costs

Note: If you are in a program that helps pay for your drugs ("Extra Help"), **the information about costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also called the Low-Income Subsidy Rider or the LIS Rider), which tells you about your drug costs. If you receive "Extra Help" and you haven't received this insert by September 30, 2023, please call Member Services and ask for the LIS Rider.

There are four **drug payment stages**. The information below shows the changes to the first two stages – the Yearly Deductible Stage and the Initial Coverage Stage. (Most members do not reach the other two stages – the Coverage Gap Stage or the Catastrophic Coverage Stage.)

Changes to the Deductible Stage

Stage	2023 (this year)	2024 (next year)
Stage 1: Yearly Deductible Stage	Because we have no deductible, this payment stage does not apply to you.	Because we have no deductible, this payment stage does not apply to you.

Changes to Your Cost Sharing in the Initial Coverage Stage

Stage	2023 (this year)	2024 (next year)
Stage 2: Initial Coverage Stage During this stage, the plan pays its share of the cost of your drugs, and **you pay your share of the cost.** Most adult Part D vaccines are covered at no cost to you. The costs in this row are for a one-month (30-day) supply when you fill your prescription at a network pharmacy that provides standard cost sharing. For information about the costs for a long-term supply or for mail-order prescriptions, look in Chapter 6, Section 5 of your Evidence of Coverage. We changed the tier for some of the drugs on our "Drug List." To see if your drugs will be in a different tier, look them up on the "Drug List."	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic:** You pay $0 per prescription. **Tier 2 Generic:** You pay $12 per prescription. **Tier 3 Preferred Brand:** You pay $47 per prescription. **Tier 4 Non-Preferred Brand:** You pay $100 per prescription. **Tier 5 Specialty Drugs:** You pay 33% of the total cost. **Tier 6 Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $4,660, you will move to the next stage (the Coverage Gap Stage).	Your cost for a one-month supply filled at a network pharmacy with standard cost sharing: **Tier 1 Preferred Generic:** You pay $0 per prescription. **Tier 2 Generic:** You pay $12 per prescription. You pay $10 per month supply of each covered insulin product on this tier. **Tier 3 Preferred Brand:** You pay $47 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 4 Non-Preferred Brand:** You pay $100 per prescription. You pay $35 per month supply of each covered insulin product on this tier. **Tier 5 Specialty Drugs:** You pay 33% of the total cost. You pay $35 per month supply of each covered insulin product on this tier. **Tier 6 Select Care Drugs:** You pay $0 per prescription. _____ Once your total drug costs have reached $5,030, you will move to the next stage (the Coverage Gap Stage).

Changes to the Coverage Gap and Catastrophic Coverage Stages

The other two drug coverage stages – the Coverage Gap Stage and the Catastrophic Coverage Stage – are for people with high drug costs. **Most members do not reach the Coverage Gap Stage or the Catastrophic Coverage Stage**.

Beginning in 2024, if you reach the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs.

For specific information about your costs in these stages, look at Chapter 6, Sections 6 and 7, in your *Evidence of Coverage*.

SECTION 2 Administrative Changes

Description	2023 (this year)	2024 (next year)
Fitness Membership	Our plan will reimburse you up to a maximum of $200 annually for fitness center membership.	You will receive a Mastercard® Prepaid Card in the mail to use to pay for fitness center membership. The maximum benefit is $200 annually.
Over the Counter (OTC) Items	Must use your OTC Network card at participating retailers or shop online through Medline at Home.	Must use NationsBenefits. You will receive a Mastercard® Prepaid Card in the mail to use to purchase eligible products at participating retailers or you can shop online through NationsBenefits and get free home delivery. For more information, please call Member Services at 833-358-2404 or visit the NationsBenefits website at: www.McLarenMedicare.NationsBenefits.com.

SECTION 3 Deciding Which Plan to Choose

Section 3.1 – If you want to stay in McLaren Medicare Inspire Flex

To stay in our plan, you don't need to do anything. If you do not sign up for a different plan or change to Original Medicare by December 7, you will automatically be enrolled in our McLaren Medicare Inspire Flex.

Section 3.2 – If you want to change plans

We hope to keep you as a member next year but if you want to change plans for 2024 follow these steps:

Step 1: Learn about and compare your choices

- You can join a different Medicare health plan,
- *OR*-- You can change to Original Medicare. If you change to Original Medicare, you will need to decide whether to join a Medicare drug plan. If you do not enroll in a Medicare drug plan, please see Section 2.1 regarding a potential Part D late enrollment penalty.

To learn more about Original Medicare and the different types of Medicare plans, use the Medicare Plan Finder (www.medicare.gov/plan-compare), read the *Medicare & You 2024* handbook, call your State Health Insurance Assistance Program (see Section 5), or call Medicare (see Section 7.2). As a reminder, McLaren Health Plan, Inc. (Plan/Part D sponsor) offers other health plans. These other plans may differ in coverage, monthly premiums, and cost-sharing amounts.

Step 2: Change your coverage

- To **change to a different Medicare health plan**, enroll in the new plan. You will automatically be disenrolled from McLaren Medicare Inspire Flex.
- To **change to Original Medicare with a prescription drug plan,** enroll in the new drug plan. You will automatically be disenrolled from McLaren Medicare Inspire Flex.
- To **change to Original Medicare without a prescription drug plan**, you must either:
    - Send us a written request to disenroll.
    - Contact Member Services if you need more information on how to do so.
    - – *or* – Contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Deadline for Changing Plans

If you want to change to a different plan or to Original Medicare for next year, you can do it from **October 15 until December 7.** The change will take effect on January 1, 2024.

Are there other times of the year to make a change?

In certain situations, changes are also allowed at other times of the year. Examples include people with Medicaid, those who get "Extra Help" paying for their drugs, those who have or are leaving employer coverage, and those who move out of the service area.

If you enrolled in a Medicare Advantage plan for January 1, 2024, and don't like your plan choice, you can switch to another Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without Medicare prescription drug coverage) between January 1 and March 31, 2024.

If you recently moved into, currently live in, or just moved out of an institution (like a skilled nursing facility or long-term care hospital), you can change your Medicare coverage **at any time**. You can change to any other Medicare health plan (either with or without Medicare prescription drug coverage) or switch to Original Medicare (either with or without a separate Medicare prescription drug plan) at any time.

SECTION 5 Programs That Offer Free Counseling about Medicare

The State Health Insurance Assistance Program (SHIP) is an independent government program with trained counselors in every state. In Michigan, the SHIP is called Michigan Medicare/Medicaid Assistance Program (MMAP).

It is a state program that gets money from the Federal government to give **free** local health insurance counseling to people with Medicare. MMAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare plan choices and answer questions about switching plans. You can call MMAP at 800-803-7174. You can learn more about MMAP by visiting their website (www.mmapinc.org).

SECTION 6 Programs That Help Pay for Prescription Drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. To see if you qualify, call:
    - 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;
    - The Social Security Office at 1-800-772-1213 between 8 am and 7 pm, Monday through Friday for a representative. Automated messages are available 24 hours a day. TTY users should call, 1-800-325-0778; or
    - Your State Medicaid Office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the Michigan HIV/AIDS Drug Assistance Program (MIDAP). For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 888-826-6565.

SECTION 7 Questions?

Section 7.1 – Getting Help from McLaren Medicare Inspire Flex

Questions? We're here to help. Please call Member Services at 833-358-2404. (TTY only, call 711). We are available for phone calls April 1-Sept. 30: Monday through Friday, 8 a.m. to 8 p.m. Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p.m. (except Thanksgiving and Christmas days). Calls to these numbers are free.

Read your 2024 Evidence of Coverage (it has details about next year's benefits and costs)

This Annual Notice of Changes gives you a summary of changes in your benefits and costs for 2024. For details, look in the 2024 Evidence of Coverage for McLaren Medicare Inspire Flex. The Evidence of Coverage is the legal, detailed description of your plan benefits. It explains your rights and the rules you need to follow to get covered services and prescription drugs. A copy of the *Evidence of Coverage* is located on our website at www.mclarenhealthplan.org/mclarenmedicare. You may also call Member Services to ask us to mail you an *Evidence of Coverage*.

Visit our Website

You can also visit our website at www.mclarenhealthplan.org/mclarenmedicare. As a reminder, our website has the most up-to-date information about our provider network (Provider/Pharmacy Directory) and our List of Covered Drugs (Formulary/"Drug List").

Section 7.2 – Getting Help from Medicare

To get information directly from Medicare:

Call 1-800-MEDICARE (1-800-633-4227)

You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Visit the Medicare Website

Visit the Medicare website (www.medicare.gov). It has information about cost, coverage, and quality Star Ratings to help you compare Medicare health plans in your area. To view the information about plans, go to www.medicare.gov/plan-compare.

Read *Medicare & You 2024*

Read the *Medicare & You 2024* handbook. Every fall, this document is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this document, you can get it at the Medicare website (https://www.medicare.gov/Pubs/pdf/10050-medicare-and-you.pdf) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Method	Member Services – Contact Information
CALL	833-358-2404 Calls to this number are free. Hours of operation: April 1-Sept. 30: Monday through Friday, 8 a.m. to 8 p.m. Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p.m. (except Thanksgiving and Christmas days). This call is free. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. Hours of operation: April 1-Sept. 30: Monday through Friday, 8 a.m. to 8 p.m. Oct. 1-March 31: Seven days a week, 8 a.m. to 8 p.m. (except Thanksgiving and Christmas days). This call is free.
WRITE	McLaren Medicare PO Box 44092 Indianapolis IN 46244-0092
WEBSITE	www.mclarenhealthplan.org/mclarenmedicare

McLarenHealthPlan.org/McLarenMedicare