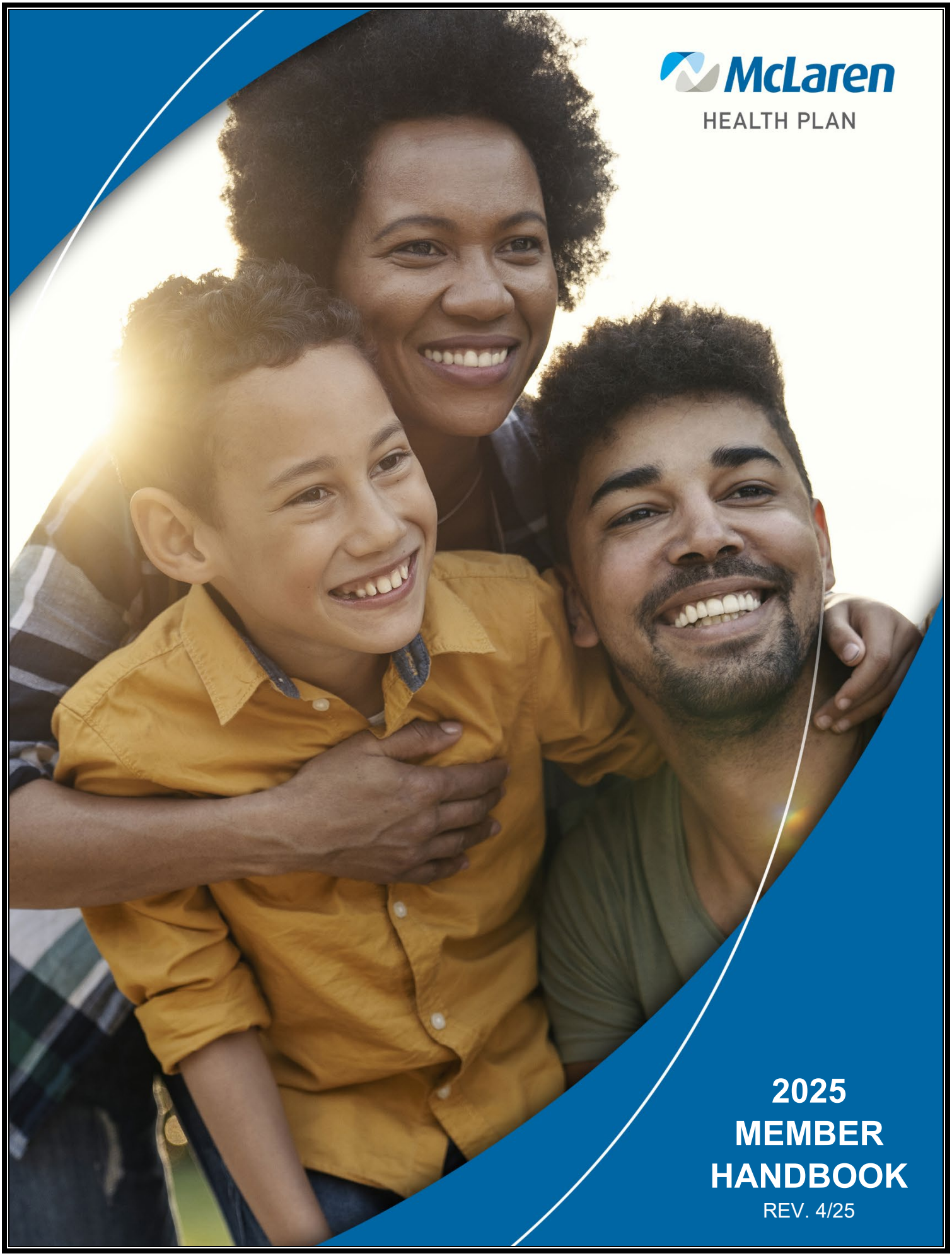

McLaren
HEALTH PLAN
2025
MEMBER
HANDBOOK
REV. 4/25

Contents

Welcome to McLaren Health Plan

McLaren Health Plan has a contract with the Michigan Department of Health and Human Services to provide health care services to Medicaid Enrollees. We work with a group of doctors and specialists to help meet your needs.

This handbook is your guide to the services we offer. It will also give you helpful tips about McLaren Health Plan. Please read this book and keep it in a safe place in case you need it again. Additional copies are available upon request and free of charge from Customer Service. We will send it to you within 5 days of your request. You can also access this handbook on our website at www.mclarenhealthplan.org/member-communications.

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call 888-327-0671 or TTY: 711 for help getting an interpreter or to ask for our materials in another language or format to meet your needs. McLaren Health Plan complies with all applicable federal and state laws with this matter. This includes Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 regarding programs and activities, Titles II and III of the Americans with Disabilities Act, and section 1557 of the Patient Protection and Affordable Care Act.

¿Habla Espanol? Por favor contacte a al 888-327-0671 or TTY: 711.

Hearing and Vision Impairment

TTY/TDD or Michigan Relay services are available free of charge if you have hearing problems or speech impaired. The TTY/TDD line is open 24/7 by calling 711 for Michigan Relay.

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in alternative formats such Braille and large print upon request and free of charge. Call Customer Service at 888-327-0671 to request materials in a different format to meet your needs.

McLaren Health Plan makes sure services are provided in a culturally competent manner to all members:

- With limited English proficiency
- Of diverse cultural and ethnic backgrounds
- With a disability
- Regardless of gender, sexual orientation, or gender identity

Important Numbers and Contact Information

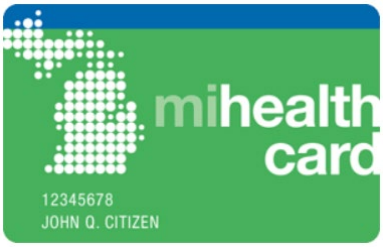
Customer Service Toll-Free Help Line Monday-Friday 8 a.m. to 6 p.m.	888-327-0671
Customer Service Help Line TTY/TDD	711
Website	www.McLarenHealthPlan.org
Address	G-3245 Beecher Rd Flint, MI 48532
24 Hour Toll-Free Emergency Line	888-327-0671
24 Hour Toll-Free Nurse Line	888-327-0671
Medical Management	888-327-0671
Pharmacy Services	888-327-0671
Transportation Services (non-emergency) 24 hours/7days per week/365 days a year	888-327-0671
Dental Services	Delta Dental 866-558-0280
Vision Services	888-327-0671
Mental Health Services	888-327-0671
To file a complaint about a health care facility	888-327-0671 or email **MHPappeals@mclaren.org**
To file a complaint about Medicaid services	888-327-0671 or email **MHPappeals@mclaren.org**
To request a Medicaid Fair Hearing	888-327-0671 or email **MHPappeals@mclaren.org**
Grievance and Appeals	888-327-0671 or email **MHPappeals@mclaren.org**
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	855-444-3911
To report Medicaid fraud and/or abuse	866-866-2135 or email **MHPcompliance@mclaren.org**
To find out information about domestic violence	866-864-2338
To find information about urgent care	888-327-0671

Michigan ENROLLS	1-888-367-6557
Michigan Beneficiary Help Line	1-800-642-3195 or TTY: 866-501-5656.
MIChild Program	1-888-988-6300
MDHHS office locations and phone numbers	**https://www.michigan.gov/mdhhs/inside-mdhhs/county-offices**
Women, Infants and Children (WIC)	1-800-942-1636
Free service to find local resources. Available 24/7	2-1-1
Social Security Administration	800-772-1213 TTY/TDD: 800-325-0778
In an emergency	9-1-1
Suicide and Crisis Lifeline	9-8-8

Identification Cards

Your State Issued Medicaid ID Card

When you have Medicaid, the Michigan Department of Health and Human Services will send you a mihealth card in the mail. The mihealth card does not guarantee you have coverage. Your provider will check that you have coverage at each visit. You may need your mihealth card to get services that McLaren Health Plan does not cover. Always keep this card even if your Medicaid coverage ends. You will need this card if you get coverage again.



If you have questions about this coverage or need a new mihealth card, you should call the Beneficiary Help Line at 800-642-3195. This number is located on the back of your mihealth card.

It is important to keep your contact information up to date, so you don't lose any benefits. Any changes in phone number, email, or address should be reported to MDHHS. You can do this by calling your local MDHHS office or by visiting www.michigan.gov/mibridges. If you do not have an account, you can create one by selecting "Register". Once in your account, when reporting changes, please make sure you do so in both the profile section and the report changes area.

Your McLaren Health Plan Member ID Card

You should have received your McLaren Health Plan ID card in the mail. Call us if you have not received your card or if the information on your card is wrong. Each member of your family in our plan should have their own Member ID card.

If you have questions about this coverage or need a new McLaren Health Plan Member ID card, you should call Customer Service at 888-327-0671 or TTY: 711 or access our online request at www.mclarenhealthplan.org/mclaren-health-plan/contact-us-id-card-request. You also can access an electronic version of your ID card by registering on the McLaren Health Plan member portal, McLaren CONNECT. Go to www.mclarenhealthplan.org/mclarenconnect to register.

Important ID Card Notes

- Carry both cards with you at all times and show them each time you go for care.
- Make sure all of your information is correct on both cards
- Call your local MDHHS office to change your records if your name or address changes
- When getting care you may be asked to show a picture ID. This is to make sure the right person is using the card
- Do not let anyone else use your cards

Getting Help from Customer Service

Our Customer Service Department can answer all of your questions. We can help you choose or change your doctor, find out if a service is covered, replace a lost ID card, find out how to appeal something we denied, find out how to file a grievance when you are unhappy with your care, help you understand written materials, and more. You can call us anytime.

Contact Us

You may call us at 888-327-0671, or TTY 711, Monday through Friday 8 a.m. to 6 p.m.

For **urgent** medical concerns regarding you or your child's health after hours, we can connect you to our medical Emergency Help Line for assistance. Call 888-327-0671, or TTY 711.

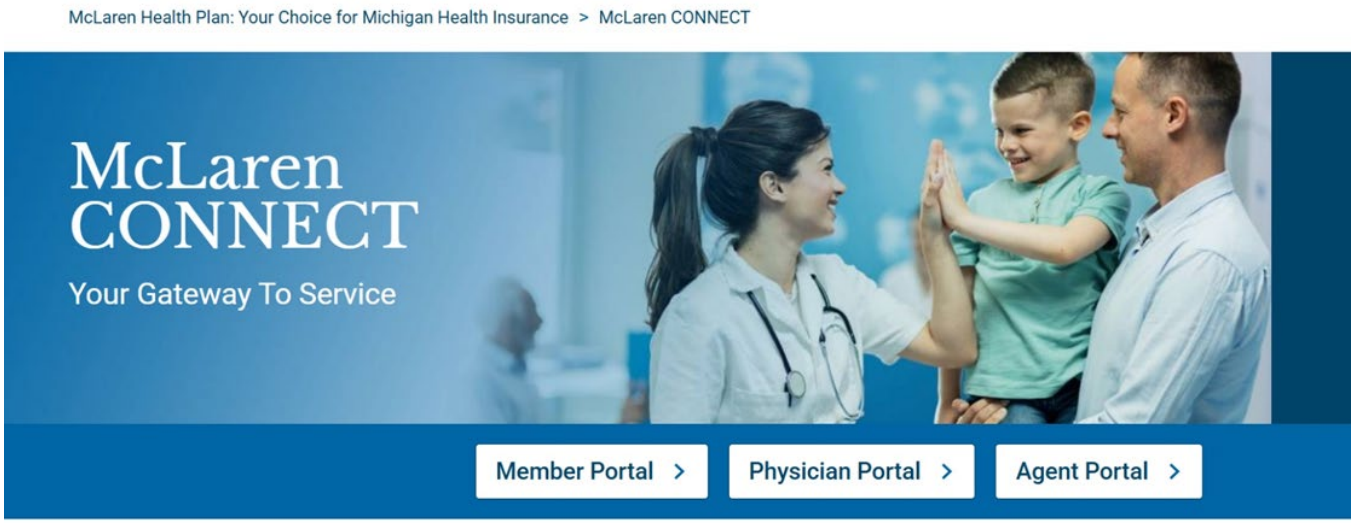
Our Website

You can visit our website at www.mclarenhealthplan.org to access online services such as:

- Certificate of Coverage, which tells you about covered services
- Provider directory, which lists hospitals, providers and dentists, and NEMT Providers
- Clinical Practice Guidelines, which are standards of care for our physicians to follow
- Quality information
- Member handbook

Confidentiality

Your privacy is important to us. You have rights when it comes to protecting your health information. McLaren Health Plan recognizes the trust needed between you, your family, and your providers. McLaren Health Plan staff have been trained in keeping strict member confidentiality.



Member Portal

McLaren Health Plan offers a member portal, McLaren CONNECT. At McLaren CONNECT, you can sign up to review your enrollment history, request a primary care physician change, view and print ID cards, view plan summaries, look up prescription information and more. Go to www.mclarenhealthplan.org/mclarenconnect to register. There's a mobile app, too!

Transition of Care

If you're new to McLaren Health Plan, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Examples include medical, behavioral health, and pharmacy services.

If you are pregnant, you can stay with your doctor through the pregnancy and post-partum period.

If you are a McLaren Health Plan member and your doctor no longer participates with us, you can continue to see your doctor if you are receiving treatment for certain chronic diseases.

We will not approve continued care by a non-participating doctor if:

- You only require monitoring of a chronic condition
- The doctor has a restriction, and you might be at risk
- The doctor is not willing to continue your care

- Care with the non-participating doctor was started after you enrolled with McLaren Health Plan
- The doctor does not meet McLaren Health Plan policies or criteria

McLaren Health Plan will help you choose new doctors and help you get services in our network. Your doctor may call Customer Service if they want to be in our network.

If you are receiving Children's Special Health Care Services (CSHCS), please contact us for help transitioning your care services.

Please contact us at 888-327-0671 or TTY 711 to request transition of care services or if you have any questions about your care. Our Transitions of Care policy is available on our website at www.mclarenhealthplan.org/mclaren-health-plan/transitions-of-care-policy-mhp

Youth Transition into Adulthood

McLaren Health Plan is here to help you and your child with their healthcare needs when approaching age 18. Here are things to consider:

- At age 18, your child is a legal adult and will be responsible for giving consent for care or treatment
- You will no longer be able to obtain health information for your child without written consent or a legal order

- Your child's care may need to transition from pediatric providers to adult providers
- Your child's social security benefits may change
- Your child may no longer be eligible for resources that assist only children

Please contact us at 888-327-0671 or TTY 711 to request transition of care services beginning at age 14, or if you have any questions about your care.

Getting Care

Choosing A Primary Care Provider

When you enroll in our plan, you will need to choose a primary care provider (PCP). Your PCP is the health care provider or doctor who takes care of all your health needs. You can choose a different doctor for each family member, or you can choose one doctor for the whole family.

You can choose one of the following provider types as your primary care provider:

- General practice doctor
- Family practice doctor
- Nurse Practitioner
- Internal medicine doctor
- Pediatrician doctor
- OB/GYN doctor

If you do not choose a doctor within 30 days of enrollment, we will select one for you. You can change your doctor anytime.

You do not need a referral to see an in-network pediatrician or OB/GYN provider for routine and preventive health services.

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, telephone numbers, office hours, languages spoken, specialties, board certification and information about accessibility. It is located at www.mclarenhealthplan.org/mclaren-health-plan/provider-directory-mhp . You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling 888-327-0671 or TTY: 711. Remember provider information changes often. Visit our website for the most up-to-date information. Call Customer Service if you need help finding a doctor or if you want to know more about a provider. We can tell you the medical school or residency he or she attended as well.

You can also get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable) in-network or out-of-network with no prior authorization required .

If you have certain health care needs, you may be able to choose a specialist as your primary care provider. Talk to your doctor or call Customer Service for more information.

Make sure you ask the provider office if they participate in the McLaren Health Plan network.

Getting Care From Your Doctor

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at 888-327-0671 or TTY: 711.

Your visit is important. Please be on time. Call the office as soon as you can if you cannot make it to your visit. You can set up a new visit when you call to cancel. Some offices will not see you again if you do not call to cancel.

Getting Care From A Specialist

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. A written referral is needed if your PCP decides you need to see a specialist who does not participate with McLaren Health Plan. Your PCP will fill out the paperwork. Your PCP is the only one who can ask for a referral to a specialist who does not participate with McLaren Health Plan. Talk to your doctor or call Customer Service for more information.

Out-of-Network Services

You must get most of your care from providers in our provider network. Customer Service can help you find a provider in our network.

If we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a

necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

McLaren Health Plan provides services in all 68 counties of lower Michigan. All services received in the Upper Peninsula require prior authorization or approval. McLaren Health Plan covers emergency care in Upper Peninsula.

Out of State Services

McLaren Health Plan covers emergency care if you need to go out of state. Go to the nearest hospital if you have an emergency. All other services out of the state require prior authorization.

Out of Country Services

Health care services provided outside the country are not covered by McLaren Health Plan.

Physician Incentive Disclosure

You may ask how we pay our providers, especially if you think it changes how your provider treats you. Call Customer Service if you have any questions.

McLaren Health Plan makes decisions about the use of medical services based on whether they are appropriate and a covered benefit. No one at McLaren Health Plan, or providers, or any employee, is rewarded for making decision not to give you care. We want you to get all the care you need.

There are no incentives for anyone at McLaren Health Plan to deny you care. This is an important message. Call Customer Service at 888-327-0671 or TTY: 711 if you need help.

Prior Authorization

Some services and medications will need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that requires PA. We must approve the PA request before you get the care. If we do not approve the service, we will notify the doctor and send you a written notice of the decision. You do not need a written authorization from your PCP to visit or get services in the office of an in-network specialist.

Additional information about PAs including a list of specific services, are on our website at https://www.mclarenhealthplan.org/mclaren-health-plan/referral-guidelines-mhp1

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a McLaren Health Plan in-network provider or out-of-network. Second opinions do not require prior authorization from us if the provider is in-network with McLaren Health Plan. Please call Customer Service to learn how to get a second opinion or if you need assistance with a second opinion from an out-of-network provider.

New Medical Care

McLaren Health Plan knows that new medical care options become available. We have a process to look at these options to decide if we will cover the new care. This includes procedures, medications, and devices. This process includes reviewing all the medical information.

A special committee does the review. This committee considers many things, such as:

- Is the care safe?
- Is the care approved by the FDA?
- Is it covered by Medicaid?
- Is there a more cost-effective choice?

The committee then decides if the new care is covered. If you or your PCP has a question about any new medical care that becomes available, please call Customer Service at 888-327-0671 or TTY: 711 and ask for Medical Management. We can help answer your questions.

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a McLaren Health Plan member, you do not have to pay co-pays for covered services under the Medicaid or Healthy Michigan Plan. See Cost Sharing and Copayments section for more information.

If there are any significant changes to the covered services outlined in this handbook, we will notify you in writing at least 30 days before the date the change takes place.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. The COC is available on our website at www.mclarenhealthplan.org/member-communications.

Make sure a service is covered before the service is done. You may have to pay for services not covered by McLaren Health Plan under the Medicaid program.

McLaren Health Plan does not deny reimbursement or coverage for services on any moral or religious grounds.

Telehealth/Telemedicine Services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses and mental health needs without having to go to the emergency room or urgent care. For non-emergency issues, including the flu, allergies, rash, upset stomach, other illnesses, and mild to moderate mental health care, you can connect with a Provider through your phone or computer to receive care where you are, when you need it. Providers can diagnose, treat, and even prescribe medicine, if needed. Call your provider's office to see if they offer telehealth services or contact Customer Service for more information. Customer Service can also assist you with virtual care options.

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program (BMP). This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

- Going to the emergency room when it's not an emergency
- Seeing too many different doctors instead of your primary care doctor
- Getting more medicines than may be safe
- Activity that may indicate fraud

Using the right health services in the right amount helps us make sure you're getting the very best care. Call Customer Service if you have questions about the BMP.

Covered services include:

Listed below is information to help you understand your covered health care services provided by McLaren Health Plan. Provider office visits, routine physicals, routine immunizations (shots) and healthy baby care/healthy childcare (well-child visits) are covered. Remember, if you are told a service is not a covered benefit, call Customer Service at 888-327-0671 or TTY: 711 to verify. Have your provider call Customer Service if he or she has a question regarding your benefits.

• Ambulance and other emergency transportation when necessary	• Intermittent or short-term restorative or rehabilitative services (in a nursing facility) up to 45 days
• Blood lead tests and follow-up	• Long-term Acute Hospital Services (LTACH)
• Breast pumps	• Maternal Infant Health Program (MIHP)
• Certified nurse midwife	• Medically necessary weight reduction services
• Certified pediatric & family nurses practitioner services	• Mental Health Services
• Chiropractic services (up to 18 visits per calendar year, additional visits require preauthorization	• Non-Emergency Medical Transportation (NEMT) to medically necessary covered services and Medicaid services covered outside of the health plan
• Community Health Worker (CHW)/Community Health Representative (CHR) services	• Out-of-state services, when authorized
• Dental services	• Parenting and birthing classes
• Diagnostic services (lab, x-ray, other imaging)	• Pharmacy services
• Doula Services	• Podiatry services
• Durable Medical Equipment and supplies	• Practitioners' services
• Emergency services, including transportation	• Preventive services
• End Stage Renal Disease (ESRD) services	• Prosthetic and orthotics

• Family Planning services (e.g., examination, sterilization procedures, limited infertility screening, and diagnosis)	• Restorative and rehabilitative services in a place of service other than a nursing facility
• Food Services (In Lieu of Services-ILOS)	• Sexually Transmitted Infection (STI) treatment
• Habilitative services (HMP members only)	• Tobacco cessation treatment, including pharmaceutical and behavioral support
• Health education	• Therapies (speech, language, physical, occupational and therapies to support activities of daily living)
• Hearing and Speech services	• Specialist visits with referrals
• Hearing aids	• Telemedicine or telehealth services
• Home Health Services	• Transplant services
• Hospice services	• Vision services
• Immunizations (shots)	• Well-child/EPSDT for persons under age 21
• Inpatient and outpatient hospital services	

You can call Customer Service at 888-327-0671 or TTY: 711 if you have questions about these or other services. Please call Customer Service for more information if you do not understand the limits or if you are told something is not covered.

Care Coordination

Do you have a chronic health problem or disability? Do you have barriers that are causing you issues with accessing your care? Do you see multiple providers or need special care? It's easy to feel overwhelmed with being in charge of your care if you have many health issues and see many providers. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personalized care coordination services to help guide you through health care. We have nurses, care coordinators, social workers, and other health experts to help you get the best care possible from your care team.

The care coordination program focuses on you and your needs. We help you reduce the barriers you are having accessing your care by linking you to services and resources near you to help improve your health. We also assist you in reducing your barriers by helping to arrange care with your care team and providers. This ensures you are able to better manage your health and improve your quality of life.

How Can Care Coordination Help You?

If you are eligible, you will be assigned your own care coordinator. This person helps you address and eliminate barriers that cause you issues with obtaining care by:

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments
- Helping you better control your healthcare needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits
- Coordination of care between providers, services, and social support providers

Call Customer Service for more information about the care coordination program.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This is a voluntary program that allows you to talk with a care coordinator about your health care. A care coordinator helps you:

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions
- Access community-based supports, services, and resources

Members, their caregivers, and practitioners may refer you for care management. If you are interested in joining this program, please call Customer Service to be connected with a care coordinator.

Some of our available chronic care programs include:

- Asthma
- Diabetes
- Weight Management
- Tobacco cessation
- Sickle Cell disease
- Depression
- Hypertension

You may be automatically enrolled in one of these programs. To enroll in one of these programs or to opt out, contact Customer Service at 888-327-0671.

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

Babies from birth through 15 months need at least six well-child visits. These visits often are at these ages:

3-5 days	2 weeks	1 month
2 months	4 months	6 months
9 months	12 months	15 months

It is important for your child to get a blood lead test once before age one and again before age two. Children who are at risk or who are high risk should be checked more often. These children should be tested at least one time per year. Children who are high risk are those who have had lead poisoning in the past. This includes children who live in old homes or apartments. Lead poisoning can happen even if you do not live in an older home. Lead can be found in paint, soil, ordinary dust, playgrounds, and toys, as well as other places. Have your child tested for lead poisoning so that it may be treated. If untreated, lead poisoning can lead to disabilities and behavioral problems. This simple test will help keep your little one on track!

Teenagers should also receive annual well-child visits. At these visits, teens will have their height, weight and BMI checked. Providers can talk about health, safety and preventive measures that are useful to teens. Required immunizations can also be given at these visits.

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special healthcare program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended preventive services and any medical treatment needed to promote healthy growth and development. EPSDT can provide coverage for medically necessary services even if these are not normally covered by Medicaid. For more information on EPSDT, go to the Bright Futures website http://brightfutures.aap.org/ or contact Customer Service.

EPSDT checkups include:

Well-care visits	Physical and mental developmental/behavioral assessments
Health history and physical exam, including school and sports physicals	Crucial lab tests, including lead screening
Developmental screening	Nutrition assessment
Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children's Special Health Care Services

If your child has a serious, chronic medical condition, they may be eligible for Children's Special Health Care Services (CSHCS).

CSHCS provides extra support for children and some adults who have special health care needs. This is in addition to the medical care coordination from McLaren Health Plan.

There is no cost for this program. It doesn't change your child's McLaren Health Plan benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies.

McLaren Health Plan works closely with local health departments, PCPs, and specialists to provide full-service care and access to community resources, case management, transportation, provider visits, and many more services. Please call Customer Service to find out more at 888-327-0671 or TTY: 711.

MDHHS Family Center for Children and Youth with Special Health Care Needs:

This center provides a parent support network and training programs. It may also provide financial help for conferences about special needs and more. If you have questions about this program, call the CSHCS Family Phone Line at 1-800-359-3722 from 8 a.m. to 5 p.m. Monday through Friday.

Local County Health Department:

Your local county health department can help you find local resources. These may include parent support groups, adult transition help, childcare, vaccines and more. For help finding your local county health department, visit your county's website or Michigan.gov. Call Customer Service for assistance.

Children's Special Needs Fund:

The Children's Special Needs fund helps families get items not covered by Medicaid or CSHCS. These items promote the health, mobility, and development of your child. They may include wheelchair ramps, van lifts and mobility equipment. To see if you qualify for help from this fund call 1-517-241-7420.

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services beginning at age 14.

Community Health Workers (CHW)

Community Health Workers are the front-line public health workers within the community, assisting members with navigating health care. CHWs serve as a bridge between health care and social services by building trusting relationships. CHWs full range of services include:

- Meeting face to face to improve your access to health care
- Helping find providers and set up visits
- Finding local support like food and housing
- Teaching ways to live a healthy life
- Helping with provider follow-up visits after going to the hospital or emergency room
- Helping set up rides for medical or pharmacy visits

Contact Customer Service for more information.

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with Delta Dental to provide your dental benefits.

If you have any questions about your dental services, please contact Delta Dental at 866-558-0280 or visit www.dentaldentalmi.com/member/plans/medicaid=medicare-advantage/healthy-michigan-plan. Please Call McLaren Health Plan at 888-327-00671 or TTY: 711 if you need transportation to a dental appointment.

You must receive dental services from a dentist participating in Delta Dental's Healthy Michigan Plan network, which serves both Medicaid and Health Michigan Plan members. A dentist participating in Delta Dental's Healthy Michigan Plan network will be referred to as a Participating Provider. Services will not be covered unless your dentist participates in Delta Dental's Healthy Michigan Plan network.

For help finding a Delta Dental Healthy Michigan Plan dentist in your area, call Delta Dental's

customer service at 866-558-0280 (TTY users call 711). This call is free. You may also use the provider directory which can be found at www.providers4you.com/medicaid.

Covered dental services include:

- Oral exams (1 in 6 months)
- Comprehensive Periodontal Evaluation (1 in 12 months)

Note: Comprehensive Periodontal Evaluation is not a covered benefit when billed in conjunction with, or within six months of other oral exams

- Assessment (1 in 6 months)
- X-rays
    - Bitewing X-rays (1 in 12 months)
    - Full mouth or panoramic X-rays (1 in 5 years)
- Teeth cleaning (prophylaxis) (1 in 6 months)
- Scaling in the Presence of Inflammation (1 in 6 months)

Note: Scaling in the presence of inflammation is not covered within 6 months of prophylaxis, scaling and root planning, periodontal maintenance, or debridement procedures

- Periodontal Maintenance (1 in 6 months)

Note: Any combination of teeth cleanings (prophylaxis, scaling in the presence of inflammation and periodontal maintenance procedures) are covered once per 6 months

- Scaling and Root Planing (1 in 2 years per quadrant, maximum of 2 quadrants per day)
- Sealants (1 in 3 years for first and second primary (baby) molars and first and second permanent (adult) premolars and molars)
- Filings
- Sedative filling
- Crowns, including porcelain, metal and resin based (1 in 5 years)

Note: Crowns are payable only for extensive loss of tooth structure for caries or fracture. Tooth loss must be at least 50%.

- Crown buildup, including pins
- Re-cement crowns and bridges
- Root canals
- Extractions, simple and surgical
- Limited other oral surgery
- Emergency treatment of dental pain
- IV sedation (when medically necessary)
- Complete denture (1 in 5 years)
- Partial denture (1 in 5 years)
- Denture adjustments and repairs
- Denture rebase and reline (1 time in 2 years)

In addition, if you are under age 21, the services listed below are also covered for you:

- Fluoride varnish (1 in 6 months)
- Topical application of Fluoride (1 in 6 months)

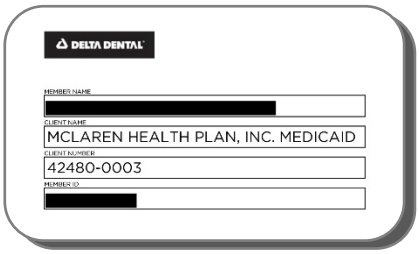
Note: Topical application of fluoride cannot be combined with fluoride varnish with the same six months

- Temporary partial denture (only to replace front teeth)
- Stainless steel crown (prefabricated) (1 In 2 years on same tooth)

Some services are NOT covered. Excluded dental services are:

- Bite guards
- Removal of healthy third molars (wisdom teeth)
- Bridges and inlays
- Implants
- Braces
- Cosmetic dentistry
- Removable space maintainers
- Services covered under a hospital, surgical/medical, or prescription drug program
- Treatment of TMJ (TMJ is a problem that can cause pain in your jaw joint and can also cause pain the muscles that control jaw movement)
- Cone Beam CTs
- Nitrous Oxide

To use these benefits, schedule a visit with a participating provider. Bring your Delta Dental ID card to your dental visits. If you lose your card, call Delta Dental at 866-558-0280 for a replacement card at no charge. Be sure to ask your dentist if a service is covered before the service is done. You must pay for services that are not covered.



Delta Dental does not limit its payment on services based on moral or religious grounds.

If you need translation or language services for dental services, Delta Dental has the following options:

- On-demand access to our interpretation line
- In-office interpretation services during appointments with 72 hours advance notice
- Translation of any significant materials in any language
- Translation of any significant materials in an alternative format for enrollees with special

needs

You should tell your Delta Dental provider or call Delta Dental at 866-558-0280 if you need any of these services. Delta Dental will arrange for services at no cost to you or your dentist.

Emergency Dental Care

A dental emergency is a service needed to control bleeding, relieve pain, get rid of acute infection, prevent loss of teeth and treat injuries.

If a dental emergency happens, call your dental office and ask what you should do. If you currently do not have a regular dentist, call Delta Dental's customer service at 866-558-0280 to receive a list of dentists, or go to https://www.providers4you.com/medicaid to find a dentist near you.

If you are not in Michigan when a dental emergency happens you can call Delta Dental's customer service toll-free at 866-558-0280 for help finding a dentist. If you have a dental emergency outside of Michigan, your service will be covered even if the dentist is not a participating dentist. A prior authorization is not needed for emergency services. If the emergency is life threatening, call 911.

You can also access teledentistry.com for 24-hour emergency dental care.

Dental Grievances and Appeals

If you have a question about a dental claim, call customer service at 866-558-0280. If you are unhappy for any reason related to dental services you received, participating providers, or Delta Dental's customer service you may file a grievance. You can do this by calling Delta Dental's customer service at 866-558-0280 or mailing your grievance to:

Delta Dental
Attn: Medicaid Grievances
PO Box 9230
Farmington Hills, MI 48333-9230
Fax: 517-381-5527

Be sure to include your name, ID number, and a full explanation of your grievance in your letter. Delta Dental will investigate your grievance and respond to you within 90 calendar days of receiving your call or letter.

If your complaint involves the quality of care provided by a Delta Dental dentist, Delta Dental may refer the problem to the Michigan Dental Association for Peer Review Committee.

If Delta Dental, make an adverse benefit determination you have the right to ask for a review of their decision by asking for an internal appeal. You can do this by calling customer service or writing via fax or mail. You can ask for an internal appeal within 60 calendar days of the date

on the adverse benefit determination. We can give you more time if you have a good reason for missing the deadline.

If Delta Dental is stopping or reducing a service, you can keep getting the service while your case is being reviewed. If you want to continue receiving these services while your case is under review, you must ask for an internal appeal within 10 calendar days of the date of adverse benefit determination or before the service is stopped or reduced, whichever is later.

You could be responsible for the cost of these services if Delta Dental's decision is upheld. You can ask for an internal appeal by calling customer service at 866-558-0280 or following the steps below to send your appeal in writing:

Step 1: You, your representative, or your dentist (provider) acting as your representative must ask for an internal appeal. Your written request must include:

- Your name
- Address
- Delta Dental ID number
- Reasons for appealing
- Any evidence you want Delta Dental to review, such as medical records, dentists' letters, or other information that explains why you need the item or service. Call your dentist if you need this information.

Keep a copy of everything you send with your appeals for your own records.

You can ask to see, free of charge, all documents, records, and other information used to make the decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines Delta Dental used to make their decision.

Step 2: Mail or Fax your appeal to:

Delta Dental
Attn: Medicaid Appeals
PO Box 9230
Farmington Hills, MI 48333-9230
Fax: 517-381-5527

Delta Dental will give you a decision on your appeal within 30 calendar days. If we uphold our decision or you do not receive a timely decision you can ask for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rulings (MOAHR). You can also ask for an external review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services. Your written decision will give you instructions on how to request a State Fair Hearing and external review.

If you have an urgent situation where taking the time for a standard internal appeal could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, you can request an expedited (fast) appeal by calling Delta Dental's customer service. If the situation is urgent and requires an expedited an appeal, Delta Dental will make a decision within 72 hours.

You must file an appeal with Delta Dental before asking for a State Fair Hearing. You have 120 calendar days from the date of your appeal denial notice to ask for the State Fair Hearing. A request for hearing form will be included with the notice of appeal decision that you receive from Delta Dental. It also has instructions that you should review. In order to request a State Fair Hearing, you must follow the steps below:

Step 1: You, your representative, or your dentist acting as your representative must ask for a State Fair Hearing after you have appealed to us and received the notice of appeal decision. You can also ask for a State Fair Hearing if you do not receive a decision from Delta Dental within the required time frame. Your written request must include:

- Your name
- Address
- Delta Dental ID number
- Reason for requesting a State Fair Hearing
- Any evidence you want the administrative law judge to review, such as medical records, dentists' letters, or other information that explains why you need the item or service. Call your dentist if you need this information.

Step 2: Call 800-648-3397 to have a hearing request (complaint) form sent to you. You may also call to ask questions about the hearing process.

The MOAHR will schedule a hearing. You will get a written notice of hearing telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person.

During the hearing, you will be asked to tell an administrative law judge why you disagree with Delta Dental's decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You will get a written decision within 90 calendar days from the date you request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard time frame for review would jeopardize your life or health, you may be able to qualify for an expedited (fast) State Fair Hearing. If you qualify for an expedited State Fair Hearing, MOAH must give you an answer within 72 hours.

However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions about the State Fair Hearing process, including the expedited State Fair Hearing, you can call MOAHR at 800-648-3397.

At any time of your appeal, you can name a relative, friend, attorney, dentist (provider), or someone else to act as your representative. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax this statement to us with your appeal.

If you need help filing a grievance or an appeal or need additional information about Delta Dental's decision and the appeal process, call Delta Dental's customer service toll-free at 866-558-0280 (TTY users call 711). Phones are open Monday through Friday, 8 a.m. to 8 p.m. ET. You can also visit Delta Dental's website at www.deltadentalmi.com/medicaid.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at 800-642-3195 for help.

Blue Cross Blue Shield of Michigan
Michigan Health Insurance Plans | BCBSM
Phone: 800-936-0935

Delta Dental of Michigan
Individual Dental Plans | Delta Dental of Michigan (deltadentalmi.com)
Phone: 866-696-7441

Durable Medical Equipment

Some medical conditions need special equipment. Durable medical equipment or customized durable medical equipment we cover includes:

- Equipment such as nebulizers, crutches, wheelchairs, and other devices
- Disposable medical supplies, such as ostomy supplies, catheters, peak flow meters and alcohol pads
- Diabetes supplies, such as lancets, test strips, insulin needles, blood glucose meters and insulin pumps.
- Prosthetics and orthotics – Special note: Prosthetics replace a missing body part, such as a hand or leg. They may also help the body function. Orthotics correct, align, or support body parts that may be deformed.

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from an in-network provider. To find network durable medical equipment providers, call Customer Service or use our provider directory at www.mclarenhealthplan.org/medicaid-member/find-a-provider-medicaid.

Emergency Care

Emergency care is for a life-threating medical situation or injury that a reasonable person would seek care right away to avoid severe harm. Here are some examples of emergencies:

Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)
Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call 911 or go to the emergency room. You do not need an approval from McLaren Health Plan or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Food Services

Michigan Medicaid and your Medicaid health plan are offering food services to improve your health. You may qualify for these services at no cost to you. The food service include:

- Medically Tailored Home Delivered Meals
- Healthy Home Delivered Meals
- Healthy Food Pack
- Produce Prescription

It is up to you whether you use a food service if you qualify. Your Medicaid coverage and access to other medical services will stay the same if you use a food service or choose not to.

You can file a grievance or appeal about the food service, for example, if you are not approved for a food service. Information on how to file a grievance or appeal can be found on page 56.

Keep reading to learn more about your food service options and if you may qualify for a food servicer. If you have any questions, call Customer Service to be directed to Medical Management for more information.

Medically Tailored Home Delivered Meals

Through the Medically Tailored Home Delivered Meal service, you will receive up to two healthy meals delivered to your home. Frequency approvals will be based on the appropriate clinical criteria as determined by our Medical Management Department. These meals are tailored to your health needs.

You will also get help from a registered dietitian. This person is a nutrition expert and will give you guidance on choosing healthy foods.

This service is for members who cannot get enough food when they need it, cannot shop for and cook their own healthy meals, AND:

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, sickle cell disease, renal/kidney disease, diabetes during pregnancy, or other pregnancy complications; ***OR***
- Have been in a hospital or skilled nursing facility in the last 60 days.

Healthy Home Delivered Meals

Through the Healthy Home Delivered Meal service, you will receive up to two healthy meals per day delivered to your home based on a frequency approved by our Medical Management Department.

This service is for members who cannot get enough food when they need it, cannot shop for and cook their own healthy meals ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, malnutrition, sickle cell disease, or renal/kidney disease; ***OR***
- Have been in a hospital or skilled nursing facility in the last 60 days; ***OR***

- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, and dehydration; ***OR***
- Used to be in foster care and have an illness that can be improved with a healthy diet; ***OR***
- Are a child that has too much lead in their blood or is obese; ***OR***
- Are a child eligible for the Children's Special Health Care Services (CSHCS) program.

Healthy Food Pack

Through the Healthy Food Pack service, you will be able to pick up a mix of healthy foods or have them delivered to your home based on a frequency approved by our Medical Management Department.

This service is for members who cannot get enough food when they need it, cannot shop for their own healthy foods ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, malnutrition, sickle cell disease, or renal/kidney disease; ***OR***

- Have been in a hospital or skilled nursing facility in the last 60 days; ***OR***

- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, dehydration; ***OR***

- Used to be in foster care and have an illness that can be improved with a healthy diet; ***OR***

- Are a child that has too much lead in their blood or is obese; ***OR***

- Are a child eligible for the Children's Special Health Care Services (CSHCS) program.

Produce Prescription

Through the Produce Prescription service, you will receive a voucher to buy fruits and vegetables on a frequency approved by our Medical Management Department.

This service is for members who cannot get enough food when they need it ***AND***:

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, malnutrition, sickle cell disease, or renal/kidney disease; ***OR***

- Have been in a hospital or skilled nursing facility in the last 60 days; ***OR***

- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, dehydration; ***OR***

- Used to be in foster care and have an illness that can be improved with a healthy diet; ***OR***

- Are a child that has too much lead in their blood or is obese; ***OR***

- Are a child eligible for the Children's Special Health Care Services (CSHCS) program.

Contact Customer Service for assistance with food services and other food resources you may qualify for.

Healthy Behaviors

You may be eligible to participate in a healthy behavior incentive program. McLaren Health Plan has a Member Rewards program that rewards you for making healthy lifestyle choices. Some examples of healthy lifestyle choices:

- Screening for Breast Cancer
- Complete a timely postpartum visit
- Dental Exams
- Diabetic services

For more information and specific details on the Member Rewards Program go to https://www.mclarenhealthplan.org/mclaren-health-plan/member-rewards-mhp

Hearing Services

How well you hear affects your quality of life. We cover services and supplies for the diagnosis and treatment of diseases of the ear, including:

- Hearing exams
- Medically necessary hearing aid evaluations and fittings
- Medically necessary hearing aids

If you need a hearing exam or think you need hearing aids, call Customer Service at 888-327-0671 or TTY: 711. You can also call a provider from our list of hearing providers.

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see. People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

For members under age 21, the screening is covered under the Early and Periodic Screening, Diagnosis and Treatment program, or EPSDT. This includes coverage of any medically necessary follow-up services and referrals.

Home Health Care, Skilled Nursing Services and Hospice Care

Sometimes, you may need long-term care. To help you get the care you need, we may cover:

- Short-term nursing home services up to 45 days in a nursing facility (long-term care is provided by the State of Michigan)
- Home health care services for members who are homebound
- Supplies and equipment related to home health care
- Hospice care

McLaren Health Plan can help you get hospice care, contact Customer Service and ask to speak to your nurse.

Hospital Care

Hospital care is for care like delivering a baby or taking care of a bad sickness. It also covers care you would get in the hospital, like lab tests or x-rays. Your doctor sets up your hospital care if you need it. A different doctor at the hospital may fill in for your doctor to make sure you get the care you need if an emergency happens.

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was not arranged by your doctor. Ask a family member or friend to call for you if you cannot. It is important to call your doctor right away and set up a visit within seven days of being sent home. You can talk about and arrange your care after you leave the hospital during this follow-up visit.

Mental Health And Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more. Treatment for long term, severe mental conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. If you feel you have a substance abuse problem, we encourage you to seek help. If you need help getting services, call your doctor or Customer Service.

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often

- Performing poorly at work or school
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.
- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down
- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substance's effects
- Giving up or reducing important social, work, or recreational activities because of substance use
- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits call Customer Service. You can also call your local CMHSP agency.

If you need emergency care for a life-threatening condition, or if you're having thoughts of suicide or death, go to the nearest emergency room or call 911. You can also call the Suicide and Crisis Lifeline by dialing 988. Help is available for you now.

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network. Routine and preventive services include but are not limited to prenatal care, breast exams, mammograms, PAP tests, and chlamydia screenings. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN or Certified Nurse Midwives, even if they aren't your primary care doctor.

To make sure you get the care you need to be at your best for you and your family, we cover:

Family Planning	Prenatal and postpartum care

Pregnancy testing	Midwife services in a health care setting
Birth control and birth control counseling	Delivery care
HIV/AIDS testing and treatment of sexually transmitted diseases	Parenting and birthing classes
Pregnancy and maternity care, including the Maternal Infant Health Program	Mammograms and breast cancer services, such as treatment and reconstruction
Doula Services	Pap tests
Depression Screening	

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor, OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Customer Service as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
  (It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Call your PCP right away if you think you may be pregnant. Your PCP can confirm your pregnancy and help you find a specialist to provide your care. It is very important to see your OB-GYN provider on a regular basis throughout your pregnancy and after you have your baby. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Customer Service and your local MDHHS office as soon as you find out you are pregnant so we can provide support. We want to talk to each and every member who is pregnant.

Ask to speak to your nurse when you call Customer Service. McLaren Health Plan has a program called McLaren Miracles. We want to talk with you!

McLaren Miracles has special nurses who will send you information on what to expect now that you are pregnancy. You will receive all kinds of information on health habits. Your special nurse can help you with any questions or problems you may be having.

McLaren Miracles covers breast pumps! We care about the health of you and your baby and want to give you the best possible care. Talk to your doctor about a fully covered breast pump prescription today!

Members identified as currently pregnancy are automatically enrolled in the McLaren Miracles program. Members can become ineligible if they are incorrectly identified as being pregnant, are no longer an MHP member (termed/expired) or if the member chooses to opt out of this program.

Doula services are available. Doulas are non-clinical support people who assist with your pregnancy.

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. We cover this exam.

The doctor may check your blood pressure and your weight. They may talk to you about birth control, feeding options, and provide other postpartum counseling. You can also talk to your doctor about any new feelings you may have.

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Customer Service to report the change. This starts the process of signing your baby up for health care services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Customer Service if you need help.

Maven

As a McLaren Health Plan member you have access to Maven which provides free 24/7 support for you and your baby. With Maven you have access to:

- Unlimited online appointments and messages with doctors
- A dedicated Care Advocate to help you find the right provider
- Trusted resources like articles and parenting classes.

Maven offers support services like:

- Your mental health
- Concerns about your pregnancy
- Questions as you recover from birth
- Learning more about your baby's milestones
- Nursing or formula feeding
- And much more!

Maven is a free resource for you as a McLaren Health Plan Member. Find more information on Maven by calling customer service or visit their website at: https://www.mavenclinic.com/maven-enrollment/mclaren-health-plan?organization_id=2048&install_source=payer&install_content=launchcomms&install_campaign=2024_launch_mclaren

Change in Family Size

When you experience a change in family size, contact Customer Service to let us know and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size.

Maternal Infant Health Program (MIHP)

The MIHP is a home visiting program for women and infants to promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development. MIHP covered services include:

- Prenatal teaching
- Childbirth education classes
- Nutritional support, education, and counseling
- Breastfeeding or formula feeding support
- Help with personal problems that may complicate your pregnancy
- Newborn baby assessments
- Referrals to community resources and help finding baby cribs, car seats, clothing, etc.
- Support to stop smoking
- Help with substance abuse
- Personal care or home help services

Call Customer Service for more information on how you can access these services.

Pharmacy Services (Medication)

Sometimes your provider feels you need a medication. Some medications you may need are covered by McLaren Health Plan. Others are covered by Medicaid. Medications covered by McLaren Health Plan do not have a copayment, unless otherwise noted. McLaren Health Plan follows the common drug formulary required by MDHHS. A drug formulary is a list of medications covered by McLaren Health Plan. Sometimes the medication your provider things is the best treatment for you is not on the common drug formulary. We may have a way to get those medications for you. Your provider can fill out a preauthorization request form for McLaren Health Plan to review.

McLaren Health Plan will review the request. We will tell your provider if the medication request has been approved. We may give your provider another choice of medications.

Call your PCP or McLaren Health Plan Customer Service at 888-327-0671 or TTY: 711 if you are trying to fill a prescription and are told by the pharmacy that it is not covered. We can help you. It may mean your medication is not on the common drug formulary.

It is important for you to know that McLaren Health Plan has worked with MDHHS to provide a common drug formulary that will meet your needs. Your provider knows about the common drug formulary. To get medications fast, ask your provider to use the common drug formulary.

Remember to take your McLaren Health Plan ID card and your Medicaid ID card with you to the pharmacy. Call Customer Service if you have any questions.

You can find a list of covered medications from McLaren Health Plan on our website at www.mclarenhealthplan.org/mclaren-health-plan/drug-formulary-search-and-resources

Preventive Health Care For Adults

Preventive health care for adults is important to McLaren Health Plan. You should have a wellness exam each year to prevent and detect health problems. It is important to find and treat health problems early.

Make sure to schedule an appointment and ask your doctor to check:

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings

You can also ask your doctor about:

- Immunizations
- HIV/AIDS testing and treatment of sexually transmitted diseases

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have programs to help you make good preventive health choices for yourself and your family.

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you should and should not do to take control of your health are listed below.

Things you should do:	Things you should **not** do:

• Eat healthy • Exercise • Get enough sleep • Manage your stress • Don't smoke or use tobacco • Don't use drugs or drink alcohol • Go to the dentist for regular cleanings and preventive services • Visit your doctor each year for yearly preventive care	• Eat foods high in fat, sugar, and salt • Live an inactive lifestyle • Hold in your feelings or emotions if you're feeling stressed or depressed • Use drugs, alcohol, or tobacco • Forget to set up your dentist visits for regular cleanings and preventive services • Forget to set up a yearly visit to your doctor • Avoid going to the doctor

Routine Care

Routine care is for things like:

- Yearly wellness exams
- School physicals
- Health screenings
- Immunizations
- Vision and Hearing Exams
- Lab tests

Your doctor should set up a visit within 30 business days of request.

Transportation Services

Non-Emergency Transportation

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement. These services are available 24 hours a day, 7 days a week, 365 days a year. McLaren Health Plan contracts with ModivCare to provide non-emergency transportation services, including, scheduling rides, reimbursing mileage or travel expenses incurred by or on behalf of the member,

when appropriate, providing bus tokens, etc. There is an internal review process if you need transportation outside the county you live in.

ModivCare will determine the most appropriate mode of transportation to meet your medical needs and based on your individual circumstances. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement. This includes, but is not limited to, special transport requirements for members who are medically fragile, members with physical or mental health needs, members with an Intellectual and/or Developmental Disability (I/DD), pregnant members, infants, members with children, and additional riders needed to accompany the member. ModivCare also considers the need for car seats, whether housing status may affect pick-up and drop-off location(s), and any circumstance where the appointment(s) need to be kept confidential. Special transport includes but is not limited to medically necessary wheelchair lift-equipped vehicles, Medi-Van vehicles, medically necessary attendants, and other transportation-related needs supported by medical documentation and/or safety protocols.

ModivCare provides transportation to ongoing services, such as dialysis, chemotherapy, substance use disorder (SUD) services, physical therapy, speech therapy, and occupational therapy. Additionally, to Maternal Infant Health Programs (MIHP) or other MDHHS approved evidence-based home-visiting program, enrolled pregnant and infant beneficiaries to access health care and pregnancy-related appointments and for a mother to visit their hospitalized infant. Pregnancy related appointments include those for oral health services, WIC services, mental or substance use disorder treatment services, and childbirth and parenting education classes. Medically necessary, non-emergency ambulance transportation to Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) related services.

Please call Customer Service at 888-327-0671 or TTY: 711 for more information and to schedule a ride. Please call 2-3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

- Your name, Medicaid ID number and date of birth
- The address and phone number of where you will be picked up
- The address and phone number of where you are going
- Your appointment date and time
- The name of your provider

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor. Let us know if you have additional riders. Door-to-door service is available upon request, and we comply with paratransit via the Americans with Disabilities Act (ADA). You may be asked

for additional documentation based on your trip needs.

In addition, Modivcare manages the coverage of Meals and Lodging for McLaren members. Modvicare and McLaren follow the MDHHS guidelines for meals and lodging coverage and reimbursement. Services for meals and lodging must be pre-approved by Modivcare.

Please be sure to call us as soon as possible if you need to cancel. If you have a complaint regarding non-emergency transportation services call Customer Service.

Emergency Transportation

If you need emergency transportation, call 911

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. McLaren Health Plan can also help you. To get more information, call Customer Service. We cover the following services to help you:

- Therapy and counseling services
- Educational materials
- Prescription inhalers or nasal sprays used to stop smoking
- Non-nicotine drugs
- Over-the-counter items to help you stop smoking
    - Patches
    - Gums
    - Lozenges

McLaren Health Plan has a free program to help you quit smoking. Call 1-800-784-8669 to enroll.

Urgent Care and After-Hours Care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.
These places can treat illnesses that should be cared for within 48 hours, such as the flu, high

fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office.

Vision Services

Eye care is an important part of your overall health. To make sure your eyes are healthy and help you see the best you can, we cover the following services:

- One eye exam every 24 months
- One pair of glasses every 24 months
- Eye glass frames
- Contact lenses

You do not need a referral to get eye care from in-network providers. If you have diabetes, you can go to an in-network eye professional every year without a referral. Call Customer Service at 888-327-0671 or TTY: 711 if you need glasses or an eye exam. You can also call a provider from our list of vision providers at www.mclarenhealthplan.org/mclaren-health-plan/provider-directory-mhp. For medical eye problems, talk to your doctor.

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources.

- Do you and your family struggle with having enough to eat?

- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need help keeping your benefits?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

If you answered yes to any of the above questions, we could help. MyCommunity Connect can help you apply for public benefit programs like food assistance, Medicaid, and utility or weatherization programs included through use of MI Bridges: www.michigan.gov/mibridges.

We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to McLaren Health Plan. Please call Customer Service at 888-327-0671. TTY users should call 711.

You can also access resources at the following:

- Online through our website: https://gethelp.mclaren.org
- Online through the State of Michigan portal: https://www.michigan.gov/mibridges
- Online through the Michigan 2-1-1 website: www.mi211.org

Women, Infants, and Children (WIC) is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Call 800-262-4784 to find a WIC clinic near you or call Customer Service for assistance.

Supplemental Nutrition Assistance Program (SNAP) or Food Assistance Program (FAP) is a free program that provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and well-being.

Visit the MI Bridges: www.michigan.gov/mibridges for more information or call Customer Service for MyCommunity Connect assistance.

Community Based Supports and Services are available in all of McLaren Health Plan's service area.

Cost Sharing and Copayments

A copayment (sometimes called "co-pay") is a set dollar amount you are required to pay as your share of the cost for a medical service or supply. McLaren Health Plan does not require you pay a copayment or other costs for covered services under the Medicaid or Healthy Michigan Plan program.

You must go to a doctor in McLaren Health Plan Medicaid network, unless otherwise approved. If you go to a doctor that is not in McLaren Health Plan Medicaid network and did not get approval to do so, you may have to pay for those services. You should not receive a bill from your doctor for covered services within the plan's network. If you receive services covered by MDHHS not McLaren Health Plan, you may have copayments.

If you have questions about how co-pays may apply to you or if you receive a bill for covered services, contact 888-327-0671 or TTY: 711.

Services Covered by Medicaid Not McLaren Health Plan

McLaren Health Plan does not cover all services that you may be eligible for as a member of Medicaid.

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at 800-642-3195.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for Enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
    - Screening and assessment
    - Detox
    - Intensive outpatient counseling
    - Other outpatient care
    - Methadone treatment

If you need transportation to or from an appointment, contact Customer Service at 888-327-0671 or TTY: 711.

Non-Covered Services

- Elective abortions and related services
- Experimental/investigational drugs, biological agents, treatments, procedures, devices, or equipment
- Elective cosmetic surgery
- Services for the treatment of infertility

Member Reimbursement

You should not pay a provider for a covered service. If you do – and you can prove that you have – McLaren Health Plan may reimburse you for those services.

- You must provide written proof of the payment within 12 months of the date of service and complete a Direct Member Reimbursement Form. You can call Customer Service to request a paper copy of the form. The form will have instructions on how to submit it.
- Claims submitted more than 12 months after the date of service will not be paid.
- Services must be a covered benefit and McLaren Health Plan will reimburse you the amount that would have been paid to the provider, which may be less than what you paid.

Rights and Responsibilities - McLaren Health Plan

You have rights and responsibilities as our member. Our staff and contracted providers will observe and respect your rights. We will not discriminate against you for using your rights. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services including beneficiary and plan information, including structure and operation
- Be treated with dignity and respect with due consideration for your dignity and privacy
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private by McLaren Health Plan and your Primary Care Provider (PCP)
- Participate in decisions regarding your health care, including the right to refuse treatment,

obtain a second opinion and express preferences about treatment options

- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the McLaren Health Plan, providers, or the State treats you
- To file a grievance, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act. Including the right that you or a provider cannot be penalized for filing a complaint or appeal in compliance with federal and state laws
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services in-network or out-of-network without a referral
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval
- To continue receiving services from a provider who has been terminated from the plan's network through episode of care as long as it remains medically necessary to continue treatment with this provider, including female members who are pregnant have the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to six weeks after delivery
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- To obtain a current directory of participating providers and access to a choice of specialists within the network who are experienced in treatment of chronic disabilities with a referral
- The right to obtain routine OB/GYN specialists and pediatric covered services from network providers necessary to provide routine and preventive health care services without a referral

- The right to have access to your PCP or provider designee 24 hours a day, 365 days a year for urgent care
- The right to be free from other discrimination prohibited by State and Federal regulations, including but not limited to:
    - Title VI of the Civil Rights Act of 1964
    - The Age Discrimination Act of 1975
    - The Rehabilitation Act of 1973
    - Title IX of the Education Amendments of 1972
    - Titles II and III of the Americans with Disabilities Act
    - Section 1557 of the Patients Protection and Affordable Care ACt
- The right to participate or refuse to participate in McLaren's In Leu of Services (ILOS), as well as express any dissatisfaction with the program

You have the Responsibility to:

- Review this handbook and McLaren Health Plan's Certificate of Coverage
- Make and keep appointments with your McLaren Health Plan doctor or if necessary, canceling your appointment as soon as possible
- Use the hospital emergency room only for acute or emergency care, not for routine care. This means following emergency protocol and using the emergency room only when medically necessary and contacting your PCP prior to the visit to the emergency room. If it is a life-threatening emergency go to the nearest emergency room or call 911
- Treat doctors and their staff with respect
- Carry your McLaren Health Plan Member ID card and protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.

- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to www.michigan.gov/mibridges.
- Allowing McLaren Health Plan to assist with health care and services to which you are entitled and notifying McLaren Health Plan of any problem related to health care, benefits, etc.
- Forwarding suggesting to McLaren Health Plan in writing or by contacting Customer Services

Rights and Responsibilities – Delta Dental

You have the Right to:

- Receive information on your dental benefits administered by Delta Dental
- Receive paper copies of this handbook and Delta Dental's provider directory, free of charge
- Be treated with respect and with due consideration for your dignity and privacy
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your information kept confidential
- Participate in decisions regarding your dental care, including the right to refuse treatment and express preferences about treatment options. (Be sure that the treatment is covered service as defined in this handbook and provided by a Delta Dental dentist.)

- Receive a second opinion from a Participating Provider or a Nonparticipating Provider, if one is not available, at no cost to you
- A reasonable accommodation
- To have your dental Provider advise or advocate on your behalf for the following:
    - Your health status, medical care or treatment options, including any alternative treatment that may be self-administered
    - Any information you need to decide among all relevant treatment options
    - The risks, benefits, and consequences of treatment or nontreatment
    - Your right to participate in decisions regarding your health care, including the right to refuse treatment and to express preferences about future treatment decisions
- Receive clinical practice guidelines to better understand how claims decisions are made. Clinical practice guidelines are scientific resources used by dental professionals to help them make treatment decisions after considering the options available. If you would like more information, please call Delta Dental customer service at 866-558-0280
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your dental records, and request those be changed or corrected
- Receive dental services consistent with this handbook and state and federal regulations
- Be free to exercise your rights without negatively affecting the way Delta Dental, Delta Dental dentists, or the State of Michigan treats you
- Be free from enrollment discrimination without restrictions regarding:
    - Your health status or the need for health and/or dental services
    - Your race, color, national origin, age, disability, sex, sexual orientation, and religion
- Be free from disenrollment discrimination. Delta Dental will not disenroll based on your:
    - Change in physical or mental health status
    - Use of dental ices

- Diminished mental capacity or uncooperative or disruptive behavior resulting from your special needs (Except when your continued enrollment seriously impairs Delta Dental's ability to furnish covered services to you or other enrollees)

- Be free from discrimination based on the following:
  - Age
  - Sex
  - Sexual orientation
  - Religion
  - Medical condition (including physical and mental illness)
  - Claims experience
  - Receipt of dental care
  - Medical/Dental history
  - Genetic information
  - Disability
- Be free from other discrimination prohibited by state and federal regulations
- To disenroll:
  - For cause, at any time
  - Without cause, at the following times:
    - During the 90 days following the date of your initial enrollment or during the 90 days following the date the State sends you notice of that enrollment, whichever is later
    - At least once every 12 months thereafter
    - If the State imposes an intermediate sanction on Delta Dental
- Receive information on available treatment options and alternatives, given in a manner appropriate to your condition and ability to understand
- Receive dental services from a Federally Qualified Health Center, Rural Health Clinic,

and Indian Health Coverage Program (as applicable) and mobile dental facility, and SEAL! Michigan

- To know if Delta Dental has any provider incentives, such as pay-for-performance
- To as about stop loss coverage
- Request and receive MDHHS network adequacy standards
- Request information on how Delta Dental operates as it relates to your dental benefits
- Delta Dental and its Delta Dental dentists will comply with all requirements concerning your rights.

You have the Responsibility to:

- Review this handbook
- Receive covered services from dentists that participates in the Delta Dental Healthy Michigan Plan network
- Make and keep appointments with your Delta Dental dentist
- Seek out information in order to make best use of the dental services
- Contribute toward your own oral health by taking responsibility for your oral health practices
- Treat dentists and their staff with respect
- Update family information. Tell your MDHHS case worker if there are changes in the following:
    - Change in your address
    - Get Married
    - Get divorced
    - Have a baby
    - Adopt a child or gain legal guardianship of a child
- Protect your ID card against misuse

- Contact Delta Dental if you suspect fraud

Grievances and Appeals

We want you to be happy with the services you get from McLaren Health Plan and our providers. If you are not satisfied, you can file a grievance or appeal.
Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help, call McLaren Health Plan at 888-327-0671 TTY: 711.

Please contact Delta Dental at 866-558-0280 if you have any concerns or complaints related to your dental services or if you want to appeal a denied service related to dental.

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you or your representative can file a grievance at any time. McLaren Health Plan has special procedures in place to help members or their representative who file grievances. We will do our best to answer your questions or help to resolve your concern. Filing a grievance will not affect your health care services or your benefits. These are examples of when you might want to file a grievance.

- Your provider or a(n) McLaren Health Plan staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a(n) McLaren Health Plan staff member was rude to you.
- Your provider or a(n) McLaren Health Plan staff member was insensitive to your cultural needs or other special needs you may have.
- Access to care issues, including vision, behavioral health, routine healthcare, transportation, prescriptions, or other Covered services
- Billing issues for any situation in which you received a bill for services you believe should be covered by McLaren
- NEMT related services, including but not limited to those relating to drivers failure to arrive on time or at all and failure to provide transportation that accommodates the

members' needs

- Issues related to In-Lieu of Services (ILOS)

You or your representative can file your grievance on the phone by calling McLaren Health Plan at 888-327-0671 (TTY: 711). You can also file your grievance in writing via mail or fax at:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Rd
Flint, MI 48532
Email: MHPappeals@mclaren.org
Fax: 810-600-7984

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling 888-3270-0671 (TTY: 711). We will let you know when we have received your grievance either orally or in writing within five days of receipt. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your “representative.” If you decide to have someone represent you or act for you, inform McLaren Health Plan in writing with the name of your representative and their contact information. Your grievance will be reviewed by staff not previously involved in your grievance. They will also not be a subordinate to any person involved in your grievance. If required, we will use an appropriate clinical person to review your grievance. If the grievance is related to a CSHCS member, McLaren will utilize an appropriate pediatric subspecialist provider to review, if the grievance is clinical in nature.

Your grievance will be resolved within 30 calendar days of submission, with the exception of Access to Care or Billing complaints/grievances. Access to care complaints will be resolved within 24-48 hours of receipt. Billing related complaints/grievances will be updated or resolved within 2 weeks of receipt. McLaren Health Plan has a two-step process for reviewing grievances. We will complete Step 1 within 15 days of receipt of the grievance. McLaren Health Plan will provide you with a written decision. If you are not happy with our decision, you may move to Step 2 by appealing to McLaren Health Plan in writing or by phone within five days of our decision letter. McLaren Health Plan will review your grievance appeal and provide final decision within 30 days from the initial grievance receipt. We will send you a letter of our decision.

How Can You Expedite Your Grievance?

We will treat your grievances as fast, if a doctor confirms the 30-day time frame would risk your life or your ability to regain the most function. Call McLaren Health Plan to file an expedited grievance. We will decide quickly. We will call you and your doctor to tell you of our decision within 72 hours. After we call you, we will send you a letter with our decision within two days. You or your representative can, but you don't have to, file an appeal of an expedited grievance with us.

You or your representative may file a request for an expedited external review at the same time you file a request for expedited internal grievance. If you file a request for an expedited external review, your expedited internal grievance will be pended until the Michigan Department of Insurance and Financial Services (DIFS) decides whether to accept your request. If DIFS accepts your expedited external review request, you will be considered to have exhausted the McLaren Health Plan's internal grievance process.

Appeal Process

An appeal is a way for you to ask for a review of our actions. If we decide that a requested service or item cannot be approved, or if a service is reduced or stopped, you will get an "Adverse Benefit Determination" letter from us. This letter will tell you the following:

- Information sufficient to identify the claim or service involved
- The Adverse Benefit Determination the contractor has made or intends to make
- The reasons for the Adverse Benefit Determination
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing/External Review and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services
- Notice of the availability of, and contact information for, the DIFS consumer ombudsman who will assist members with the appeal process, specifically, the Michigan Health Insurance Consumer Assistance Program (HICAP)

You or your representative may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The Adverse Benefit Determination either suspends, reduces, or terminates services you previously were receiving. McLaren Health

Plan's adverse notice to suspend, reduce or terminate a service will occur at least 10 days before the change in services. The list below includes examples of when you might want to file an appeal.

- Not approving or paying for a service or item your provider asks for
- Stopping a service that was approved before
- Not giving you the service or items in a timely manner
- Not telling you of your right to freedom of choice of providers
- Not approving a service for you because it was not in our network

McLaren Health Plan will continue your benefits if all the following conditions apply:

The appeal is filed timely, meaning on or before the latter of the following:

- Within ten days of McLaren Health Plan mailing the Adverse Benefit Determination
- The intended effective date of McLaren Health Plan's proposed action
- The appeal involved the termination, suspension, or reduction of previously authorized course of treatment
- An authorized provider ordered the services
- The authorization period has not expired
- You request an extension of benefits

If McLaren Health Plan continues or reinstates your benefits while the appeal is pending, the services will continue until one of the following occurs:

- You withdraw the appeal
- You do not request a fair hearing and continuation of benefits within ten days from the date McLaren Health Plan mails an Adverse Benefit Determination
- A State Fair Hearing adverse decision to you occurs
- The authorization expires or authorized service limits are met

McLaren Health Plan will pay for services provided while the appeal was pending if we reverse the adverse action decision or if a State Fair Hearing reverses it. We will authorize or provide the disputed services no more than 72 hours after we get a reversal notice. McLaren Health Plan will do this as fast as your health requires.

If an adverse State Fair Hearing decision is made, you may be required to pay the cost of your services. McLaren Health Plan may only do this as allowed by Michigan policy.

You or your representative can file your appeal on the phone by calling McLaren Health Plan at 888-327-0671 (TTY: 711). You can also file your appeal in writing via mail or fax at:

McLaren Health Plan
Attn: Member Appeals
G-3245 Beecher Rd
Flint, MI 48532
Email: MHPappeals@mclaren.org
Fax: 810-600-7984

You have several options for assistance. You may:

- Call Customer Service and we will assist you in the filing process.
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either: 1) send us a letter informing us that you want someone else to represent you and include in the letter their contact information or, 2) fill out the Authorized Representative form. You may call and request the form or find this form on our website at www.mclarenhealthplan.org/mclaren-health-plan/forms-documents-member. You may appoint an Authorized Representative at any step of the appeal process. Your estate representative may represent you if your appeal continues after you are deceased. The appeal process will start once we receive your Authorized Representative form.

We will send you a notice saying we received your appeal and explain the appeal process. The letter will include the time and date of the appeal meeting. You or your Authorized Representative may speak before the committee. You can present evidence, testimony and make legal and factual arguments. You must contact McLaren Health Plan if you want to take part in the appeal meeting. We will tell you if we need more information and how to give us such information in person or in writing. Any documents or information provided will be considered during the review of your appeal. If the appeal is related to a CSHCS member, McLaren will utilize an appropriate pediatric subspecialist provider to review. A provider with the same or similar specialty as your treating provider will review your appeal. It will not be the same provider who made the original decision to deny, reduce, or stop the medical service or a provider who was a subordinate of anyone who previously made a decision on your service.

McLaren Health Plan will send our decision in writing to you within 30 calendar days of the date we received your appeal request, or within 10 calendar days if you are receiving CSHCS benefits. McLaren Health Plan may request an extension up to 14 more days in order to get more information before we make a decision; the extension must be in your best interest. We will call you or your provider if we need to request an extension. We will follow up with a letter telling you of the delay as well. You may file an appeal if you disagree with the extension. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

You will get a written letter letting you know of our final decision within three days. We may call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If McLaren Health Plan's decision agrees with the Notice of Adverse Benefit Determination, you may have to pay for the cost of the services you got during the appeal review. If McLaren Health Plan's decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.
Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when McLaren Health Plan reviews your appeal.

You may request copies of information relevant to your appeal from Customer Service. This is free of charge to you. McLaren Health Plan will provide you with any new or added information considered, relied upon or generated by us related to your appeal. We will also give you any new or added rationale for a denial of your claim or appeal. We will give you a reasonable opportunity to respond.

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life, health, or ability to regain the most function due to your health situation you or your representative can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal.

We may decide not to treat your appeal as expedited. If so, we will make reasonable efforts to call you and tell you this. We will also mail you a letter within two days of your request to tell you we will not treat your appeal as expedited. If this happens, your appeal will be treated as standard.

If we accept your expedited appeal request, we will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision within two days.
You or your authorized representative may file a request for an expedited external review at the same time you file a request for an expedited internal appeal with McLaren Health Plan. If you choose to file a request for an external expedited review, your internal appeal will be

pended until DIFS decides whether to accept your request. If DIFS accepts your request, you will be considered to have exhausted the internal appeal process with McLaren Health Plan. DIFS will make a decision on your appeal.

How Can You Withdraw an Appeal?

You or your representative have the right to withdraw your appeal for any reason, at any time, during the appeal process. However, you or your authorized representative must do so in writing, using the same address as used for filing your appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. McLaren Health Plan will acknowledge the withdrawal of your appeal by sending a notice to you or your authorized representative. If you need further information about withdrawing your appeal, call McLaren Health Plan at 888-327-0671 (TTY: 711).

What Happens Next?

After you receive the McLaren Health Plan Notice of Internal Appeal Decision in writing, you do not have to take any action and your appeal file will be closed. However, if you disagree with the decision made on your appeal, you or your representative can take action by asking for a State Fair Hearing from the Michigan Office of Administrative Hearings and Rules (MOAHR) and/or asking for an External Review under the Patient Right to Independent Review Act (PRIRA) from the Michigan Department of Insurance and Financial Services (DIFS). You can choose to ask for both a State Fair Hearing and an External Review or you may choose to ask for only one of them.

State Fair Hearing Process

You, your representative, or your provider can ask for a State Fair Hearing with MOAHR. You must do this within 120 calendar days from the date of your appeal denial notice. A Request for Hearing form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. If you asked for services to continue in your health plan appeal and want to continue your services during the State Fair Hearing process, you must ask for a State Fair Hearing within 10 calendar days of the date on the decision notice. If you do not win this hearing, you may be responsible for paying for the services provided to you during the hearing process. You can also ask for a State Fair Hearing if you do not receive a Notice of Internal Appeal Decision from us within the required time frame.

Call McLaren Health Plan at 888-327-0671 or (TTY: 711) if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for

hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

If the standard timeframe for review would jeopardize your life or health, you may be able to qualify for an expedited State Fair Hearing. If you qualify for one, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.

If you have any questions, you can call MOAHR at 800-648-3397.

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review. DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 14 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS within 10 calendar days after receiving a final determination. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send you request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Or call: 877-999-6442
Fax: 517-284-8838
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Make Your Wishes Known: Advance Directives

McLaren Health Plan supports your right to file an "Advance Directive" according to Michigan law. This document is a written statement of your wishes for medical care. It explains, in advance, what treatments you want or don't want if you have a serious medical condition that prevents you from telling your provider how you want to be treated.

The state of Michigan only recognizes an advance directive called a *durable power of attorney for health care*. To create one, you will need to choose a patient advocate.

This person carries out your wishes and makes decisions for you when you cannot. It is important to pick a person that you know and trust to be your advocate. Make sure you talk with the person to let them know what you want.

Talk to your family and primary care physician about your choices. File a copy of your advance directive with your other important papers. Give a copy to the person you designate as your patient advocate. Ask to have a copy placed in your medical record.

Call Customer Service for more information and the forms you need to write an advance directive.

If your wishes aren't followed or if you have a complaint about how your provider follows your advance directive, you may file a complaint with:

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670 Lansing,
MI 48909-8170
Call: 517-373-9196
Or click below:
https://www.michigan.gov/lara/bureau-list/bpl
Click on *File a Complaint*

If you have complaints about how McLaren Health Plan follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at 877-999-6442 or go to https://www.michigan.gov/difs.

Disenrollment

Members may request a disenrollment "for cause" orally or in writing or without cause at the following times:

- New members have 90 days from the enrollment begin date with McLaren or during the

90 days following the date MDHHS sends the member notice of enrollment, whichever is later, to change health plans without cause. Enrollment changes will be approved and implemented by MDHHS.

- At least annually every 12 months after enrollment
- Upon automatic enrollment, if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.
- If the state imposes an intermediate sanction on the health plan in which all new enrollment including default enrollment has been suspended from the health plan for a violation of any requirement under sections 1903(m) or 1932 of the Social Security Act.

The following are causes for Member requested disenrollment:

- The member has a serious medical condition and is undergoing active treatment for that condition with a physician who does not participate with the health plan at the time of enrollment. Members must submit a medical exception request to MDHHS in this instance.
- The member moves out of the health plan's service area
- The health plan does not, because of moral or religious objections, cover the service the member seeks
- The member needs related services to be performed at the same time; not all related services are available within the network; and the member's Primary Care Provider or another physician determines that receiving the services separately would subject the member to unnecessary risk
- Lack of access to providers or necessary specialty services covered. Members must demonstrate that appropriate care is not available within the health plan's network or through out-of-network providers approved by the health plan
- Concerns with quality of care

McLaren Health plan may initiate a disenrollment to MDHHS in the following instances:

- The member acts in a violent or threatening manner not resulting from the member's special needs as prohibited in the Disenrollment Discrimination section. Violent/threatening situations involve physical acts of violence; physical or verbal threats of violence made against the Health Plan, it's providers, staff or the public at the health plan's locations or stalking situations.
- The member has moved out of the health plan's service area
- The member is admitted to a nursing facility for custodial care or remains in a nursing facility for rehabilitative care longer than 45 days.
- Member's circumstances change such that the member no longer meets the criteria for enrollment with the health plan as defined by MDHHS.

McLaren Health Plan will not initiate disenrollment in these instances:

- Ad adverse change in member's health status
- The member's utilization of medical services

- The member's diminished mental capacity
- Uncooperative or disruptive behavior resulting from his or her special needs (except when continued enrollment in the health plan seriously impairs McLaren's ability to furnish services to either this particular member or other members)

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse. McLaren Health Plan works hard to prevent fraud, waste and abuse within its networks, and you can help.

Knowing what fraud, waste, and abuse looks like is the first step to preventing it:

Fraud

Fraud is purposefully misrepresenting facts.

Here are some examples of fraud:

- Using someone else's member ID card
- Changing a prescription written by a doctor or selling your prescription
- Changing medical records
- Changing referral forms
- Letting someone else use your McLaren Health Plan ID card to get health care benefits.

Here are some examples of fraud by a doctor or provider:

- Billing for services that were not provided
- Billing for the same service more than once
- Providing services or prescribing medicine that is not needed

Waste

Waste is carelessly or ineffectively using resources. It is not a violation of the law, but it takes money away from health care for people who need it.

Here are some examples of waste by a member:

- Using transportation services for non-medical appointments

Here are some examples of waste by a doctor or provider:

- Ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources.

Here are some examples of abuse by a member:

- Using the emergency room for non-emergent health care reasons
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a doctor's office, hospital, or pharmacy
- Receiving services that are not medically necessary

Here are some examples of abuse by a doctor or provider:

- Billing for unnecessary services
- Misusing codes on a claim, such as upcoding or unbundling
- Unknowingly excessively charging for services and supplies

You Can Help

We work to find, investigate, and prevent health care fraud. You can help. Know what to look for when you get health care services. If you get a bill or statement from your doctor or an Explanation of Benefit Payments statement from us, make sure:

- The name of the doctor is the same doctor who treated you
- The type and date of service are the same type and date of service you received
- The diagnosis on your paperwork is the same as what your doctor told you

You might be the target of a fraud scheme if you receive medical supplies that you or your doctor did not order. You can take the following actions to protect your benefits:

- Refuse medical supplies you did not order
- Return unordered medical supplies that are shipped to your home
- Report companies that send you these items
- Identity theft can lead to higher health care costs and personal financial loss. Don't let anybody steal your identity. Current fraud schemes to be on the lookout for include:
    - Be wary of people calling you to ask for your health plan numbers
    - Do not let people bribe you to use a doctor you don't know to get services you may not need

You are one of the first lines of defense against fraud. Do your part and report services or items that you have been billed for but did not receive

Review your plan explanation of benefits (EOBs) and bills from physicians and report any item or services that you did not receive by:

- Making sure you received the services or items billed
- Checking the number of services billed
- Ensuring the same service has not been billed more than once

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and/or abuse has taken place, please report it. You do not have to give your name. Call McLaren Health Plan's Fraud and Abuse line at 866-866-2135 if you think a doctor (or other health care provider) or member might be committing fraud, waste or abuse. You can email McLaren's Compliance Department at MHPcompliance@mclaren.org.

You also can write to McLaren Health Plan at:

McLaren Health Plan, Inc.
Attn: Compliance
P.O. Box 1511
Flint, MI 48501-1511

You may also report or get more information about health care fraud by writing:

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909

Or call toll-free: 1-855-MI-FRAUD (1-855-643-7283)

Or visit: michigan.gov/fraud Information may be left anonymously.

In addition to the above methods, you may also contact the State of Michigan if you think a member has committed fraud, waste or abuse by:

- Calling the MDHHS office in the county where you think the fraud, waste, or abuse took

place
- Calling the MDHHS office in the county where the member lives

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook.

Appeal: An appeal is the action you can take if you do not agree with a coverage or payment decision made by your Medicaid Health Plan. You can appeal if your plan:

Denies your request for:

- A healthcare service
- A supply or item
- A prescription drug that you think you should be able to get

Reduces, limits, or denies coverage of:

- A healthcare service
- A supply or item
- A prescription drug you already got

Your plan stops providing or paying for all or part of:

- A service
- A supply or item
- A prescription drug you think you still need

Does not provide timely medical services

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:

- A doctor's visit
- Hospital outpatient visit
- Prescription drug

Durable Medical Equipment: Equipment and supplies ordered by a healthcare provider for everyday or extended use. This may include:

- Oxygen equipment
- Wheelchairs
- Crutches
- Blood testing strips for diabetics

Emergency Medical Condition: An illness, injury, or condition so serious that you would seek care right away to avoid harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.
Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Medical services that your plan doesn't pay for or cover.

Grievance: A complaint that you let your plan know about. You may file a grievance if you have a problem calling the plan or if you're unhappy with the way a staff person or provider treated you. A grievance is not the way to deal with a complaint about a treatment decision or a service that is not covered or denied (see Appeal).

Habilitation Services and Devices: Health care services that help a person keep, learn, or improve skills and functioning for daily living. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Services for people with disabilities

Health Insurance: Health insurance is a type of coverage that pays for medical and/or drug costs for people. It can pay the person back for costs from illness or injury. It can also pay the provider directly. Health insurance requires the payment of premiums (see premium) by the person getting the insurance.

Home Health Care: Healthcare services that a healthcare provider decides you need in your home for treatment of an illness or injury. Home health care helps you regain independence and become as self-sufficient as you can.

Hospice Services: Hospice is a special way of caring for people who are terminally ill and provide support to the person's family.

Hospitalization: Care in a hospital that needs admission as an inpatient and could require an overnight stay. An overnight stay for you to be looked after could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually does not need an overnight stay.

Medical Health Plan: A plan that offers healthcare services to members who meet State eligibility rules. The State contracts with certain Health Maintenance Organizations (HMO) to provide health services for those who are eligible. The State pays the premium on behalf of the member.

Medically Necessary: Healthcare services or supplies that meet accepted standards of medicine needed to diagnose or treat:

- An illness
- Injury
- Condition
- Disease or
- Symptom

Network: Health care providers contracted by your plan to provide health services. This includes:

- Doctors
- Hospitals
- Pharmacies

Network Provider/Participating Provider: A healthcare provider that has a contract with the plan as a provider of care.

Non-Participating Provider/Out-of-Network Provider: A healthcare provider that *does not* have a contract with the Medicaid Health Plan as a provider of care.

Physician Services: Healthcare services provided by a person licensed under state law to practice medicine.

Plan: A plan that offers health care services to members that pay a premium.

Preauthorization: Approval from a plan that is required before the plan pays for certain:

- Services
- Medical equipment or
- Prescriptions

This is also called prior authorization, prior approval, or precertification. Your plan may require preauthorization for certain services before you receive them. This excludes an emergency.

Premium: The amount paid for health care benefits every month. Medicaid Health Plan premiums are paid by the State on behalf of eligible members.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that require a prescription by law by a licensed Provider.

Primary Care Physician: A licensed physician who provides and manages your health care services. (See Primary Care Provider.)

Primary Care Provider: A licensed physician, nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides and manages your health care services. This can also be called a Primary Care Physician. Your primary care provider is the person you see first for most health problems. They make sure that you get the care you need to keep you healthy. They also may talk with other doctors and healthcare providers about your care and refer you to them.

Provider: A person, place or group that's licensed to provide health care like doctors, nurses, and hospitals.

Referral: A request from a PCP for his or her patient to see another provider for care.

Rehabilitation Services and Devices: Rehabilitative services and/or equipment ordered by your doctor to help you recover from an illness or injury. These services can be done inpatient or outpatient and may include:

- Physical and occupational therapy
- Speech-language pathology
- Psychiatric rehabilitation services

Skilled Nursing Care: Services in your own home or in a nursing home provided by trained:

- Nurses
- Technicians
- Therapists

Specialist: A licensed physician specialist that focuses on a specific area of medicine or a

group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

Urgent Care: Care for an illness, injury, or condition bad enough to seek care right away but not bad enough that it needs emergency room care.

Notice of Privacy Practices

MCLAREN HEALTH PLAN, INC., MCLAREN HEALTH PLAN COMMUNITY, AND MCLAREN HEALTH ADVANTAGE ARE AFFILIATED COVERED ENTITIES. THIS NOTICE DESCRIBES HOW PERSONAL AND MEDICAL INFORMATION ABOUT MEMBERS OF THOSE PLANS MAY BE USED AND DISCLOSED AND HOW A MEMBER CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding the Type of Information We Have. We get information about you when you enroll in our health plans that is referred to as Protected Health Information or PHI. It includes your date of birth, gender, ID number, and other personal information. We also get bills and reports from your doctor and other data about your medical care which are also PHI.

Our Privacy Commitment to You. We care about your privacy. The PHI we use or disclose is private. We are required to give you this Notice of Privacy Practices and describe how your PHI may be used and disclosed. Only people who have both the need and the legal right may see your PHI. Many uses and disclosures require your permission or authorization. For example, most uses and disclosures of psychotherapy notes (where appropriate), uses and disclosures of PHI for marketing purposes and disclosure that constitute a sale of PHI require your authorization. Other uses and disclosures not described in this Notice of Privacy Practices will be made only with your permission or authorization.

Uses and Disclosures That Usually Do Not Require Your Authorization:

- Treatment. We may disclose medical information about you to coordinate your health care. For example, we may notify your doctor about care you get in an emergency room.
- Payment. We may use and disclose information so the care you get can be properly billed and paid for. For example, we may ask an emergency room for details before we pay the bill for your care.
- Health Care Operations. We may need to use and disclose information for our health care operations. For example, we may use information for enrollment purposes or to review the quality of care you get.
- As Required by Law. We will release information when we are required by law to do

so. Examples of such releases would be for law enforcement or national security purposes, subpoenas, or other court orders, communicable disease reporting, disaster relief, review of our activities by government agencies, to avert a serious threat to health or safety, or in other kinds of emergencies.

With Your Permission. In most cases, if you give us permission in writing, we may use and disclose your personal information to the extent you have given us authorization. If you give us permission, you have the right to change your mind and revoke it. This must be in writing, too. We cannot take back any uses or disclosures already made with your permission. Note: We are prohibited from and will not use your genetic information for underwriting purposes even with your permission or authorization.

Your Privacy Rights

You have the following rights regarding your PHI that we maintain.

Your Right to Inspect and Copy. In most cases, you have the right to look at or get copies of your records. You may be charged a fee for the cost of copying your records.

Your Right to Amend. You may ask us to change your records that are in our possession if you feel that there is a mistake. We can deny your request for certain reasons, but we must give you a written reason for our denial.

Your Right to a List of Disclosures. You have the right to ask for a list of disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was disclosed with your authorization. Your Right to Request Restrictions on Our Use or Disclosure of your PHI. You have the right to ask for limits on how your PHI is used or disclosed. We are not required to agree to such requests.

Your Right to Receive Notification of a Breach. If our actions result in a breach of your unsecured PHI we will notify you of that breach.

Your Right to Request Confidential Communications. You have the right to ask that we share information with you in a certain way or in a certain place. For example, you may ask us to send you information at your work address instead of your home address.

Genetic Information. Genetic information is health information. We are prohibited from and do not use or disclose your genetic information for underwriting purposes.
Who to Contact. To exercise any of your rights, to obtain additional copies of this Notice or if you have any questions about this Notice please write to:

McLaren Health Plan
Attn: Privacy Officer

P.O. Box 1511
Flint, MI 48501-1511

Additional Information:

Find the Notice on Our Website: You can also view this Notice of Privacy Practices on our website at www.McLarenHealthPlan.org.

Changes to this Notice. We reserve the right to revise this Notice. A revised Notice will be effective for PHI we already have about you as well as any information we may receive in the future. We are required by law to comply with whatever Notice is currently in effect. Any changes to our Notice will be published on our website at www.McLarenHealthPlan.org.