McLaren POS

Large Group Member Handbook

2023

Discrimination is against the law

McLaren Health Plan, McLaren Health Plan Community, McLaren Health Advantage and McLaren Medicare Supplement (collectively McLaren) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

McLaren:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact McLaren's Compliance Officer. If you believe that McLaren has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

- McLaren's Compliance Officer
  - Write: G-3245 Beecher Rd., Flint, MI 48532
  - Call: 866-866-2135, TTY: 711
  - Fax: 810-733-5788
  - Email: mhpcompliance@mclaren.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, McLaren's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
800-368-1019, 800-537-7697 (TTY)

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

McLaren HEALTH PLAN | McLaren HEALTH PLAN COMMUNITY | McLaren HEALTH ADVANTAGE | McLaren MEDICARE

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:

ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܫܬܟܚܝ ܠܘܟܘܢ ܬܫܡܫܝܬ̈ܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（TTY：711)。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671（TTY:711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).

G-3245 Beecher Road ● Flint, Michigan ● 48532
tel 888- 327-0671 ● fax 833-540-8648
McLarenHealthPlan.org

2021
Table of Contents

Welcome to McLaren Health Plan Community

Welcome to McLaren Health Plan Community (MHP Community). We are happy to have you as a member and look forward to helping you with your health care needs. MHP Community and its entire staff are dedicated to providing our valued members with high quality, cost effective health care.

The information in this handbook will help you understand your benefits and how MHP Community will support your health care needs.

Key Contacts

Customer Service: Available to answer your calls Monday through Friday, 8:30 a.m. to 6 p.m. Call 888-327-0671 and a Customer Service representative will help you with questions regarding eligibility, covered benefits, PCP changes and any other questions you may have about MHP Community.

Medical Management: Each member is assigned a personal nurse and is available during normal business hours, Monday through Friday, 8:30 a.m. to 5 p.m. Call 888-327-0671 and ask for "your nurse" to assist with questions related to disease management, health assessments, and other questions you may have about your health care. You can call us during normal hours or after hours.

Website: Visit McLarenHealthPlan.org for the most current information, including the provider directory, frequently asked questions, healthy reminders and much more. You may obtain a printed copy of any information on our website by calling Customer Service at 888-327-0671.

Language Assistance: If you need help understanding any of the written materials or need interpretation services, call Customer Service at 888-327-0671. Please note, if a provider speaks a language other than English, it is listed in the provider directory.

If you are deaf, hard of hearing, or have speech problems, call 711 and Michigan Relay will assist you. Michigan Relay is available 24 hours a day.

Your Privacy: MHP Community cares about your privacy. We have a Privacy Notice available to all of our members. We have policies and procedures in place that protect the privacy of your information:

- Every MHP Community work force member signs a statement when they are hired that states they are required to keep member information private.
- Every MHP Community workforce member receives training every year on keeping information private.

- MHP Community only allows workforce members who are authorized with a password to access electronic information.
- Paper information is stored in secure places.
- Only employees who need to manage your care are allowed to see your personal information.
- MHP Community policies protect your PHI, whether in an oral, written or electronic format.
- Information about MHP Community policies relating to its use and disclosure of protected health information (PHI), use of authorizations, access to PHI and protection of oral, written and electronic PHI is available in MHP Community's Notice of Privacy Practices, which is located in this handbook and on our website.
- MHP Community provides group health plan sponsors and employers enrollment information, which is PHI.
- Certain plans and plan sponsors may receive other PHI from MHP Community.
- When we disclose PHI to plans and plan sponsors, they must follow all state and federal laws having to do with the use and disclosure of your PHI.

Your MHP Community Identification Card

You will receive an MHP Community identification card. Your ID card includes the following information:

1. Contract number
2. Subscriber name
3. Group number
4. Plan ID
5. Applicable copayments, coinsurance and deductibles

Always show your MHP Community ID card when you or a covered family member receive services. Do not let anyone else use your card. If you have questions about your ID card or need to order an additional card, please call Customer Service at 888-327-0671.

Selecting a Primary Care Physician (PCP)

When you join MHP Community, each family member who is covered by MHP Community must choose a PCP from the provider directory. A member under the age of 18 years may choose a pediatrician as his or her PCP. The provider directory will give you a list of PCPs to choose from. This list will include doctors who specialize in Family Practice, Internal Medicine and Pediatrics.

Your PCP will work closely with you and coordinate your health care needs. Your PCP will be responsible for sending you to a specialist when it is medically necessary. Your responsibility is to always work with your PCP. If you do not select a PCP, or if your PCP does not coordinate your health care needs, eligible medical services that you receive may not be covered. Use these guidelines as a reference when choosing a PCP:

- Availability. Is the doctor accepting new patients? What are the office hours?
- Does the doctor listen well and does he or she spend enough time with you?
- Do you think you could build a good relationship with this doctor?
- What is the doctor's education and experience?

Remember to review the provider directory before choosing your PCP. The provider directory will indicate if the PCP is accepting new patients. We continually update our provider directory, so you should call Customer Service at 888-327-0671 to verify your PCP's status.

The Role of Your PCP

Your PCP is an integral part of your health care. Your PCP should understand your health care needs, direct the care you receive, decide the need for a specialist and determine the hospital you should use when needed. Your PCP should be available to you 24 hours a day, 7 days a week. Your PCP will provide you with a "medical home" where the patient care record will be maintained.

Changing Your PCP

If you need to change your PCP, please call Customer Service at 888-327-0671. They can assist you with your request and confirm if the PCP you have chosen is accepting new patients. You may also visit McLarenHealthPlan.org for the current provider directory. The change will be effective the first day of the month following notification to MHP Community. You may start seeing your new PCP when the change becomes effective.

Provider Directory

Many doctors and other providers of health care will be taking care of you. The MHP Community provider directory lists health care providers' names, addresses, telephone numbers, specialties and board certification. If you want to know more about a providers' qualifications, such as medical schools attended or residency information, call Customer Service at 888-327-0671. You may also visit our website at McLarenHealthPlan.org for the current provider directory. If you would like a printed copy of anything on our website, call Customer Service.

Your POS Benefits

OPTION A BENEFITS

Option A works like a traditional HMO. Under this option, your PCP coordinates your medical care and obtains preauthorization for specialty care, when needed. All of your health care is provided for the lowest out-of-pocket expense to you. In order to receive Option A Benefits, your PCP must arrange any care not provided by him or her by issuing a referral and, when needed, obtaining preauthorization from MHP Community (see your Certificate of Coverage for more details). It is important to obtain a referral from your PCP before you receive specialty care. If a required preauthorization is not issued, the service is paid under the Option B Benefit and you have more out-of-pocket costs.

OPTION B BENEFITS

Option B Benefits allow you to self-refer, meaning a referral from a PCP is not required. In addition, you can choose to receive services from any doctor or hospital, whether the provider participates with MHP Community or not. In exchange for this flexibility, the out-of- pocket expenses are higher than under Option A. **If you choose to receive services from a non-participating/out-of-network provider, you may have to pay the price difference between the cost of the services and what MHP Community pays the out-of-network provider for the service ("balance bill"). These costs can be significant, which is why it is important to understand your liability when using a non-participating/out-of-network provider.**

Option B does not waive the requirement for preauthorization for certain services (see your Certificate of Coverage or call Customer Service for a complete, up-to-date list of services requiring preauthorization). If preauthorization is not received from your PCP and MHP Community for those services, no coverage will be provided.

Note: Certain services are only covered under Option A (see your Certificate of Coverage). If services are not covered under Option B and you choose to self-refer for such services, MHP Community will not cover the services even if provided by a provider who participates with MHP Community.

Preventive Services

Preventive services are screenings, immunizations, lab tests and other services that help prevent illness or help finding diseases or medical conditions before you experience symptoms. Some services are preventive services only for specified age groups or genders.

Preventive services provided by an in-network provider are covered in full without a copayment, coinsurance or deductible.

Review your Certificate of Coverage for more detailed information about services that are preventive services, or visit the USPSTF website at ***http://www.uspreventativeservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/*** or ***www.HealthCare.gov.*** This information may also be obtained by calling Customer Service at 888-327-0671.

Women's Health

MHP Community wants you to stay well. We cover annual well check-ups for all our members. While your PCP is well trained and able to provide you with an annual well check-up, it is your right to choose to receive these services from an in-network OB-GYN physician. A referral is not required for these services as long as they are received from an in-network OB-GYN physician. Remember to include your PCP in your decision to have your annual well visits from an OB-GYN. This will help your PCP and your OB-GYN work together to provide you with the best possible health care.

Laboratory and Radiology Services

MHP Community covers medically necessary lab work, x-rays and other radiological exams when provided by a physician and a part of your MHP Community benefits.

Emergency Care / Urgent Care

At MHP Community, we realize that emergencies do occur. Emergency care is a covered MHP Community benefit. While these services may require a copayment for each emergency visit, the copayment will be waived if you are admitted to the hospital.

We cover medically necessary emergency services provided by an out-of-network provider, but if you receive services from an out-of-network provider, you may have to pay a price difference between the cost of the services and what MHP Community pays the out-of-network provider for the service ("balance bill"). These costs can be significant, which is why it is important to understand your liability when using an out-of-network provider.

If you are hospitalized in an out-of-network facility as a result of seeking emergency care, we may require that you be transferred to an in-network hospital or another facility within your service area once you are stabilized.

When you believe that you have a medical emergency, first contact your PCP. He or she will help you determine if the situation requires immediate attention. Your PCP will work with you to make sure you get the care that you need.

If you have a serious medical emergency that you feel is life threatening, go immediately to the nearest emergency room or call 911. As soon as possible after you are treated at an emergency facility, you will need to contact your PCP, so they are aware of the treatment you are receiving.

MHP Community requires notification of all hospital admissions, including emergency admissions. This is required within 24 hours of admission, or as soon thereafter as possible.

Routine or non-urgent care received outside of the MHP Community service area without preauthorization by MHP Community, will not be covered. If you seek care for non-emergency conditions while you are out of the service area, you may have to pay for these services.

Some illnesses do occur when your PCP's office is closed. When your PCP's office is closed and you need care that cannot wait until the next day. You may seek care from an urgent care center. Your costs will be less if you use an in-network urgent care center. You should still consult with your PCP through their answering service for directions regarding urgent care services. For emergency care, go to the nearest hospital or call 911.

Specialty and Hospital Care

Your PCP will provide you with a "medical home," but sometimes you may need to see a specialist or go to the hospital. It is recommended that you consult with your PCP who can help direct you to the most effective, high quality care, and oversee ongoing coordination of your health. If you think you need a second opinion, you can get one from a participating/in-network provider. If you want a second opinion from a non-participating/out-of-network provider you will be responsible for higher member cost sharing (including any balance bills). All inpatient admissions require preauthorization, other than for maternity or emergency care.

Behavioral Health

MHP Community has in-network mental health/substance abuse providers available to you. You can find the list of these providers by visiting McLarenHealthPlan.org, or contact Customer Service for assistance. Included on this list are psychiatrists, psychologists, social workers and counselors. You may also obtain services from an out-of-network provider, but you will be responsible for higher member cost sharing (including any balance bills).

Out of Area Care

If you are out of the MHP Community service area, you are covered for emergency care. If you have an emergency, go to the nearest hospital. Under your option B benefits

many services may be covered out-of-area, but you will be responsible for higher member cost sharing (including balance bills). Some services require preauthorization, and some services are not covered under option B. Check your Certificate of Coverage or call Customer Service.

Prescription Medications

MHP Community administers the pharmacy benefit in conjunction with our pharmacy benefit manager, MedImpact. MHP Community, MedImpact, and physicians on our Quality Improvement committee work closely together to provide you with access to the most clinically appropriate, safe and cost-effective medications.

Your pharmacy benefit is based on the Plan you are enrolled in and the MHP Community formulary. The formulary is a list of preferred prescription medications. It is a useful reference and educational tool that assists our providers in selecting cost-effective therapies of the highest quality.

When you are prescribed a medication that is available in generic form, MHP Community will cover the generic form of the medication. If you request the brand name instead of the generic alternative, you may be responsible for additional costs or a higher copay. If your physician requests a brand name drug when a generic alternative is available, your physician must request a preauthorization. This request will be made to our pharmacy benefit manager, MedImpact.

There are some medications that are only covered when preauthorized by MHP Community. When a preauthorization is necessary, your physician will fill out a preauthorization request form and send it along with the appropriate documentation to our pharmacy benefit manager, MedImpact. Your provider has a copy of the MHP Community formulary, so he or she will know when a medication requires preauthorization.

Most covered medications can be dispensed in a 90-day supply by mail-order. After a minimum 30-day trial with the medication, most generic medications can be dispensed in a 90-day supply at a retail pharmacy. You must obtain a prescription for a 90-day supply from your physician in order to participate.

If you have any questions regarding your prescription benefit, you may call Customer Service at 888-327-0671.

Tobacco Cessation Treatment

As an MHP Community member, you are entitled to a free stop smoking Quitline. Call 800-784-8669 to get enrolled. You should also talk to your doctor for more information on how to quit smoking.

Medical Management Overview

Medical Management, along with the PCP, works with our members to ensure they receive high quality, cost-effective services. This helps ensure consistent communication between your PCP and any specialists you have been referred to. In order to reach this goal, we have many tools available to use, such as:

- Provider referral process/form
- Member health assessments: "Staying In Touch" welcome survey
- Case management: Individualized member contact and follow up
- Disease education and support: asthma, diabetes, depression, ADHD, hypertension, stroke, and pregnancy
- Pharmacy services: Formulary maintenance

There may also be instances when the MHP Community's Medical Director will review a service requested by your PCP to determine if the service is medically necessary and appropriate. If the Medical Director determines that the service is not medically necessary and appropriate, you will receive notification in writing of the denial and the reason or criteria on which the decision was based. If you disagree with the decision of the Medical Director you have the right to appeal this decision.

To make these decisions in a fair and consistent manner we use nationally recognized guidelines and criteria. Our Quality Improvement committee reviews these guidelines. The physicians and nurses involved in the Medical Management process do so based only on the appropriateness of care. They are not rewarded for issuing denials and are not compensated in any way that would motivate them to make inappropriate coverage decisions or encourage underutilization of services.

Preventive education is extremely important to MHP Community as we strive to help you get the best care available to you. We support member preventive education by distributing Preventive Health Guidelines to our members and our PCPs. We have established call programs in which we contact our members and assist them in getting appropriate screenings scheduled. We also send healthy reminder cards and semi-annual newsletters to our members highlighting preventive health information.

Disease Management is also offered to our members with chronic illnesses such as asthma and diabetes. This program offers our members help in developing a customized program to meet their health care needs. We provide education, monitor clinical outcomes, evaluate member health status, and teach our members self-management to help improve their health status. If you have any questions about any of Medical Management's services, call us at 888-327-0671.

Diabetes services:

Benefits for equipment, supplies, and educational training for the treatment of diabetes are covered when medically necessary and ordered by or under the direction of your PCP. These include:

- Blood glucose monitors and blood glucose monitors for the legally blind.
- Test strips for glucose monitors, visual reading and urine testing strips, lancets and spring-powered lancet devices.
- Syringes
- Insulin pumps and medical supplies required for the use of an insulin pump.
- Diabetes self-management training to ensure that persons with diabetes are trained on proper self-management and treatment of their diabetic condition.

Benefits are available for diabetes equipment that meets the minimum specifications for your needs. If you choose to purchase diabetes equipment that exceeds these minimum specifications, we will pay only the amount that we would have paid for equipment that meets the minimum specifications, and you will be responsible for paying any difference in cost.

Benefits are available for diabetes self-management training when it is provided by a provider who has appropriate certification to receive reimbursement for these services.

Covered Benefits and Exclusions from Coverage

For a complete list of your covered benefits and exclusions from coverage please refer to your Certificate of Coverage and applicable riders. You can also call Customer Service at 888-327-0671 for questions regarding covered and non-covered services.

Benefit Interpretation and New Technology Evaluation

MHP Community realizes that medical technology is constantly advancing and improving. In order to do our best for our members, we have developed a process to evaluate new medical procedures, medications, and devices, taking into consideration existing technology. This process includes reviewing information from government agencies, published information, and findings from studies. Our Quality Improvement committee is also involved in this review process. Some factors they consider are patient safety, clinical contraindications, experimental services, clinical efficacy and cost effectiveness. Any benefit changes made as a result of this review will be communicated as appropriate to our members and providers.

Copayments and Coinsurance

Many of your covered benefits have a copayment or coinsurance for which you are responsible. A copayment is a fixed dollar amount, and coinsurance is a percent of charges. Your copayment amount is due when services are received. Please refer to your Certificate of Coverage and applicable riders to determine your copayment and coinsurance amounts for certain covered benefits.

Eligibility

If you have questions regarding eligibility, you need to contact your Employer's Human Resources or Personnel department. Employers have various eligibility requirements concerning who you may enroll in your MHP Community coverage.

Enrolling New Dependents

To enroll new dependents, you must apply within 30 days of a qualifying event, such as birth, marriage or adoption. Enrollment is done through your Employer's Human Resources or Personnel department by completing an enrollment application. Failure to enroll a new dependent may result in non-payment for services.

If You Have Other Health Care Coverage

You or other family members may be covered under another health care plan. MHP Community needs to know this information to work with the other insurance to coordinate your benefits and ensure that maximum payments are made by each carrier for all allowable expenses. We will also work with automobile and worker's compensation carriers. We reserve the right to recover all costs of services to treat conditions covered by any other insurer. If you did not indicate other coverage on your enrollment form, you may utilize the form attached in the back of this handbook or call Customer Service at 888-327-0671.

Member Reimbursement

There is no reason for you to pay a provider for covered services under your Certificate of coverage (other than copayments and/or coinsurance), but if circumstances require that you do, and you can prove that you have, MHP Community will reimburse you for those covered services at the MHP Community reimbursement amount.

- You must provide written proof of the payment within 12 months of the date of service and complete an MHP Community Direct Member Reimbursement form. You can find the form at McLarenHealthPlan.org or you can obtain the form by calling Customer Service at 888-327-0671.

NOTE: The proof of payment documentation must include the procedure code, diagnosis code, charges, the amount you paid, and the provider tax ID number.

- Claims submitted more than 12 months after the date of service will not be paid.

When Coverage Terminates

Your MHP Community coverage will terminate if:

1. You no longer meet eligibility requirements
2. A contract is cancelled for non-payment
3. The group's coverage is cancelled
4. MHP Community exits the market or the plan is terminated
5. The group moves outside of the MHP Community service area or the group ceases to be a member of an association through which the group has achieved eligibility.
6. The group changes products
7. You fail to pay copayments or coinsurance or other fees within 90 days of their due date or you do not make and comply with acceptable payment arrangements with the provider to correct the situation

Rescission of a Member's Coverage

Rescission of coverage means the member's coverage ends retroactive to the date a member committed fraud against MHP Community or a provider of benefits, or intentionally misstated or intentionally withheld a material fact. MHP Community will provide at least thirty (30) days advance notice of a rescission. A member may appeal a recession of coverage by following the MHP Community member appeals procedure. Fraud or intentional misstatement or withholding of a material fact includes:

- Intentional misrepresentation of the eligibility of a member;
- Fraudulent use of the MHP Community ID card;
- Fraudulent use of the MHP Community system.

Any amounts paid by MHP Community after the event are due and owing from the member.

Option to Continue Group Coverage (COBRA)

COBRA is the continuation of group coverage, but at the member's expense, for members who lose eligibility. If you are eligible for this option and choose it, you must make regular monthly payments. Most groups with over 20 employees are required by Federal law to offer this coverage. If you have questions about COBRA coverage, contact your Human Resource or Personnel department.

Converting to an Individual Plan

If your group coverage ends, you may be eligible to purchase an individual plan from MHP Community or another carrier either on or off the Michigan Insurance Marketplace at Healthcare.gov. In most cases you must apply within 30 days after your group coverage ends.

Member's Rights and Responsibilities

As a MHP Community member you have the right to:

- Confidentiality
- Be treated with respect and with recognition of your dignity and the right to privacy, including to be free from restraint and seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Have access to a primary care provider or provider designee 24 hours a day, 365 days a year for urgent care.
- Receive culturally and linguistically appropriate services.
- Obtain a current provider directory of participating providers and access to a choice of specialists within the network who are experienced in treatment of chronic disabilities. Preauthorization by MHP Community is required for some services.
- Obtain OB-GYN and pediatric services from network providers without a referral.
- Continue receiving services from a provider who has been terminated from the plan's network through the episode of care, as long as it remains medically necessary to continue treatment with this provider, including a pregnant female member who has the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to 6 weeks after delivery.
- Receive covered benefits consistent with the member's contract and State and Federal regulations.
- The right to have no "gag rules" from MHP Community; including having a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Participate in decision-making regarding your health care, including the right to refuse treatment, to obtain a second opinion and express preferences about treatment options
- Receive a copy, an amendment and/or a correction of your medical record upon request.

- Know how the plan pays its doctors, allowing members to know if there are financial incentives or disincentives tied to medical decisions; and the right to be provided with a telephone number and address to obtain additional information about compensation methods, if desired.
- Voice complaints or appeals about MHP Community the care provided or a decision to deny or limit coverage, without risk of penalty.
- Receive information about the structure and operation of MHP Community, including the services provided, the practitioners and providers, and your rights and responsibilities.
- Make recommendations regarding your rights and responsibilities.
- Have your protected health information kept confidential by MHP Community and the PCP.
- Be free from other discrimination prohibited by State and Federal regulations.

MHP Community members have the <u>responsibility</u> to:

- Schedule appointments in advance and be on time; cancel an appointment with the doctor's office as soon as possible.
- Use the hospital emergency room only for acute or emergency care, not for routine care. This means following the protocol and using the emergency room only when medically necessary and contacting the PCP prior to a visit to the emergency room.
- Become a partner with the PCP in planning individual health care and completing treatments, including supplying the information (to the extent possible) to practitioners, providers, and the health plan that is necessary to deliver the services needed.
- Follow plans and instructions for care that you have agreed to with all your treating health care providers and practitioners.
- Understand your health problems and participate in developing treatment goals to the degree possible.
- Notify MHP Community's Customer Service immediately for any change in address or telephone number.
- Allow MHP Community to assist with health care and services to which you are entitled, and notify MHP Community of any problem related to health care, benefits, etc.
- Forward suggestions to MHP Community in writing or contact Customer Service for assistance.
- Carry the MHP Community member ID card at all times

Patient Bill of Rights Notification

As a member of MHP Community, you have certain rights as specified by a Michigan law called the Patient Bill of Rights. This notice will explain those rights and will help you understand the health coverage provided by MHP Community:

1. MHP Community Service Area – As a state licensed HMO, MHP Community is licensed to enroll individuals within the McLaren Community "Service Area" as defined by the Department of Insurance and Financial Services.
2. MHP Community Certificate of Coverage – In order for you to understand your health care benefits, you will be provided with a copy of the applicable MHP Community Certificate of Coverage and Rider(s). These documents will contain information regarding covered benefits, prescription drug coverage, with information about requirements for the use of generic drugs, a description of emergency health coverage and benefits, out of area coverage and benefits. It will also detail your financial responsibility, if any, for copayments, coinsurance, deductibles and any other out-of-pocket expenses. It will also tell you how to file an appeal.
3. Continuity of Treatment – If an in-network provider terminates from the MHP Community network, MHP Community will do either of the following; arrange for the continuation of treatment by that provider or assist the member in selecting a new provider to continue with the treatment.
4. As a member of MHP Community, you have the right to request and receive additional information about MHP Community, which includes:
    - Provider information – You are entitled to receive a copy of the MHP Community provider directory, which will give you information about our in-network physicians (names, locations and specialty). It will also specify which physicians are accepting new patients.
    - Physician credentials – You are entitled to receive information about in-network physicians, including: degrees received, certification date, if applicable, and identification of the affiliated facilities where the physician has privileges for any treatment, illness or procedure you identify.
    - Physician status/discipline – If you have questions about disciplinary actions taken against your doctor or want to know about any formal complaints against your doctor, please visit the Department of Insurance and Financial Services website at www.7.dleg.state.mi.us/free/.
    - Specific benefits – You are entitled to information concerning any requirements, limitations, restrictions, or exclusions including, but not limited to, information regarding the MHP Community drug formulary, benefits and providers.

Patient Advocate

Many people today are worried about the medical care they will receive should they become terminally ill and are unable to communicate. You may now state your wishes regarding your health care in writing while you are still healthy and able to make such decisions. We are giving you this information to tell you about your right to make your own decisions about your medical treatment. As a competent adult, you have the right to accept or refuse any medical treatment. “Competent” means you have the ability to understand your medical condition and the medical treatments for the condition, to weigh the possible benefits and risks of each such treatment, and then decide whether you want to accept treatment or not.

As long as you are competent, you are the only person who can decide what medical treatment you want to accept or reject. You will be given information and advice about the pros and cons of different kinds of treatment and you can ask questions about your options. But only you can say “yes” or “no” to any treatment offered. You can say “no” even if the treatment you refuse might keep you alive longer and even if others want you to have it.

If you are not able to make your own decisions about medical care, someone else will have to make those decisions for you. If you haven’t stated your wishes in writing, no one will know what you would want. There may be difficult questions that will need to be answered and when your wishes are not known, your family or the courts may have to decide what to do.

While you are competent, you can name someone to make medical treatment decisions for you should you ever be unable to make them for yourself. To be certain that the person you name has the legal right to make those decisions, you must fill out a form called either a Durable Power of Attorney for Health Care or a Patient Advocate Designation. By completing this form, you are giving this person the right to give your written or spoken instructions about what medical treatment you want and don’t want to receive. You can choose anyone to be your Patient Advocate who is at least 18 years old. You may pick a family member or a friend or any other person you trust. But you should make sure that person is willing to serve by signing an acceptance form. It’s a good idea to have a backup choice in case the first person is unwilling or unable to act when the time comes.

You can get a Patient Advocate Designation form from a hospital, nursing home, hospice, or home health care agencies. These are available to people free of charge. Many lawyers also prepare Patient Advocate Designations for their clients. The forms are not all alike, so you should pick the one that best suits your situation.

You must fill in the name of the advocate and sign the form in front of two witnesses; however, under Michigan law there are some people who cannot be your witnesses. Your family members cannot witness your signature; neither can anyone who could be your heir, who is named to receive something in your will, or who is an employee of a company who insures your life or health. Friends or co-workers are often good people to ask to be witnesses since they see you often and can, if necessary, swear that you acted voluntarily and were of sound mind when you made out the form.

You should give copies of the completed forms to your doctor and/or health care facility so they can be placed in your medical records.

It is also a good idea to have your wishes in writing to give to your Patient Advocate. This will help in case it is necessary for these decisions to be made. If you want your Patient Advocate to be able to refuse treatment and let you die, you have to say so specifically in the Patient Advocate Designation form. Remember, it is the Patient Advocate's job to follow your instructions.

Advance Directive

If you do not want to name a Patient Advocate, you can write what is called an "Advance Directive". This is a written statement of your choices about medical treatments. This could be a very valuable document, because it will help those taking care of you to understand your treatment choices. Your PCP may also have an Advance Directive form. It will give written notice to health care workers who may be treating you. Should you become unable to make your own decisions regarding medical treatment, the Advance Directive will give written notice of your wishes to health care workers treating you.

You don't have to fill out a Patient Advocate Designation or Advance Directive form and you don't have to tell anybody your wishes about medical treatment. No one can force you to fill out these forms. You will still get the medical treatment you choose now, while you are competent. If you become unable to make decisions, but you've made sure that your family and friends know what you want, they will be able to follow your wishes. Without instructions, family and friends may still be able to agree on your medical treatment. If they don't agree, the court may have to name a guardian to make those decisions for you.

If you do fill out these forms, you may change them at any time in writing or orally. You should review your Patient Advocate Designation form or Advance Directive at least once a year to make sure it still accurately states how you want to be treated, and includes the name of the person you want to make decisions for you.

Notice of Privacy Practices

for McLaren Health Plan, Inc. and McLaren Health Plan Community

MCLAREN HEALTH PLAN, INC. AND MCLAREN HEALTH PLAN COMMUNITY 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 Community
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 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 McLarenHealthPlan.org.

[Notice of Privacy Practices - MHPCC20151106 - Rev. 12/2015]

How to Use Your Rights Under This Notice

If you want to use your rights under this notice, you may call us or write to us. Your request must be in writing, and we will help you prepare your written request, if you wish.

Complaints to the Federal Government. If you believe that your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Office of Civil Rights
Dept. of Health and Human Services
200 Independence Avenue,
S.W. Washington, D.C. 20201
Phone: 866-627-7748
TTY: 886-788-4989

Email: ocrprivacy@hhs.gov

You will not be penalized for filing a complaint with the federal government.

Complaints and Communication to Us. If you want to exercise your rights under this notice or if you wish to communicate with us about privacy issues or if you wish to file a complaint, you can write to:

ATT: Privacy Officer
McLaren Health Plan Community
P.O. Box 1511
Flint, MI 48501-1511

You will not be penalized for filing a complaint. You have the right to receive an additional copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Please call Customer Service at 888-327-0671 or write to us to request a copy.

Janet's Law

On October 21, 1998, President Clinton signed into law the "Women's Health & Cancer Rights Act of 1998." This Act is also known as Janet's Law.

Your MHP Community Certificate of Coverage explains the medical and surgical benefits in connection with a mastectomy as provided by this Act. If you have had a mastectomy and wish to elect breast reconstruction in connection with the mastectomy, please note that the following coverage is available to you:

1. Reconstruction of the breast on which the mastectomy has been performed
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance
3. Prostheses, if prosthetic devices are listed as a covered benefit in your Benefit Rider
4. Care for physical complications from all stages of the mastectomy including lymph edemas

The above-described coverage must be provided in a manner determined in consultation with you and your attending physician. Please note that the above-described coverage is subject to any applicable deductibles, coinsurance and copayments as provided in your Certificate of Coverage, Schedule of Copayments and Deductibles, and Rider(s). If you have any questions call Customer Service at 888-327-0671.

Fraud, Waste, and Abuse: What You Should Know

Fraud is defined as doing something intentionally that may cause harm to MHP Community. Examples of member fraud would include intentionally giving wrong information to a doctor or filing a claim that contains any false or misleading information.

Abuse is when something is done that causes unnecessary cost to MHP Community. Examples of member abuse would be using the Emergency Room for routine or non-emergent care or requesting services or equipment that are not medically necessary.

Waste is asking for services and medications that are not needed and result in extra costs, such as when you have a cold and want your doctor to prescribe an antibiotic.

Health care providers can also commit fraud. Examples would include doctors who provide services or prescribe drugs that are not medically necessary or send out bills for services that they did not provide.

If you think another person or a medical provider might be committing fraud or abuse, call MHP Community's Fraud & Abuse Hotline at 866-866-2135. You may also notify us in writing (anonymous notification is also acceptable) to:

McLaren Health Plan Community.
P.O. Box 1511
Flint, MI 48501-1511
Attention: Compliance Officer

or by email at : ***MHPcompliance@mclaren.org***

Member Complaint, Grievance, and Appeals Procedure

At MHP Community, we want to hear your comments so that we can make our services better for our members. We want you to be able to receive answers to any questions that you have about MHP Community. We also want to provide you ways of reaching fair solutions to any problems that you may have with MHP Community. When you have any comments or concerns, please call Customer Service at 888-327-0671.

Customer Service will assist you in documenting your complaint/grievance. We have 30 calendar days to complete our investigation and resolution to your complaint/grievance. You will receive notification either orally or in writing within three (3) calendar days of the determination of the complaint/grievance.

If you are dissatisfied with the resolution of a grievance/complaint other than adverse determination, you may appeal to MHP Community in writing or by phone by contacting the Appeals Coordinator, so long as the appeal is received and can be resolved within 35 days from the initial date of the grievance/complaint. Appeals relating to adverse determinations will be made following the internal appeal process.

If you are dissatisfied with MHP Community's decision related to your grievance/complaint on appeal, you may appeal in accordance with the External Appeals section of this handbook.

Regular Internal Appeals

An appeal is the process used to handle a complaint regarding an adverse benefit determination or termination of coverage. An adverse determination means health care services have been reviewed and denied, reduced or terminated. An untimely response to a request may become an adverse determination. Members or their authorized representative have 180 days from the date of the notification letter to file a written appeal.

You can send your appeal request along with any additional information to:

McLaren Health Plan Community
G-3245 Beecher Road
Flint, MI 48532
Attn: Member Appeals

Email: MHPAppeals@mclaren.org

Fax: 810-600-7984

Covered benefits continue pending resolution of the appeal. If you wish to have someone else act as your authorized representative to file your appeal, you will need to complete McLaren's authorized representative form which can be found on our website at ***MclarenHealthPlan.org*** or you may call Customer Service at 888-327-0671 for a copy to be mailed to you.

You may request copies of information relevant to your appeal, free of charge, by contacting Customer Service at 888-327-0671. If you request such information, MHP Community will provide you with any additional information that it may later consider relevant to your appeal without requiring you to make a separate request. We will also provide you with any new or additional rationale for a denial of your claim or appeal. You will be given a reasonable opportunity to respond to such new information or rationale.

Members have the right to ask MHP Community to arrange a meeting with the appeal review committee. Members or an authorized representative may attend the meeting in person or by telephone. A person not involved in the initial decision can review the appeal. The person who reviews the appeal will be of similar specialty.

MHP Community has thirty (30) calendar days to complete the internal appeal process for a pre-service appeal request, and sixty (60) days for post-service appeal request. You will receive notification in writing within three (3) calendar days of the determination of the appeal.

Expedited Complaint, Grievance, and Appeals

If your treating physician advises us that he or she believes that due to your medical status, resolution of your complaint/grievance and/or appeal within MHP Community's normal time frames would seriously jeopardize your life or health or ability to regain maximum function, the expedited complaint/grievance or appeals process may be utilized.

A request for an expedited complaint/grievance or appeal should be made by telephoning MHP Community at 888-327-0671.

MHP Community will make a determination concerning your expedited complaint/grievance or appeal and communicate that to you and your physician as expeditiously as the medical condition requires, but no later than seventy-two (72) hours after receipt. Most MHP Community decisions for an expedited complaint/grievance or appeal will be communicated to you and/or your physician by telephone. If so, you and your physician will be provided with written confirmation of this decision within two (2) calendar days after the telephone notification.

If your physician substantiates either orally or in writing that you have a medical condition where the time frame for completion of an MHP Community expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, you or your authorized representative may file a request for an expedited external review at the same time you or your authorized representative files a request for an expedited MHP Community complaint/grievance or appeal. You will need to follow the procedure explained below under the heading, "Expedited External Appeals."

External Appeals

If after your appeal we continue to deny payment, Coverage, or the service requested, or you do not receive a timely decision, you can ask for an external appeal with the State of Michigan, Department of Insurance and Financial Services (DIFS). You must do this within sixty (60) days of receiving MHP Community's appeal decision. MHP Community will provide the form required to file an external appeal.

These requests should be mailed to:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Service
PO Box 30220
Lansing, MI 48909-7720

Delivery service:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan Ste., 7th Floor
Lansing, MI 48933-1521

Toll Free Telephone: 877-999-6442
FAX: 517-284-8838
Web: ***http://www.michigan.gov/difs***
Phone: 877-999-6442

When appropriate, DIFS will request a recommendation by an independent review organization. The independent review organization is not part of McLaren. DIFS will issue a final order.

Expedited External Appeals

If after your expedited complaint/grievance or appeal we continue to deny Coverage or the service requested, you can ask for an expedited external appeal with the State of Michigan, Department of Insurance and Financial Services (DIFS). You must do this within ten (10) days of receiving McLaren's appeal decision. McLaren will provide the form required to file an expedited external appeal.

These requests should be mailed or faxed to:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Service
PO Box 30220
Lansing, MI 48909-7720

Delivery service:

Office of General Counsel – Health Care Appeals Section
Department of Insurance and Financial Services
530 W. Allegan Ste., 7th Floor
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Web: ***http://www.michigan.gov/difs***
Phone: 877-999-6442

When appropriate, DIFS will request a recommendation by an independent review organization. The independent review organization is not a party of McLaren. DIFS will issue a final order.

Coordination of Benefits Form

Are you or any of your covered dependents also covered by another group health plan? Yes ☐ No ☐

Another group health plan is defined as one that is generally an employer provided health plan though the employee may be sharing costs. Medicare is not an employer provided health plan. However, if you have Medicare, indicate **NO**, but complete section 5.

SECTION 2: OTHER GROUP HEALTH CARE PLAN OR PROGRAM INFORMATION (If Medicare, go to Section 5)

Employer	Street Address	City	State	Zip Code
Insurance Company	Street Address	City	State	Zip Code
Contract Number	Policy Number	Effective Date	Cancellation Date	
Name of Subscriber	Sex M F	Relationship to Subscriber	Birth Date	

Type of Coverage: Single ☐ Two Person ☐ Family ☐

Type of Plan (check all that apply): Hospital ☐ Surgical/Medical ☐ Prescription Drug ☐ Vision ☐ Hearing ☐ Dental ☐ Other ☐ (please describe): _____

SECTION 3: DEPENDENT INFORMATION

Members (other than Subscriber above) covered under the contract above. If there are more than five, list them on the other side.

Name	Self	Spouse	Child	Birth Date
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	

SECTION 4: DIVORCE/CUSTODY INFORMATION

Fill out this section **only** if you have children and/or step-children covered by other health care coverage through court order (i.e. divorce, separation, etc.) List the covered children below. If there are more than three, list them on the other side.

Name	Responsible Parent: Father	Mother	Other	Birth Date
	☐	☐	☐	
	☐	☐	☐	
	☐	☐	☐	
If no court order exists, which parent has custody?	☐	☐	☐	

Name of Insured Person for Child's Coverage (First & Last)				Birth Date
Employer	Street Address	City	State	Zip Code
Insurance Company	Street Address	City	State	Zip Code
Group Policy Number:	Effective Date:	Cancellation Date:		

SECTION 5: MEDICARE INFORMATION

Name of Member Covered by Medicare (self)		Name of Member Covered by Medicare (spouse if applicable	
Medicare ID Number	Sex M F	Medicare ID Number	Sex M F
Effective Date of Medicare Part A: _____ Part B: _____ Part D: _____		Effective Date of Medicare Part A: _____ Part B: _____ Part D: _____	

Please return this form to McLaren Health Plan/Health Advantage Recovery Department:
P.O. Box 1511, Flint MI 48501-1511 Or Fax to (810) 733-9652

HEALTH PLAN

McclarenHealthPlan.org

MHPC40193003 Large Group POS

G-3245 Beecher Rd. • Flint, Michigan 48532-1511 • 888-327-0671 • Fax 833-540-8648