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

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

Questions? Call [Member Services] at [insert plan info] or TTY [insert plan info]. Visit our website at [insert plan info]

Contents

Welcome to [Insert Plan Name]

[Insert Plan Name] has a contract with the Michigan Department of Health and Human Services to provide dental services to people under 21 with Medicaid. This is called the Healthy Kids Dental Program. You are enrolled in Healthy Kids Dental with [Insert Plan Name]. We work with a group of dental care providers 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].

*In this handbook we will use the words “you” and “your” to refer to the enrollee and/or the parent or guardian of the enrollee.

Interpreter Services

We can get an interpreter to help you speak with us or your dentist in any language. We also offer our materials in other languages. Interpreter services and translated materials are free for our members. 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]

Si usted no habla inglés, llámenos al [Insert Plan Info. Including TTY]. Ofrecemos servicios de interpretación y podemos ayudarle a responder preguntas en su idioma. También podemos ayudarle a encontrar un proveedor de salud que pueda comunicarse con usted en su idioma.

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

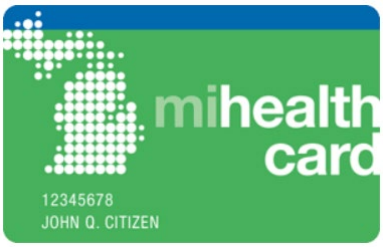
[Plans should add operating hours where applicable]

[Member Services] Help Line	[Insert Dental Health Plan Info Here]
[Member Services] Help Line TTY/TDD	[Insert Dental Health Plan Info Here]
Website	[Insert Dental Health Plan Info Here]
Address	[Insert Dental Health Plan Info Here]
24 Hour Dental Emergency Line	[Insert Dental Plan 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
Transportation Services (non-emergency)	Members enrolled in a Medicaid Health Plan should contact their health plan for transportation services. Aetna Better Health of MI: 1-844-610-7437 Blue Cross Complete of MI: 1-888-803-4947 HAP CareSource: 1- 833-230-2053 McLaren Health Plan: 1-855-251-7100 Meridian Health Plan of MI: 1-888-437-0606 Molina Healthcare of MI: 1-888-898-7969 Priority Health Choice: 1-888-975-8102 UnitedHealthcare Community Plan: 1-877-892-3995 Upper Peninsula Health Plan: 1-800-835-2556 If you are not in a Medicaid Health Plan and are a resident of Wayne, Oakland, or Macomb counties contact ModivCare at: 866-569-1902. If you are not in a Medicaid Health Plan and do not live in Wayne, Oakland, or Macomb counties contact your local MDHHS office. MDHHS office locations and phone numbers may be found at: https://mdhhs.michigan.gov/CompositeDirPub/CountyCompositeDirectory.aspx
To report suspected cases of abuse,	1-855-444-3911

neglect, abandonment, or exploitation of children or vulnerable adults	
To report Medicaid fraud and/or abuse	1-855-MI-Fraud (643-7283) [Insert Dental Plan Info Here also]
To file a complaint about a dental care facility	Add number and website
To request a Medicaid Fair Hearing	[Insert info]
To file a complaint about Medicaid dental services	[Insert info]
Grievance and Appeals	[Insert Dental Plan Info Here]
To find information about urgent care	[Insert info]
Women, Infants and Children (WIC)	1-800-942-1636
Free service to find local resources. Available 24/7	2-1-1
In an emergency	911
[Other Dental Health Plan Specific Contract Here]	
[Other Dental Health Plan Specific Contract Here]	

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 Dental 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 your mihealth card and Member ID card 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 visit 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 [Member Services]

Our [Member Services] Department can answer all of your questions. We can help you choose or change your Dentist, 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].

[Plans may add additional **contact information** specific to their plan. This may include

enrollee benefit to utilize care coordinators, etc.]

For **urgent** dental concerns regarding you or your child's health after hours, we can connect you to our Dental Emergency Help Line for assistance. Call [Insert Plan Information].

Our Website

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

- [Insert Dental Health Plan Specific Info]
- [Insert Dental Health Plan Specific Info]
- [Insert Dental Health Plan Specific Info]
- [Insert Dental 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] and were receiving covered services from regular Medicaid or another Healthy Kids Dental Health Plan in the last 6 months, we can help you continue your care. You can continue to access and receive services that you have been receiving, if without these continued services, you would suffer serious harm to your oral health. This is called continuity of care.

- You, your provider, or your appointed representative may ask for continuity of care for you.
- Requests can be made by contacting [Member Services].
- Requests can be made verbally or in writing. Please include the name of the provider, contact person, phone number, service type and appointment date, if applicable.
- Visit our website [Add link to TOC policy] or call [Member Services] for more

information. We can help to make sure you receive continued services throughout your transition.

Choosing A HKD Dentist

You may choose any [Insert Plan Name] HKD dentist. You can choose a different HKD dentist for each family member or you can choose one HKD dentist for the entire family. You may switch to a different HKD dentist at any time. You may choose to see a pediatric dentist for routine and preventive health services. You can also get dental care from these types of dental providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHCs), Indian Health Care Providers (IHCPs) (as applicable), mobile dental facilities, and through the SEAL! program.

Make sure you ask the dental office if they participate in the [Insert Plan Name] HKD network. If they do not, you may be responsible to pay for the services provided. Contact [Member Services] for more information.

You can use our Provider Directory to find HKD dentists and dental 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 also request a paper copy of our provider directory, free of charge by calling [Insert Plan Information]. Call [Member Services] if you need help finding a HKD dentist.

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

Getting Care from Your HKD Dentist

Your general dentist office should be your primary care for oral health. You should see your dentist at least twice a year for cleanings and checkups. Call your dentist office to make an appointment or if you have questions about your dental 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.

Specialist Referrals and Out-of-Network Services

If you need care that a general dentist cannot give, they will refer you to a dental specialist who can. Your HKD dentist works with you to choose a specialist and arrange your care. Talk with your dentist or call [Member Services] if you have any questions about how referrals work.

If you think a specialist does not meet your needs, you can talk to your dentist or call [Member

Services] to help you find a different specialist.

[There are some treatments and services that your dentist must ask [Insert Plan Name] to approve before you can get them. Your dentist will be able to tell you what they are.]

If you are having trouble getting a referral you think you need, contact [Member Services].

If there are no dentists or specialists in our provider network in your area who can give you the care you need, we will get you the care you need from a dentist or specialist outside our plan. This is called an out-of-network referral. It is important that you get approval from [Insert Plan Name] before you see an out-of-network provider. We will only cover the services by an out-of-network dental provider if you have approval before your appointment. You may have to pay for any out-of-network services not authorized by [Insert Plan Name]. [All services out of the state require prior authorization except in cases of emergency.] Prior authorization is not required for emergency dental services. If you need help or have any questions, please call [Member Services].

Covered Services

It is important you understand the benefits covered under your plan. As a Healthy Kids Dental member, you do not have to pay co-pays for covered services.

If there are changes in covered services or other changes that will affect you, we will notify you in writing at least 30 days before the date the change takes place.

Your Certificate of Coverage (COC) has the complete list of covered care. The COC is available on our website. If you want a printed copy of the COC or have questions regarding your benefits, contact [Member Services].

[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.]

Covered services include:

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

Be sure to ask your dentist if a service is covered <u>before</u> the service is done. You must pay for services not covered by [Insert Plan Name] under the Healthy Kids Dental program.

Some services <u>NOT</u> covered are:

- Orthodontic Services
- Full mouth or panoramic X-rays under age 5
- Bridges, inlays and onlays
- Bite Splints, mouthguards, sports appliances
- Bite Guards
- Removal of healthy third molars (wisdom teeth)
- Implants
- Cosmetic dentistry
- Treatment of TMJ
- Nitrous Oxide
- Cone Beam CTs
- Services covered under a hospital, surgical/medical, or prescription drug program

  *NOTE: If your child has certain medical or dental conditions, some services may be covered under the Children's Special Health Care Services (CSHCS) program. Contact your local health department regarding CSHCS eligibility.

Information About Your Covered Services

Prior Authorization [Pre-Treatment Estimate can be inserted here]

Some services may need to be approved before you or your child can get them. This is called Prior Authorization (PA). Your dentist 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 can get the care. If we do not approve the service, we will notify the dentist and send you a written notice of the decision. [This section may be removed if it does not apply to your plan.]

Transportation Services

Non-Emergency

Your Healthy Kids Dental benefit provides options for transportation to and from dental office visits. If you need transportation to or from an appointment, and are also enrolled in a Medicaid Health Plan (MHP), call your MHP to arrange for a ride. If you are not enrolled in a MHP and live in Wayne, Oakland and Macomb counties, call ModivCare at (866)569-1902 to arrange a ride. If you are not enrolled in a MHP and 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/dhs-countyoffices

Emergency

If you need emergency transportation, call 911

Pregnant Women

Oral care is 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.

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.

All infants, children and teens should receive regular well-child check-ups of their physical and mental health, growth, development, and nutritional status. PCPs should provide an oral health screening and caries risk assessment for beneficiaries at each well-child visit as recommended by the American Academy of Pediatrics periodicity schedule.

For children's oral health, coverage includes regular preventive dental care and treatment to relieve pain and infections, restore teeth, and maintain dental health and emergency, preventive, and therapeutic services for dental disease that, if left untreated, may become acute dental problems, or cause irreversible damage to the teeth or supporting structures.

Children's Health

Helping your child have healthy teeth starts at birth. Your baby's gums should be wiped twice a day. Use a wet gauze pad or a clean, damp cloth. Gently wipe all the surfaces of your baby's gums. The first dental visit should occur within six months after your baby's first tooth appears, but no later than the child's first birthday.

When your baby has teeth, start using a soft infant toothbrush and a smear of fluoride toothpaste (about the size of a grain of rice). Do not worry about your baby not being able to spit out the toothpaste. The toothpaste left in your baby's mouth helps to protect teeth.

A visit to the dentist can keep you or your children from getting cavities, gum disease, and other problems. Children should see a dentist within 90 days of enrollment in the HKD program. After the first appointment, your child should see the dentist once every 6 months or sooner if a dental problem arises. Regular dental visits can prevent major problems that cause

children to miss school and parents to miss work. Be sure to schedule the next dental visit before leaving the dentist's office.

Keep your teeth healthy with these tips:

- Brush twice a day
- Floss daily
- Do not share toothbrushes
- Replace toothbrushes every three to four months
- Store toothbrushes with bristles on top
- Do not cover toothbrushes- they need to dry out
- Children should never be put to bed with juice or milk. This can rot the teeth
- Only water should be given after brushing at bedtime
- Use soap and water to clean baby bottles, sippy cups, pacifiers, and teething toys
- Talk to your dentist if your child uses a pacifier or sucks their fingers or thumbs
- Babies and toddlers should drink fluoridated water and use fluoride toothpaste
- Eat a well-balanced diet and avoid sugary foods and drinks

Dental Emergency Care

A dental Emergency is a service needed to control bleeding, relieve pain, get rid of acute infection, prevent loss of teeth, and treat injuries. If you have a dental emergency, call your dental office, and ask what you should do. If you need help finding a dentist, call [Insert plan and phone information]. We will give you a list of dentists, including after-hours dentists available in your area.

You have the right to use any provider, hospital, or other setting for emergency dental services.

If you are not in Michigan when a dental emergency happens, you can call [insert plan name and phone information] for help finding a dentist. The HKD program will cover the service even if it is not a [insert plan name] HKD dentist. A prior authorization is not needed for emergency services.

If you or your child is having a life-threatening emergency, call 911 or go to the emergency room. You do not need approval from [Insert Dental Health Plan Name] or your dentist before getting emergency care.

If you or your child have gone to the emergency room or a dentist outside of your area for a dental emergency, call your dentist for a follow-up appointment.

Cost Sharing and Copayments

You do not have to pay a co-pay or other costs for covered services under the HKD program. You must go to a dentist in [Insert Dental Health Plan Name] HKD network, unless otherwise approved. If you go to a dentist that is not in [Insert Dental Health Plan Name] HKD network and did not get approval to do so, you may have to pay for those services.

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 Dental Health Plan and any of its network providers will comply with the requirements concerning your rights.

You have the Right to:

- Receive information about your dental 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 dental records, and request those be amended or corrected
- Be furnished dental services consistent with this Contract and State and federal regulations
- Be free to exercise your rights without adversely affecting the way the Dental Health Plan, providers, or the State treats you
- 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, Rural Health Center, Indian Health Coverage Program (as applicable) and mobile dental facility, and SEAL! Services

- To request information regarding provider incentive arrangements including those that cover referral services that place the dental 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 Dental Health Plan]

You have the Responsibility to:

- Review this handbook and [insert Dental name] Certificate of Coverage
- Make and keep appointments with your [insert Dental name] HKD dentist
- Treat dentists and their staff with respect
- Protect your Medicaid and Healthy Kids Dental ID cards against misuse
- Contact us if you suspect fraud, waste, or abuse
- Give your Dental Plan and your dentists as much info about your health as possible
- Learn about your health status
- Work with your dentist to set care plans and goals
- Follow the plans for care that you have agreed upon with your dentist
- Live a healthy lifestyle
- Make responsible care decisions
- Tell your local MDHHS office if your contact info (like your address or phone number) changes

Grievances and Appeals

We want you to be happy with the services you get from [Insert Dental Health Plan Name] and our providers. If you are not happy, 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 dentist. Your dentist can often handle the problem. If you have questions or need help, call [Member Services] at [Insert 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 dentist, you can file a grievance at any time. [Insert

Dental 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 Dental 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 Dental Health Plan] staff member was rude to you
- Your provider or a(n) [Insert Dental 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 Dental Health Plan] at [Insert Dental Health Plan TN] (TTY: XXX). You can also file your grievance in writing via mail or fax at:

[Insert Dental 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 Dental 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 Dental Health Plan Name] in writing the name of your representative and their contact information. Your grievance will be resolved within 90 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 Dental Health Plan 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 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 Dental Health Plan] at [Insert Dental Health Plan TN] (TTY: XXX). You can also file your appeal in writing via mail or fax at:

[Insert Dental 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 dentist 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 Dental 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 Dental Health Plan Name] will send our decision in writing to you within 30 calendar days of the date we received your appeal request. [Insert Dental 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 Dental 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 Dental Health Plan Name]'s decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services to start 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 Dental 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?

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 Dental 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 Dental Health Plan] at [Insert Dental 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 have the right to a State Fair Hearing with the state of Michigan. Your dentist or representative could also ask for a hearing. You must complete an appeal with us before you can ask for a State Fair Hearing. You must make your request for a State Fair Hearing within 120 calendar days from the date on the Notice of Internal Appeal Decision.

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 Notice of Internal Appeal Decision. A Request for Hearing form will be included with the Notice that you receive from us.

Send your request per the instructions on the form to:

Michigan Department of Health and Human Services
Michigan Administrative Hearing System (MOAHR)
PO Box 30763
Lansing, MI 48909
Or call: 800-648-3397
Fax: 517-763-0146

Call [Member Services] if you need a hearing request form sent to you or if you need help completing the request.

External Review of Appeals

Our decision on your appeal is final. If you do not agree with our final decision, you can ask for an external review from the Michigan Department of Insurance and Financial Services. You must complete an appeal with us before you can ask for an external review. You must make your request for an external review within 127 calendar days from the date on the Notice of Internal Appeal Decision.

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 Resources

For help finding community-based support services in your area, call 211 or visit 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.

Help Identify Fraud, Waste and Abuse

Medicaid pays dentists, 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 is purposefully misrepresenting facts.
- Abuse is excessively or improperly using those resources.
- Waste occurs from practices that result in unnecessary costs.

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 dentist is the same dentist 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 dentist told you

Health care fraud is a felony in Michigan. Some common ways fraud is committed include:

- Letting someone else use your HKD and/or Medicaid ID card. Only you have permission to use your card to get covered services.
- Falsifying medical bills, claims and other documents.
- Using an expired ID card to obtain products or services.
- Trying to get payment from multiple insurance policies for the same illness or injury.

Being involved in fraud or abuse can put your benefits at risk or make other legal problems. Help minimize fraud and abuse. If you suspect fraud, you can report it anonymously by calling our fraud hotline.

[Insert Dental Health Plan fraud TN] [Insert hours and/or alternative ways member can report fraud. Also indicate if there is a way to report 24 hours a day, 7 days a week]
Or visit our website at [Insert Dental Health Plan Fraud Info]. If you notice any problems or want to report fraud, waste, or abuse, you may also write:

[Insert Dental Health Plan Info]

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.

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

Denies your request for:

- A dental service
- A dental appliance or device

Reduces, limits or denies coverage of:

- A dental service

- A dental appliance or device

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

- A dental service
- A dental appliance or device

Does not provide timely dental services

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

- A dental visit
- A dental appliance or device

Dental Health Plan: A plan that offers dental services to members who meet State eligibility rules. The State contracts with certain dental organizations to provide dental services for those who are eligible. The State pays the premium on behalf of the member.

Dental Insurance: Dental insurance is a type of coverage that pays for dental costs for people. It can pay the person back for costs from dental injury or treatment. It can also pay the provider directly. Dental insurance requires the payment of premiums (see premium) by the person getting the insurance.

Emergency Dental Condition: A dental injury or condition so serious that you would seek care right away to avoid harm.

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

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

Excluded Services: Dental 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).

Medically Necessary: Dental services or supplies that meet accepted standards of dental practices needed to diagnose or treat an oral health:

- Injury

- Condition
- Disease or
- Symptom

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

- Dentists
- Dental Specialists

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

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

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

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

- Services
- Appliances or devices

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 dental benefits every month. Dental Plan premiums are paid by the State on behalf of eligible members.

Provider: A person, place or group that's licensed to provide dental services like dentists

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

Urgent Care: Care for a dental injury or condition bad enough to seek care soon but not bad enough that it needs emergency room care. Urgent dental care can be treated with a quick dental appointment.