McLaren HEALTH PLAN

Member Complaint/Grievance Procedure

A complaint/grievance is something you are unhappy with. You can call or write to McLaren Health Plan when you have a problem. We would like to hear what you think so we can make our services better. We want to know if you have a complaint about a doctor's office. You can tell us if you think the office was not clean or safe. You can also tell us if there was not enough space in the waiting room or the exam room. In this case, Customer Service will help you.

To report a grievance, call Customer Service at (888) 327-0671. They will help you fill out a form to begin looking into the problem.

McLaren Health Plan has a process for complaints/grievances. A special person handles the complaints/grievances. We will get back to you within 30 calendar days, except if waiting that long would hurt your health. In those cases, we will get back to you within 3 calendar days.

Member Appeals Procedure

If McLaren Health Plan has decided to deny, terminate, or reduce any covered service, you can file an appeal. You can call or write to McLaren Health Plan when you want to appeal a denial by calling Customer Service at (888) 327-0671. If needed, Customer Service can help you file an appeal. A special committee will discuss your problem. You also have the right to go to a hearing if you wish (see Fair Hearing Process).

If you want to request an appeal with McLaren Health Plan's Appeals Committee, you or your authorized representative must send your request **in writing within 90 calendar days** of McLaren Health Plan's answer to your complaint or denial of services. If you choose to have an authorized representative request an appeal for you, you must sign an authorized representative form. The authorized representative form is on our website at MclarenHealthPlan.org or you can get one by calling Customer Service at (888) 327-0671. McLaren Health Plan cannot start the appeals process until we receive your signed authorized representative form.

You have the right to submit written comments, documents, or other information relevant to the appeal with your appeal request.

Once McLaren Health Plan receives your appeal request, we will send you a letter within 5 calendar days telling you that we received your appeal. The letter will also tell you about the appeals process and the time and location of the appeal meeting. You or your authorized representative will be given the opportunity to speak before the committee in person or by telephone.

If your appeal request is about a denial for medical services, McLaren Health Plan will make sure that a Physician Advisor who was not involved in the denial reviews the appeal case. McLaren Health Plan will also make sure that the Physician Advisor that reviews the appeal case has the appropriate clinical expertise.

McLaren Health Plan has 30 calendar days to complete the process regarding your concern. McLaren Health Plan may use a 10 business day extension only when we have not received requested additional information from a health care facility or doctor and the extension helps the member or if the member requests the extension.
When McLaren Health Plan makes a decision subject to appeal, McLaren Health Plan will provide a written adverse action notice to you and the requesting provider, if applicable. Adverse action notices for the suspension, reduction, or termination or services must be made at least 12 days prior to the change in services. McLaren Health Plan will continue your benefits if all the following conditions apply:

- The appeal is filed timely, meaning on or before the later of the following
  - Within 10 days of McLaren Health Plan mailing the notice of action
  - The intended effective date of McLaren Health Plan's proposed action
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment

- The services were ordered by an authorized provider
- 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 benefits will be continued until one of the following occurs:

- You withdraw the appeal
- You do not request a fair hearing within 10 days from when McLaren Health Plan mails an adverse action notice
- A State Fair Hearing decision adverse to you is made
- The authorization expires or authorization service limits are met

If McLaren Health Plan reverses the adverse action decision or the decision is reversed by a State Fair Hearing, McLaren Health Plan will pay for services provided while the appeal was pending and authorize or provide the disputed services promptly, and as expeditiously as your health condition requires.

Expedited Appeal

An expedited appeal can be requested if your doctor believes that the normal appeal timeframes would seriously harm your health or life. An expedited appeal request should be made by calling Customer Service at (888) 327-0671. McLaren Health Plan will tell you and your doctor our decision of your expedited appeal within 72 hours and send you written notice within 2 calendar days. You may request a 10 day extension of an expedited appeal, once you request an extension. McLaren Health Plan may deny the request for an expedited appeal and move the appeal to the 30 day timeframe.

You will receive a written notice from McLaren Health Plan within 3 calendar days of the appeal meeting. The written notice will tell you McLaren Health Plan's decision and the benefit and medical necessity information that was used in making the decision. If your appeal was approved, you will be given information on how to get your benefits.

If, after your appeal, you are still unhappy with the decision that McLaren Health Plan has made about your grievance, you can ask for an external appeal. You must do this within 60 calendar days of receiving our appeal decision. Call Customer Service to get the form you need or call the Office of Financial and Insurance Regulation at (877) 999-6442.

Fair Hearing Process

You may also file a complaint directly with the Michigan Administrative Hearing Systems (MAHS) for the Michigan Department of Community Health (MDCH). You must file your complaint with MAHS within 90 days of your denial from McLaren Health Plan.

You do not have to file a complaint with McLaren Health Plan Customer Service before you contact MAHS. Listed below are the steps for MAHS's Medicaid fair hearing process.

Step 1: Call (877) 833-0870 or email the MAHS at administrativetribunal@michigan.gov to have a hearing request (complaint) form sent to you. You may also call to ask questions about the hearing process.
Step 2: Fill out the request (complaint form) and return it to the address listed on the form.
Step 3: You will be sent a letter telling you when and where your hearing will be held.
Step 4: The results will be mailed to you after the hearing is held. If your complaint is taken care of before your hearing date, you must call to ask for a hearing request withdrawal form. You can call (877) 833-0870 or email MAHS at administrativetribunal@michigan.gov to request that form.