McLaren
HEALTH PLAN

2024 MEMBER HANDBOOK

Contents

Welcome to McLaren Health Plan

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

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

Interpreter Services

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

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

Hearing and Vision Impairment

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

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

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

- with limited English proficiency
- of diverse cultural and ethnic backgrounds
- with a disability
- regardless of gender, sexual orientation, or gender identity

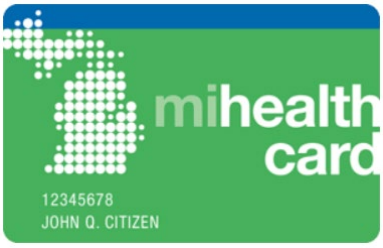
Important Numbers and Contact Information

Customer Service Toll-Free Help Line Monday-Friday 8 a.m. to 6 p.m.	888-327-0671
Customer Service Help Line TTY/TDD	711
Website	**www.McLarenHealthPlan.org**
Address	G-3245 Beecher Rd Flint, MI 48532
24 Hour Toll-Free Emergency Line	888-327-0671
24 Hour Toll-Free Nurse Line	888-327-0671
Case Management	888-327-0671
Pharmacy Services	888-327-0671
Transportation Services (non-emergency) [Monday-Friday 8 a.m. to 6 p.m.]	888-327-0671
Dental Services	Delta Dental 866-558-0280
Vision Services	888-327-0671
Mental Health Services	888-327-0671
To file a complaint about a health care facility	888-327-0671 or email **MHPappeals@mclaren.org**
To file a complaint about Medicaid services	888-327-0671 or email **MHPappeals@mclaren.org**
To request a Medicaid Fair Hearing	877-833-0870 or email **administrativetribunal@michigan.gov**
Grievance and Appeals	888-327-0671 or email **MHPappeals@mclaren.org**
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	855-444-3911
To report Medicaid fraud and/or abuse	866-866-2135 or email **MHPcompliance@mclaren.org**
To find out information about domestic violence	866-864-2338
To find information about urgent care	888-327-0671
Michigan ENROLLS	1-888-367-6557
Michigan Beneficiary Help Line	1-800-642-3195 or TTY: 866-501-5656.
MIChild Program	1-888-988-6300
MDHHS office locations and phone numbers	**https://www.michigan.gov/mdhhs/inside-mdhhs/county-offices**

Women, Infants and Children (WIC)	1-800-942-1636
Free service to find local resources. Available 24/7	2-1-1
Social Security Administration	800-772-1213 TTY/TDD: 800-325-0778
In an emergency	9-1-1
Suicide and Crisis Lifeline	9-8-8

Your State Issued Medicaid ID Card

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

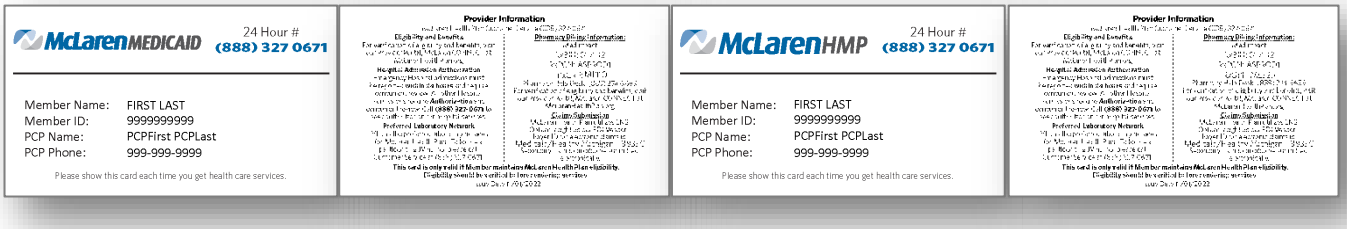


Call the Beneficiary Help Line at 800-642-3195 if you have questions about this coverage or need a new mihealth card. This number is located on the back of your mihealth card.

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

Your McLaren Health Plan Member ID Card

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



If you have questions about this coverage or need a new McLaren Health Plan Member ID card, you should call Customer Service at 866-327-0671 (TTY: 711) or access our online request at www.mclarenhealthplan.org/mclaren-health-plan/contact-us-id-card-request. You also can access an electronic version of your ID card by registering on the McLaren Health Plan member portal, McLaren CONNECT. Go to www.mclarenhealthplan.org/mclarenconnect to register.

Important ID Card Notes

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

Getting Help from Customer Service

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

Contact Us

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

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

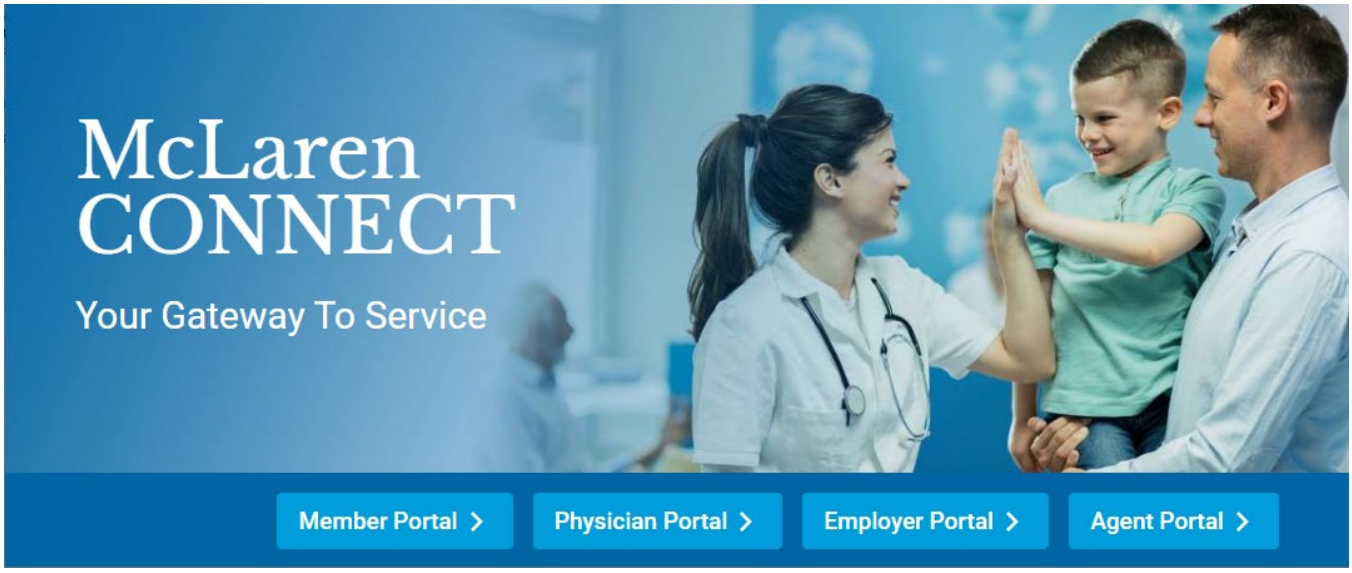
Our Website

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

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

Confidentiality

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



Manage Your Digital Health Records/Member Mobile Application

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

Transition of Care

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

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

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

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

- You only require monitoring of a chronic condition
- The doctor has a restriction and you might be at risk
- The doctor is not willing to continue your care
- Care with the non-participating doctor was started after you enrolled with McLaren Health Plan
- The doctor does not meet McLaren Health Plan policies or criteria

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

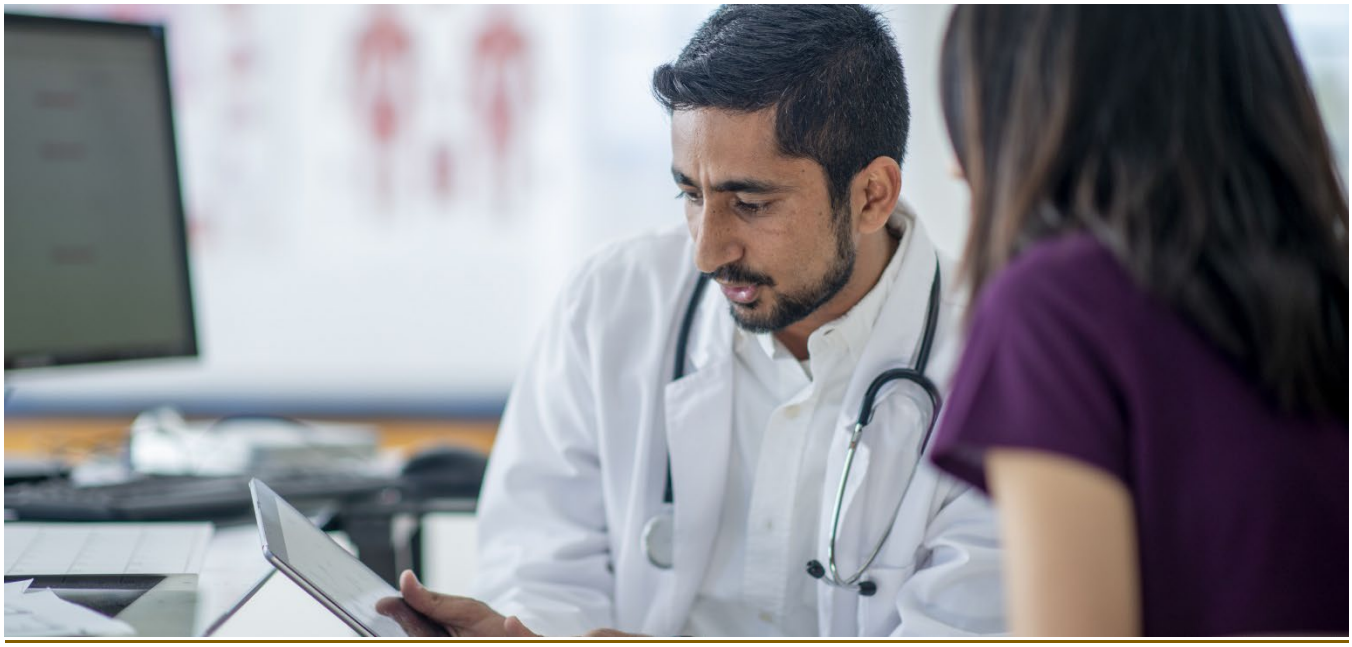
Our Transitions of Care policy is available on our website at www.mclarenhealthplan.org/mclaren-health-plan/transitions-of-care-policy-mhp

Youth Transition into Adulthood

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

- At age 18, your child is a legal adult and will be responsible for giving consent for care or treatment
- You will no longer be able obtain health information for your child without written consent or a legal order
- Your child's care may need to transition from pediatric providers to adult providers
- Your child's social security benefits may change
- Your child may no longer be eligible for resources that assist only children

Please contact us at 888-327-0671 (TTY: 711) for help transitioning your care if you are receiving Children's Special Health Care Services (CSHCS) or if you have any questions about your care.



Choosing A Primary Care Provider

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

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

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

We will select a doctor for you who is located close to your home if you do not choose one within 30 days of enrollment. You can change your doctor anytime.

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

You can use our provider directory to find doctors and specialists who are in our network. The provider directory lists addresses, telephone numbers, office hours, languages spoken, specialties, board certification and information about accessibility. It is located at www.mclarenhealthplan.org/mclaren-health-plan/provider-directory-mhp. You can view or print

the provider directory from the website. You can also request a copy of our provider directory, free of charge, by calling 888-327-0671 (TTY: 711). Provider information changes often. Visit our website for the most up-to-date information. Call Customer Service if you need help finding a doctor or if you want to know more about a provider. We can tell you the medical school or residency he or she attended as well.

You also can get medical care from these types of medical providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

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

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

Getting Care from Your Doctor

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

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

Getting Care from a Specialist

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

Out-of-Network Services

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

We will get you the care you need from a provider outside our network if we do not have a doctor or specialist in our provider network in your area who can give you the care you need, or if we do not have a provider who can see you timely. This is called an out-of-network referral. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

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

Out of State Services

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

Out of Country Services

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

Physician Incentive Disclosure

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

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

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

Prior Authorization

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

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

Getting a Second Opinion

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

New Medical Care

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

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

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

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

Information About Your Covered Services

It is important you understand the benefits covered under your plan. As a McLaren Health Plan member you do not have to pay co-pays for covered services under the Medicaid or Healthy Michigan Plan. See Cost Sharing and Copayments section for more information.
We will notify you in writing at least 30 days before the date the change takes place if there are any significant changes to the covered services outlined in this handbook.

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. The COC is available on our website at www.mclarenhealthplan.org/member-communications. **Make sure a service is covered before the service is done or you may have to pay for services not covered by McLaren**

Health Plan under the Medicaid program.

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

Telehealth/Telemedicine Services

Telehealth/Telemedicine care is a convenient way to get care for a variety of common illnesses without having to go to the emergency room or urgent care. For non-emergency issues such as the flu, allergies, rash, upset stomach and much more, you can connect with a doctor through your phone or computer to receive care where you are, when you need it. Doctors can diagnose, treat, and even prescribe medicine, if needed. Call your doctor's office to see if they offer telehealth services or contact Customer Service at 888-327-0671 (TTY: 711) for more information.

Covered services

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

- Ambulance and other emergency transportation when necessary
- Blood tests and follow-up
- Breast pumps
- Certified nurse midwife
- Certified pediatric & family nurse practitioner services
- Chiropractic services (up to 18 visits per calendar year, additional visits require preauthorization)
- Dental care
- Diagnostic services (lab, x-ray, other imaging)
- Doula services
- Durable Medical Equipment and supplies
- Emergency services, including transportation
- End Stage Renal Disease (ESRD) services
- Family planning
- Health education
- Hearing and Speech
- Hearing aids (covered once every five years when provided by a participation provider)
- Home Health services
- Hospice services
- Intermittent or short-term restorative or rehabilitative services (in a

nursing facility) up to 45 days
- Immunizations (shots)
- Inpatient hospital services
- Long-term Acute Hospital Services (LTACH)
- Maternal Infant Health Program (MIHP) services
- Medically necessary weight reduction
- Office visits to your provider
- Orthotic services
- Out-of-state services, when authorized
- Outpatient hospital services
- Outpatient mental health care
- Parenting and birthing classes
- Pharmacy services
- Podiatry
- Preventive services
- Prosthetic services
- Sexually Transmitted Infection (STI) treatment
- Restorative or rehabilitative services (in a place other than a nursing facility)
- Specialist visits with referrals
- Telemedicine or telehealth services
- Therapy (speech, language, physical and occupational services)
- Tobacco cessation treatment, including pharmaceutical and behavioral support
- Transplant services
- Transportation
- Vision services
- Well-child visits

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

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older enrolled in Medicaid. We are contracted with Delta Dental to provide your dental benefits. You may find more information about your dental benefits in your Delta Dental handbook at www.deltadentalmi.com/Member/Plans/Medicaid-Medicare-Advantage/Healthy-Michigan-Plan

If you have any questions about your dental services, please contact Delta Dental at 866-558-0280 or visit www.deltadentalmi.com/Member/Plans/Medicaid-Medicare-Advantage/Healthy-Michigan-Plan . Please call McLaren Health Plan at 888-327-0671 (TTY: 711) if you need transportation to a dental appointment.

Covered dental services include:

Your dental benefit covers the following services:

- X-rays
- Teeth cleanings
- Deep teeth cleanings
- Sealants
- Root canals
- Crowns
- Care to keep your gums healthy
- Cavity filings
- Extractions (pulling teeth)
- Dentures

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

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

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

Transportation Services

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services covered by your Medicaid Health Plan, and other covered services. In some cases, we may provide bus tokens. If you have your own vehicle or someone else to drive you, you can request mileage reimbursement. There is a review process if you need transportation outside the county you live in.

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

Have this information ready when you call:

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

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor. Let us know if you have additional riders. Door-to-door service is available upon request

and we comply with paratransit via the Americans with Disabilities Act (ADA).You may be asked for additional documentation based on your trip needs.

Please be sure to call us as soon as possible if you need to cancel.

Emergency

Call 911 if you need emergency transportation.

Vision Services

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

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

You do not need a referral to get eye care. You can go to an in-network eye professional every year without a referral if you have diabetes. Call Customer Service at 888-327-0671 (TTY: 711) if you need glasses or an eye exam or find a list of McLaren Health Plan in-network eye care centers at www.mclarenhealthplan.org/mclaren-health-plan/provider-directory-mhp. Talk to your doctor if you have medical eye problems.

Hearing Services

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

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

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

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services, from any provider in our network. Routine and

preventive services include, but are not limited to: prenatal care, breast exams, mammograms, Pap tests, and chlamydia screenings. You don't need a referral or prior authorization. This includes getting routine care from an OB/GYN or Certified Nurse Midwives, even if they aren't your primary care doctor.

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

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

Family Planning Services

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

Family planning services include:

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

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Call your PCP right away if you think you may be pregnant. Your PCP can confirm your pregnancy and help you find a specialist to provide your care. It is very important to see your OB-GYN provider on a regular basis throughout your pregnancy and after you have your baby. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Customer Service at 888-327-0671 (TTY: 711) and your local MDHHS office as soon as you find out you are pregnant so we can provide support. We want to talk to each and every member who is pregnant.

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

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

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

Members identified as currently pregnant are automatically enrolled in the McLaren Miracles program. Members can become ineligible if they are incorrectly identified as being pregnant, are no longer an MHP member (termed/expired) or if the member chooses to opt out of the program. Call Customer Service toll free at 888-327-0671 (TTY: 711) if you have questions or to opt out of this program.

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

Postpartum Care

It's important to take care of yourself after you have a baby. You should have a postpartum checkup 7 to 84 days after your pregnancy. McLaren Health Plan covers this exam and other postpartum services up to 12 months after you have a baby.

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

Call McLaren Customer Service at 888-327-0671 (TTY: 711) and let us know when you have your baby. Call your local MDHHS office too so your records can be updated. This starts the process of signing your baby up for health care services. Your baby is covered by your health

plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Customer Service if you need help.

Change in Family Size

Call Customer Service at 888-327-0671 (TTY: 711) when you experience a change in family size and we will be able to assist you. A change in family size includes marriage, divorce, childbirth, adoption and/or death. Please reach out to your local MDHHS office if there is a change in family size. You can update this information in MI Bridges: www.michigan.gov/mibridges at any time.

Maternal Infant Health Program (MIHP)

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

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

Call Customer Service at 888-327-0671 (TTY: 711) for more information on how you can access these services.

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a

good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral within the McLaren Health Plan network. Children up to three years old should have a developmental screening done with their doctor once a year.

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

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

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

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT is a special health care program for children under 21 years of age who are covered by Medicaid. Under EPSDT, children and teens enrolled in Medicaid receive all recommended

preventive services and any medical treatment needed to promote healthy growth and development.

EPSDT checkups include:

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

Children's Special Health Care Services

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

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

There is no cost for this program. It doesn't change your child's McLaren Health Plan benefits, service, or doctors. CSHCS provides services and resources through the following resources and agencies. CSHCS may have direct access to a specialist as appropriate for conditions and identified needs.

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

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

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

Local County Health Department

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

Children's Special Needs Fund

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

CSHCS member transitioning to adulthood

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

Preventive Health Care for Adults

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

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

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression screening
- Prostate and colorectal screenings

You can also ask your doctor about:

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

Preventive health is also about making the right choices for good health habits. Seeing your doctor for routine care is a good preventive health habit that keeps you healthy. We have

programs to help you make good preventive health choices for yourself and your family.

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

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

Hepatitis C

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

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

Hospital Care

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

You should call your doctor as soon as you are admitted (checked in) to the hospital if it was

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

Emergency Care

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

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

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

Urgent Care and after-hours care

Urgent care centers and after-hours clinics are helpful if you need care quickly but can't see your primary care doctor. You don't need a referral or prior authorization to go to an urgent care center or after hours-clinic in our network.

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

Call your doctor if you aren't sure if you need urgent care. Your doctor may be able to treat you in the office.

Routine Care

Routine care is for things like:

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

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

Mental Health and Substance Abuse Services

We want you to feel your best, including your mental and emotional feelings. To help you, we cover short-term treatment for mental or emotional needs. This applies to members with mild to moderate mental health services. These visits may be with a network therapist, such as a counselor, licensed clinical social worker or psychologist. Telehealth may be an option for you. Talk to your mental health provider to learn more. Treatment for long term, severe mental

conditions, or severe emotional disturbances for children, as well as inpatient and intensive outpatient treatment must be arranged through the local Community Mental Health Services Program (CMHSP) agency. CMHSP can also help refer you to the right local agency when you or a family member has problems or concerns about drugs or alcohol. We encourage you to seek help if you feel you have a substance abuse problem. Call your doctor or Customer Service if you need help getting services.

Signs and symptoms of substance abuse:

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

Call Customer Service at 888-327-0671 (TTY: 711) if you have questions about your mental health or substance abuse benefits. You can also call your local CMHSP agency.

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

Pharmacy Services (Medication)

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

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

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

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

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

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

Home Health Care, Skilled Nursing Services and Hospice Care

There may be a time when you need long-term care. To help you get the care you need, we may cover:

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

Care Coordination

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

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

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

How Can Care Coordination Help You?

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

- Completing assessments and reviewing medications
- Making a plan of care to help you identify and meet your health goals
- Linking you with services and community resources near you, including the local health departments

- Helping you better control your health care needs
- Collaborating with your providers
- Taking a person-centered approach in the management of your care needs by supporting you and your care team with understanding the medical and behavioral health benefits
- Coordination of care between providers, services, and social support providers

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

Community Health Workers

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

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

Contact Customer Service for more information.

Durable Medical Equipment

Some medical conditions need special equipment. Durable Medical Equipment (DME) we cover includes:

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

support body parts that may be deformed.

You need a prescription from your doctor to get DME. You may also need prior authorization from McLaren Health Plan. You must get your item(s) from an in-network provider. To find an in-network DME provider, use our provider directory at www.mclarenhealthplan.org/Medicaid-member/find-a-provider-medicaid or call Customer Service at 888-327-0671 (TTY: 711).

Benefits Monitoring Program

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

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

Using the right health services in the right amount helps us make sure you're getting the very best care. Call Customer Service at 888-327-0671 if you have questions about the BMP.

Tobacco Cessation

We want to help you quit smoking. Talk to your doctor about quitting if you smoke. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. McLaren Health Plan also can help you. Call Customer Service at 888-327-0671 (TTY: 711) to get more information. We cover the following services to help you:

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

- Lozenges

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

Cost Sharing and Copayments

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

You must go to a doctor in McLaren Health Plan Medicaid network, unless otherwise approved. If you go to a doctor that is not in McLaren Health Plan Medicaid network and did not get approval to do so, you may have to pay for those services. You should not receive a bill from your doctor for covered services within the plan's network.
Call Customer Service at 888-327-0671 (TTY: 711) if you get a bill for services that should be covered.

Services Covered by Medicaid not McLaren Health Plan

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

Member Reimbursement
You should not pay a provider for a covered service (other than copayments noted above if they apply). If you do – and you can prove that you have – McLaren Health Plan may reimburse you for those services.

- You must provide written proof of the payment within 12 months of the date of service and complete a Direct Member Reimbursement form. You can call Customer Service at 888-327-0671 (TTY: 711) to request a form. The form will have instructions on how to submit it.
- Claims submitted more than 12 months after the date of service will not be paid.
- Services must be a covered benefit and McLaren Health Plan will reimburse you the amount that would have been paid to the provider, which may be less than what you paid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. Talk with your doctor or your local Department of Health and Human Services if you have questions about these services. You also can contact the Michigan

Beneficiary Helpline at 800-642-3195.

- Dental services for all enrollees under age 21 (Except HMP enrollees aged 19 and 20)
- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance use disorder services through accredited providers including:
    - Screening and assessment
    - Detox
    - Intensive outpatient counseling
    - Other outpatient care
    - Methadone treatment and other substance use disorder treatment
- Services, including therapies (speech, language, physical, occupational), provided to persons with intellectual and/or developmental disabilities which are billed through Community Mental Health Services Program Providers or Intermediate School Districts
- Custodial care in a nursing facility
- Home and Community-based Waiver Program services
- Personal care or home help services
- Transportation for services provided to persons with developmental disabilities which are billed through CMHSP
- Coordination of care initiatives identified by MDHHS

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, and live in Wayne, Oakland, and Macomb counties, call ModivCare at 866-569-1902 to arrange a ride. If you do not live in Wayne, Oakland, or Macomb counties, contact your local MDHHS office.

MDHHS office locations and phone numbers may be found at: www.michigan.gov/mdhhs/inside-mdhhs/county-offices

Non-Covered Services

- Elective abortions and related services

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

Rights and Responsibilities

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

You have the Right to:

- Receive information about your health care services
- Be treated with dignity and respect
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- Have your personal and medical information kept private
- Participate in decisions regarding your health care, including the right to refuse treatment, to obtain a second opinion and express preferences about treatment options
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Request and receive a copy of your medical records, and request those be amended or corrected
- Be furnished with health care services consistent with State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you
- To file a grievance or an appeal, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act. Including the right that you or a provider cannot be penalized for filing a complaint or appeal in compliance with federal and state laws
- Be free from other discrimination prohibited by State and federal regulations
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand
- Receive Federally Qualified Health Center and Rural Health Center services
- To request information regarding provider incentive arrangements including those that

cover referral services that place the provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided

- To request information on the structure and operation of McLaren Health Plan
- To make suggestions about our services and providers
- To make suggestions about member rights and responsibilities policy
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval
- Exercise your rights without adversely affecting the way the plan, providers or the State treats the enrollee
- To 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 female members who are pregnant have the right to continue coverage from a terminated provider that extends to the postpartum evaluation of the member, up to six weeks after delivery
- To have a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage
- To obtain a current directory of participating providers and access to a choice of specialists within the network who are experienced in treatment of chronic disabilities with a referral, including the right to obtain routine OB/GYN and pediatric covered services from network providers without a referral request

You have the Responsibility to:

- Review this handbook and McLaren Health Plan Certificate of Coverage
- Make and keep appointments with your McLaren Health Plan doctor
- Treat doctors and their staff with respect
- Protect your Medicaid ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give McLaren Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.

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

Grievances and Appeals

We want you to be happy with the services you get from McLaren Health Plan and our providers. If you are not satisfied, you can file a grievance or appeal.

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

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

Grievance Process

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

- Your provider or a McLaren Health Plan staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.

- You were unhappy with the quality of care or treatment you received.
- Your provider or a McLaren Health Plan staff member was rude to you.
- Your provider or a McLaren Health Plan staff member was insensitive to your cultural needs or other special needs you may have.

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

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

Give us as much information as you can in the grievance letter. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling 888-327-0671 (TTY: 711). We will let you know when we have received your grievance either orally or in writing within five days of receipt. We may contact you for more information.

At any time during the grievance process, you can have someone you know represent you or act on your behalf. This person will be your representative. If you decide to have someone represent you or act for you, inform McLaren Health Plan in writing with the name of your representative and their contact information. Your grievance will be reviewed by staff not previously involved in your grievance. They will also not be a subordinate to any person involved in your grievance. If required, we will use an appropriate clinical person to review your grievance. Your grievance will be resolved within 30 calendar days of submission. Individuals who make decisions on your grievance will not be involved in previous levels of review. They also will not be a subordinate to any person who made decisions. If required, we will use an appropriate clinical person. McLaren Health Plan has a two-step process for reviewing grievances. We will complete Step 1 within 15 days of receipt of the grievance. McLaren Health Plan will provide you with a written decision. If you are not happy with our decision, you may move to Step 2 by appealing to McLaren Health Plan in writing or by phone within five days of our decision letter. McLaren Health Plan will review your grievance appeal and provide a final decision within 30 days from the initial grievance receipt. We will send you a letter of our decision.

Expedited (Fast) Grievances
We will treat your grievance as *fast* if a doctor confirms the 30-day time frame would risk your life or your ability to regain the most function. Call McLaren Health Plan to file an expedited grievance. We will decide quickly. We will call you and your doctor to tell you of our decision

within 72 hours. After we call you, we will send you a letter with our decision within two days. You can, but you don't have to, file an appeal of an expedited grievance with us.

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

Appeal Process

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

- The adverse benefit determination the contractor has made or intends to make
- Your right to be provided upon request and free of charge, copies of all documents, records, and other information used to make our decision.
- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a State Fair Hearing/External Review and how to do it
- Your right in some circumstances to ask for an expedited appeal and how to do it
- Your right to ask to have benefits continue during your appeal, how to do it, and when you may have to pay for the services

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination that either suspends, reduces, or terminates services you previously were receiving. McLaren Health Plan's adverse notice to suspend, reduce or terminate a service will occur at least 10 days before the change in services. The list below includes examples of when you might want to file an appeal.

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

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

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

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

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

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

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

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

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

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

You have several options for assistance. You may:

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

- Choose to be represented by a legal professional.

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

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

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

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

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

Things to keep in mind during the appeal process:

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

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

How Can You Expedite Your Appeal?

If you or your provider believes our standard timeframe of 30 calendar days to make a decision on your appeal will seriously jeopardize your life, health, or ability to regain the most function due to your health situation you can ask for an expedited appeal by writing or calling you're your doctor may confirm the need for expedited appeal by phone. Expedited appeals are only available for pre-service adverse benefit determinations. This includes requests about admissions, continued stay or other health care services if you received emergency services but have not discharged from the facility. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal.

We may decide not to treat your appeal as expedited. If so, we will make reasonable efforts to call you and tell you this. We will also mail you a letter within two days of your request to tell you we will not treat your appeal as expedited. Your appeal will be treated as standard.
If we accept your expedited appeal, we will let you know within 24 hours if we need more information. Once all information is provided, we will call you within 72 hours from the time of your request to inform you of our decision and will also send you and your authorized representative the Notice of Internal Appeal Decision within two days.

You or your authorized representative may file a request for an expedited external review at the same time you file a request for an expedited internal appeal with McLaren Health Plan. If you choose to file a request for an external expedited review, your internal appeal will be pended until DIFS decides whether to accept your request. If DIFS accepts your request, you will be considered to have exhausted the internal appeal process with McLaren Health Plan. DIFS will make a decision on your appeal.

How Can You Withdraw an Appeal?

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

What Happens Next?

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

State Fair Hearing Process

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

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

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

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

External Review of Appeals

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

Send your request to:

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

Community-Based Supports and Services

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

- Do you and your family struggle with having enough to eat?
- Do you need help finding a place to stay, or do you need heating assistance?
- Do you need a ride to your doctors' appointments?
- Do you need help with employment?

We can help if you answered yes to any of the above questions. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. Reach out to your McLaren Health Plan nurse if you're struggling with a similar problem, or need assistance. Please call Customer Service at 888-327-0671 (TTY: 711) if you don't have a McLaren Health Plan nurse and need help.

You also can access resources at the following:

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

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

Care Management

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

- Coordinate care between health care providers
- Set personal goals to manage your medical conditions
- Talk to your doctors or other providers when you need help
- Understand your medical conditions
- Access community-based supports, services, and resources
- Member or practitioner referral in the language of your choosing

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

Some of our available chronic care programs include:

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

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

Make Your Wishes Known: Advance Directives

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

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

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

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

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

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

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

Questions? Call Customer Service at 888-327-0671 or TTY 711. Visit our website at www.mclarenhealthplan.org

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

Help Identify Health Care Fraud, Waste and Abuse

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

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

Fraud

Fraud is purposefully misrepresenting facts.
Here are some examples of fraud:

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

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

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

Waste

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

Examples of waste by a member include:

- Using transportation services for non-medical appointments

Examples of waste by a doctor or provider include:

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

Abuse

Abuse is excessively or improperly using those resources.

Examples of Abuse by a member include:

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

Examples of abuse by a doctor or provider include:

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

You can Help

We work to find, investigate, and prevent health care fraud. You can help and help protect yourself from being a victim of fraud.

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

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

need

- You are one of the first lines of defense against fraud. Do your part and report services or items that you have been billed for but did not receive.
- Review your plan explanations of benefits (EOBs) and bills from physicians and report any items or services that you did not receive by:
    - Making sure you received the services or items billed
    - Checking the number of services billed
    - Ensuring the same service has not been billed more than once

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

You also can write to McLaren Health Plan at:
McLaren Health Plan, Inc.
Attn: Compliance
P.O. Box 1511
Flint, MI 48501-1511

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

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

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

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

You may also contact the State of Michigan if you think a member has committed fraud, waste or abuse by:

- Filling out a fraud referral form at www.mdhhs.michigan.gov/Fraud OR
- Call the MDHHS office in the county where you think the fraud, waste or abuse took place or
- Call the MDHHS office in the county where the member lives

Helpful Definitions

These managed care definitions will help you better understand certain actions and

services throughout this handbook.

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

Denies your request for:

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

Reduces, limits, or denies coverage of:

- A health care service
- A supply or item
- A prescription drug you already got

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

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

Does not provide timely medical services

Copayment: A set amount you may be required to pay as your share of the cost for a medical service or supply. This may include:
• A doctor's visit
• Hospital outpatient visit
• Prescription drug

A copayment is usually a set amount. You might pay $2 or $4 for a doctor's visit or prescription drug.

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

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

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

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

Emergency Room Care: Care given for a medical emergency when you think that your health is in danger.

Emergency Services: Review of an emergency medical condition and treatment to keep the condition from getting worse.

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

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

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

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

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

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

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

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

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

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

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

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

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

- Doctors
- Hospitals
- Pharmacies

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

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

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

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

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

- Services
- Medical equipment or
- Prescriptions

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

Premium: The amount paid for health care benefits every month. McLaren Health Plan

premiums are paid by the State on behalf of eligible members.

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

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

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

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

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

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

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

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

- Nurses
- Technicians
- Therapists

Specialist: A licensed physician specialist that focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions.

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

Notice of Privacy Practices

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 provider 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 provider 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 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 purpose

Who to Contact. To exercise any of your rights, to obtain additional copies of this Notice or if you have any questions about this Notice please write to:
McLaren Health Plan
Attn: Privacy Officer
P.O. Box 1511
Flint, MI 48501-1511

Additional Information:
Find the Notice on Our Website: You can also view this Notice of Privacy Practices on our website at www.mclarenhealthplan.org/uploads/public/documents/healthplan/documents/MHP%20Documents/NoticeofPrivacyPracticeMHP.pdf

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

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

McLaren Health Plan complies with all applicable federal and state laws, including:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
- The Rehabilitation Act of 1973.
- Title IX of the Education Amendments of 1972 (regarding education programs and activities).
- Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.