[Insert Plan Handbook Cover Page (include date of revision)]

[Plans may add their own graphic designs throughout the handbook]

Contents

Welcome to [Insert Plan Name]

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

This handbook is your guide to the services we offer. It will also give you helpful tips about [Insert Plan Name]. Please read this book and keep it in a safe place in case you need it again. If you need another copy, it is available upon request and free of charge by contacting [Member Services]. You can also access this handbook on our website at [Insert web address].

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 [Insert Plan Info] for help getting an interpreter or to ask for our materials in another language or format to meet your needs. [Insert Plan Name] complies with all applicable federal and state laws with this matter.

[Requirement: Must be available in a prevalent language when more than 5% of the enrollees speak a prevalent language]

¿Habla español? Por favor contacte a al [Insert Plan Info].

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 [Insert Information].

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, transcription services, and assistive listening devices. We offer the Member Handbook and other materials in Braille and large print upon request and free of charge. Call [Member Services] at [Insert Health Plan Info] to request materials in a different format to meet your needs.

[Insert Plan Name] 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

[Plans should add operating hours where applicable]

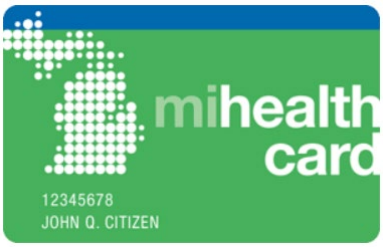
[Member Services] Toll-Free Help Line	[Insert Health Plan Info Here]
[Member Services] Help Line TTY/TDD	[Insert Health Plan Info Here]
Website	[Insert Health Plan Info Here]
Address	[Insert Health Plan Info Here]
24 Hour Toll-Free Emergency Line	[Insert Health Plan Info Here]
24 Hour Toll-Free [Nurse] Line	[Insert Health Plan Info Here]
Pharmacy [Services]	[Insert Health Plan Info Here]
Transportation Services (non-emergency)	[Insert Health Plan Info Here]
Dental Services	[Insert Health Plan Info Here]
Vision Services	[Insert Health Plan Info Here]
Mental Health Services	[Insert Health Plan Info Here]
To file a complaint about a health care facility	[Insert Health Plan Info Here]
To file a complaint about Medicaid services	[Insert Health Plan Info Here]
To request a Medicaid Fair Hearing	[Insert Health Plan Info Here]
Grievance and Appeals	[Insert Plan Info Here]
To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults	[Insert number and website]
To report Medicaid fraud and/or abuse	[Insert Health Plan Info Here]
To find out information about domestic violence	[Insert Health Plan Info Here]
To find information about urgent care	[Insert Health Plan Info Here]
[Other Health Plan Specific Contact Info Here]	
[Other Health Plan Specific Contact Info Here]	
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	**https://www.michigan.gov/mdhhs/inside-mdhhs/county-offices**

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

Identification Cards

YOUR STATE ISSUED MEDICAID ID CARD

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



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

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

YOUR [INSERT PLAN NAME] MEMBER ID CARD

You should have received your [Insert Plan Name] 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.

[Insert Health Plan Sample Card Photo(s)]

If you have questions about this coverage or need a new [Insert Plan Name] Member ID card, you should call [Member Services] at [Insert Plan Info]. [If applicable, enter any plan specific information regarding the Member ID card].

Important ID Card Notes

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

Getting Help from [Member Services]

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

CONTACT US

You may call us at [Insert Plan Information], or TTY [Insert Information], [Insert Days and Times].

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 [Insert Plan Information].

OUR WEBSITE

You can visit our website at [Insert Health Plan Web Address] to access online services such

as:

- [Insert Health Plan Specific Info]
- [Insert Health Plan Specific Info]
- [Insert Health Plan Specific Info]
- [Insert Health Plan Specific Info]

CONFIDENTIALITY

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

MANAGE YOUR DIGITAL HEALTH RECORDS/MEMBER MOBILE APPLICATION

[Insert plan specific information and name this section in accordance with the program offered. (If not applicable, do not add this section.)]

Transition of Care

If you're new to [Insert Plan Name], 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 [Insert Plan Name] 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 [Insert Plan Name]
- The doctor does not meet [Insert Plan Name] policies or criteria

[Insert Plan Name] will help you choose new doctors and help you get services in our network.

Your doctor may call [Member Services] if they want to be in our network.

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

Please contact us at [Insert contact information] to request transition of care services or if you have any questions about your care.

Getting Care

CHOOSING A PRIMARY CARE PROVIDER

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

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

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

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

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

You can use our Provider Directory to find doctors and specialists that are in our network. The Provider Directory lists addresses, office hours, languages spoken, and information about accessibility. It is located at [Insert Link]. 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 [Insert Plan Information]. Remember provider information changes often. Visit our website for the most up-to-date information. Call [Member Services] if you need help finding a doctor.

You can also get medical care from these types of medical providers: Federally Qualified

Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable).

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

Make sure you ask the provider office if they participate in the [Insert Plan Name] network.

[Plan must add restrictions, if any, on the Enrollee's freedom of choice among network providers.]

GETTING CARE FROM YOUR DOCTOR

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at [Insert Plan Info].

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 plan does not require referrals, please modify.]

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your doctor or call [Member Services] for more information.

OUT-OF-NETWORK SERVICES

You must get most of your care from providers in our provider network. [Member Services] can help you find a provider in our network.

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

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

Out of County Services

[Insert plan specific information.]

Out of State Services

All services out of the state require prior authorization. [Plans may update this section as needed if they have network providers that are located out of state.]

Out of Country Services

Health care services provided outside the country are not covered by [Insert Plan Name].

PHYSICIAN INCENTIVE DISCLOSURE

[Insert plan specific Physician Incentive Disclosure]

PRIOR AUTHORIZATION

[If applicable, plans may insert utilization management information in this section.]

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

GETTING A SECOND OPINION

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a [insert plan name] network provider. Second opinions [do/do not] require prior authorization from us. Please call [Member Services] to learn how to get a second opinion.

Information About Your Covered Services

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

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

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. [Insert Plan information, such as the COC is available on our website (include link and/or webpage address) or COC is included with this handbook.]

Make sure a service is covered before the service is done. You may have to pay for services not covered by [Insert Plan Name] under the Medicaid program.

[Insert Plan Name] does not deny reimbursement or coverage for services on any moral or religious grounds. [If applicable] [For plans that elect not to provide a counseling or referral service because of moral or religious objections, the explanation must include information on how the enrollee may access these services.]

TELEHEALTH/TELEMEDICINE SERVICES

[Plans should add any plan specific information needed in this section]

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

BENEFITS MONITORING PROGRAM

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper

use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

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

Using the right health services in the right amount helps us make sure you're getting the very best care.

Covered services include:

[Plans should list their covered services in this section (including pharmacy information and value added benefits.) Include any PA requirements and additional coverage information such as, any service limitations or exclusions.]

CARE COORDINATION

[Plans should add or remove information based on what your plan offers.]

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

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

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

How Can Care Coordination Help You?

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

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

Call [Member Services] for more information about the care coordination program.

CARE MANAGEMENT

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

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

If you are interested in joining this program, please call [Member Services] to be connected with a care coordinator.

CHILDREN'S HEALTH

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

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

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

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

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

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

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

[**Note to Plans:** When including coverage throughout model handbook, in areas where EPSDT services might be applicable, include language that differentiates EPSDT members from typical benefit, and include any service limits.]

EPSDT checkups include:

Well-care visits	Physical and mental developmental/behavioral assessments
Health history and physical exam, including	Crucial lab tests, including lead screening

school and sports physicals	
Developmental screening	Nutrition assessment
Health education guidance	Immunizations
Hearing, vision, and dental screening assessment	Follow-up services

Children's Special Health Care Services

[Plans may insert any plan specific information of services available if applicable.]

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 [Insert Plan Name].

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

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

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

Local County Health Department:

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

COMMUNITY HEALTH WORKERS (CHW)

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

- Meeting face to face to improve your access to health care
- Helping 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 [Member Services] for more information.

DENTAL SERVICES

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with [Insert dental vendor name] to provide your dental benefits. [If plan does not have a separate vendor, change this sentence to, "We are contracted with many dentists to provide dental benefits."]

If you have any questions about your dental services, please contact [Insert dental vendor name and contact information.]

Covered dental services include:

[Plans should list their covered dental services in this section. Include any PA requirements and additional coverage information such as, any service limitations or exclusions.]

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. The two plans available are Blue Cross Blue Shield of Michigan and Delta Dental of Michigan. You will get an identification card and Member

Handbook from the dental plan you are enrolled in. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at 800-642-3195 for help.

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

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

DURABLE MEDICAL EQUIPMENT

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

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

To get durable medical equipment, you need a prescription from your doctor. You may also need prior authorization from us. You must get your item from a network provider. To find network durable medical equipment providers, call [Member services].

EMERGENCY CARE

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

Convulsions	Broken bones
Uncontrollable bleeding	Loss of consciousness (fainting or blackout)

Chest pain	Jaw fracture or dislocation
High fever	Tooth abscess with severe swelling
Serious breathing problems	Knife or gunshot wounds

If you believe you have an emergency, call 911 or go to the emergency room. You do not need an approval from [Insert Health Plan Name] 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.

[If MHP offers ILOS, include the following.]

FOOD SERVICES

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

[MHPs only list those that are offered.]

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

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

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

Keep reading to learn more about your food service options and if you may qualify for a food service, or. If you have any questions, call [insert Member services information] for more information [or insert any additional information needed to direct MHP enrollees to request ILOS.]

Medically Tailored Home Delivered Meal [If Offered]

Through the Medically Tailored Home Delivered Meal service, you will receive up to two healthy meals delivered to your home for [insert duration]. These meals are tailored to your health needs.

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

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

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, diabetes during pregnancy, other pregnancy complications, a substance use disorder or a mental health disorder; ***OR***
- Have been in a hospital or skilled nursing facility in the last 90 days.

[Plans may insert any plan specific information of services available if applicable.]

Healthy Home Delivered Meal [If Offered]

Through the Healthy Home Delivered Meal service, you will receive up to two healthy meals per day delivered to your home for [insert duration].

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

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder; ***OR***
- Have been in a hospital or skilled nursing facility in the last 90 days; ***OR***

- Are likely to end up in the hospital or another facility if they cannot access healthy food; ***OR***
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, a mental health condition ***OR***
- Used to be in foster care and is at risk of developing an illness; ***OR***
- Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food; ***OR***

- Are a child eligible for the Children's Special Health Care Services (CSHCS) program; ***OR***
- Are an adult eligible for the Persons with Special Health Care Needs (PSHCN) program; ***OR***
- Have a disability.

[Plans may insert any plan specific information of services available if applicable.]

Healthy Food Pack [If Offered]

Through the Healthy Food Pack service, you will be able to pick up a mix of healthy foods or have them delivered to your home [MHP inserts frequency and duration].

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

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder; ***OR***
- Have been in a hospital or skilled nursing facility in the last 90 days; ***OR***
- Are likely to end up in the hospital or another facility if they cannot access healthy food; ***OR***
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, a mental health condition ***OR***
- Used to be in foster care and is at risk of developing an illness; ***OR***
- Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food
- Are a child eligible for the Children's Special Health Care Services (CSHCS) program; ***OR***
- Are an adult eligible for the Persons with Special Health Care Needs (PSHCN) program; ***OR***
- Have a disability.

[Plans may insert any plan specific information of services available if applicable.]

Produce Prescription [If Offered]

Through the Produce Prescription service, you will receive a voucher to buy fruits and vegetables for [insert frequency and duration].

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

- Have an illness that can be improved with a healthy diet, like diabetes, heart conditions, stroke, lung disorders, hypertension, human immunodeficiency virus (HIV), cancer, obesity, oral health disease, sickle cell disease, renal/kidney disease, a substance use disorder or a mental health disorder; ***OR***
- Have been in a hospital or skilled nursing facility in the last 90 days; ***OR***
- Are likely to end up in the hospital or another facility if they cannot access healthy food; ***OR***
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, preterm labor, an infection, and a mental health condition ***OR***
- Used to be in foster care and is at risk of developing an illness; ***OR***
- Are a child that has too much lead in their blood, lives in a stressful environment or will develop an illness without access to healthy food
- Are a child eligible for the Children's Special Health Care Services (CSHCS) program; ***OR***
- Are an adult eligible for the Persons with Special Health Care Needs (PSHCN) program; ***OR***
- Have a disability.

HEALTHY BEHAVIORS

You may be eligible to participate in a healthy behavior incentive program. [Insert any other plan specific programs your health plan offers] To get more information, call [Member services].

HEARING SERVICES

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

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

If you need a hearing exam or think you need hearing aids, call [Insert plan or vendor name and contact information]. You can also call a provider from our list of hearing providers.

HEPATITIS C

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

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

HOME HEALTH CARE, SKILLED NURSING SERVICES AND HOSPICE CARE

[Plans should add any plan specific information needed in this section]

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

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

HOSPITAL CARE

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

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

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

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

If you have questions about your mental health or substance abuse benefits call [Insert plan information]. You can also call your local CMHSP agency.

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

OBSTETRICS AND GYNECOLOGY CARE

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network [or outside our network (if applicable)]. You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN 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 [Member Services] 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
- [Plans may add additional bullets if applicable.]

Pregnancy Services

[Plans may insert vendor partner contact information in this section if applicable. Plans may also insert other plan specific services if applicable.]

If you are pregnant, early and regular checkups can help protect you and your baby's health. 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 [Member Services] and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

Postpartum Care

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

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

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

Change in Family Size

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

Maternal Infant Health Program (MIHP)

[Plans may insert vendor partner contact information in this section if applicable.]

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

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

Call [Member Services] for more information on how you can access these services.

PREVENTIVE HEALTH CARE FOR ADULTS

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

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

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

You can also ask your doctor about:

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

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

You can improve you and your family's health by taking responsibility and following healthy behaviors. Getting needed yearly preventive care is the first step! Some other things you

should and should not do to take control of your health are listed below.

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

ROUTINE CARE

Routine care is for things like:

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

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

TRANSPORTATION SERVICES

Non-Emergency

Your Medicaid benefit provides options for transportation. We provide transportation free of charge for doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly. In some cases, we may provide bus tokens or if you have your own vehicle or someone else to drive you, you can request mileage reimbursement.

Please call [Member Services- direct member where to schedule] for more information and to schedule a ride. Please call [2-3 days] before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

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

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.
If you are receiving services through the local Community Mental Health Services Program (CMHSP) agency, there may be some transportation services that you will continue to receive through the local CMHSP agency. Contact your local CMHSP agency for questions about this benefit.

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

[Plans should enter any plan specific information as needed.]

Emergency

If you need emergency transportation, call 911

URGENT CARE AND AFTER-HOURS CARE

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

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

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

VISION SERVICES

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

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

You do not need a referral to get eye care. If you need glasses or an eye exam, call [Insert plan or vendor name and contact information]. You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Community-Based Supports and Services

We want to provide efficient and appropriate care in a timely manner. We also connect our members to community resources. [If applicable, insert any other community support services your plan offers]

- 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?

If you answered yes to any of the above questions, we can help. We know it's difficult to get to your doctor for important health screenings or other care when you're facing these challenges. If you're struggling with a similar problem, or need assistance, reach out to your [Care Manager]. If you don't have a [Care Manager], and need help please call [Member Services] at [Insert Health Plan TN]. TTY users should call [Insert Health Plan Info].

You can also access resources at the following:

- Online through our website: [Insert address]
- Online through the State of Michigan portal: https://newmibridges.michigan.gov

- 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 [Member Services] for assistance.

[Plans may insert any plan specific information of services available if applicable.]

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. [Insert Health Plan Name] 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 [Insert Health Plan Name] Medicaid network, unless otherwise approved. If you go to a doctor that is not in [Insert Health Plan Name] 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. [Insert any other plan specific information regarding copays]. If you have questions about how co-pays may apply to you, contact [Insert member services number].

Services Covered by Medicaid Not [Insert Health Plan Name]

[Insert health plan name] does not cover all services that you may be eligible for as a member of Medicaid.

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. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at 800-642-3195.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services

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

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, contact [Insert member services number].

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. This Medicaid Health Plan and any of its affiliated providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your health care services
- 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 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, to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act
- 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 the [Insert Health Plan Name]
- 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

You have the Responsibility to:

- Review this handbook and [Insert Health Plan Name] Certificate of Coverage
- Make and keep appointments with your [Insert Health Plan Name] 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 your Health Plan and your doctors as much info about your health as possible
- Learn about your health status
- Work with your doctor to set care plans and goals
- Follow the plans for care that you have agreed upon with your doctor
- Live a healthy lifestyle
- Make responsible care decisions
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to https://newmibridges.michigan.gov/.

Grievances and Appeals

[Plans may add information about dental appeals in this section, if applicable]

We want you to be happy with the services you get from [Insert Health Plan Name] 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 [Insert Health Plan] at [Insert Health Plan TN] (TTY: XXX).

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. [Insert Health Plan Name] 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(n) [Insert Health Plan Name] staff member did not respect your rights.
- You had trouble getting an appointment with your provider in an appropriate amount of time.
- You were unhappy with the quality of care or treatment you received.
- Your provider or a(n) [Insert Health Plan] staff member was rude to you.
- Your provider or a(n) [Insert 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 [Insert Health Plan] at [Insert Health Plan TN] (TTY: XXX). You can also file your grievance in writing via mail or fax at:

[Insert Health Plan Contact Information]

In the grievance letter, give us as much information as you can. For example, include the date and place the incident happened, the names of the people involved and details about what happened. Be sure to include your name and your Medicaid member ID number. You can ask us to help you file your grievance by calling [Insert Health Plan TN] (TTY: XXX). We will let you know when we have received your grievance. 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 [Insert Health Plan Name] in writing with the name of your representative and their contact information. Your grievance will be resolved within [90 - If less than 90, enter info. here] calendar days of submission. We will send you a letter of our decision.

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. 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

You can file your appeal on the phone by calling [Insert Health Plan] at [Insert Health Plan TN] (TTY: XXX). You can also file your appeal in writing via mail or fax at:

[Insert Health Plan Information]

You have several options for assistance. You may:

- Call [Member Services] 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 Appeals form]. You may call and request the form or find this form on our website at [Insert Health Plan Information].

We will send you a notice saying we received your appeal. We will tell you if we need more information and how to give us such information in person or in writing. 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.

[Insert Health Plan Name] will send our decision in writing to you within 30 calendar days of the date we received your appeal request, or within 10 calendar days if you are receiving CSHCS benefits. [Insert Health Plan Name] may request an extension up to 14 more days in order to get more information before we make a decision. You can also ask us for an extension if you need more time to get additional documents to support your appeal.

We will call you to tell you our decision and send you and your authorized representative the Notice of Internal Appeal Decision. The Notice of Internal Appeal Decision will tell you what we will do and why.

If [Insert Health Plan Name]'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 [Insert Health Plan Name]'s decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

Things to keep in mind during the appeal process:

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

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 or health, you can ask for an expedited appeal by writing or calling us. If you write to us, please include your name, member ID number, the date of your Notice of Adverse Benefit Determination letter, information about your case, and why you are asking for the expedited appeal. We 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.

How Can You Withdraw an Appeal?

[If needed, plans may update this information to be plan specific.]

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. [Insert 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 [Insert Health Plan] at [Insert Health Plan TN] (TTY: XXX).

What Happens Next?

After you receive the 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 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 [Insert Health Plan name and number] if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

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

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

External Review of Appeals

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

Send you request to:

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

Make Your Wishes Known: Advance Directives

[Plans may insert plan specific information regarding your Advance Directives policy.]

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

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

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

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

Call [Member Services] for more information and the forms you need to write an advance directive.

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

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

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

Help Identify Health Care Fraud, Waste and Abuse

Medicaid pays doctors, hospitals, pharmacies, clinics, and other health care providers to take care of adults and children who need help getting medical care. Sometimes, providers and patients misuse Medicaid resources. Unfairly taking advantage of Medicaid resources leaves less money to help other people who need care. This is called fraud, waste, and abuse.

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
- Billing for services that were not provided
- Billing for the same service more than once

Waste

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

- Using transportation services for non-medical appointments
- Doctors ordering excessive or unnecessary testing
- Mail order pharmacies sending you prescriptions without confirming you still need them

Abuse

Abuse is excessively or improperly using those resources. Here are some examples of abuse:

- 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

You Can Help

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

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

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. [Insert plan fraud contact information, including information for a 24/7 fraud hotline, website, email and/or mailing address].

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

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

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

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

Helpful Definitions

These managed care definitions will help you better understand certain actions and services throughout this handbook. [Plans may insert other definitions as applicable.]

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

Denies your request for:

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

Reduces, limits, or denies coverage of:

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

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

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

Does not provide timely medical services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Doctors
- Hospitals
- Pharmacies

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

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

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

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

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

- Services

- Medical equipment or
- Prescriptions

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

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

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

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

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

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

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

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

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

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

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

- Nurses
- Technicians

- Therapists

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

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

Notice of Privacy Practices

[Plans should insert their plan specific information, whether it is the notice or a link to where the member can find the notice, etc.]

[Plans should continue to send pertinent info with the notices and taglines.]