McLaren
HEALTH PLAN COMMUNITY

Thank you for choosing McLaren Health Plan Community (MHP Community). This guide has been designed to provide you with a resource for MHP Community's administrative procedures.

If you require any information not covered in this guide, or if you need clarification of any information, please contact an Account Service Representative toll free at 888-327-0671, Option 3. See ***Section 1: Contact Information*** for additional departments' mailing addresses and telephone numbers.

Introduction

McLaren Health Plan, Inc. is a Michigan nonprofit corporation certified by the State of Michigan as a health maintenance organization (HMO). In this Guide, the terms "McLaren Health Plan" and "MHP Community" also include reference to McLaren Health Plan Community, a Michigan nonprofit corporation and HMO that is a wholly-owned subsidiary of McLaren Health Plan.

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Section 1: Contact Information

McLaren Health Plan Community Contacts

Department	Address
Premium Remittance	McLaren Health Plan Community P.O. Box 771983 Detroit, MI 48277-1983 **888-327-0671 Main** **810-733-9750 Finance** **810-600-7947 Fax** Overnight payments should be sent to: McLaren Health Plan Attn: Finance Department G-3245 Beecher Road Flint, MI 48532 Electronic payments: www.pay.instamed.com/mclaren.comm
Customer Service	McLaren Health Plan Community Attn: Customer Service Department G-3245 Beecher Road Flint, MI 48532 customerservice@mclaren.org 888-327-0671 (TTY: 711)
Membership/Enrollment	McLaren Health Plan Community Attn: Membership Department G-3245 Beecher Road Flint, MI 48532 enrollments@mclaren.org 810-600-7944 Fax
Sales Department	McLaren Health Plan Community Attn: Sales Department G-3245 Beecher Road Flint, MI 48532 mhpsales@mclaren.org 888-327-0671, Option 3 810-600-7931 Fax

Section 2: General Information

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2.1 Frequently Asked Questions

The following questions and answers provide you with information on the most frequently asked questions and will help you find the information you need in this guide. If you're still having trouble finding what you need, please call an Account Service Representative at 888-327-0671, option 3.

- **How do I enroll a new employee, terminate coverage for an employee or make another type of eligibility change?**
  See Section 3, *Enrollment Process* (3.1).

NOTE: Enrollment/Change forms *must* be received within 30 days from the date of the event the member became eligible (new hire, marriage, birth, adoption, etc.). Enrollment forms received after 30 days will not be processed, and the member will not be eligible for coverage under MHP Community until the group's next renewal date.

- **Can any employee leaving my company continue their coverage?**
  Yes, please see the information in the Section 3 titled "COBRA" (3.6) or "Other Options for Coverage" (3.7).

- **How do I get additional forms, provider directories, etc.?**
  Call the Account Service Department at 888-327-0671, option 3.

- **Where do I send my company's monthly payment?**
  Please send your payment to:
  McLaren Health Plan Community
  P.O. Box 771983
  Detroit, MI 48277-1983

- **Can I pay my premium invoice online?**
  Yes, you can pay online.
  www.pay.instamed.com/mclaren.comm

- **Where should I send any enrollment or change forms?**
  Please send any forms to:
  McLaren Health Plan Community
  Attention: Membership Department
  G-3245 Beecher Road
  Flint, MI 48532 or FAX to: (810) 600-7944
  enrollments@mclaren.org

- **Who should I call if I have a question about my bill?**
  Call the Finance Department at 888-327-0671.

2.2 Key Terms

Certificate of Coverage: Defines the benefit coverage and limitations.

Coinsurance: A percentage of MHP Community's reimbursement amount for which the member is responsible to pay for certain benefits. The coinsurance applies to the coinsurance maximum and the out-of-pocket maximum. Refer to the policy to verify which benefits have a coinsurance requirement.

Co-payment (Co-pays): A fixed dollar amount the member is required to pay for some benefits. Refer to the policy to verify which benefits have a copayment requirement.

Covered Person: Either the subscriber or enrolled dependent; applies only while coverage of such person under the policy is in effect.

Deductible: The annual amount of money payable by you or the member for covered services. The deductible applies to your out-of-pocket maximum. The annual deductible resets on January 1 of each year.

Dependent: A family dependent may be:

- The legally married spouse of the subscriber
- At the group's option, a domestic partner also may be included as a dependent (large group only)
- A child of the subscriber (or of the subscriber's spouse) by birth, legal adoption or legal guardianship, and who has not attained the age of 26 years
- A child does not need to be named as a dependent on the parent's federal income tax return to qualify as a family dependent.

Dependent children: The dependent's coverage terminates at the end of the calendar year in which they become 26 years old, or sooner if agreed upon by MHP Community and the group.

Domestic Partner: A domestic partner is the subscriber's same or opposite sex, unmarried adult partner. This is only available for large groups. The large group will determine eligibility.

Eligible Person: (1) An employee of the enrolling group; or (2) Other person who meets the eligibility requirements specified in both the application and the policy; and (3) who resides and/or is employed within the MHP Community service area.

Enrolled Dependent: A dependent who is properly enrolled for coverage under the policy.

Enrolling Group: The employer or other defined or otherwise legally constituted group to whom the policy is issued.

Enrollment: The submission of a completed form approved by MHP Community by which an individual seeks to enroll one or more persons in MHP Community, and receipt of the necessary premium by MHP Community.

Group: The legal entity that contracted with MHP Community to provide the benefits described in the Certificate to its employees and their eligible dependents.

Large Group: 51 or more full time equivalents.
Small Group: 2-50 eligible employees

Initial Eligibility Period: The initial period of time, determined by the enrolling group's new hire waiting period, during which an eligible person may enroll themselves and dependents under the policy.

Member: The subscriber or an eligible dependent entitled to benefits under the MHP Community certificate.

Network or Participating Providers: Providers, such as physicians, hospitals, urgent care facilities, ancillary providers, and pharmacies, that contract directly with MHP Community.

Open Enrollment Period: A period of time each year set by the group where an eligible person may enroll, make changes, or terminate coverage.

Out of Area Member: An employee of an enrolled group who does not reside within MHP Community's service area and to whom MHP Community has granted an out-of-area waiver.

Out-of-Pocket Maximum: The most a member may have to pay during a calendar year for certain expenses related to covered services. The out-of-pocket maximum includes your medical and pharmacy deductible, copayment, and coinsurance. This limit never includes your premium, balance billed charges, or health care that MHP Community does not cover.

Policy: The Certificate of Coverage, any individual subscriber applications, amendments, schedules, ID card and riders, which constitute the agreement regarding the benefits, exclusions, and other conditions of coverage.

Premium: The amount prepaid monthly for MHP Community coverage.

Primary Care Physician (PCP): A PCP is a licensed medical doctor (MD) or doctor of osteopathy (DO) who is a participating provider (contracted with MHP Community). A member must select a PCP. The member's PCP provides, arranges, and coordinates all aspects of the member's health care to help them receive the right care, in the right place, at the right time.

Qualifying Event: Events that qualify an individual to enroll in this plan outside of the open enrollment period. Circumstances that may be considered as a qualifying event include, (but are not limited to) marriage, birth, adoption, changing from part-time to full-time employment, return from layoff or leave (the maximum leave is 12 months; if leave is greater than 12 months, the employee is considered a new hire), and a voluntary or involuntary loss of other qualifying coverage.

Rider or Schedule: A legal document that is part of the Certificate of Coverage that explains any additional benefits, limitations, or other modifications to the coverage outlined in the certificate. For example, a rider or schedule may add or remove benefits from those listed in the certificate. When there is a conflict between the certificate and the rider or schedule, the rider or schedule takes precedence.

Special Enrollment Period: A period outside the annual open enrollment period, during which you and your eligible dependents may enroll in this plan or, if you are already enrolled, during which you may change your coverage elections. You are only eligible to enroll or change your coverage elections during a special enrollment period in certain situations (see **Qualifying Events** above).

Subscriber: The eligible person who has enrolled for health care coverage with MHP Community. This person is the one whose employment is the basis of coverage eligibility. This person is also known as a member. Other members are those family dependents of the subscriber who are eligible for coverage.

2.3 Provider Directory

Members of MHP Community will need to determine if their provider participates with McLaren Health Plan. A provider directory that lists MHP Community's network physicians, hospitals, urgent care facilities, ancillary providers, and pharmacies, is available at www.McLarenHealthPlan.org or by calling Customer Service at 888-327-0671. The directory is updated regularly to reflect new providers joining MHP Community. If there are questions about a specific provider, a prompt answer may be obtained from Customer Service at 888-327-0671.

https://www.mclarenhealthplan.org/community-consumer/find-a-provider-community

2.4 Authorization Process

HMO Plans:
Preauthorization requirements: certain services and supplies require preauthorization by MHP Community before they will be covered. Participating providers can assist you in obtaining preauthorization from MHP Community, but the member is ultimately responsible to ensure any necessary preauthorization is obtained. If MHP Community preauthorizes a service, we will notify your PCP or the provider who makes the request.

Covered services you receive from a non-participating provider must be preauthorized in advance by MHP Community to be covered. A referral from your PCP or another participating provider is not enough if you want the services to be covered. A request for preauthorization for covered services from a non-participating provider must be provided to MHP Community prior to receiving services. MHP Community will review the clinical indications and factors of the case and will determine whether the services are available from a participating provider.

If MHP Community determines the services are not available from a participating provider, MHP Community will direct you to the provider deemed to be the most appropriate to address your medical needs and your cost sharing will be no greater than if the services were provided by a participating provider. If MHP Community determines that the requested services can be provided by a participating provider, you will be responsible for the full costs of services obtained from a non-participating provider. If you do not receive approval from MHP Community prior to seeking covered services from a non-participating provider, you will be responsible for the full cost. In no case will MHP Community authorize services from a non-participating provider if the services can be obtained by a participating provider, as determined by MHP Community.

Point of Service Plans:
Certain services and supplies require preauthorization by MHP Community before they will be covered under either Option A or Option B. Participating providers can assist you in obtaining preauthorization from MHP Community, but the member is ultimately responsible to ensure any necessary preauthorization is obtained. If MHP Community preauthorizes a service, we will notify your PCP or the provider who makes the request.

If you obtain services from a non-participating provider, they will usually be covered under Option B. **Please note,** however, that certain services must be preauthorized by MHP Community to be covered under Option B. For those services, a referral from your PCP or another participating provider is not enough if you want the services to be covered; they must be preauthorized by MHP Community. If you do not receive approval from MHP Community prior to seeking covered services from a participating or non-participating provider, you will be responsible for the full cost. In no case will MHP Community authorize services from a non-participating provider if the services can be obtained by a participating provider, as determined by MHP Community.

Below are the general categories of services and supplies that require preauthorization by MHP Community for HMO and Point-of-Service plans.

- Inpatient and long-term acute hospital services, including inpatient mental health or substance abuse treatment
- Skilled nursing home
- Outpatient hospital and clinic services for dorsal spinal stimulators
- Oral surgery, TMJ treatments and orthognathic surgery
- Special surgical procedures (see Certificate of Coverage)
- Durable medical equipment (DME) costing more than $3,000
- Prosthetics, orthotics, and corrective appliances costing more than $3,000
- Insulin pumps and continuous glucose monitors (CGMs)
- Genetic testing (including BRCA testing; see Certificate of Coverage)
- Autism services and Applied Behavioral Analysis (ABA Therapy)
- Electroconvulsive therapy (ECT)
- Contact lenses as a part of pediatric vision coverage
- Routine patient costs provided as a part of an approved clinical trial
- Non-emergency ground ambulance services
- Residential mental health services
- Residential substance abuse services
- Partial hospitalization for mental health services
- Partial hospitalization for substance abuse services
- Organ and tissue transplants
- Habilitative services, including habilitative services for treatment of Autism Spectrum Disorder
- Outpatient rehabilitation services
- Infertility treatment
- Voluntary sterilization procedures
- Termination of pregnancy
- Proton beam radiation
- Photo chemotherapy
- Home health care
- Hospice
- Gender reassignment surgery
- Select injectable and infusion medications provided in the office setting or in an infusion center
- Pain management services
- Non-emergent or non-urgent services provided by a non-participating provider
- Inpatient hospice care
- Certain prescription drugs

The complete and detailed list of services requiring preauthorization is available by calling our Customer Service department or visiting our website at www.McLarenHealthPlan.org. The list may change throughout the plan year as new technology and standards of care emerge.

Timing of Request and MHP Community Response

Definition: Urgent preauthorization request means a request for medical care or treatment for which resolution within MHP Community's normal time frames, due to the medical status of the Member, would seriously jeopardize the life or health of the member or the ability to regain maximum function, or, in the opinion of the treating provider, would subject the member to severe pain that could not be adequately managed without the requested service.

- Except for urgent preauthorization requests, if preauthorization is required for a service, preauthorization must be requested at least five business days prior to obtaining the services.

- If the requested service is an urgent preauthorization request, the request for preauthorization should be submitted to MHP Community by the treating provider as early in advance of the service as possible. Requests for urgent preauthorization's may be made by telephone.

- For most non-urgent preauthorization requests, MHP Community or its designee will decide within 14 days after receiving the request. For urgent preauthorization requests, MHP Community or its designee will decide as expeditiously as possible considering the medical condition of the member, but no later than within 72 hours after receiving the request. MHP Community may extend the 72-hour maximum response time if the member fails to provide MHP Community with necessary information.

Denial of Request for Preauthorization: If a member disagrees with a decision regarding a preauthorization request, the member or his/her treating practitioner or designee may contact MHP Community to request a re-evaluation of the decision or utilize the appeal process. A member may request an expedited appeal for denials of urgent preauthorization requests.

2.5 Selecting a Primary Care Physician (PCP)

Each member must select a PCP from the list of MHP Community participating providers. (A parent has the option of choosing an MHP Community participating pediatrician as the PCP for a child under 18 years of age.) MHP Community will make every attempt to honor a member's choice.

Members who need to change their PCP can do this online at www.McLarenhealthplan.org or they can call Customer Service at 888-327-0671. MHP Community can assist members with their requests and verify that the PCP they have chosen is accepting new patients. Members may also visit our website at https://www.mclarenhealthplan.org/community-consumer/find-a-provider-community
for the current provider directory. The change will be effective the first day of the month following notification to MHP Community. Members may start seeing their new PCP when the change becomes effective.

2.6 Customer Service

Customer Service is the first point of contact for members with health care coverage concerns or questions. Customer Service representatives are available to respond to inquiries regarding issues such as eligibility, benefits, selecting a PCP, member ID cards, and claims processing. In addition, Customer Service representatives may assist members when they have questions regarding the administrative process in situations where services require MHP Community preauthorization, emergency services or requesting reconsideration of a claim's payment.

Customer Service is available Monday through Friday, 8 a.m. to 6 p.m. at 888-327-0671 (TTY: 711) to assist members with any health plan inquiry.

2.7 Confidentiality

All individually identifiable member information-- including medical records and information, referrals, evaluations, and personal information -- is kept confidential in accordance with federal and state laws. Employees of MHP Community follow confidentiality policies and are required to follow specific procedures while handling members' medical and personal information. Internal disclosure to MHP Community employees is permitted for the purpose of accomplishing business functions but is restricted to only those who need to know the information to perform their job duties.

Except as otherwise provided by law, MHP Community will not honor a request for the release of individually identifiable member information without the express written consent of the member or person authorized by law to act on behalf of the member. If an employee wants you (as the employer) or another person to discuss their confidential member information or receive their medical records, the employee must sign an *Authorization for Use and Disclosure of Protected Health Information* form so that MHP Community can discuss their confidential information (including claims) with you. This form can also be found on our on our website here:

https://www.mclarenhealthplan.org/mhp/auth-for-use-mhp

Except for enrollment information, information that MHP Community shares with employers is not personally identifiable unless consent is obtained from the member. MHP Community also states its expectations about the confidentiality of member information and records within all practitioner, provider, and vendor contracts.

In certain circumstances, a member may have a need to obtain copies of their medical records. This is a member's right. Please understand that because MHP Community does not directly employ providers, MHP Community is not the custodian of medical and/or clinical records. If the member wishes to obtain medical and/or clinical records, it will be necessary for them to contact the provider(s) who rendered the health services.

Section 3: Enrollment Process

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Enrollment/Change and Waiver Forms 3.4

MHP Community Identification Card 3.5

COBRA 3.6

Other Options for Coverage 3.7

3.1 Enrollment Process

The enrollment/change form is used to establish membership in the group benefit plan. After the enrollment process is completed, ID cards are issued. Enrollment/change forms are to be completed and signed by the employee. The employer reviews the form to ensure that all required information is included, that each applicant is eligible, and then completes the group portion of the form.

The group administrator collects and forwards all enrollment/change forms to the *Membership/Enrollment* address, email, or fax number listed in Section 1.1 of this guide. **You also have the option to use our group administration portal to submit forms**. Please contact mhpsales@mclaren.org if you don't already have an account created. All completed enrollment forms are due to MHP Community **within 30 days of the effective date of enrollment.**

If an enrollment form is incomplete when submitted to the membership department, the group administrator will be contacted for completion.

The group is primarily responsible for eligibility determinations. MHP Community has provided general eligibility guidelines in the Certificate of Coverage. Items to be reviewed for eligibility include:

- Existence of a qualifying event (for example, open enrollment or new hire)
- Compliance with service area residence requirements, as stated in your certificate
- Appropriate interpretation of spouse/dependent status definitions, as stated in your certificate
- Authorization for enrollment by a designated group representative

MHP Community will provide final enrollment form screening prior to system entry and will notify the group administrator of any situations requiring further review or investigation.

The effective date of coverage for mid-year enrollment is determined by date of employment and specifications stated in the *Group Enrollment and Coverage Agreement* for new hire eligibility. If you need an exception, please attach a note to the enrollment form with the requested effective date of coverage and reasons for request and send it to the membership department.

Member ID cards are issued following enrollment. Member packets and ID cards are generally received within three weeks of system entry. If a member needs to obtain an ID card prior to receipt, they may obtain this from the member portal, McLarenCONNECT. The member can contact customer service to obtain their ID number which is needed to access McLarenCONNECT.

https://www.mclarenhealthplan.org/community-member/mclaren-connect.aspx

Questions regarding enrollment processing should be directed to an account service representative at mhpsales@mclaren.org or by calling 888-327-0671, option 3.

3.2 Eligibility

All subscribers and members must meet eligibility requirements established by and the group. Certain requirements depend on whether the individual is:

- A subscriber
- A family dependent
- A dependent under a Qualified Medical Child Support Order or
- A principally supported child

A. Subscriber
A group subscriber must:

- Be the owner of the group business or an active employee of a group
- Be a citizen, national or non-citizen lawfully present in the U.S. and reasonably expected to remain so for the entire period for which enrollment is sought
- Live in the service area at least nine (9) months out of the year
- Not be incarcerated and
- Meet the eligibility requirements of and the group

B. Family Dependents
A family dependent may be:

- The legally married spouse of the subscriber
- A domestic partner; only available for large group
- A child of the subscriber, or of the subscriber's spouse, by birth, legal adoption, or legal guardianship who has not attained the age of 26 years

And MUST:

- Be a citizen, national, or non-citizen lawfully present in the U.S. and reasonably expected to remain so for the entire period for which enrollment is sought and
- Not be incarcerated

A child's coverage terminates at the end of the calendar year in which he or she becomes 26 years old.

Exception
An unmarried, dependent child who becomes 26 while enrolled in and who is totally and permanently disabled may continue coverage if:

- The dependent child is incapable of self-sustaining employment because of mental or physical disability

- The dependent child relies on you for more than half of his or her support, as determined under Section 152 of the Internal Revenue Code, as amended and
- The dependent child is unmarried

The subscriber must submit to the proof of this disability and dependence within 30 days of the child's 26th birthday. MHP Community may require annual proof of continued disability and dependence.

Note: **A dependent whose only disability is a learning disability or substance abuse does not qualify for coverage after 26 under this exception.**

C. Dependent under a Qualified Medical Child Support Order or "QMCSO"

The child of the subscriber or the subscriber's spouse is eligible to enroll in a plan if the subscriber provides MHP Community with a copy of a court or administrative order that requires the subscriber or spouse to provide health coverage for the child in accordance with state and federal law (a "Qualified Medical Child Support Order" or "QMCSO"). The QMCSO must name the subscriber or subscriber's spouse as the participant in order to enroll the child. The child must be otherwise eligible for coverage as a family dependent. If MHP Community receives a copy of the QMCSO but the subscriber fails to enroll the child for coverage, the child may be enrolled by the Friend of the Court or by the child's other parent or guardian through the Friend of the Court. We will not terminate the coverage of a child who is enrolled under a QMCSO unless:

- The child is no longer eligible as a family dependent
- Premiums have not been paid as required by the certificate or
- We receive satisfactory written proof that the QMCSO is no longer in effect or that the child has or will have comparable health coverage beginning on or before the date the child's coverage with us is terminated

D. Court-Appointed Guardianship

A family dependent may include a child for whom the subscriber or the subscriber's spouse is the court-appointed permanent or limited guardian. The child may be enrolled from the moment they are in the subscriber's physical custody. We will not cover any expenses incurred for the child's health care before the child is in the subscriber's physical custody. "Physical custody" means that the child is legally and physically placed in the subscriber's home. The subscriber must provide acceptable proof that the child meets the above requirements (for example, the court order) within 31 days of MHP Community's request of proof. The child is eligible for coverage until the end of the day on which the child turns 18 years of age.

3.3 Enrollment Periods

Open Enrollment Period for Subscribers and Family Dependents
Subscribers and eligible dependents may enroll during the annual open enrollment period set by the group.

Note: If the subscriber does not enroll themselves and eligible dependents during the specified timeframe, they cannot enroll until the next open enrollment period.

Special Enrollment of Newly Eligible and Dependents
Certain events may qualify the subscriber to enroll in a MHP Community group plan outside of the open enrollment period. These are referred to as qualifying events. In most cases a subscriber is entitled to a **30-day special enrollment period** from the date of the qualifying event as follows:

- New Family Dependents
  If the subscriber is already enrolled in this plan and they gain a new dependent because of marriage, birth, adoption, or placement for adoption the new dependent may be added to the plan.

- Loss of other coverage
  If the subscriber or a family dependent lost other minimum essential coverage, including Medicaid, the subscriber may enroll themselves and/or the family dependent.
  Note: If the subscriber or a family dependent loses Medicaid or CHIP coverage due to loss of eligibility, they have 60 days within which to enroll with MHP Community.

- Other Events and Circumstances
  - Change in citizenship, state, national or lawfully present status or
  - The subscriber permanently moves to a new state and gains access to an employer's health plan

  If a subscriber or dependent loses coverage under another health plan for the following reasons, they are *not* eligible for special open enrollment:
  - Nonpayment of their share of the premiums on a timely basis or
  - Coverage was terminated for cause such as for making a fraudulent claim or giving false information or
  - Voluntarily dropping their other coverage mid-year for any reason, including an increase in premium or change in benefits

Notification of change in status or other changes that affect coverage and eligibility
McLaren Health Plan must be notified by the group administrator about any changes that affect their employees' coverage under the plan. For example, notice should be given if any of the following happens to anyone covered under the certificate:

- Change of address
- Change in covered dependent status
- Enrolling in coverage under a group health plan
- Eligibility for federal, state, county or local governmental or quasi-governmental health coverage
- Coverage by any other insurance or health plan

Medicare Eligibility
- **Medicare Effective Date:** Enter the date on which the employee became eligible for Medicare

Coordination of Benefits with Medicare

Use the link below to find your type(s) of coverage and situation to see which payer pays first:

https://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Coordination-of-Benefits-and-Recovery-Overview/Medicare-Secondary-Payer/Medicare-Secondary-Payer

3.4 Enrollment/Change Form and Waiver Form

- **Enrollment/Change Form**: http://www.mclaren.org/Uploads/Public/Documents/HealthPlan/documents/Agents/Member%20Enrllment%20Change%20Form.pdf

McLaren
HEALTH PLAN COMMUNITY

ENROLLMENT/CHANGE FORM

SUBSCRIBER INFORMATION - COMPLETE SECTION 1 - 4

SECTION 1

Social Security Number/Contract Number	Subscriber Last Name ☐ check if new	Subscriber First Name	Middle Initial

Street Address ☐ check if new	City	State	Zip Code	County

Area Code	Home Phone Number	Area Code	Work Phone Number	Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

SECTION 2

List All Persons to be Added or Deleted									Primary Care Physician Information (REQUIRED FOR EACH ENROLLEE)			
Member Type	Circle One	Last Name	First Name	Middle Initial	Gender	Date of Birth MM/DD/YYYY	Social Security Number	Relationship Code*	Last Name	First Name	City	Seen in Last 12 Months
Subscriber	Add Delete				☐ M ☐ F							☐ Y ☐ N
Spouse	Add Delete				☐ M ☐ F							☐ Y ☐ N
Dependent 1	Add Delete				☐ M ☐ F							☐ Y ☐ N
Dependent 2	Add Delete				☐ M ☐ F							☐ Y ☐ N
Dependent 3	Add Delete				☐ M ☐ F							☐ Y ☐ N

If address of any dependent(s) listed above differs from the address in Section 1, please complete information below:				Previous MHP or Health Advantage Affiliation	* Relationship Code
Street Address	City	State	Zip Code	Contract Number	E - Employee/Subscriber SP - Spouse C - Child Under Age 26 SC - Stepchild Under Age 26 O - Other (Attach supporting documentation
Dependent(s) Residing at this Address					

SECTION 3

Do you, your spouse or dependent(s) maintain other health coverage? ☐ Y ☐ N **If yes, complete below:**

Company Name	Company Address (where claims are sent)		Policy Effective Date
Name of Policy Holder	Employer of Policy Holder	Date of Birth of Policy Holder	Dependent(s) Covered Under this Contract

Are you, your spouse or any dependents listed in Section 2 enrolled in Medicare? ☐ Y ☐ N If yes, please select reason for Medicare eligibility ☐ End Stage Renal Disease ☐ Disabled ☐ Over Age 65 ☐ Over Age 65 working

SECTION 4

MEDICAL INFORMATION is NOT to be provided for ACA plans.

ACCURACY OF INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us") I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage.

Employee Signature	Date

SECTION 5

GROUP USE ONLY - CHECK AND COMPLETE APPROPRIATE BOXES

Group Name			
☐ Enrollment	Effective Date	Date of Hire	Reason for Enrollment Eligibility ☐ New Hire ☐ Open Enrollment ☐ Other Please Explain:
☐ Change	Effective Date	Select Reason for Change Below and Attach any Supporting Documentation to Substantiate Change ☐ Marriage ☐ Birth/Adoption of Child ☐ Name Change ☐ Address Change ☐ Change to COBRA ☐ Other Please Explain:	
☐ Termination	Date to Terminate Coverage	Terminate (select one) ☐ Contract ☐ Spouse ☐ Dependent(s)	Reason for Termination ☐ Left Employment ☐ Divorce ☐ Dependent Over Age ☐ Other Please Explain:
☐ Medicare Eligibility	Medicare Effective Date	Primary Contract ☐ Medicare ☐ MHP	Group Administrator Signature

- **Employee Waiver Form**: https://www.mclarenhealthplan.org/Uploads/Public/Documents/HealthPlan/documents/Agents/Waiver%20of%20Medical%20Coverage%20Form.pdf

Employee Waiver Form

Group Name: ______________________________

This form is required for all eligible employees who are not enrolling with McLaren Health Plan Community (MHP Community) at the time of initial enrollment and/or group's open enrollment period.*

I waive the right to enroll with MHP Community as offered to me by my employer for the following reason (Please check one):

- ☐ I have other coverage offered by my employer
- ☐ I have other coverage through my spouse or family member
- ☐ I have other coverage through Medicare or as a retiree from another employer
- ☐ I have individual coverage through another source that is not employer-sponsored or employer-paid
- ☐ I have no other coverage but choose not to enroll in my employer's plan

I understand that I will not be eligible for coverage through MHP Community until my employer's next open enrollment period unless I qualify for coverage due to a HIPAA qualifying event (such as marriage, birth of child, adoption, or loss of other coverage).

____

Employee name printed

______________________________ ________

Employee signature Date

______________________________ ________

Group Administrator signature Date

*Groups may elect to submit a list of employee waivers including reasons listed above in lieu of individual forms. The list may be attached to this form and must be signed by an authorized group representative.

3.6 COBRA

COBRA is the continuation of group coverage, but at the member's expense, for members who lose eligibility. Most groups with over 20 employees are required by federal law to offer this opportunity. The group is the administrator of its COBRA plan. Members should direct COBRA questions to their group.

Note: Groups with fewer than 20 employees, church-related groups, and federal employee groups are exempt from COBRA.

3.7 Other Options for Coverage

If the subscriber or a family dependent no longer meets eligibility requirements for group coverage, an alternative may be to purchase individual coverage on the Michigan Health Insurance Marketplace. Individuals can review coverage offered by MHP Community or another carrier at www.HealthCare.gov In most cases an individual must apply for individual coverage within 30 days of loss of coverage.

Section 4: Monthly Client Billing

Monthly Billing Payment Policy	4.1
Payment Policy and Procedures	4.2
Automatic Payment of Premiums	4.3
Termination of Group Coverage	4.4
Wash Method	4.5

4.1 Monthly Billing Payment Policy

We require the group to pay the amount billed. Retroactive adjustments will usually be reflected on the following month's billing. The premium payment should be sent to the remittance address on the bill.

NOTE: Enrollment changes are not to be submitted with the premium payment.

Premium payments are due in full at MHP Community on the first day of each month for that month's coverage. Premium payments are subject to a 30-day grace period, during which time premiums may be made to MHP Community without a lapse in coverage. If the premium is not paid within that period, coverage may be terminated at MHP Community's discretion. If the premium is not paid and coverage is terminated, members will be responsible for the costs of all covered services received after the terminate date.

The group is responsible for any and all costs and expenses, including reasonable attorney's fees, incurred by MHP Community in collecting past due premiums.

4.2 Payment Policy and Procedures

The contracting group will receive monthly billings for premiums due for the subsequent coverage period.

NOTE: Premiums are due on the first of each month and are considered late if not received by this date.

Bills are processed and mailed to each group between the 10th and 20th of each month prior to the billed period.

The bill includes

- Account summary – a list of billing periods, premiums due, and applied payments.
- Current subscriber detail – a list of each covered employee and their ID number, coverage type (single, double, family), and premium.
- Retroactive adjustments - a listing of premium adjustments for enrollments or terminations that affect previous periods.

4.3 Automatic Payment of Premiums

MHP Community prefers to accept funds electronically for monthly health coverage premiums.

If you would like to pay electronically, please call the billing department at 810-733-9528 to receive MHP Community's banking information.

You also have the option of remitting premium payment through this secure site:
www.pay.instamed.com/mclaren.comm

4.4 Termination of Group Coverage

The contract between a group and MHP Community may be terminated as follows:

- The group or MHP Community may terminate the certificate with 30 days written notice.
- Coverage may be terminated if MHP Community exits the applicable market or the plan is terminated pursuant to applicable federal and state laws or decertified.
- Coverage may be terminated by MHP Community if the group moves outside of the MHP Community service area
- This coverage may be terminated if the group fails to pay the premium by the due date. A grace period of 31 days will be granted.
- If the coverage is terminated, all rights to benefits end on the date of termination. MHP Community will cooperate with the group to arrange for continuing care of members who are hospitalized on the termination date.

Note: MHP Community requires written notice 30 days prior to the requested termination date.
Note: If group is terminated for nonpayment of premium, at MHP Community's discretion, a one-year waiting period may be imposed before it will be eligible to reapply for coverage. If a group is terminated for non-payment of premiums, automatic bill payment will be required for reinstatement or reapplication.

4.5 Wash Method

While MHP Community does not prorate the amount of premium billed, we use the wash method to determine whether an entire month's premium will be billed.

- **Enrollment –** Employees enrolled from the first through the fifteenth day of the month will be billed for the entire month. Employees enrolled from the sixteenth day through the end of the month will not be billed for that month of coverage.
- **Disenrollment –** Employees who are terminated from the first through the fifteenth day of the month will not be billed for that month. Employees who are terminated between the sixteenth day and the end of the month will be billed for the entire month.

Note: The employer is responsible for reviewing monthly billing invoices and for notifying MHP Community of any corrections within 30 calendar days after the date of each invoice. Failure to promptly notify MHP Community of changes will limit premium adjustment.

Section 5: Group Enrollment and Renewals

Group Enrollment Requirements 5.1

Renewal Process 5.2

5.1 Group Enrollment Requirements

- A group must enroll and maintain a minimum of two (2) employees per benefit plan to be eligible.
- Small group coverage is available only for businesses with at least one full-time equivalent (FTE) employee other than owners, partners, or family members.
  Note: A family member is considered as living within the same household.
- Group must be of a permanent nature and financially stable.
- Group must have been formed for the purpose other than to secure group insurance.
- Eligible employees are employees who receive a W-2 form and who work a minimum of 30 hours per week. Part-time employees are eligible provided they work a minimum of 17.5 hours per week. Eligibility is specified in the Group Enrollment and Coverage Agreement and rules are applied to all employees uniformly.
- Seasonal employees, directors, corporate officers, trustees, corporate lawyers and owners or partners are not eligible unless they are full-time employees. Contracted employees (1099) are not eligible.
- The Group must carry workers' compensation insurance unless it is not required by law. If the employer is exempt from providing workers' compensation insurance, the *Notice of Exclusion* form must be provided. The form must include the Michigan Department of Labor Notice of Exclusion stamp in the upper right-hand corner.
- Group must have a physical presence in the MHP Community approved service area.
- No more than 10 percent of eligible employees may reside outside the MHP Community approved service area. (Contact your sales executive with questions).

5.2 Renewal Process

Renewal Requirements. Approximately 90 days prior to renewal month, MHP Community will provide group renewal package with new rates, additional plan options, and a group status verification form.
a. Group Status Verification – Group must complete and return the group status verification form at least 30 days prior renewal date to ensure timely implementation of any change(s) and to allow ample time to re-issue ID cards if there is a change.
b. Waivers – Group must provide a current list of employees waiving coverage and their reason at least 30 days prior to the renewal date each year.
c. Workers' Compensation Insurance Declarations Page – Group must maintain valid and up-to-date workers' compensation coverage and supply an updated copy of the policy to MHP Community upon request, unless group is exempt from maintaining workers' compensation. Proof of exemption will be required.
d. Quarterly Wage Detail Report – Upon MHP Community's request, group must provide a copy of the most recent *Quarterly Wage Detail* report when submitting renewal documents
Note: Large groups with less than 25 enrolled must automatically provide the *Quarterly Wage Detail* report to MHP Community at least 30 days prior to renewal. Small groups of five (5) or less enrolled must automatically provide the *Quarterly Wage Detail* report to plan at least 30 days prior to renewal.

Open Enrollment
MHP Community and the group will hold an open enrollment period where employees can make changes if they wish to. MHP Community will supply open enrollment materials and can assist with employee presentations if necessary.

Member Materials
If the group makes a benefit change (for example, office visit, or ER co-payment) that will impact the ID cards, new ID cards are issued for the entire group within 10-15 business days after the renewal is completed. Any change to the policy will be mailed to each subscriber's home within 30 days of the group's renewal.

Section 6: Online Tools

Group Information 6.1

Member Information 6.2

Member Portal 6.3

Other Resources & Links 6.4

6.1 Group Information

The MHP Community group administrator portal can be accessed on McLaren CONNECT. Log in credentials will be provided once the group is active. The portal is a secure, web-based system that allows you to:

- Verify member eligibility
- View and print member eligibility rosters
- View and print member benefit information
- View a member's demographic information
- Enroll new employees
- Make changes to current enrollees, such as adding new dependents, performing address changes, and termination of employee policies

6.2 Member Information

MHP Community encourages employers to direct their employees to our website for useful information regarding:

- McLarenCONNECT member portal
- Review enrollment history
- Access claims history
- Request a PCP change
- View and print ID cards
- View and print EOBs
- Search for network providers
- View plan summaries
- Look up Rx claims history, prescription costs, drug interactions, and generic equivalents
- Send customer service inquiries via secure email
- Use the mobile app with all the features above (available through the Apple App Store and Google Play)
- The latest edition of the MHP Community member newsletter
- Guides to obtaining prescription medication, including how to work with MHP Community formulary

MHP Community members are also encouraged to contact Customer Service with questions concerning their health care benefits or required medical care. Customer Service representatives are available Monday through Friday from 8 a.m. to 6 p.m. at **888-327-0671 (TTY: 711).**

6.3 Member Portal

- **McLaren CONNECT:**
  https://www.mclarenhealthplan.org/community-member/mclaren-connect

6.4 Other Resources and Links

- **Find A Provider:**
  https://www.mclarenhealthplan.org/community-member/find-a-provider-community
- **Pharmacy Benefit Information:**
  https://www.mclarenhealthplan.org/community-member/pharmacy-mhp
- **Health and Wellness:**
  https://www.mclarenhealthplan.org/community-member/health-mhp
- **Member Information:**
  https://www.mclarenhealthplan.org/community-member/customer-information-mhp
- **Service Area Map:**
  https://www.mclarenhealthplan.org/Uploads/Public/Documents/HealthPlan/documents/MHP%20Documents/LargeGroupApprovedServiceAreaMap.pdf Update link
  Need to update link to correct service area map.