WELCOME LETTER

Dear Meridian Member,

Thank you for choosing Meridian Health Plan! We are here to provide quality health care to you and your family.

Meridian covers a wide range of care. This handbook helps you know your benefits and helps you get the care you need.

We want you to be happy with your health care. Please call Member Services toll-free at 888-437-0606 if you have any questions.

You can also visit our website for more information (www.mhplan.com). Please call Member Services at 888-437-0606 if you need a printed copy of any website information.

The Member Handbook is reviewed once a year. We will notify you through newsletters and other mailings if there are changes to the handbook.

Thank you again for joining the Meridian family.

Wishing you good health,

David B. Cotton, M.D.
Dr. David B. Cotton, MD
CEO
Meridian Health Plan
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MEMBER SERVICES

Welcome to Meridian Health Plan!

Our Member Services team is ready to help you get the most from Meridian. Call us toll-free at 888-437-0606. We are here to help Monday – Friday from 8 a.m. – 8 p.m.

We can help you if you need:
- More info about your benefits
- Help finding a Primary Care Provider (PCP)
- To do a Health Risk Assessment (HRA)
- To change your PCP
- A new Meridian ID card or handbook
- To change your address or phone number
- To get basic plan info

Be sure to have your Medicaid ID number ready when you call.

Your Member ID Card
You have two ID cards: your Meridian ID card and your MiHealth (Michigan Medicaid) card. Your Meridian card tells you if you are on our Healthy Michigan Plan. Keep both cards with you at all times.

Your MiHealth card lists this info:
- Your name
- Medicaid ID number

Your Meridian ID card lists this info:
- Your name
- Medicaid ID number
- Member Services phone number
- Other special instructions and info
Important ID Notes

- Bring both ID cards with you when you go to the doctor or pharmacy
- Do not let anyone else use your cards
- You may also need to show a picture ID. This is to make sure the right person is using the card
- Call your caseworker as soon as you can when you have a baby. Your caseworker will add your baby to your case. This starts the process of signing your baby up for Meridian
- Your baby is covered by Meridian at the time of birth. You need to call and tell us:
  - The day you gave birth
  - Your baby’s name
  - Your baby’s Medicaid ID number that you get from your caseworker
  - We will send you an ID card and info within 30 days of getting this info
- Call 888-437-0606 if you need help choosing a doctor for your baby
- Call your caseworker to change your records if your name changes

Call 888-437-0606 if you do not have your Meridian Member ID card. Call the Michigan Beneficiary Help Line at 800-642-3195 if you do not have your MiHealth card.

Interpreter Services

We can arrange for an interpreter to help you speak with us or your doctor in any language. Interpreter services are free for our members. Call 888-437-0606 for help.

¿Habla español? Por favor contacte a Meridian al 888-437-0606.

Hearing and Vision Impairment

We offer TTY/TDD services free of charge if you have hearing problems. The TTY/TDD line is open 24/7 at 711.

We offer the Member Handbook and other materials in Braille if you have vision problems. Our website also has buttons to make the print bigger and simpler to read.
Routine Transportation
You have options for transportation to and from the doctor, behavioral health visits, pharmacies, durable medical equipment vendors and health departments. You can also get paid back for gas for driving yourself to and from office visits. You should call 800-821-9369 at least five days before your appointment to talk about your options.

Have this info ready when you call:
- Your name, Medicaid ID number and date of birth
- The address and phone number where you will be picked up
- The address and phone number where you are going
- Your appointment date and time
- The name of your provider

Call 800-821-9369 to learn more about your transportation options or to set up or cancel your ride. You should call as soon as you can if you need to cancel.

BENEFITS

Care Covered by Meridian
This is a list of care you can get with Meridian. Your Certificate of Coverage (COC) has the complete list of covered care. Call 888-437-0606 if you want a printed copy of the COC or have questions.

NOTE: You may have co-pays for covered care if you are a part of our Healthy Michigan Plan. See page 18 for more info. See the section after for prior authorization info.

| Behavioral Health | Outpatient Behavioral Health (BH) | BH offers emotional support, guidance and counseling options. You are covered for 20 visits each calendar year (Jan. 1 – Dec. 31). It is covered without a referral. Our BH staff can help you get the care you need. Call 888-222-8041 for help.
| Children’s Care | Newborn Care | Newborn screenings are covered. Circumcisions done on male newborns before leaving the hospital are covered. |
## Children’s Care

**Immunizations & Vaccines (shots)**
You can get these at the doctor’s office or the local health department. They are covered according to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics vaccination schedule.

**Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (under age 21)**
Covered care include:
- Well-child visits
- Developmental screening
- Vision testing
- Behavioral screening
- Immunizations
- Hearing testing

**Lead Screening**
Lead screenings can be done at the doctor’s office or local health department. The first blood lead test should be given before age 1. A second test is due before age 2.

**Eye Care and Eyeglasses (under 21 years old)**
Each year you get:
- One eye exam and one pair of glasses
- Two replacement pairs of glasses

More visits and eyeglasses are covered if medically necessary. Other medically necessary treatment for eye illness or injury is covered.

Call your doctor right away if you injure your eye or have other eye problems.

**Office Visits**
Well-child visits, routine visits and sick visits are covered. School and sports physicals are covered. Certified pediatric and family nurse practitioner care is included.

## Women’s Care

**Birth Control**
Covered if on the drug formulary and prescribed by a doctor:
- Oral contraceptives, Depo-Provera shots, IUDs when medically appropriate and diaphragms
- Some over-the-counter family planning supplies (foam, condoms, spermicidal jelly or cream)
- Emergency contraceptive pills, as needed
<table>
<thead>
<tr>
<th><strong>Women’s Care</strong></th>
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<tbody>
<tr>
<td><strong>Family Planning</strong></td>
<td>Family planning care is covered with no out-of-pocket costs. Both men and women can get this care. Family planning helps you plan when you want to add to your family. You are covered for:</td>
</tr>
</tbody>
</table>
|                        | - Doctor visits  •  Exams  •  Pregnancy testing  
|                        | - Birth control counseling  
|                        | - Birth control methods (condoms, pills, IUDs)  
|                        | - Testing for sexually transmitted infections  
|                        | - Voluntary sterilization  •  HIV/AIDS testing and care  
|                        | This care is private. You do not need a referral for this care. Your doctor or Obstetrician/Gynecologist (OB/GYN) can give this care. |
| **Obstetric & Maternity Care** | Each pregnant member has a Maternity Care Coordinator who helps find and set up all needed care. |
|                        | You are covered for:  
|                        | - Doctor and hospital care before your baby is born (prenatal care)  
|                        | - Delivery  
|                        | - Care after birth (postpartum care)  
|                        | - Certified midwife care  
|                        | - Birthing and parenting classes  
|                        | You may choose an Obstetrician (OB) or OB/GYN for prenatal and postpartum care without a referral.  
|                        | You can stay in the hospital up to two days after a normal vaginal delivery and up to four days after a Cesarean delivery. |
| **Well-Care for Women** | You may see an OB or OB/GYN routine care without prior authorization. Covered care includes:  
|                        | - One routine gynecological exam every 12 months  
|                        | - Mammogram/Breast Cancer Screening (ages 40 and older)  
|                        | - Surgical breast biopsy  
|                        | Treatment of breast cancer (reconstructive plastic surgery, chemotherapy and/or radiation therapy, physical therapy, psychological and social support services and other services when medically necessary and ordered by your doctor). |
| **Sterilization**       | Sterilization needs prior authorization.  
| **Abortions**           | Covered if medically necessary as defined by Michigan state law. |
## Emergency and Urgent/Hospital Care

### Emergency Room Care, Ambulance & Other Emergency Transportation

Emergency care is for a medical issue that is a threat to your life or that can badly harm your health if you do not get care right away. Here are some examples of emergencies:

- Convulsions
- Uncontrollable bleeding
- Chest pain
- High fever
- Serious breathing problems
- Knife or gunshot wounds
- Broken bones
- Loss of consciousness (fainting or blackout)

**Emergency care does not need prior authorization. You can get this care out-of-network, including post-stabilization care.** Post-stabilization care includes the care you get after an emergency to make you stable or to maintain, improve or resolve your health condition.

Ambulance services for emergency transportation are covered. Hospital-billed ambulance services to and from a nursing facility or your home is also covered.

<table>
<thead>
<tr>
<th>Medical Inpatient Care</th>
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<tbody>
<tr>
<td>Hospital inpatient care is covered when medically necessary.</td>
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<tr>
<th>Urgent Care Visits</th>
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<tr>
<td>Urgent care is for problems that need prompt medical attention, but are not life threatening. Here are some examples of urgent care:</td>
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<td>- Sore throat or cough • Back pain • Tension headache</td>
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<tr>
<td>- Earache • Flu or cold symptoms • Frequent urination</td>
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<tr>
<td>- Minor sickness • Minor injury</td>
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<tr>
<td>Visits to urgent care are covered.</td>
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</table>

### Outpatient Care

<table>
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<tr>
<th>Office Visits</th>
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<tr>
<td>Office visits (routine physical exams, routine care and sick visits) are covered.</td>
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</table>

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<thead>
<tr>
<th>Cardiac &amp; Pulmonary Rehab</th>
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<tbody>
<tr>
<td>Covered when medically necessary with prior authorization.</td>
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<tr>
<th>Home Health Care</th>
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<tr>
<td>Care given in the home by a home health care agency, registered nurse, licensed practical nurse or physical therapist is covered. The caregiver must be certified by us first.</td>
</tr>
</tbody>
</table>

Custodial care (care provided by non-skilled or non-licensed person) is not covered, even if you get home health care with custodial care.
<table>
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<tr>
<th><strong>Outpatient Care</strong></th>
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</table>
| **Rehabilitative and Habilitative Services and Devices** | This type of care is given after serious illness or injury to restore function:  
  - Physical therapy • Occupational therapy  
  - Speech/language therapy • Reconstructive Surgery  
  - Chiropractic Care (see section below) • Prosthetics  
  - Orthotics • Medical equipment • Medical supplies  
  
  Prior authorization is needed.  |
| **Skilled Nursing Facility** | We may cover care given in a skilled nursing facility, inpatient rehabilitation or hospice facility (such as a nursing home). There is a 45-day limit for this care. Prior authorization is needed.  |
| **Specialty Care (Office Visits & Clinics)** | You do not need prior authorization to see a specialist. Talk to your doctor to see if you need specialty care. Your doctor will refer you to a specialist if needed.  |
| **Diagnostic Testing** | These lab tests are covered:  
  - Blood tests • Anemia testing  
  - Urinalysis and urine cultures  
  - Pregnancy testing • Radiology services (x-rays)  
  
  Other tests are also covered. Audiology services need prior authorization.  |

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<tr>
<th><strong>Surgery</strong></th>
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</table>
| **Inpatient, Ambulatory, Outpatient, Emergency & Reconstructive Surgeries** | Outpatient/ambulatory surgeries may be performed in a hospital or in a freestanding surgical care center. Surgery for medical emergencies is covered.  
  
  Plastic surgery is only covered when it is medically necessary to treat illness or injury. Oral surgery is covered only for diseases of the mouth and jaw and unplanned injury. Breast reconstruction surgery is covered after a mastectomy (breast removal). Breast reduction surgery is covered when medically necessary.  
  
  Surgeries are covered when asked for by a Meridian doctor. All surgeries and some services need prior authorization.  |
| **Transplants** | Transplant surgery and the facility need prior authorization. It must be medically necessary and non-experimental. These organ transplants are covered:  
  - Cornea • Heart • Lung • Kidney • Bone marrow • Liver • Pancreas • Small bowel  |
### Hospice

**Hospice Care**
Hospice care is for people with an illness causing limited life expectancy as determined by your doctor. It is most often given in the home. Your doctor will help you arrange the care you need. Hospice care needs prior authorization.

### Other Covered Care & Programs

| Asthma Care | Covered equipment, supplies and care include:  
|            | • Peak flow meters • Spacers • Nebulizers & masks  
|            | • Regular doctor visits • Specialist visits  
|            | • Other supplies needed to manage asthma  
|            | • Certified asthma education classes  
|            | Only medications on the drug formulary are covered. |

| Care Coordination | The Care Coordination program links you to services and resources. This helps improve your health by coordinating your care team and doctors. See page 26 for more info. |

| Chiropractic care | You can get up to 18 visits each year without prior authorization. Prior authorization is needed for more visits. |

| Dental Care  
(covered for those with Healthy Michigan Plan only) | Covered care includes:  
|            | • Diagnostic • Preventive • Restorative • Prosthetic  
|            | • Medically/clinically necessary oral surgery (including extractions)  
|            | We are contracted with a dental vendor for your dental check-ups. Call 855-898-1478 to find a dentist  
|            | Orthodontic care (braces) is not covered. |

| Diabetes Care | Covered equipment, supplies and care include:  
|              | • Glucometers and lancets • Dilated retinal eye exams  
|              | • Insulin injection aids • Pumps • Some syringes and needles  
|              | • Therapeutic molded shoes • Diabetic nutrition counseling  
| Glucometers and other supplies are sent to you for free by Healthy Living Medical Supply (HLMS). Call HLMS at **866-779-8512** if you have questions about your meter or need more supplies.  
| Only medications on the drug formulary are covered. |

| Dialysis | Dialysis and other medically necessary services are covered if you have End Stage Renal Disease (ESRD). |

<p>| Disease Management (DM) | DM helps you stay on track managing chronic diseases. See page 29 for more info. |</p>
<table>
<thead>
<tr>
<th>Other Covered Care &amp; Programs</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>DME items have a medical purpose. They would not be used if a person did not have an illness. Wheelchairs and hospital beds are types of DME. Most DME is covered. You need a prescription from your doctor and you should use a Meridian DME provider. Some DME may also need medical need determination and/or prior authorization.</td>
</tr>
<tr>
<td><strong>End-Stage Renal Disease (ESRD) Care</strong></td>
<td>ESRD care and dialysis are covered when authorized with the necessary doctor referrals.</td>
</tr>
</tbody>
</table>
| **Eye Care & Eyeglasses (21 and older)** | Every two years you get:  
- One eye exam  
- One pair of glasses  
More visits are covered when medically necessary. Other medically necessary eye treatment is covered.  
Contact lenses need prior authorization and are covered only if medically necessary. |
| **Hearing Services** | Your covered care:  
- Hearing services to evaluate and treat hearing diseases  
- Hearing exams  
- Hearing aid evaluation  
- Hearing aids and fittings  
Call your doctor. A referral, prior authorization and clinical info may be needed to get some of this care. **Hearing aids are covered for those 21 years old and older with the Healthy Michigan Plan.** |
| **Nutritional Classes/Counseling** | Nutritional care/counseling must be given by a licensed dietician. It is covered if you have certain medical conditions. You must be referred by a Meridian doctor. |
| **Podiatry (Foot) Care** | Routine foot care is covered for persons with diabetes. |
| **Prescription and Over-the-Counter (OTC) Drugs** | Most FDA-approved drugs are covered when ordered by your doctor. We only cover drugs on our formulary. We are a mandatory generic plan. A generic drug is equal to a brand-name drug. Generic medications are given when possible.  
Many OTC drugs and supplies are covered when prescribed by one of our doctors and dispensed by an in-network pharmacy. We do not cover prescription drugs that are prescribed for experimental, investigational or non-FDA approved indications, dosages or routes of administration. Please see our formulary at www.mhplan/mi for details. Call 888-437-0606 for a printed copy or if you have questions. |
<table>
<thead>
<tr>
<th>Other Covered Care &amp; Programs</th>
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<tbody>
<tr>
<td>Preventive &amp; Wellness Care and Chronic Disease Management</td>
<td>We ask that see your doctor within 60 days of choosing or being assigned to a health plan.</td>
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<tr>
<td></td>
<td>Your covered care:</td>
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<tr>
<td></td>
<td>• Yearly check-ups • Immunizations (shots) • Doctor visits</td>
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<tr>
<td></td>
<td>• Hearing check-ups (including hearing aid evaluation)</td>
</tr>
<tr>
<td></td>
<td>• Health education</td>
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<tr>
<td></td>
<td>This care is covered through the Early, Periodic, Screening, Diagnostic and Treatment (EPSDT) program if you are under 21 years of age.</td>
</tr>
<tr>
<td>Prosthetics &amp; Orthotics</td>
<td>These items need prior authorization.</td>
</tr>
<tr>
<td>Weight Management (WM)</td>
<td>WM programs are covered when medically necessary. Prior authorization is needed.</td>
</tr>
<tr>
<td>Smoking cessation (quitting smoking)</td>
<td>We offer our own smoking cessation program. Smoking cessation counseling is covered. Some smoking cessation medicines are covered. These medicines may need prior authorization or step therapy before you can get them. Call 844-854-5576 to get more info and to enroll.</td>
</tr>
<tr>
<td>Transportation (non-emergency)</td>
<td>You have options to get to and from office visits, behavioral health appointments, the pharmacy, DME vendors and health departments. Call <strong>800-821-9369</strong> to talk about your options.</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>A FQHC offers primary and preventive health care. A FQHC may also give oral, mental health or substance abuse care. You can go to any FQHC in any county. You do not need a referral from your doctor.</td>
</tr>
<tr>
<td>Tribal Health Centers</td>
<td>We are contracted with some Tribal Health Centers (THC). Native American members may choose a contracted THC provider as their doctor.</td>
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</tbody>
</table>

*There is not a yearly or lifetime maximum covered benefit as long as you are enrolled with us. We do not deny any service based solely on grounds of moral or religious objection. We are only responsible for services we authorize or are required to cover through the contract with the Michigan Department of Health and Human Services (MDHHS).*

**Care Covered by the MDHHS**

This is a list of care covered by the MDHHS. You must use your MiHealth card to get this care. This is not a full list.
<table>
<thead>
<tr>
<th>MDHHS Covered Care &amp; Programs</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Behavioral Health (BH) &amp; Psychiatric Care</td>
<td>MDHHS covers BH visits after you use the 20 visits we cover.</td>
<td>MDHHS also covers some BH/psychiatric drugs. You may have to</td>
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<tr>
<td></td>
<td>MDHHS also covers this care:</td>
<td>pay a co-pay to get these drugs.</td>
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<tr>
<td></td>
<td>• Intensive outpatient counseling</td>
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<tr>
<td></td>
<td>• Inpatient hospital psychiatric services</td>
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<td></td>
<td>• Outpatient partial hospitalization psychiatric care</td>
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<tr>
<td></td>
<td>• BH care for serious mental illness or severe emotional</td>
<td></td>
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<tr>
<td></td>
<td>disturbances</td>
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<td></td>
<td>• Substance abuse care</td>
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<tr>
<td></td>
<td>Mental health services are coordinated through local Community</td>
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<tr>
<td></td>
<td>Mental Health Services Programs (CMHSPs). Call 888-222-8041 for</td>
<td></td>
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<td></td>
<td>more info on the CMHSP in your county.</td>
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<tr>
<td>Substance Abuse Care</td>
<td>Substance abuse care must be given by an accredited provider.</td>
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<td></td>
<td>It includes:</td>
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<td></td>
<td>• Screening and assessment</td>
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<td></td>
<td>• Detox</td>
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<td></td>
<td>• Intensive outpatient counseling</td>
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<td></td>
<td>• Other outpatient care</td>
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<td></td>
<td>Methadone treatment is also covered. Michigan’s Substance</td>
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<td></td>
<td>Abuse Regional Coordinating Agencies (CAs) provides this care.</td>
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<tr>
<td></td>
<td>Call <strong>888-222-8041</strong> to find a CA near you.</td>
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<tr>
<td>Dental Care (for those under 19 years old)</td>
<td>Dental care is covered for those younger than 19 years old.</td>
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<tr>
<td></td>
<td>You don’t need a referral from your doctor to see your dentist.</td>
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<tr>
<td></td>
<td>Kids should see a dentist starting at age 2. The dentist checks</td>
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<td></td>
<td>their tooth development and you can learn how to keep their</td>
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<tr>
<td></td>
<td>teeth healthy.</td>
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<tr>
<td>Material Infant Health Program (MIHP)</td>
<td>MIHP supports healthy pregnancies and healthy babies. It is</td>
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<tr>
<td></td>
<td>open to all pregnant women and babies with Medicaid.</td>
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<tr>
<td>Nursing Facility</td>
<td>Custodial care only (care provided by a non-skilled or non-</td>
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<tr>
<td></td>
<td>licensed person).</td>
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<tr>
<td>Psychotropic and HIV/AIDS Drugs</td>
<td>MDHHS covers these. Call <strong>800-642-3195</strong> for info.</td>
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<tr>
<td>Therapies (Speech, Occupational &amp; Physical)</td>
<td>This care is given through the Intermediate School District</td>
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<tr>
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<td>for people with developmental disabilities for those under 19</td>
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<td>years old.</td>
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MDHHS Covered Care & Programs

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<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility</td>
<td>MDHHS covers intermittent or short-term restorative or rehabilitative care after the Meridian 45-day benefit is used.</td>
</tr>
<tr>
<td>Traumatic Brain Injury Program</td>
<td>MDHHS offers rehabilitative and home and community-based care to persons who have suffered a qualifying traumatic brain injury (TBI). Call 888-437-0606 for info.</td>
</tr>
</tbody>
</table>

**Non-Covered Care**  
This is a list of non-covered care, treatment and supplies. It is not covered unless required to under State or federal law.

<table>
<thead>
<tr>
<th>Non-Covered Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
</tr>
<tr>
<td>Adaptive aides/self-help items</td>
</tr>
<tr>
<td>Allergy testing</td>
</tr>
<tr>
<td>Biofeedback for Mental Health Diagnoses</td>
</tr>
<tr>
<td>Clinical Ecology and Environmental Medicine</td>
</tr>
<tr>
<td>Cosmetic services</td>
</tr>
<tr>
<td>Custodial care</td>
</tr>
<tr>
<td>Ear plugs</td>
</tr>
<tr>
<td>Educational services and services for behavioral disorders</td>
</tr>
<tr>
<td>Experimental, investigational or unproven services or drugs</td>
</tr>
<tr>
<td>Hair analysis</td>
</tr>
<tr>
<td>Hypnotherapy</td>
</tr>
<tr>
<td>Infertility care and medicine for erectile dysfunction</td>
</tr>
<tr>
<td>Inpatient mental health services</td>
</tr>
<tr>
<td>Leave of absence</td>
</tr>
<tr>
<td>Marital counseling</td>
</tr>
<tr>
<td>No-show charges</td>
</tr>
</tbody>
</table>

What is Medically Necessary?

- Care is covered to prevent, diagnose, correct, improve or cure conditions that endanger life, cause pain, result in illness or could cause or worsen a handicap or physical defect
- “Medically necessary” care must be appropriate for the specific health issue or when no other equally effective care is an option

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Co-Pays and Payments
You have co-pays with our Healthy Michigan Plan. You must pay co-pays to the doctor when you get care before you sign up for a health plan.

Most co-pays are made to the health plan after you are enrolled in one. Co-pays are paid through a special healthcare account called the MI Health Account. Co-pays are not collected for the first six months you are part of our plan. You will pay co-pays to your health plan through the MI Health Account at a later time.

<table>
<thead>
<tr>
<th>Covered Care</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor Office Visit (include free-standing urgent care centers)</td>
<td>$2 per visit if you’re 21 and older</td>
</tr>
<tr>
<td>Outpatient Hospital Clinic Visit</td>
<td>$1 per visit if you’re 21 and older</td>
</tr>
<tr>
<td>Emergency Room Visit for Non-Emergency Care</td>
<td>$3 per visit if you’re 21 and older</td>
</tr>
<tr>
<td>• Co-pay only applies to non-emergency care</td>
<td></td>
</tr>
<tr>
<td>• No co-pay for true emergency care</td>
<td></td>
</tr>
<tr>
<td>Inpatient Hospital Stay (with the exception of emergency admissions)</td>
<td>$50 for the first day of the hospital stay if you’re 21 and older</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>$1 generic drugs if you’re 21 and older</td>
</tr>
<tr>
<td></td>
<td>$3 name-brand drugs if you’re 21 and older</td>
</tr>
<tr>
<td>Chiropractic Visits</td>
<td>$3 per visit if you’re 21 and older</td>
</tr>
<tr>
<td>Dental Visits</td>
<td>$3 per visit</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$3 per aid</td>
</tr>
<tr>
<td>Foot Doctor Visits</td>
<td>$2 per visit if you’re 21 and older</td>
</tr>
<tr>
<td>Vision Visits</td>
<td>$2 per visit if you’re 21 and older</td>
</tr>
</tbody>
</table>

Co-pay exemptions are the same as with Medicaid. Call 888-437-0606 if you have problems with medical bills for covered care. Sometimes you may get a bill for care you got before joining our plan. Call your doctor’s office for help with this type of bill.

Contributions
The Healthy Michigan Plan requires those with yearly incomes between 100% and 133% of the federal poverty level to contribute 2% of their yearly income for cost-sharing. You can reduce your yearly contribution and co-pays if you take part in our healthy behavior activities.
This includes filling out a health risk assessment each year and changing unhealthy behaviors. Total cost sharing (including co-pays) cannot exceed 5% of your yearly income.

**Emergency Care**

Emergency care is for a life-threatening medical situation or injury that can badly harm your health if you do not get care right away.

Here are some examples of emergencies:

- Convulsions
- Uncontrollable bleeding
- Chest pain
- High fever
- Serious breathing problems
- Knife or gunshot wounds
- Broken bones
- Loss of consciousness (fainting or blackout)

Do not drive yourself to the hospital if you think you need emergency care. Call 911 if there is no one to drive you. Call the nearest ambulance service if there is no 911 service in your area.

We cover emergency care given in any in-network or out-of-network hospital. You do not need prior authorization to get emergency care and post-stabilization care. Post-stabilization is care you get after you are stabilized from an emergency. Post-stabilization care lets you stay stable or improve or resolve the condition.

You should call your doctor within 24 hours after you go to the emergency room. Your doctor will make sure you get the follow-up care you need.

**Not sure? Call your doctor.** Call our after-hours line at 888-437-0606 if your doctor does not call you back.

**Prior Authorization**

*What is a Prior Authorization (PA)?*

We cover most care without a referral or medical review. However, some care needs a PA. A PA means that one of our doctors reviews the care request to see if it is the best choice for you. Your doctor has a list of care that needs PA.

Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need care that needs PA. *Note: We must approve the PA request before you can get the care.*
How do I know if the PA is approved?
We tell your doctor when the PA is approved or denied. Call your doctor first to check the status. Call 888-437-0606 if your doctor does not know the status.

Will my PA still apply if I leave Meridian?
Your PA may or may not be accepted if you leave our plan. You need to ask your new insurance if they accept our PAs.

Pharmacy and Prescription Drug Coverage
We are contracted with MeridianRx. MeridianRx is a Pharmacy Benefits Manager (PBM). MeridianRx chooses pharmacies for you to use and what drugs are covered. Visit the MeridianRx website at www.meridianrx.com to find a MeridianRx pharmacy near you. Select “Pharmacy Lookup” under the Quick Links menu. You can also call 866-984-6462 if you need help. We are a mandatory generic plan. A generic drug has the same medicine as a brand-name drug. Generic drugs are used when possible.

Pharmacy FAQs
What is a formulary?
A formulary is a list of safe and covered drugs used to treat sick people and improve health. We use clinical advice from doctors, pharmacists and other medical experts to come up with this drug list. The formulary lists covered prescription drugs and also some over-the-counter medicines. Some drugs are not part of the formulary. We do not cover these drugs.

Your doctor needs to write you a prescription if you need a drug. The current formulary is on our website at www.mhplan.com/mi/member. Look under “Pharmacy Info.” Call 888-437-0606 if you want a printed copy.

What is prior authorization (PA)?
Some drugs in the formulary need prior authorization (PA). This means one of our pharmacists reviews the requested drug to make sure it is the best choice for you. Your doctor needs to fill out a Prior Authorization Request Form and send it to us if you need a drug with a PA. Note: We must approve the PA before you can fill the prescription.

What is step therapy?
Sometimes more than one drug can be used to treat your condition. Step therapy means that one drug must be tried first before another drug can be given. Your doctor or pharmacist can tell you which drug must be tried first.
How can I request a formulary exception?
We do not pay for drugs not in the formulary unless there is an exception. Some drugs are excluded by the State of Michigan. No exceptions can be made for these drugs. Your doctor can ask for a different drug if a formulary drug does not work for you or the drug makes you sick. Your doctor needs to fill out a Formulary Exception Form if a drug is not in the formulary. Note: We must approve the formulary exception before you can fill the prescription.

**MeridianRx Mobile**
You have an easy and convenient way to get your personal health information with the FREE MeridianRx Mobile app. The app has many tools to help you manage your health. You can:
- Get an electronic version of your ID card
- Find your doctor’s info
- Get driving directions to your doctor or pharmacy
- Contact us by phone or email
- View details for any prescription filled in the past 30, 60 or 90 days
- Search for a pharmacy near you
- Stay healthy with wellness reminders

The mobile app works with all Apple or Android phones and tablets. Scan the QR code below to download the FREE app or to learn more. You can find the QR code and more information on the MeridianRx website at www.meridianrx.com.

Call MeridianRx at 866-984-6462 if you have questions.

Scan here to instantly download the FREE mobile app or to learn more!

**Away from Home**
Take these steps if you are away from home and need medical care:
- Call your doctor to talk about your illness or concern if it is not an emergency
- Go to the nearest emergency room or call 911 if it is an emergency

**Moving?**
Don’t forget to call us and Michigan Enrolls with your new address.
- Michigan ENROLLS: 888-ENROLLS (888-367-6557)
- Meridian: 888-437-0606
PRIMARY CARE PROVIDER

Your Primary Care Provider (PCP) gives you most of your care. Your PCP works with you to keep you healthy. Your PCP sends you to other doctors if you need special care.

What is a PCP?

- A person who practices medicine
- A doctor, nurse practitioner, physician assistant or anyone listed in “Choosing Your PCP”

Choosing Your PCP

You can choose your own PCP. You can have one PCP for your whole family or you can choose PCPs for each family member. You can choose one of these providers as your PCP:

- General doctor
- Family doctor
- Nurse practitioner (nurse with special training)
- Physician assistant (supervised by a doctor)
- Internist (doctor for adults)
- Pediatrician (doctor for kids/teens)
- OB/GYN (doctor for women)

KEYS TO CARE

Your PCP’s office is your medical home. They arrange all your health care and make sure you get the care you need.

You can also pick a specialist as your PCP. Call us right away to choose your PCP. We can help you find a PCP near you. We will choose a PCP for you if you did not choose one when you filled out your enrollment paperwork.

You can also find a PCP in the Provider Directory on our website:

www.mhplan.com/mi/providerdirectory

The Provider Directory lists PCPs and their addresses, office hours and languages spoken. It also gives info about doctor specialties and qualifications, like:

- Medical school
- Residency
- Board certification
You can also use the Provider Directory to find specialists, hospitals, pharmacies and other healthcare support. Call 888-437-0606 if you want a printed copy of the Provider Directory.

Visit one of these websites for more info on doctors:
- American Board of Medical Specialties: http://www.abms.org
- American Medical Association: https://apps.ama-assn.org/doctorfinder
- American Osteopathic Association: http://www.osteopathic.org

**Changing Your PCP**
We want you to be happy with your PCP. Call 888-437-0606 if you want to change your PCP. Tell us which new PCP you want. You can also ask to change your PCP through My MHP. My MHP is the secure, member-only online portal. Visit www.mhplan.com/mi/MyMHP to learn more.

We will send you a letter if your PCP leaves our network. We will give you a new PCP within 30 minutes or 30 miles from your home if this happens. You can also choose a PCP from the Provider Directory. We will work with you to make sure your healthcare needs are met.

We track how many times you change your PCP. We have the right to review your PCP change if it could impact your care coordination.

**Getting Care from Your PCP**
Your PCP’s office is your medical home. The office arranges all your health care and makes sure you get the care you need. Your medical records are stored there. You get better care because your PCP knows all of your needs.

You can call your PCP’s office 24/7 if you have questions about your health or medical care.

Call your PCP’s office when you need care. Call us for help setting up a visit.
KEYS TO CARE

Health tips are not clear at times. The Ask Me 3™ program run by the National Patient Safety Foundation can help. The program gives you three questions to ask your doctor during a visit:

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

Asking questions helps you know how to stay well or get better!

For more information on Ask Me 3™, please visit www.npsf.org. Ask Me 3™ is a registered trademark of the National Patient Safety Foundation (NPSF).

Meridian Health Plan is not affiliated with nor endorsed by NPSF.

Your visit is important. Please take it seriously and get to the office 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.

What should you bring to your PCP visit?
- Your member ID card
- Your MiHealth card
- A picture ID
- All of your medicines, vitamins & over-the-counter drugs
- A list of questions you want to ask

You will wait a few minutes after you check-in at the office. You will then wait a few more minutes in the exam room. A normal wait time is 30 minutes. Some wait times may be longer if the doctor has an emergency. Wait times are also longer at walk-in clinics.

Urgent Care and Routine Care

Urgent care is for things like:
- Sore throat or cough
- Back pain
- Tension headache
- Earache
- Flu or cold symptoms
- Frequent urination
- Minor sickness
- Minor injury

These need to be looked at soon, but are not life-threatening. Your PCP should set up a visit with you within one or two days for urgent care.

Routine care is for things like:
- Yearly wellness exams
- School physicals
- Health screenings
- Vision exams
- Lab tests
- X-rays
Your PCP should set up a visit within 30-45 days for routine adult care. A visit for routine child care should be set up within two weeks for children under 18 months old and within four weeks for children over 18 months old.

Call 888-437-0606 if you have questions about wait times to see your PCP.

You can ask for non-urgent care if you’re out-of-county or out-of-state in some situations. You must get prior authorization to do so. One of our doctors reviews the requests and decides if:

- It is medically necessary
- You can get the care from a doctor in our network
- The out-of-state doctor has proper licensing and credentials

**DO I NEED A SPECIALIST?**

Your PCP can give you most of the care you need. Sometimes you need care from a different type of doctor. Your PCP works with you to choose a specialist if you need one. Your PCP arranges your specialist care.

**What is a specialist?**
A doctor for certain types of health care like cardiology (heart health), orthopedics (bones and joints) or gynecology (women’s health).

You can use the Provider Directory to find a list of specialists near you. You can also call 888-437-0606 for help finding one. You can see an out-of-network doctor to give you medically necessary care if there is not a doctor in our network to give you the care you need. We will work with the out-of-network doctor for payment so there is no cost to you.

You can ask for a second opinion about your care at no cost to you. The second opinion can be from one of our doctors or an out-of-network doctor. Call us if you need help getting a second opinion.

**HOSPITAL CARE**

Your PCP sets up your hospital care if you need it. Some other doctor at the hospital may fill in for your PCP to make sure you get the care you need if an emergency happens.
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.

Call your PCP as soon as you are admitted (checked in) to the hospital if it was not arranged by your PCP. Ask a family member or friend to call for you if you cannot. It is important to call your PCP 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.

SPECIAL HEALTHCARE PROGRAMS

Care Coordination
Do you have a chronic health problem or disability? Do you see more than one doctor or need special care? Do you need help with your diet or day-to-day life changes? Do you have a child with special needs and/or disabilities?

It’s easy to feel overwhelmed with being in charge of your care if you have many health issues and see many doctors. It can add more stress to your daily life. We are here to help you!

Our goal is to offer personal care and help make your life better. We have nurses, Care Coordinators, social workers and other health experts to help you get the best care possible from your care team.

What is Care Coordination?
The Care Coordination program focuses on you and your needs. We link you to services and resources near you to help improve your health. We also arrange care with your care team and doctors. This ensures you take care of your health as planned and improves your quality of life.

How can Care Coordination help you?
We give you your own Care Coordinator. This person helps you:
- Make a plan of care to meet your health goals
- Link with services and resources near you
- Control your health issues
- Know your benefits
- Talk about any questions or concerns you have

Call 888-437-0606 for more info about the Care Coordination program.
Maternity Care Coordination
Each pregnant member is paired with a Maternity Care Coordinator who finds and arranges all needed care.

All pregnant women need to start care within the first 12 weeks of their pregnancy. You may see any of our OBs or OB/GYNs without a referral from your doctor. Call your Maternity Care Coordinator if the OB or OB/GYN you want is not in our network. We will work with your doctor to make sure you can keep getting care.

Maternity Care Coordinators help you have a healthy pregnancy by:
- Helping you find an OB or OB/GYN
- Reminding you about prenatal visits
- Completing a prenatal screening. A Case Manager helps you find a high-risk doctor if needed
- Running depression screenings. This is good to do after your baby is born. Your Care Coordinator refers you for behavioral health if needed
- Setting up office visits for you. Your appointments should be at:

<table>
<thead>
<tr>
<th>Stage of Your Pregnancy</th>
<th>When to See Your Doctor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 13 weeks (or as soon as you think you are pregnant)</td>
<td>Get your first prenatal visit as soon as you can</td>
</tr>
<tr>
<td>14 – 28 weeks</td>
<td>Every four weeks</td>
</tr>
<tr>
<td>29 – 36 weeks</td>
<td>Every two weeks</td>
</tr>
<tr>
<td>37 – 40 weeks</td>
<td>Every week</td>
</tr>
<tr>
<td>After you give birth</td>
<td>Get your postpartum checkup three to six weeks after birth</td>
</tr>
</tbody>
</table>

- Referring you to a Maternal Infant Health Program (MIHP). MIHP teaches you about pregnancy and taking care of a newborn. See page 34 for more info
- Checking in with you after birth to make sure you and your baby are doing well. Your Care Coordinator can help you set up your postpartum visit and your baby’s first check-up

**KEYS TO CARE**
Make your postpartum (after birth) office visit and your baby’s first check-up exam while in the hospital.
Your baby should see the doctor one to two weeks after birth or sooner. Your Care Coordinator can help you make this appointment. You need postpartum care after your baby is born. You should see your doctor three to six weeks after your baby is born. At this visit, your doctor:

- Chooses the best birth control for you. See the Family Planning section on page 33 for more info
- Helps you find the Women, Infants and Children (WIC) program near you. You may be able to get free formula, milk and food from WIC. Talk to your doctor or local health department about these services

**Behavioral Health Care Coordination**

Behavioral Health offers mental health care. Behavioral Health Care Coordinators help you get the care you need by finding you a behavioral health provider and setting up visits. They can also help you find substance abuse care near you. They check-in with you to make sure you are getting the right care. All services are private. Call 888-222-8041 for more info.

**Weight Management Care Coordination**

The Weight Management Care Coordination program is here to help if you want to and are ready to lose weight. We give you a Nutrition Care Coordinator to help you stay on track and lose weight. You are enrolled in Weight Watchers® if you qualify. Call 888-437-0606 for more info or to see if you qualify for the Weight Management program.

**Complex Case Management**

You are given a Nurse Case Manager if you have many and/or complex health issues. The Nurse Case Manager works with you to set goals to optimize health, improve self-management and support plans of care.

The Complex Case Management program:

- Gives personal attention and arranges your care
- Teaches you and your care team about your benefits
- Teaches you about your health issue(s), treatment and medicine(s)
- Gives you tips to self-manage your health issue(s)
- Helps you tell your care team about your needs and ask questions
- Helps you get care near you, including care offered by mental health providers and/or schools
- Works with you and your doctor(s) to arrange the best possible care
- Makes sure you get all of the care you need
Nurse Case Managers help you:
- Know your situation and take care of your health
- Learn more about the medicines your doctors give you
- Make and fulfill your own plan of care

**Disease Management (DM)**
DM helps you manage chronic diseases. Our DM programs are for people with:
- Asthma • Diabetes • Heart Disease • COPD • Congestive Heart Failure

DM members get this info:
- A welcome packet
- Educational info about your health issue
- DM newsletters mailed two times a year
- Reminders of preventive care you need to stay healthy
- Referral to a Care Coordinator if you need more help

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**How do I become part of a Special Healthcare Program?**
- Your PCP can refer you to a program
- Refer yourself by calling 888-437-0606
- Sign up using My MHP. My MHP is our secure, member-only online portal. Visit www.mhplan.com/mi/MyMHP to learn more
- You may be signed up automatically when we pay a bill related to your lab test, medicine or office visit

Call 888-437-0606 if you want to be taken out of a Special Healthcare Program. We’ll be happy to help you.

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**Children’s Special Health Care Services (CSHCS)**
CSHCS is a State program that serves children and some adults with special healthcare needs. It covers more than 2,700 medical conditions.

You get these extra benefits if you are enrolled with CSHCS:
1. Help from your local health department with:
   - Community resources – schools, community mental health, respite care, financial support, childcare, Early On and WIC
   - Transitioning to adulthood
2. Help from the Family Center for Children and Youth with Special Health Care Needs
   - CSHCS Family Phone Line – a toll-free number (800-359-3722) open Monday – Friday from 8 a.m. to 5 p.m.
   - Parent-to-parent support network
   - Parent/professional training programs
   - Financial help to go to conferences about CSHCS medical conditions. Also help for siblings of children with special needs to attend the “Relatively Speaking” conference

3. Help from the Children’s Special Needs (CSN) Fund. The CNS Fund helps CSHCS families get items not covered by Medicaid or CSHCS. Call 517-241-7420 to see if you qualify for help from the CNS fund. Examples of help include:
   - Wheelchair ramps
   - Van lifts and tie downs
   - Therapeutic tricycles
   - Air conditioners
   - Adaptive recreational equipment
   - Electrical service upgrades for eligible equipment

Text Messaging Program
You may get text messages from us on your cell phone. These messages remind you of doctor visits and needed preventive care. You are signed-up for this program when you join our plan. You may opt-out at any time by texting “STOP” to 647526 or by calling us at 888-437-0606. For full terms and conditions, visit [http://www.mhplan.com/mi/members](http://www.mhplan.com/mi/members) and click “Privacy Practices” on the left side. Standard message and data rates may apply.

Smoking Cessation Program
Ready to quit? We have our own smoking cessation program to help you. Our program offers:
   - Educational materials
   - Your own Smoking Cessation Coordinator – a health coach that supports you
   - Coaching calls to help you through quitting
   - And much more!

Call 844-854-5576 to learn more.
Benefits Monitoring Program
The Benefits Monitoring Program (BMP) is a State program run by Medicaid health plans. It tracks people who may be over-using or misusing benefits. Our members in the BMP are watched closely by Care Coordinators to make sure they are using their benefits the right way.

You can be placed in the BMP for:
- Misusing the ER
- Misusing medical transportation
- Misusing the pharmacy
- Misusing doctor care

You must meet strict criteria to be put in the BMP. You will get a letter telling you why you were placed in the BMP. The BMP lasts for at least two years, even if you change health plans.

PREVENTIVE HEALTH

Preventive health is 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 you and your family. Those with our Healthy Michigan Plan are covered for extra preventive care as required by the Patient Protection and Affordable Care Act (PPACA).

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.

Each well-child visit should have:
- Health history
- Physical exam
- Shots (if needed)
- Height & weight
- Developmental assessment
- Health info to keep your child healthy
What is a Developmental Assessment?

- Helps measure your child’s growth to make sure they are on track
- Checks your child’s physical, language, mental and feeling/social skills
- Hearing and eyesight may also be tested
- Be ready to answer questions about:
  - Your family health history
  - Your child’s health history, including:
    - Sleep patterns
    - Feeding and eating habits
    - Fears
    - Play
    - Social, coping, language and communication skills

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

- 1-14 days
- 2 months
- 4 months
- 9 months
- 12 months
- 15 months

**KEYS TO CARE**

Set up your child’s next visit when you check out after a visit.
Ask for a reminder card or phone call so you remember the visit date.
Always reschedule cancelled visits the same day you call to cancel.

Your child also needs two blood lead tests. The first blood lead test should be before age one. The second blood test should be done before age two. These blood lead tests are important even if you do not live in an older home. Lead can be found in playgrounds and other toys.

We offer reminder calls, postcards and incentives to make sure your child gets this important care.

**Women’s Health**

You can see any of our OB/GYNs for yearly care. You do not need a referral. Your doctor may be able to give this care. Ask your doctor if this can be done in the office.

This care is covered for women:

- **Mammogram** (breast cancer screening): One mammogram every one to two years is covered for women age 50 and older
- **Pap Test** (cervical cancer testing): One test is covered each year for women age 21 and older
• **Chlamydia Test** (STI testing): Covered for women ages 16-24 who are sexually active
• **Annual Well Exam:** Includes counseling on family planning and inter-conception care (how to get your body ready if you are thinking of getting pregnant and how to space out your pregnancies)
• **Flu Shots and Immunizations:** Covered if needed

**Pregnant Women**

Pregnant women need to start care within the first 12 weeks of their pregnancy. You may see any of our OBs or OB/GYNs without a referral. Call your Maternity Care Coordinator if the OB or OB/GYN you want to see is not in our network. We will work with your doctor to make sure you can keep getting care.

Your baby should see the doctor one to two weeks after birth or sooner. You need postpartum care after your baby is born. You should see your doctor three to six weeks after your baby is born. At this visit, your doctor:

- Chooses the best birth control for you. See the Family Planning section below for more info
- Helps you find the WIC program near you. You may be able to get free formula, milk and food from WIC. Talk to your doctor or local health department about these services. See page 36 for more info on WIC

**Family Planning**

You can get family planning info from your doctor, OB, OB/GYN or a Family Planning Center. Family planning includes counseling, supplies and birth control. It is important to get a Pap test and chlamydia test before getting birth control. You do not need a referral from your doctor for this care.

**Men’s Health**

We cover and encourage male members to:

- Go for wellness exams each year
- Have tests on time to find health problems early. You have more care options when problems are found early. Be sure to have these tests:
  - Blood pressure
  - Cholesterol
  - Diabetes
  - Depression
  - Colorectal cancer
- Quit smoking
- Get needed immunizations. You need a flu shot each year. Your doctor may also suggest the pneumonia shot
COMMUNITY HEALTHCARE RESOURCES

Developmental Disability
Your local Community Mental Health Services Program (CMHSP) provides help if you or a family member has a developmental disability. CMHSP offers services to treat and manage these conditions:

• Cerebral palsy  • Mental retardation  • Autism
• Challenging or troubling behaviors • An IQ of 70 or below

Children with Special Needs (zero to three years old)
The “Early On®” program offers resources to help these kids. This program is offered through the Michigan Intermediate School Districts (ISDs).

Students with Disabilities (three to 26 years old)
The ISDs provide physical, speech and occupational therapy services.

Women, Infants and Children (WIC)
WIC helps moms and their children get food coupons, health education and nutrition support. You must meet certain conditions to get WIC goods. Call WIC at 800-532-1579 to learn more. You can also talk to your case worker, doctor or local health department about WIC if you have questions.

Maternal and Infant Health Program (MIHP)
MIHP supports healthy pregnancies and healthy infants. It is open to all Medicaid-eligible pregnant women. It also serves infants with Medicaid. We refer all pregnant women to the MIHP program. Your doctor may also refer you to MIHP. MIHP services include:

• Visits during and after your pregnancy to help you take care of yourself and your baby
• Nurses who teach about pregnancy, labor and delivery. They also teach you how to care for your baby
• Social workers who help with housing, baby supplies and other support
• Dietitians who teach about eating healthy during pregnancy. They also teach you how to feed your baby
• Parenting classes
• Referrals to local community services*
• Referrals to local childbirth classes
• Transportation to services*

*If needed
Call 888-437-0606 if you have questions about MIHP.

**GRIEVANCES**

We hope that you are always happy with us and our providers. There may be times when you are not.

We can help resolve problems. Please call us first at 888-437-0606. We are here for you Monday – Friday from 8 a.m. – 8 p.m. We have an after-hours service so someone will answer your call 24/7. This helps if you need an expedited (fast) decision. All calls you make are toll-free.

You can file a grievance if we cannot resolve your problem on the phone. We will not treat you any differently if you choose to use your right to file a grievance.

A grievance is a complaint about anything other than a denied, reduced or terminated (ended) medical service.

These are examples of when you might want to file a grievance:
- Your doctor or our staff did not respect your rights
- You had trouble getting an appointment with your doctor in an appropriate amount of time
- You were unhappy with the quality of care or treatment you got
- Your doctor or our staff was rude to you
- Your doctor or our staff was insensitive to your cultural needs or other special needs you may have

You can file a grievance by calling 888-437-0606.

A formal grievance can be made if you are not happy with the decision made on the phone. You need to file a formal grievance in writing. Your doctor or an authorized representative may file this for you. Include a phone number where we can reach you with your written grievance. Mail your written grievance to:

Meridian Health Plan
Grievance Coordinator
777 Woodward Avenue. Suite 600
Detroit, MI 48226
We will acknowledge your grievance by sending you or your representative a letter. The letter is sent within five business days of getting your grievance. Your Level One Grievance will be resolved within 15 calendar days. We will call you with the decision. We will also send a written response.

You may file a Level Two Grievance with us if you are not happy with your Level One Grievance results. You must file a Level Two Grievance within five business days of getting your Level One Grievance decision.

Level Two Grievances are reviewed by our Grievance Committee. This Committee is formed by our Board of Directors. You or your representative may appear in person or by phone before the Grievance Committee. You can also send written info for the Grievance Committee to review.

You or your representative will be notified within three business days of the Grievance Committee’s decision. We will call you with the decision. We will also send you a written response. The combined time frame for the Level One and Level Two Grievance process is not more than 30 calendar days.

**External Review of Grievances**
You or your representative can submit a request for external review if you are unhappy with our decision. You must file this request in writing to the Department of Insurance and Financial Services (DIFS). This must be sent within 60 days of getting our final decision from our internal grievance process. Send your request for external review to:

Department of Insurance & Financial Services
Office of General Counsel/PRIRA
PO Box 30220
Lansing, MI 48909-7720
Phone: 877-999-6442
Fax: 517-284-8838

**APPEALS**

You may file an appeal if you are not happy with a decision we made. An appeal is about a denied, reduced or terminated (ended) medical service. It is a formal way of asking us to review and change a coverage decision.

These are some examples of when you might want to file an appeal:
• Not approving or paying for a service or item your doctor asks for
• Stopping a service that was approved before
• Not giving you the service or items in a timely manner
• Not advising you of your right to freedom of choice of providers
• Not approving a service for you because it was not in our network

You have 90 days after you get notice of a denial from us to file an appeal. You can keep getting benefits during the appeals and fair hearing process if we are going to reduce or stop a service we already approved. You must meet these criteria to do so:
• The appeal must be filed within 10 days of the date the denial letter was mailed
• You must ask to keep the service

The service will stop if:
• You withdraw your appeal
• You do not ask for a State Fair Hearing within 10 days from getting the denial letter
• A State Fair Hearing decision is made against you
• The authorization ends or authorization service limits are met

You may have to pay for care you got during the appeals process if:
• The final decision is the same as our initial decision
• The services were only given as part of this appeal process

You can ask another person to appeal for you. This person can be your doctor, family or a friend. You must put in writing that you want the person to appeal for you. You must also give this person access to your health info.

You have the right to ask for 14 more days if you need time to get more info for your appeal. We may ask for 14 more days. This happens if we need more info and it is in your best interest. We will send you written notice of the reason for the delay if this happens.

You can appeal by calling 888-437-0606. We can help you file your appeal with interpretation and teletypewriter services. You can also appeal in writing or use the Internal Appeal Form that is sent with the denial letter. Include a phone number where we can reach you if you write to us. We will let you know when we get your appeal.
Mail your written appeal to:

Meridian Health Plan
Appeals Coordinator
777 Woodward Avenue, Suite 600
Detroit, MI 48226
Fax: 313-463-5259

Internal Appeal Process - Level One
A doctor with the same or like specialty as your treating doctor will review your appeal. It will not be the same doctor as the doctor who made the original decision to deny, reduce or stop the medical service.

We will send you a letter letting you know our decision:
• Within 14 calendar days if you are waiting to get the care
• Within 20 calendar days if you already had the medical service

We may need to take up to 10 more business days if we are waiting for info from your doctor. We will send you a letter if this happens.

You get a letter with our decision. The letter will explain your further appeal rights if we do not completely approve your request during the Level One review.

Internal Appeal Process - Level Two
Our Appeal Committee will review your appeal. We will let you know when the Level Two hearing will be held. You have the right to speak at the Level Two hearing. You can also ask someone else to speak for you. A final decision will be mailed to you within three days of the hearing date.

The combined time frame for the Level One and Level Two Appeal process shall not be more than 30 calendar days.

External Review of Appeals
You may appeal our final decision if you or your authorized representative is not happy with it. You must complete our entire internal appeal process before you can file an appeal with DIFS. You must appeal within 60 days of getting our final decision. To appeal, please write to the DIFS at:
State Fair Hearing
You have the right to request a Fair Hearing with the State of Michigan if you or your authorized representative disagrees with one of our decisions. You must ask for a Fair Hearing within 90 days of the denial letter. Write to the MDHHS to ask for a Fair Hearing:

Michigan Administrative Hearing System
For the MDHHS
P.O. Box 30763
Lansing, MI 48909
Fax: 517-373-4147

Urgent Appeal
Sometimes you may need a decision made about your care very quickly. You can call 888-437-0606 to ask for an urgent appeal. Your doctor must agree to the urgent appeal. You can ask for an urgent appeal 24/7.

We will tell you of all the needed info to process your appeal within 24 hours of getting your urgent appeal request. We will decide on your appeal within three days of getting all needed info. We will let you, your doctor and any other doctor involved in the appeal know the decision by phone. We will also send you a letter with the decision.

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.

You have the right to:
- Get healthcare services that comply with our contract with the State and all State and federal laws
- Ask for and be sent info about:
• Meridian
• Our services
• Our providers
• Member rights and responsibilities
• Our structure and operation
• Our provider incentive programs. (We may give providers incentives to help make sure you get the care you need when you need it)
• Your medical records
• Changing or correcting your medical records
• Be treated with respect
• Have your dignity and right to privacy recognized
• Have your personal and medical info kept private
• Work with doctors to make decisions about your health care. This includes the right to refuse care and state your preferences about care
• Talk about appropriate or medically necessary care options, regardless of cost or coverage
• File complaints or appeals about us or care we provide
• Be free:
  • From any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
  • From other discrimination prohibited by State and federal regulation, including race, color, religion, sex, national origin, ancestry, age and physical or mental disability
  • To use all of these rights without adversely affecting the way we, providers or the State treats you
• Suggest changes to these rights and responsibilities

You have the responsibility to:
• Learn about these rights and responsibilities
• Give Meridian 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
• Tell us if your contact info (like your address or phone number) changes

Questions? Call 888-437-0606.
SUMMARY OF PRIVACY PRACTICES

This summary tells you how personal and medical info about you may be used, disclosed and how you can access it.

Please visit www.mhplan.com/mi for the full Notice of Privacy Practices (NPP). You can also call us at 888-437-0606 to ask for a printed copy.

INFORMATION WE HAVE
We have enrollment info about you. This includes your date of birth, sex, ID number and other personal info. We also get bills, doctor reports and other info about your care.

OUR PRIVACY POLICY
We care about your privacy. We guard your info carefully in oral, written and electronic form. We are required to keep your info private by law. We must also give you this NPP. We will not sell any info about you. Only people who have both the need and the legal right may see your info. Unless you give us written authorization, we will only give out your info for:

- TREATMENT
  We may give out your medical info to help coordinate your care. For example, we may notify your doctor about care you get in an emergency room.

- PAYMENT
  We may use and give out your info so that your doctors can bill and get paid for your care. For example, we may ask an emergency room for details about your care before we pay the bill.

- BUSINESS OPERATIONS
  We may use and give out your medical info for our business operations. For example, we may use your medical info to check the quality of your care.

- AS REQUIRED BY LAW
  We will give out your info when the law requires it. For example, we may give your info out for court orders or to prevent health emergencies.

- AUTHORIZATIONS
  We may use and give out your personal info if you give us written permission. You have the right to change your mind and take back that permission.
COPIES OF THIS NOTICE
You have the right to get a copy of this NPP at any time. You are entitled to a paper copy of this NPP even if you agreed to get it electronically. Please call or write to us to get a copy.

CHANGES TO THIS NOTICE
We have the right to change this NPP. A revised NPP will be effective for any medical info we already have about you and for any future info we may get. We are required by law to comply with the most current notice. Any changes to our notice will be printed in our Member Newsletter.

YOUR RIGHT TO INSPECT AND COPY
You have the right to inspect the info we have about you and to get copies of it. You must ask for it in writing. We can deny your request for some reasons, but we must give you a written reason for our denial. We may charge a fee for copying your records.

YOUR RIGHT TO AMEND
You can ask us in writing to change your info if you think it is incomplete or wrong. We can deny your request for some reasons, but we must give you a written reason for our denial.

YOUR RIGHT TO A LIST OF DISCLOSURES
You have a right to get a list of our disclosures of your info, except when you authorized those disclosures or if the disclosures are made for care, payment or healthcare operations. You must ask in writing. We are not required to give you a list of disclosures made before April 14, 2003.

YOUR RIGHT TO REQUEST RESTRICTIONS ON OUR USE OR DISCLOSURE OF INFORMATION
You have the right to ask for restrictions on the info we may use or give out about you. You must ask us in writing. We are not required to agree to such requests.

YOUR RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS
You have the right to ask that we tell you about medical matters in a certain way or at a certain location. You must ask us in writing. For example, you can ask that we only contact you at home, only at a certain address or only by mail.
HOW TO USE YOUR RIGHTS UNDER THIS NOTICE
Your request to use your rights under this notice must be in writing. You can call us for help writing your request, if needed.

COMPLAINTS TO THE FEDERAL GOVERNMENT
If you believe your privacy rights have been violated, you have the right to file a complaint with the federal government. You may write to:

Office for Civil Rights
U.S. Department of Health & Human Services
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601

You can also visit their website at http://www.hhs.gov/ocr. You will not be penalized for filing a complaint with the federal government.

COMPLAINTS AND COMMUNICATIONS TO US
To use your rights under this NPP, talk with us about privacy or file a privacy-related complaint, write to:

Meridian Health Plan
Chief Privacy Officer
777 Woodward Avenue, Suite 600
Detroit, MI 48226

You can also call us at 888-437-0606. You will not be penalized for filing a complaint.

FRAUD, WASTE AND ABUSE

Healthcare fraud, waste and abuse (FWA) costs millions of dollars each year. This money should be spent on health care for people who need it. FWA violates State and federal law.

Here are some examples of fraud:
• Using a member ID card that belongs to someone else
• Changing a prescription written by a doctor
• Billing for services that were not provided
• Billing for the same service more than once
• Allowing or knowing someone else is using your card
Here are some examples of abuse:
- Using the emergency room for non-emergency health care
- Going to more than one doctor to get the same prescription
- Threatening or offensive behavior at a doctor’s office, hospital or pharmacy

Waste goes beyond fraud and abuse. Waste usually means poor management, inappropriate actions or inadequate oversight. It is not a violation of the law, but it takes money away from health care for people who need it.

**Reporting FWA**
You must report any members, providers or pharmacies who commit fraud, waste or abuse. You do not have to give your name to report it.

You can report fraud, waste or abuse to us at:

Meridian Health Plan
Compliance Officer
777 Woodward Avenue, Suite 600
Detroit, MI 48226
Phone: 877-218-7949
Email: fwa.mi@mhplan.com

You can also report fraud, waste or abuse to the State at:

Office of the Inspector General
P.O. Box 30479
Lansing, MI 48909
Toll-free: 855-MI-FRAUD (855-643-7283)
www.michigan.gov/fraud

**OTHER IMPORTANT INFO**

**How Meridian Makes Healthcare Decisions**
Our doctors and healthcare staff make decisions based on the care that is right for you and what is covered by your Medicaid benefits. This is called Utilization Management (UM). UM is based on national standards of care created by doctors.
We do not reward providers for denying your care. Our employees who make UM decisions are not rewarded for limiting your care. You can call us at 888-437-0606 if you have a question about your benefits, providers or any service you have asked for or received. We are open Monday – Friday from 8 a.m. – 8 p.m. When our representatives answer the phone, they will greet you by telling you their name, title and company. We have 24/7 phone coverage. All calls you make are toll-free.

**New Technology**
We want to make sure you have access to new health technologies and procedures. You can recommend that we cover new technology. Our doctors and clinical staff will research the new technology before it is approved. Any updates that affect you are noted in the Member Newsletter.

This info comes from medical professional groups, Medicaid, other government groups and scientific groups.

**Quality Improvement Program**
The Quality Improvement (QI) Program is designed to give you quality health care and great customer service. Our QI Program sets quality goals each year. The QI Program also measures how well we meet those goals. We send members a survey to learn how satisfied they are with us and our providers each year. It also helps us find out how we can improve care and customer service.

Call 888-437-0606 if you would like more information on our QI Program.

**Advance Health Directives**
Advance directives are legal documents. They are used when you are very sick and cannot explain the kind of care you want. They let your family, friends and doctors know about your end-of-life decisions ahead of time.

There are two kinds of advance directives:

- **Living Will** – A living will tells others how you feel about care that continues your life. This kind of care includes:
  - The use of dialysis and breathing machines
  - Tube feeding
  - Organ or tissue donation
  - If you want to be saved when your breathing or heartbeat stops
You can accept or refuse any of this care. Your living will becomes active ONLY when you are not able to make decisions on your own.

**Durable Power of Attorney for Health Care** – A durable power of attorney for health care lets you choose a healthcare agent. A healthcare agent is someone who can make decisions about your care when you are not able to.

You may not be able to make your own healthcare decisions if you are seriously injured or sick. Your healthcare agent can make decisions about your care in these cases.

Your healthcare agent can:
- See your medical and personal info
- Choose and dismiss your doctors
- Say yes or no to medical care
- Sign waivers and other documents to allow or stop your medical care

Your agent should be someone you trust, like a family member or a friend. Talk with your agent about your values and wishes. The more your agent knows about you, the better decisions he or she can make.

Call 888-437-0606 if you have questions about advance directives. You can get advance directive forms at your doctor’s office or local hospital.

**Healthy Michigan Plan** members can register their advance directives with the Peace of Mind Registry. This is a free and voluntary registry that securely stores your advance directives and allows your doctors to access them if needed. You can get advance directives and register them online by visiting [www.mipeaceofmind.org](http://www.mipeaceofmind.org). Please call 800-482-4881 if you have any questions.

If you think your doctor did not follow your wishes, you can contact:

**Bureau of Health Professions (BHP)**  
**Complaint & Allegation Division**  
P.O. Box 30670  
Lansing, MI 48909-8170  
Phone: 517-373-9196  
Email: bhpinfo@michigan.gov
You can also visit the BHP website www.michigan.gov/healthlicense. Click on “How to file a complaint.”

If you think your health plan did not follow your wishes, please contact: the Michigan Department of Insurance and Financial Services at 877-999-6442 or visit www.michigan.gov/difs.

**If You Get a Bill or Statement**

**Only people on our Healthy Michigan Plan have co-pays.** You should never get any bills for covered care, pre-authorized services or medical supplies if you are not a part of the Healthy Michigan Plan. If you get a bill by mistake, send it to:

Meridian Health Plan  
Attention: Claims Department  
1001 Woodward Avenue, Suite 510  
Detroit, MI 48226

Call 888-437-0606 if you have any problems with medical bills for covered care.

Sometimes you may get a bill for care you had before you joined our plan. Call your doctor’s office for help for this type of bill.

**Coordination of Benefits**

Do you have other health insurance besides Medicaid? Please let us know right away. Call 888-437-0606 so we can coordinate your benefits. You could face delays at the pharmacy or other healthcare locations if your benefits are not coordinated.
SERVICE AREA

We are approved to serve these counties in the Lower Peninsula:

Alcona • Allegan • Alpena • Antrim • Arenac • Barry • Bay • Benzie • Berrien Branch • Calhoun • Cass • Charlevoix • Cheboygan • Clare • Clinton Crawford • Eaton • Emmet • Genesee • Gladwin • Grand Traverse • Gratiot Hillsdale • Huron • Ingham • Ionia • Iosco • Isabella • Jackson • Kalamazoo • Kalkaska • Kent • Lake • Lapeer • Lenawee • Livingston • Macomb • Manistee • Mason • Mecosta • Midland • Missaukee • Monroe • Montcalm • Montmorency • Muskegon • Newaygo • Oakland • Oceana • Ogemaw • Osceola • Oscoda • Otsego • Ottawa • Presque Isle • Roscommon • Saginaw • Sanilac • Shiawassee • St. Clair • St. Joseph • Tuscola • Van Buren • Washtenaw • Wayne • Wexford
## IMPORTANT NUMBERS

### In an emergency

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meridian Member Services</td>
<td>888-437-0606</td>
</tr>
<tr>
<td>TTY/TDD</td>
<td>711</td>
</tr>
<tr>
<td>Transportation (non-emergency)</td>
<td>800-821-9369</td>
</tr>
<tr>
<td>Meridian Behavioral Health</td>
<td>800-222-8041</td>
</tr>
<tr>
<td>MeridianRx (pharmacy)</td>
<td>866-984-6462</td>
</tr>
<tr>
<td>Michigan ENROLLS</td>
<td>888-367-6557</td>
</tr>
<tr>
<td>Women, Infants and Children (WIC)</td>
<td>800-532-1579</td>
</tr>
</tbody>
</table>

### My PCP’s Phone Number:

### My Pharmacy’s Phone Number:

### Phone Number of Closest Urgent Care:

### Other Phone Numbers:

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Habla español?
Por favor contacte a Meridian al 888-437-0606.
NEED HELP? We’re Here for You!  
**CALL US!**

**Member Services:** 888-437-0606 | TTY/TDD: 711
**Hours:** Monday – Friday from 8 a.m. to 8 p.m.

[www.mhplan.com](http://www.mhplan.com) Visit us today for:
- Preventive & chronic health tips
- Special Healthcare program info
- Member newsletters
- Privacy info
- Online Provider Directory
- Useful links
- And more

**My MHP (Member Portal)**
My MHP is our member-only online portal. It is an easy and secure way to handle your health info. You can use My MHP to:
- Ask to change your Primary Care Provider (PCP)
- Get a replacement ID card
- Fill out your Health Risk Assessment (HRA)
- Change your address or phone number
- Order a Member Handbook
- Find PCP, specialist and vision providers in your area

You can sign up for My MHP online at [www.mhplan.com/mi/MyMHP](http://www.mhplan.com/mi/MyMHP).
You can also call Member Services at 888-437-0606 for help. You will need your Medicaid ID number to sign up.

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Meridian Health Plan

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www.facebook.com/MeridianHealthPlan