2027

HAP CareSource

Member Handbook

Helping you understand your Medicaid plan

HAP CareSource™

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Welcome to HAP CareSource

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

This handbook is your guide to the services we offer. It will also give you helpful tips about HAP CareSource. 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 **HAPCareSource.com.**

Interpreter Services

We can get an interpreter to help you speak with us or your doctor in any language. We also offer our materials in other languages. Interpreter services and translated materials are free of charge. Call **1-833-230-2053 (TTY: 711)** for help getting an interpreter or to ask for our materials in another language or format to meet your needs. HAP CareSource complies with all applicable federal and state laws with this matter.

Hearing and Vision Impairment

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

We provide free auxiliary aids and services to people with disabilities to communicate effectively with us, 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 within five business days and free of charge. Call Member Services at **1-833-230-2053 (TTY: 711)** to request materials in a different format to meet your needs.

HAP CareSource 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

Member Services Toll-Free Help Line

- **1-833-230-2053** 24 hours a day, seven days a week

Member Services Help Line TTY/TDD

- **711** 24 hours a day, seven days a week

CareSource MyLife℠ (member portal):

- **MyLife.CareSource.com**

Website

- **HAPCareSource.com**

Address

HAP CareSource
P.O. Box 1025
Dayton, Ohio 45401

24-Hour Toll-Free Emergency Line

- **1-833-687-7370 (833-NURSE-70) -** 24 hours a day, seven days a week

24-Hour Toll-Free Nurse Advice Line

- **1-833-687-7370 (833-NURSE-70) -** 24 hours a day, seven days a week

Pharmacy Services

- **1-833-230-2053 -** 24 hours a day, seven days a week

Transportation Services (non-emergency)

- **1-833-230-2053 -** 24 hours a day, seven days a week

Dental Services

- **1-866-558-0280 -** Monday through Friday, 8 a.m. to 8 p.m.

Vision Services

- **1-833-918-0496 -** Monday – Friday, 8 a.m. – 8 p.m.

Mental Health Services

- **1-833-230-2053 -** 24 hours a day, seven days a week

To file a complaint about a health care facility

- **1-833-230-2053 -** 24 hours a day, seven days a week

To file a complaint about Medicaid services

- **1-833-230-2053 -** 24 hours a day, seven days a week

To request a Medicaid Fair Hearing

- **1-800-648-3397** or **1-517-335-7519**
- Fax: **517-763-0146**

Grievance and Appeals

- **1-833-230-2053 -** 24 hours a day, seven days a week

Care Management

- **1-844-217-1357 -** 24 hours a day, seven days a week

To report suspected cases of abuse, neglect, abandonment, or exploitation of children or vulnerable adults

- **1-855-444-3911 -** 24 hours a day, seven days a week

To report Medicaid fraud, waste and/or abuse

- **1-844-415-1272 (TTY: 711) -** 24 hours a day, seven days a week

To find out information about domestic violence

- **1-800-799-SAFE (7233) -** 24 hours a day, seven days a week

To find information about urgent care

- **1-833-230-2053 -** 24 hours a day, seven days a week

Addiction Support Line

- **1-833-674-6437 -** 24 hours a day, seven days a week

Michigan ENROLLS

- **1-800-975-7630**

Michigan Beneficiary Help Line

- **1-800-642-3195** or **TTY: 1-866-501-5656.**

MIChild Program

- **1-888-988-6300**

MDHHS office locations and phone numbers

- **www.michigan.gov/mdhhs/inside-mdhhs/county-offices**

Women, Infants and Children (WIC)

- **1-800-942-1636**

Free service to find local resources

- **2-1-1 -** Available 24 hours a day, seven days a week

Social Security Administration

- **1-800-772-1213 TTY/TDD: 1-800-325-0778**

In an emergency

- **9-1-1**

Suicide and Crisis Lifeline

- **9-8-8**

Identification Cards

When you have Medicaid, the Michigan Department of Health and Human Services (MDHHS) 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 HAP CareSource 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 **1-800-642-3195.** This number is located on the back of your mihealth card.



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

If you have questions about this coverage or need a new **HAP CareSource member ID card,** you should call Member Services at 1-833-230-2053 (TTY: 711).

Or sign into your CareSource MyLife account at **MyLife.CareSource.com** to request a new member ID 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 **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.

Important Member ID Card Notes:

- Carry both cards with you at all times and show them each time you go for care.
- Make sure all of your information is correct on both cards.
- Call your local MDHHS office to change your records if your name, address, phone number or email 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 HAP CareSource Member Services

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

You can also use your secure member CareSource MyLife account at **MyLife.CareSource.com**. Access plan benefits, find your member ID, change your primary care provider, update your address and more.

Materials can be provided in Braille, large print or voice recorded CD formats for sight-impaired individuals, upon request. Member Services can also read member materials aloud if a member requires it. Call **1-833-230-2053 (TTY: 711)** to request any of these services.

Contact Us

You may call us at **1-833-230-2053 (TTY: 711)**
24 hours a day, seven days a week

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

24-Hour Nurse Advice Line

24-Hour Nurse Advice Line provides around-the-clock access to a caring and experienced staff of registered nurses who:

- Assess your symptoms and help you decide when self-care, a doctor visit, telehealth, or the emergency room is appropriate
- Help you understand a medical condition or recent diagnosis
- Help you find out more about prescriptions or over-the-counter medicines

Call **1-833-687-7370 (833-NURSE-70)**, 24 hours a day, 7 days a week, 365 days a year.

Our Website

You can visit our website at **HAPCareSource.com** to access online services such as:

- Handbook and Certificate of Coverage
- A doctor, dentist or pharmacy directory
- Newsletters

- Health and wellness information
- Health management programs (programs that help you take care of your health)
- Rights and responsibilities
- Prescription coverage and the covered drug list
- Prior authorization information
- How to file a grievance or appeal
- Notice of privacy practices
- Quality improvement programs
- Fraud, waste and abuse
- Member resources
- Non-discrimination notice
- Your online HAP CareSource member portal
- Clinical practice guidelines

Confidentiality

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

Manage your Digital Health Records/Member Portal

Manage your health plan and get support for everyday care. CareSource MyLife℠ gives you the tools and information – right when you need them. We make it easy for you to see your plan information with your online CareSource MyLife account.

Once you register, here are just a few of the things you can do with your CareSource MyLife account:

- View your member ID card
- Search for a doctor or hospital in your area
- Choose or change your provider
- Check your claims
- Online health risk assessment
- View your personal health record

Visit **MyLife.CareSource.com**. Or download the app from Google Play or the Apple App Store.

Transition of Care

If you're new to HAP CareSource, you may be able to keep your doctors and services for at least 90 days from your enrollment date. Please note, to continue care with your provider, your provider should submit a prior authorization. Examples include medical, behavioral health, and pharmacy services.

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

If you are a HAP CareSource member and your doctor(s) no longer participates with us, you may be able to see your doctor if you are receiving treatment for certain chronic diseases.

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

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

HAP CareSource will help you choose new doctors and help you get services in our network. Your doctor can visit hap.org/providers/become-a-provider if they want to join our network.

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

Please contact Member Services at 1-833-230-2053 (TTY: 711) to request transition of care services or if you have any questions about your care.

Getting Care

Choosing A Primary Care Provider

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

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

- General practice doctor
- Family practice doctor
- Physician assistant
- Pediatrician doctor
- OB/GYN doctor

- Nurse practitioner
- Internal medicine doctor

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

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

You can use our Provider Directory to find doctors and specialists that are in our network. The provider directory lists addresses, phone number, office hours, languages spoken, information about accessibility, professional qualifications, specialty, medical school attended, residency completion, and board certification status. It is located at **FindADoctor.CareSource.com**. You can view or print the provider directory from the website. You can also request a copy of our provider directory, free of charge by calling Member Services. Remember provider information changes often. Visit our website for the most up-to-date information. Call Member Services if you need help finding a doctor.

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

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

Make sure you ask the provider office if they participate in the HAP CareSource network.

You may request a printed copy of HAP CareSource Provider Network Standards or Provider Incentive Program by calling Member Services at 1-833-230-2053 (TTY: 711).

Getting Care from Your Doctor

Your doctor's office should be your main source for medical health. You should see your doctor for preventive checkups. Call your doctor's office to make an appointment or if you have questions about your medical care. If you need help setting up an appointment, please call us at 1-833-230-2053 (TTY: 711).

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

Getting Care from a Specialist

If you need care that your doctor cannot give, they will refer you to a specialist who can. Your doctor works with you to choose a specialist and arrange your care. If you have special health

care needs or a chronic health problem like diabetes or renal disease, you may be able to have a specialist take care of you as your PCP. Talk to your doctor or call Member Services at 1-833-230-2053 (TTY: 711) for more information.

Out-of-Network Services

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

If we do not have a doctor or specialist (including family planning services and supplies) in our provider network in your area who can give you the care you need, or if we do not have a provider that can see you timely, we will get you the care you need from a provider outside our network. This is called an out-of-network referral. Please call Member Services for help.

Prior authorization is needed beforehand. We will only cover the services by an out-of-network provider if we are unable to provide a necessary and covered service in our network and if you have approval before your appointment. We will coordinate payment with the out-of-network provider. We also ensure that the cost to you is no greater than it would be if the service was provided in-network.

Out of County Services

Members can see any provider in the HAP CareSource network

Out of State Services

All services, except for emergency services, out of the state require prior authorization.

Out of Country Services

Health care services provided outside the country are not covered by HAP CareSource.

Emergency or Urgent Care Outside of Our Service Area

Did you get emergency care that was not in-network? Did you need urgent care outside of the service area? You may need to send the bill to us with a claim form.

You can get a Member Claim Form at **CareSource.com/mi/members/tools-resources/forms/medicaid/**. You can also call Member Services or our 24-Hour Nurse Advice Line for help. Both phone numbers can be found in the ***Important Numbers and Contact Information*** section of this handbook.

Physician Incentive Disclosure

Your health is our first concern. We do not pay doctors, workers, or other providers to withhold care or services. We do not reward anyone for denying services. We do not have incentives for

decision makers. Decisions about your health care are based on quality medical care and benefit coverage.

You may request a printed copy of Provider Incentive Program by calling Member Services at 1-833-230-2053 (TTY: 711).

Prior Authorization

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

Getting a Second Opinion

If you do not agree with your doctor's plan of care for you, you have the right to a second opinion. There is no additional cost to you for a second opinion from a HAP CareSource network provider.

Second opinions sometimes require prior authorization from us. Please call Member Services to learn how to get a second opinion. You can get a second medical opinion from an out-of-network provider if someone in-network is not available. HAP CareSource will arrange for an out-of-network provider. HAP CareSource approval is required.

Utilization Management

Our Utilization Management (UM) team reviews the health care you get based on a set of guidelines. We review care to make sure it is the best for your needs. You can ask how care is reviewed for procedures including:

- preservice review
- urgent concurrent review
- post service review
- filing an appeal

HAP CareSource does not reward providers or our staff for denying services. We want you to get the care you need. We can arrange interpreter services if you or your family's primary language is not English. We can also help if you have problems with your eyesight, hearing, or have trouble reading.

Call 1-833-230-2053 (TTY: 711) if you have any questions about UM. When calling UM, please keep this in mind:

- We are open for calls Monday through Friday from 8 a.m. to 5 p.m.
- You can leave a message after normal business hours.

- You can reach UM using the secure "Tell Us" form under Tools and Resources at **HAPCareSource.com**. You will get an answer the next business day.
- UM staff will say their name and title and that they are from HAP CareSource when initiating or returning calls regarding UM issues.

New Care Approvals

HAP CareSource may decide that a new development not currently covered by Medicaid will be a covered benefit.

This includes newly developed:

- Health care services
- Medical devices
- Therapies
- Treatment options

Review of New Technology

HAP CareSource depends on research and advances in science to provide their patients with evidence-based, high quality-care. Our New Technology Committee, made up of physicians across HAP CareSource, evaluate medical advances to determine their quality and safety. Participating providers may submit requests for evaluation. By regularly reviewing medical technologies and our benefit coverage, we strive to provide up-to-date, effective, and affordable medical care.

HAP CareSource will review any requests for newly developed technology or services that are not currently covered by your plan. This involves:

- Updated Medicaid rules
- External technology assessment guidelines
- Food and Drug Administration (FDA) approval
- Medical literature recommendations

Authorization Time Frames

Standard authorization requests will be decided within 7 calendar days after we get the request. HAP CareSource will tell you and your doctor if the services have been approved. You, your provider, or HAP CareSource can ask for more time to review. The review can last an additional 14 calendar days. This would happen if more information is needed to make a decision and is in your best interest.

Your provider or HAP CareSource can ask for an expedited (fast) authorization request. This is if the standard time frame could cause you harm. HAP CareSource will decide on these requests within 72 hours from receipt. We can ask for up to 14 calendar days for post service

review timeframe for UM. This would happen if more information is needed to make a decision and is in your best interest.

Information About Your Covered Services

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

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

This list of benefits and exclusions may not be a complete list. More benefits not listed here may be available. Limits and exclusions may apply to each item on this list. Your Certificate of Coverage (COC) has the complete list of covered care. Visit Member Resources section on **HAPCareSource.com** to find COC. If you want a printed copy of the COC or have questions regarding your benefits, call Member Services at 1-833-230-2053 (TTY: 711).

Make sure a service is covered before the service is done. You may have to pay for services not covered by HAP CareSource under the Medicaid program.

HAP CareSource does not deny reimbursement or coverage for services on any moral or religious grounds.

Telehealth/Telemedicine Services

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

Teladoc

If your provider doesn't offer telehealth, or has limited hours, you may use Teladoc® to speak to a board-certified provider 24/7. Skip the trip and the wait. Save money, time and worry when you use Teladoc. You and your family can talk to a Teladoc provider by phone or video from wherever you are. You can access Teladoc in your CareSource MyLife account. Use Teladoc for general medical and behavioral health services, like:

General Health	Behavioral Health*
Talk to a provider 24/7. Use for non-emergency health care needs like:	Talk to a therapist or prescriber seven days a week, 7 a.m. to 9 p.m.

- Cold and flu
- Sore throat
- Sinuses
- Allergies
- Pink eye
- Ear infections
- Urinary tract infections
- Rash
- Skin conditions
- And more

- Anxiety
- Depression
- Stress
- Substance use
- Trauma
- Relationship issues
- And more

**Age restrictions apply.*

Connecting with Teladoc is easy.

- Visit www.Teladoc.com/CareSource.
- Call 1-800-TELADOC (835-2362).
- Access from CareSource MyLife
- Referral and direct connection from 24-Hour Nurse Advice Line.
- Download the Teladoc app from your smartphone

Benefits Monitoring Program

We participate in MDHHS' Benefits Monitoring Program. This program helps ensure you're using the correct benefits and services to manage your care. If the services you use aren't needed for your health condition, we'll enroll you in this program. We'll teach you the proper use of medical services and help you get services from appropriate providers. Examples of things that could get you enrolled in this program include:

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

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

Covered Services Include:

The following are covered services:

- Ambulance and emergency medical transportation
- Bilateral cochlear implantation, mapping, and calibration (ages 1-20)
- Blood lead screening and follow-up services (ages 21 and under)

- Care Management services
- Certified nurse midwife care
- Certified pediatric and family nurse practitioner care
- Chiropractic care, up to 18 visits per calendar year, limited to specific diagnoses and procedures*
- Contraceptive medications and devices
- Dental services
- Durable medical equipment and supplies*
- Early and periodic screening, diagnosis and treatment services (EPSDT) (ages 21 and under)
- Emergency care
- End-stage renal disease (ESRD) services
- Family planning services
- Health education and outreach
- Hearing care – hearing exams, supplies, hearing aids and batteries are covered. Hearing aids are covered for all ages.
- Hearing and speech services (ages 21 and under)
- Home health care services and wound care, including medical and surgical supplies*
- Hospice services*:
  - Inpatient hospital services
  - Outpatient hospital services
  - Diagnostic and therapeutic services: diagnostic lab, X-ray and imaging services
- Infusion Therapy
- Maternal Infant Health Program (MIHP)
- Maternity care:
  - Hospital and physician care
  - Certified nurse midwife services
  - Parenting and birthing classes
  - Doula services – 1 labor visit and 12 pre/postpartum visits*
  - Prenatal care
  - Newborn childcare – for the month of birth

- Home care services
- Breast pumps, i.e., hospital-grade electric, personal-use double electric and manual

- Medically necessary weight reduction services, mental health services – outpatient Psychiatric Collaborative Care in PCP office
- Podiatry services
- Preventive services required by the Patient Protection and Affordable Care Act
- Prescription drugs
  - Up to a 34-day supply per fill for most drugs on the formulary list, with up to a 102-day supply for certain drugs that you take every day and up to a 12-month supply for oral contraceptives, patches and the vaginal ring. Check the preferred drug list to see if prior authorization is required.
- Professional care services by physicians or other health care professionals
- Certified pediatrics and family nurse practitioner care
- Preventive care and screenings
  - Routine pediatric and adult immunizations
  - Health education
  - Second opinion from a provider
  - Services of other doctors when referred by your PCP
  - Services provided by local health departments
- Prosthetic devices and orthotics*
- Radiology examinations and laboratory procedures*
- Prevention, diagnosis and treatment of health impairments
- Rehabilitative nursing care – intermittent or short-term restorative or rehabilitative services up to 45 days in a nursing facility
- Restorative or rehabilitative services in a place of service other than a nursing facility*
- Services to achieve age-appropriate growth and development
- Screening mammography and breast cancer services
- Skilled nursing facility*
- Therapy
  - Physical therapy • Occupational therapy • Speech therapy
- Tobacco cessation treatment, including prescription and over-the-counter drugs and

support programs

- Treatment for sexually transmitted diseases (STDs)
- Transportation
    - To doctor's visits, lab visits, non-emergency hospital services, prescription pick-up, dental services, and other Medicaid covered services, whether those services are provided by your Medicaid health plan or through MDHHS directly
- Vaccines
- Vision services*
- Well-child services (ages 21 and under)
- New Technology*
    - HAP CareSource depends on research and advances in science to provide their patients with evidence-based, high quality-care. Our New Technology Committee, made up of physicians across HAP CareSource, evaluates medical advances to determine their quality and safety. Participating providers may submit requests for evaluation. By regularly reviewing medical technologies and our benefit coverage, we strive to provide up-to-date, effective and affordable medical care. The state of Michigan also looks at new procedures and technology. It then decides what should be on the list of benefits. We pay for services and technology that the state has approved for Medicaid.

* Prior authorization (PA) may be required. Contact Member Services to learn more.

Prescription Drugs

You pay zero for covered drugs. For drugs your doctor prescribes, you must use a pharmacy in the network. You can find a list of doctors and pharmacies at **FindADoctor.CareSource.com**.

Always take your HAP CareSource and mihealth ID cards to the pharmacy. There are some drugs that are covered by the State with your mihealth card. These are called carve-out drugs. Your pharmacy will know which card to use.

We use a drug list called the preferred drug list or common formulary. Drugs on the list are covered. Sometimes the brand-name drug is covered instead of the generic drug. Your pharmacy will give you the drug that is covered. We also cover some over-the-counter drugs if your doctor gives you a prescription. Some examples are pain medicines such as aspirin, Tylenol, and ibuprofen. We also cover products to help you stop smoking, insulin syringes and test strips, and condoms.

We cover up to a 34-day supply per fill for most drugs. We cover up to a 102-day supply for certain drugs you take every day. We cover up to a 12-month supply of birth control pills, patches and the vaginal ring. For safety, we limit how soon you can refill your drugs.

We cover drugs that you get at the pharmacy (pharmacy drugs). We also cover drugs you get in the doctor's office or a facility (medical drugs).

Some drugs need approval to be covered. Some drugs have restrictions or a limit on how many you can get. Or you might need to try one drug before another drug is covered. We work with your doctor when approval is required. If you need a drug that isn't on the list or isn't covered, you or your doctor can ask for an exception. The drug list is developed by the State and health plans and is updated at least 4 times a year. If we make a change in the drug list that affects you, we will send a letter to you and your doctor so you can talk to your doctor about the change.

If you are new to HAP CareSource and are already taking a drug that is not covered or has restrictions, we will work with your doctor or pharmacy for a temporary supply.

You can find the drug list and changes to the drug list at **HAPCareSource.com**. There is also information about medical drugs. You can search the drug list by brand or generic name of the drug. You can also ask for a printed copy of the list. Just call Member Services at 1-833-230-2053 (TTY: 711).

Care Coordination

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

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

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

How Can Care Coordination Help You?

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

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

Call our Care Management team at **1-844-217-1357 (TTY: 711)** for more information about the care coordination program.

Care Management

We offer a care management program for members with chronic and/or complex health conditions. This includes support to Children's Special Health Care Services (CSHCS) plan members, children and youth in foster care, and transitional foster care populations. This is a voluntary program that allows you to talk with a care manager about your health care. A care manager helps you:

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

If you are interested in joining this program, please call our Care Management team at 1-844-217-1357 (TTY: 711) to be connected with a care manager.

Children's Health

Children change a lot as they grow. They should see their doctor at least once a year to check their growth, even if they are healthy. This is known as a well-child visit. Well-child visits are a good time for you to ask questions about your child's health and how it can be better. Children can see a pediatrician for routine preventive care and well-child visits without a referral. Children up to three years old are recommended to have a developmental screening done with their doctor once a year.

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

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

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

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

Early Periodic Screening, Diagnosis and Treatment (EPSDT)

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

EPSDT checkups include:

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

Children's Special Health Care Services (CSHCS)

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

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

There is no cost for this program. It doesn't change your child's HAP CareSource benefits, service, or doctors. CSHCS provides services and resources through the following resources through the following agencies. Call HAP CareSource Care Management team at 1-844-217-1357 for help connecting to benefits and applying for CSHCS and Health Care Transition to adult providers when needed.

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

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

Local County Health Department:

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

Children's Special Needs Fund:

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

CSHCS member transitioning to adulthood

We can help members who have special health care needs on how to plan a successful move from pediatric health care to adult health care services. Call CSHCS Family Phone Line: 1-800-359-3722 to learn more. You can also visit Gottransition.org to complete assessments to see if it is time for your child to begin the transition to adult providers.

Community Health Workers (CHW)

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

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

Contact Member Services for more information.

Dental Services

Dental care is important. We offer dental coverage to all beneficiaries ages 19 and above enrolled in Healthy Michigan Plan, as well as all enrollees ages 21 and older, enrolled in Medicaid. We are contracted with Delta Dental® to provide your dental benefits.

All enrollees must receive dental services from a dentist participating in Delta Dental's network, which serves both Medicaid and Healthy Michigan Plan members.

You must go to a dentist in the Delta Dental network, unless otherwise approved. If you go to a dentist that is not in the Delta Dental network and did not get approval to do so, you may have to pay for those services.

Always take your HAP CareSource member ID card to your appointments.

You will find a list of dentists in the provider directory.

If you have any questions about your dental services, please contact Delta Dental at 1-866-327-0568 (TTY: 711).

Covered dental services include:

- Oral exams *(1 in 6 months)*
- Comprehensive Periodontal Evaluation *(1 in 12 months)*
    - Note: comprehensive periodontal evaluation is not a covered benefit when billed in conjunction with, or within six months of other oral exams
- Assessment *(1 in 6 months)*
- X-rays
- Bitewing X-rays *(1 in 12 months)*
- Full mouth or panoramic X-rays *(1 in 5 years)*
- Teeth cleaning (prophylaxis) *(1 in 6 months)*

- Scaling in the Presence of Inflammation* *(1 in 6 months)*
    - Note: scaling in the presence of inflammation is not covered within 6 months of prophylaxis, scaling and root planing, periodontal maintenance, or debridement procedures
- Periodontal Maintenance *(1 in 6 months*)
    - Note: Any combination of teeth cleanings (prophylaxis, scaling in the presence of inflammation and periodontal maintenance procedures) are covered once per 6 months.
- Scaling and Root Planing* *(1 in 2 years per quadrant, maximum of 2 quadrants per day)*
- Sealants *(1 in 3 years for first and second primary (baby) molars and first and second permanent (adult) premolars and molars)*
- Fillings
- Sedative filling
- Crowns* (for extensive loss of tooth structure for caries or fracture. Tooth loss must be at least 50%), including porcelain, metal and resin based *(1 in 5 years)*
- Crown buildup, including pins*
- Re-cement crowns and bridges
- Root canals
- Extractions, simple and surgical
- Limited other oral surgery
- Emergency treatment of dental pain
- IV sedation (when medically necessary)
- Complete denture (1 in 5 years)
- Partial denture (1 in 5 years)
- Denture adjustments and repairs
- Denture rebase and reline (1 time in 2 years)

In addition, if you are under age 21, the services listed below are also covered for you:

- Fluoride Varnish (1 in 6 months)
- Topical application of Fluoride (1 in 6 months)
- Note: Topical application of fluoride cannot be combined with fluoride varnish within the same six months.
- Temporary partial denture (only to replace front teeth)
- Stainless steel crown (prefabricated) (1 in 2 years on same tooth)

Some services are NOT covered. Excluded services are:

Bite guards

- Removal of healthy third molars (wisdom teeth)
- Bridges and inlays
- Implants
- Braces
- Cosmetic dentistry
- Removable space maintainers
- Services covered under a hospital, surgical/medical, or prescription drug program
- Treatment of TMJ (TMJ is a problem that can cause pain in your jaw joint and can also cause pain in the muscles that control jaw movement.)
- Cone Beams CTs
- Nitrous Oxide

* Prior Authorization is required.

Be sure to ask your dentist if a service is covered before the service is done. You must pay for services that are not covered.

Please note: Children under age 21 and enrolled in Medicaid are automatically enrolled into the **Healthy Kids Dental program**. All children in the Healthy Kids Dental program receive their coverage through Delta Dental of Michigan. You will get an identification card and Member Handbook from the dental plan. If you are enrolled in this program, please refer to your Healthy Kids Dental Member Handbook for information on your dental benefits. You can also call the Michigan Beneficiary Helpline at 1-800-642-3195 for help.

Delta Dental of Michigan

Individual Dental Plans | Delta Dental of Michigan (deltadentalmi.com)

Phone: 1-866-696-7441

Diabetes Services

Prediabetes and diabetes mean your blood glucose (sugar) levels are higher than normal. If you have been diagnosed with prediabetes or diabetes, you may be able to receive education and support that can help you improve your condition. For people with prediabetes, the Michigan Diabetes Prevention Program (MiDPP) is a covered service required to be provided by your plan that can help you reduce your risk of developing diabetes. MiDPP teaches you about what you can do to lower your risk through healthy lifestyle changes and links you with a lifestyle coach for a year. For people with diabetes, the Diabetes Self-Management Education and Support (DSMES) can help you learn to manage diabetes by working with a diabetes care and education specialist that can help you set and track goals.

Durable Medical Equipment

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

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

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

Emergency Care

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

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

If you believe you have an emergency, call 911 or go to the emergency room. You do not need an approval from HAP CareSource or your doctor before getting emergency care. You can go to any hospital. Be sure to follow up with your doctor to make sure you get the right follow-up care and services.

Food Services

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

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

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

You can file a grievance or appeal about the food service, for example, if you are not approved for a food service. Information on how to file a grievance or appeal can be found on page 45.

Keep reading to learn more about your food service options and if you may qualify for a food service. If you have any questions, call Member Services for more information.

Medically Tailored Home Delivered Meal
Through the Medically Tailored Home Delivered Meal service, you will receive up to two healthy meals delivered to your home per day, 7 days a week, up to 3 months, with a re-assessment once services begin. These meals are tailored to your health needs.

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

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

- Have an illness that can be improved with a healthy diet, like diabetes, heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, sickle cell disease, renal/kidney disease, diabetes during pregnancy, other pregnancy complications, ***OR***
- Have been in a hospital or skilled nursing facility in the last 60 days.

Produce Prescription
Through the Produce Prescription service, you will receive a monthly voucher to buy fruits and vegetables for up to 3 months, with a re-assessment once services begin.

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

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, malnutrition, sickle cell disease, or renal/kidney disease; ***OR***
- Have been in a hospital or skilled nursing facility in the last 60 days; ***OR***
- Are pregnant and currently have, a history of, or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, dehydration; ***OR***

- Used to be in foster care and have an illness that can be improved with a healthy diet; ***OR***
- Are a child that has too much lead in their blood or is obese; ***OR***
- Are eligible for the Children's Special Health Care Services (CSHCS) program.

Healthy Home Delivered Meal

Through the Healthy Home Delivered Meal service, you will receive up to two healthy meals per day delivered to your home 7 days a week, for up to 3 months. This service is for members who cannot get enough food when they need it, cannot shop for and cook their own healthy meals AND:

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, malnutrition, sickle cell disease, or renal/kidney disease; OR
- Have been in a hospital or skilled nursing facility in the last 60 days; OR
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, and dehydration; OR
- Used to be in foster care and have an illness that can be improved with a healthy diet; OR
- Are a child that has too much lead in their blood or is obese; OR
- Are eligible for the Children's Special Health Care Services (CSHCS) program.

Healthy Food Pack

Through the Healthy Food Pack service, you will be able to pick up a mix of healthy foods or have them delivered up to two times per day to your home, 7 days a week for up to 3 months with a re-assessment once services begin. This service is for members who cannot get enough food when they need it, cannot shop for their own healthy foods AND:

- Have an illness that can be improved with a healthy diet, like diabetes, congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, human immunodeficiency virus (HIV), cancer with malnutrition, malnutrition, sickle cell disease, or renal/kidney disease; OR
- Have been in a hospital or skilled nursing facility in the last 60 days; OR
- Are pregnant and currently have, have a history of or are at risk of complications from being pregnant, including things like diabetes while pregnant, preeclampsia, dehydration; OR

- Used to be in foster care and have an illness that can be improved with a healthy diet; OR
- Are a child that has too much lead in their blood or is obese; OR
- Are eligible for the Children's Special Health Care Services (CSHCS) program.

Healthy Behaviors

You may be eligible to participate in a healthy behavior incentive program. Staying healthy is more important than ever. Here at HAP CareSource, we encourage our members to stay on top of their wellness screenings and tests. To help reward your healthy behavior, we offer the HAP CareSource Rewards program. You could earn gift cards for tests and services you're probably already planning on getting. Learn more about these rewards and how to sign up at **CareSource.com/HAPRewards**.

Call Member Services to learn more**.**

Hearing Services

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

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

If you need a hearing exam or think you need hearing aids, call NationsHearing® at 1-877-484-2688. You can also call a provider from our list of hearing providers.

Hepatitis C

Treatment is available for Hepatitis C. Hepatitis C is a liver infection caused by the Hepatitis C virus. It's spread through contact with blood from an infected person, even amounts too small to see.

People with Hepatitis C often don't feel sick or show symptoms. When symptoms do appear, they're often a sign of advanced liver disease. It's important to get tested (screened) for Hepatitis C before it becomes severe, when it's easier to treat. All adults should be screened for Hepatitis C at least once. Pregnant beneficiaries should be screened during each pregnancy.

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

Home Health Care, Skilled Nursing Services and Hospice Care

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

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

Hospice Care

Hospice is a health care program designed to meet the needs of terminally ill individuals when the individual decides that the physical and emotional toll of curative treatment is no longer in their best interest. These individuals choose palliative care, which is not a cure, but ensures comfort, dignity, and quality of life. Hospice is intended to address the full range of needs for the individual with a terminal illness while also considering family needs. Care must be consistent with the individual's values regardless of the location where care is provided.

- Inpatient and outpatient hospice care is covered when:
    - Your doctor informs us that your condition is terminal
    - HAP CareSource determines hospice to be Medically/Clinically necessary
    - You choose hospice service
    - The provider is within a certified hospice program
    - Nursing care by, or under the supervision of, a Registered Nurse, home health aide and homemaker services.
    - Inpatient hospice care
        - Short-term inpatient care, medical supplies and drugs.
    - Medical social services (including needs assessment, psychological and dietary counseling).
        - Bereavement counseling.

Enrolling in Hospice:

Step 1: Discuss with your doctor

- **Receive a doctor's referral.** A doctor must confirm that you or your loved one has a terminal illness with a prognosis of six months or less to live if the illness runs its natural course.
- **Request a referral.** Your doctor can provide a hospice referral directly.

Step 2: Contact a hospice provider

- **Make a self-referral.** You or your family can contact a hospice provider directly to request an assessment.
- **Check your provider network coverage.** While hospice is covered outside of your specific HAP CareSource plan, it's wise to ensure the provider is certified by Medicare, as HAP CareSource works with Medicare and Medicaid.

Step 3: Notify HAP CareSource

- **Inform HAP CareSource of your decision.** Once you have chosen a hospice provider and begun the enrollment process with them, contact HAP CareSource for specific details regarding coverage and coordination of benefits. Call HAP CareSource Member Services at 1-833-230-2053 (TTY: 711).

Based on hospice eligibility criteria, the duration of hospice services is six months or less. There is no minimum period of hospice enrollment. A change in prognosis could eliminate the need for hospice care. Hospice services may be canceled at any time by the Member without cause.

Hospital Care

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

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

Mental Health and Substance Abuse Services

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

Signs and symptoms of substance abuse:

- Failure to finish jobs at work, home, or school
- Being absent often
- Performing poorly at work or school
- Using alcohol or drugs when it is dangerous. This includes while driving or using machines.

- Having legal problems because of drinking or drug use
- Needing more of the substance to feel the same effects
- Failing when trying to cut down
- Failing when trying to control the use of the substance
- Spending a lot of time getting the substance
- Spending a lot of time using the substance
- Spending a lot of time recovering from the substance's effects
- Giving up or reducing important social, work, or recreational activities because of substance use
- Continuing to use the substance even though it has negative effects

If you have questions about your mental health or substance abuse benefits, call Member Services at 1-833-230-2053 (TTY: 711). You can also call your local CMHSP agency.

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

Obstetrics and Gynecology Care

You may get routine obstetrics and gynecology (OB/GYN) care and other health services, including routine and preventive services from any provider in our network or outside our network (see *Out-of-Network Services* section for details). You don't need a referral or prior authorization. This includes getting routine care from your OB/GYN even if they aren't your primary care doctor.
To make sure you get the care you need to be at your best for you and your family, we cover:

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

Family Planning Services

Family planning care is covered. Both men and women can get this care. Family planning is an important part of staying healthy. You can get family planning information from your doctor,

OB/GYN, or a Family Planning Center. You do not need a referral from your doctor for this care. Please contact Member Services as soon as you discover you are pregnant to help maximize the support and benefits available to you.

Family planning services include:

- Counseling to help you decide when to have children
- Help to decide how many children to have
- Birth control services and supplies
  (It is recommended to get a Pap test and chlamydia test before getting birth control)
- Sexually transmitted disease testing and treatment
- Testicular and prostate cancer screening
- Pregnancy testing
- Help in planning a healthy pregnancy when you want a baby
- Help in choosing the birth control method that best fits your life

Pregnancy Services

If you are pregnant, early and regular checkups can help protect you and your baby's health. Care should start within the first 12 weeks of pregnancy. Oral care is also important for you and your baby while you are pregnant. Routine dental care can be done during pregnancy. Please call Mom and Baby Beginnings at **1-833-230-2034 (TTY: 711)** and your local MDHHS office as soon as you find out you are pregnant so we can provide support.

The Mom and Baby Beginnings program is here to support you during your pregnancy. As a HAP CareSource member, you can get help from nurses, social workers, behavioral health specialists, substance use case managers, and breastfeeding experts. Our team is ready to provide extra support and connect you with special rewards and programs just for pregnant or recently delivered members.

If you want to learn more about how this program can help you, please call **1-833-230-2034 (TTY: 711)**. You can also access the program through **MyLife.CareSource.com**. We'll help you find OB providers and doulas so you can get the right care for yourself and your baby. We'll also connect you with dental providers, because taking care of your teeth is important during pregnancy. Plus, you'll have access to other helpful resources through our interactive app.

Postpartum Care

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

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

When you have your baby, let us know. Call your local MDHHS office so your records can be updated. Also call Mom and Baby Beginnings at **1-833-230-2034 (TTY: 711)** to report the change. This starts the process of signing your baby up for health care services. Your baby is covered by your health plan at the time of birth. Make sure you tell us the day you gave birth, your baby's name, and your baby's Medicaid ID number that you get from your local MDHHS office. We will send a member ID card for your baby within 30 days after we get this information. Call Mom and Baby Beginnings at **1-833-230-2034 (TTY: 711)** if you need help.

If you have a baby in the NICU, we have a team that specializes in helping coordinate NICU care. Call **1-833-230-2034** (**TTY: 711)** to find out more about our program.

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

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

Call Mom and Baby Beginnings at **1-833-230-2034 (TTY: 711)** for more information on how you can access these services.

Preventive Health Care for Adults

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

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

- Blood pressure
- Cholesterol
- Diabetes
- Body Mass Index
- Blood sugar
- Depression Screening
- Prostate and Colorectal Screenings
- Breast cancer screening (mammogram)

- Cervical cancer screening

You can also ask your doctor about:

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

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

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

Things you should do:

- Eat healthy
- Exercise
- Get enough sleep
- Manage your stress
- Don't smoke or use tobacco
- Don't use drugs or drink alcohol
- Go to the dentist for regular cleanings and preventive services
- Visit your doctor each year for yearly preventive care

Things you should not do:

- Eat foods high in fat, sugar, and salt
- Live an inactive lifestyle
- Hold in your feelings or emotions if you're feeling stressed or depressed
- Use drugs, alcohol, or tobacco
- Forget to set up your dentist visits for regular cleanings and preventive services
- Forget to set up a yearly visit to your doctor
- Avoid going to the doctor

You can also find wellness tools on CareSource MyLife. Get started on by going to **MyLife.CareSource.com.**

Routine Care

Routine care is for things like:

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

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

Transportation Services

Non-Emergency

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

Please call Member Services at 1-833-230-2053 (TTY: 711) for more information and to schedule a ride. Please call 2-3 days before an appointment so we can make sure we have someone available to transport you. You can request same-day transportation for an urgent non-emergency appointment.

Have this information ready when you call:

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

Members with any special needs (wheelchair accommodations, oxygen resources, etc.) will want to schedule transportation as early as possible in order to meet your needs with the appropriate vendor.

For children aged 12 to 18, a consent letter from a parent, guardian, or caregiver is needed for unaccompanied transportation.

Parental consent is not required for children who are emancipated or those seeking certain healthcare services they can legally consent to and do not need a consent letter. These services include care related to pregnancy, sexually transmitted infections (STIs), HIV/AIDS, substance use disorders, or outpatient care from Community Mental Health Services Programs (CMHSP).

If you are receiving services through the local Community Mental Health Services Program (CMHSP) agency, there may be some transportation services that you will continue to receive through the local CMHSP agency. Contact your local CMHSP agency for questions about this benefit.

Please be sure to call us as soon as possible if you need to cancel. Call Member Services 24 hours in advance at 1-833-230-2053 (TTY: 711).

Transportation is available 24 hours per day, 7 days a week, 365 days per year.

Additional Transportation services include:

- Ongoing services (e.g., dialysis, chemotherapy, substance use disorder (SUD) services, physical therapy, speech therapy and occupational therapy)
- MIHP, or other MDHHS approved evidence-based home-visiting program
- Health care and pregnancy-related* visits pregnant people and infants
- Rides for a mother to visit their hospitalized infant.
- You also get 5 round trip visits per month to pick up health food and personal care items at food banks, food pantries and picking up online orders at grocery stores. Visits must be within a 25-mile radius of your location.

* Pregnancy-related appointments include those for oral health services, WIC services, mental or substance use disorder treatment services, and childbirth and parenting education classes.

Medically necessary, non-emergency ambulance transportation to Prepaid Inpatient Health Plan (PIHP) and Community Mental Health Services Program (CMHSP) related services.

Emergency

If you need emergency transportation, call 911.

Tobacco Cessation

We want to help you quit smoking. If you smoke, talk to your doctor about quitting. If you are pregnant and smoke, quitting now will help you and your baby. Your doctor can help you. HAP CareSource can also help you. To learn more, call Member Services **1-833-230-2053 (TTY: 711).** We cover these services to help you:

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

The Michigan Tobacco Quitline is a free phone-based program to help you quit smoking. You'll work with a health coach to make a quit plan. To sign up, call 1-800-

QUIT-NOW (784-8669). To learn more, call Member Services 1-833-230-2053 (TTY: 711).

Urgent Care and After-Hours Care

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

These places can treat illnesses that should be cared for within 48 hours, such as the flu, high fevers, or a sore throat. They can also treat ear infections, eye irritations and low back pain.

If you fell and have a sprain or pain, it can be treated at an urgent care center.

If you aren't sure if you need urgent care, call your doctor. They may be able to treat you in their office. You can also call our 24-Hour Nurse Advice Line for help at 1-833-687-7370 (833-NURSE-70).

Vision Services

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

- One eye exam every 24 months
- One pair of glasses every 24 months (including frames and lenses)
- Eye glass frames
- Contact lenses are covered with medical necessity

You do not need a referral to get eye care. If you need glasses or an eye exam, call EyeMed® at 1-833-918-0496. You can also call a provider from our list of vision providers. For medical eye problems, talk to your doctor.

Community-Based Supports and Services

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

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

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

Member Services at 1-833-230-2053. TTY users should call 711.

You can also access resources at the following:

- Online through our website: **HAPCareSource.com**
- Online through the State of Michigan portal: https://newmibridges.michigan.gov
- Online through the Michigan 2-1-1 website: www.mi211.org

Supplemental Nutrition Assistance Program (SNAP) provides food benefits to low-income families to supplement their grocery budget so they can afford the nutritious food essential to health and well-being. SNAP is sometimes also called food stamps or the Food Assistance Program (FAP). To apply, go to https://newmibridges.michigan.gov

Temporary Assistance for Needy Families (TANF) helps families pay for food, housing, home energy, and child care. In Michigan, TANF funds several programs like Cash Assistance, Child Care, and other programs. To apply, go to https://newmibridges.michigan.gov

Utility and Weatherization Programs can help pay for heating, cooling, and home weatherization. State Emergency Relief (SER) can help families facing financial crisis. One of the ways SER can help is by helping with utility costs. To apply for SER, go to https://newmibridges.michigan.gov There are also several other utility and weatherization programs that can help with the cost of utilities or home weatherization. To find out more about those programs, contact 2-1-1 or go to their website www.mi211.org

Women, Infants, and Children (WIC) is a free program that provides a combination of nutrition education, supplemental foods, breastfeeding promotion and support, and referrals to health care. Apply online at MI Bridges or call 1-800-942-1636 to find a WIC clinic near you or call Member Services for assistance.

Cash Assistance
Information on the Family Independence Program, State Disability Assistance, SSI, Refugee, and other cash assistance. Apply online at MI Bridges.

Child Care Assistance
If you cannot afford child care, payment assistance is available. Apply online at MI Bridges.

Housing and Homeless Services

Services for Farmworkers
Our migrant program works with a number of organizations to provide services for Michigan's migrant and seasonal farmworkers. Apply online at MI Bridges.

Refugee Assistance
A federal program which helps persons admitted into the U.S. as refugees to become self-sufficient after their arrival. Apply online at MI Bridges.

Cost Sharing and Copayments

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

You must go to a doctor in HAP CareSource Medicaid network, unless otherwise approved. If you go to a doctor that is not in HAP CareSource Medicaid network and did not get approval to do so, you may have to pay for those services. Medicaid only covers medically necessary services. You get them at no cost to you unless your plan has copays. Medically necessary means you need the services to prevent, diagnose, or treat a medical condition. You should not get a bill for these services. If you have questions about how co-pays may apply to you or you get a bill, contact Member Services at 1-833-230-2053 (TTY: 711).

Services Covered by Medicaid not HAP CareSource

HAP CareSource does not cover all services that you may be eligible for as a member of Medicaid.

Services Covered by State of Michigan Medicaid:

The following services are covered by the State of Michigan Medicaid program. You must use your mihealth card to get this care. If you have questions about these services talk with your doctor or your local Department of Health and Human Services. You can also contact the Michigan Beneficiary Helpline at 1-800-642-3195.

- Services provided by a school district and billed through the Intermediate School District
- Inpatient hospital psychiatric services
- Outpatient partial hospitalization psychiatric care
- Intermittent or short-term restorative or rehabilitative services (in a nursing facility beyond 45 days)
- Behavioral health services for enrollees meeting the guidelines under Medicaid Policy for serious mental illness or severe emotional disturbance
- Substance Abuse Care including:
    - Screening and assessment
    - Detox
    - Intensive outpatient counseling

- Other outpatient care
- Methadone treatment

Your State of Michigan Medicaid benefit provides options for transportation to and from these visits. If you need transportation to or from an appointment, contact Member Services at 1-833-230-2053 (TTY: 711).

Non-Covered Services

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

Rights and Responsibilities

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

You have the right to:

- Receive information about HAP CareSource, its services, its practitioners and providers, and member rights and responsibilities.
- Be treated with respect and recognition of your dignity and your right to privacy.
- Receive Culturally and Linguistically Appropriate Services (CLAS)
- To receive Food Services as medically appropriate.
- 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.
- Voice complaints or appeals about HAP CareSource or the care it provides.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Request and receive a copy of your medical records, and request those be amended or corrected.
- Be furnished with health care services consistent with State and federal regulations.

- Be free to exercise your rights without adversely affecting the way the Contractor, providers, or the State treats you.
- To file a grievance and/or appeal to request a State Fair Hearing, or have an external review, under the Patient's Right to Independent Review Act.
- Be free from other discrimination prohibited by State and federal regulations.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and your ability to understand.
- HAP CareSource may not prohibit or otherwise restrict a provider acting within the lawful scope of practice, from advising or advocating on behalf you as the patient.
- Receive Federally Qualified Health Center (FQHC) and Rural Health Center (RHC) services.
- To request information regarding provider incentive arrangements including those that cover referral services that place the Provider at significant financial risk (more than 25%), other types of incentive arrangements, and whether stop-loss coverage is provided.
- To request information on the structure and operation of the HAP CareSource.
- To make suggestions about our services and providers.
- To make suggestions about member rights and responsibilities policy.
- To request information about our providers, such as: license information, how providers are paid by the plan, qualifications, and what services need prior approval.
- A candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Disenroll from the health plan

You have the responsibility to:

- Review this handbook and HAP CareSource Certificate of Coverage.
- Make and keep appointments with your HAP CareSource doctor.
- Treat doctors and their staff with respect.
- Protect your Medicaid ID cards against misuse.
- Contact us if you suspect fraud, waste, or abuse.

- Give your Health Plan and your doctors as much info about your health as possible in order to provide care.
- Learn about your health status.
- Work with your doctor to set care plans and goals.
- Follow the plans for care that you have agreed upon with your doctor.
- Live a healthy lifestyle.
- Make responsible care decisions.
- Contribute towards your health by taking responsibility, including appropriate and inappropriate behavior.
- Apply for Medicare or other insurance when you are eligible.
- Report changes to your local MDHHS office if your contact info (like your address or phone number) changes.
- Report changes that may affect your Medicaid eligibility to your local MDHHS office (like changes in income or changes to your family size). You can call your local MDHHS office or go to **newmibridges.michigan.gov/.**
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

Grievances and Appeals

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

Grievances are complaints that you may have if you are unhappy with our plan or if you are unhappy with the way a staff person or provider treated you. Appeals are complaints related to your medical coverage, such as a treatment decision or a service that is not covered or denied. If you have a problem related to your care, talk to your doctor. Your doctor can often handle the problem. If you have questions or need help, call HAP CareSource at 1-833-230-2053 (TTY: 711).

Grievance Process

We want to know what is wrong so we can make our services better. If you have a grievance about a provider or about the quality of care or services you have received, let us know right away. If you aren't happy with us or your doctor, you can file a grievance at any time. HAP CareSource 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) HAP CareSource 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) HAP CareSource staff member was rude to you.
- Your provider or a(n) HAP CareSource 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 HAP CareSource at 1-833-230-2053 (TTY: 711).

You can also file your grievance in writing via mail or online at:

Mail: HAP CareSource
Attn: Grievance & Appeals
P.O. Box 1025
Dayton, OH 45401-1025

Online: **MyLife.CareSource.com**

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 1-833-230-2053 (TTY: 711). 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 HAP CareSource in writing with 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 contractor has made or intends to make

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

You may appeal within 60 calendar days of the date on the Adverse Benefit Determination letter. If you want your services to stay the same while you appeal, you must say so when you appeal, and you must file your appeal no later than 10 calendar days from the date on the Adverse Benefit Determination. The list below includes examples of when you might want to file an appeal.

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

You can file your appeal on the phone by calling HAP CareSource at 1-833-230-2053 (TTY: 711).

You can also file your appeal in writing via mail or online at:

Mail: HAP CareSource
Attn: Grievance & Appeals
P.O. Box 1025
Dayton, OH 45401-1025

Online: **MyLife.CareSource.com**

You have several options for assistance. You may:

- Call Member Services and we will assist you in the filing process
- Ask someone you know to assist in representing you. This could be your primary care provider or a family member, for example.
- Choose to be represented by a legal professional.

To appoint someone to represent you, either:

1) Send us a letter informing us that you want someone else to represent you and include in the letter their contact information or,
2) fill out the HAP CareSource Authorized Representation Designation form.

You may call and request the form or find this form on our website at **CareSource.com/mi/members/tools-resources/grievance-appeal/medicaid/**.

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. If the appeal has to do with a medical decision, the 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.

HAP CareSource will send our decision in writing to you within 30 calendar days of the date we received your appeal request, or within 10 calendar days if you are receiving CSHCS benefits. HAP CareSource 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 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 HAP CareSource'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 HAP CareSource's decision does not agree with the Notice of Adverse Benefit Determination, we will approve the services right away.

Things to keep in mind during the appeal process:

- At any time, you can provide us with more information about your appeal, if needed.
- You have the option to see your appeal file.
- You have the option to be there when HAP CareSource 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, or 10 calendar days if you are a CSHCS enrollee, will put your life or health at risk, 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. Expedited appeal requests must be made within 10 calendar days of the date of the Notice of Adverse Benefit Determination. 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 available methods as you have for filing the appeal. Withdrawing your appeal will end the appeal process and no decision will be made by us on your appeal request. HAP CareSource 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 HAP CareSource at 1-833-230-2053 (TTY: 711).

What Happens Next?

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

State Fair Hearing Process

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

Call HAP CareSource at 1-833-230-2053 (TTY: 711) if you need a hearing request form sent to you. You may also call to ask questions about the hearing process. You will get a written notice of hearing from MOAHR telling you the date and time of your hearing. Most hearings are heard by telephone, but you can ask to have a hearing in person. During the hearing, you will be asked to tell an administrative law judge why you disagree with our decision. You will get a written decision within 90 calendar days from the date your request for hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.

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

If you have any questions, you can call MOAHR at 1-800-648-3397.

You can mail or fax the state hearing form to:

Mail: Michigan Office of Administrative Hearings and Rules
Michigan Department of Health and Human Services
P.O. Box 30763
Lansing, MI 48909

Fax: 1-517-763-0146

External Review of Appeals

You, your representative, or your provider can ask for an external review with DIFS under the Patient's Right to Independent Review Act – PRIRA. You must do this within 127 calendar days from the date of your appeal denial notice. An External Review form will be included with the notice of appeal decision that you receive from us. It has instructions that you will need to review.

DIFS will send your appeal to an Independent Review Organization (IRO) for review. A decision will be mailed to you in 21 calendar days of accepting your appeal. You can also ask for an External Review if you do not receive a decision from us within the required time frame. You, your Authorized Representative, or your doctor can also request a fast appeal decision from DIFS. DIFS will decide if the request meets expedited or standard criteria. An Expedited or Fast External Review may be granted if an expedited appeal review has been requested with the plan and a doctor states a fast review is needed due to risk to the life or health of the member. DIFS will send your appeal to an IRO for review. You will have a decision about your care within 72 hours. During this time period, your benefits will continue.

Send your request to:

Department of Insurance and Financial Services (DIFS)
Office of Research, Rules, and Appeals – Appeals Section
P.O. Box 30220
Lansing, MI 48909-7720
Or call: 1-877-999-6442
Fax: 1-517-284-8838
Online: https://difs.state.mi.us/Complaints/ExternalReview.aspx

Dental Grievance and Appeals

If you have questions about a dental claim or want to file a grievance/complaint, call Delta Dental®. You also have the right to ask Delta Dental to review their denial decision. This is called an internal appeal. You can request this by phone or in writing via fax or mail.

Delta Dental
Attn: Medicaid Grievance and Appeals
P.O. Box 9230
Farmington Hills, MI 48333-9230
Fax: 1-517-381-5527
Phone: 1-866-327-5068

Disenrollment

There may be times when your membership in this health plan comes to an end. Either you or the health plan may end your membership.

Disenrollment by Plan

The health plan can request your disenrollment for the following:

- If you act in a violent or threatening manner. Violent or threatening situations involve physical acts of violence; physical or verbal threats of violence made against providers, staff, or the public at the health plan's locations, or stalking situations. Special considerations may be made if you have special needs.
- If you moved out of the MHP's service area.
- If you are admitted to a nursing facility for longer than 45 days.
- If you no longer meet the criteria for enrollment.

Disenrollment by You

If you are unhappy with the health plan for any reason, you may disenroll yourself on the MI Enrolls website, www.healthcare4mi.com or by calling MI Enrolls at 1-800-975-7630, TTY: 1-888-263-5897. Reasons you may disenroll include the following reasons:

You can disenroll without cause during the following times:

- At any time during the first 90 days of enrollment
- During Open Enrollment

  - Your Open Enrollment month is based on the last digit of your Case Number (example: 9 equals September). You will receive a letter the month before your Open Enrollment month letting you know when you can change your health plan
  - If you miss your Open Enrollment because you temporarily lose your Medicaid eligibility (for 2 months or less)
- If the State notifies you there is a special circumstance with the Medicaid Health Plan (these are very rare).
- Reasons you may disenroll include
- If you move.
- If the health plan does not cover the service you seek, because of moral or religions objections.
- If you need related services to be performed at the same time but not all related services are available within the provider network and receiving the services separately would subject you to unnecessary risk.
- For any other reasons such as poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with your care needs.

Make Your Wishes Known: Advance Directives

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

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

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

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

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

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

Department of Licensing & Regulatory Affairs
BPL/Investigations & Inspections Division
P.O. Box 30670
Lansing, MI 48909-8170

Call: 1-517-241-0205

Or click below:

www.michigan.gov/lara/bureau-list/bpl
Click on *File a Complaint*

If you have complaints about how HAP CareSource follows your wishes, you may call the state of Michigan's Department of Insurance and Financial Services. Call toll-free at 1-877-999-6442 or go to michigan.gov/difs.

Help Identify Health Care Fraud, Waste and Abuse

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

Fraud

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

- Using someone else's member ID card
- Changing a prescription written by a doctor
- Billing for services that were not provided
- Billing for the same service more than once

Waste

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

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

Abuse

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

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

You Can Help

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

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

Health care fraud is a felony in Michigan. Being involved in fraud or abuse can put your benefits at risk or make other legal problems. If you suspect fraud, waste, and abuse has taken place, please report it. You do not have to give your name. You can call, email or write a letter to:

HAP CareSource
Attn: Program Integrity
P.O. Box 1940
Dayton, OH 45401-1940

Fax: 1-800-418-0248

Email: fraud@CareSource.com

Online form: https://secure.ethicspoint.com/domain/media/en/gui/78536/index.html

Phone: **1-844-415-1272 (TTY: 711)** – Ask to report fraud.

All reported cases of suspected fraud waste, and abuse are monitored and handled by the HAP CareSource Office of Compliance and Special Investigations Unit (SIU).

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

Office of the Inspector General
P.O. Box 30062
Lansing, MI 48909
Or call toll-free: 1-855-MI-FRAUD (855) 643-7283

Or visit: www.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.

Adverse Benefit Determination: A formal decision made by a health plan that you are not getting a benefit that you wanted. It means that your plan is denying, limiting, reducing, or stopping a service or benefit. You may also get an Adverse Benefit Determination if the plan cannot provide you with a service in a timely manner or if they cannot make a decision on an appeal or grievance in a timely manner. The decision will be given to you in writing and will tell you what action was taken, why the action was taken, and your rights.

Advance Directive: A written legal instruction, such as a living will, personal directive, advance decision, durable power of attorney or health care proxy, where a person specifies what actions should be taken relating to the provision of health care when the individual is incapacitated.

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

Denies your request for:

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

Reduces, limits, or denies coverage of:

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

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

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

Does not provide timely medical services

Authorization: An approval for a service.

Contractor: A health plan (HAP CareSource) that was awarded a Medicaid contract

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

- A doctor's visit

- Hospital outpatient visit
- Prescription drug

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

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

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

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

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

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

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

Expedited Appeal: An appeal conducted when the contractor determines (based on the enrollee request) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. The contractor's decision must be made within 72 hours of receipt of an expedited appeal.

Experimental/Investigational: Drugs, biological agents, procedures, devices or equipment determined by the Medical Services Administration Division of MDHHS, that have not been generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are being used or are to be used.

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

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

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

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

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

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

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

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

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

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

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

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

- Doctors
- Hospitals
- Pharmacies

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

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

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

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

Post-Stabilization Services: Services related to an emergency medical condition, provided after a person is stabilized. These services maintain, improve, or fix the stabilized condition.

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

- Services
- Medical equipment or
- Prescriptions

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

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

Prepaid Inpatient Health Plan (PIHP): Provides behavioral health services to enrollees. The PIHP is responsible for treating the individual until the individual is stabilized and no longer meets the criteria for serious mental illness treatment as outlined in Medicaid policy.

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

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

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

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

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

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

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

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

- Nurses
- Technicians
- Therapists

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

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

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND GIVEN OUT. IT ALSO TELLS HOW YOU CAN GET THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. WE WILL REFER TO OURSELVES SIMPLY AS “HAP CARESOURCE” IN THIS NOTICE.

Your Rights

When it comes to health information, you have the right to:

Get a copy of your health and claims records. You can ask for a copy of your health and claims records. We will give you a copy or a summary of your health and claims records. We often do this within 30 days of your request. We may charge a fair, cost-based fee.

Ask us to fix health and claims records. You can ask us to fix health and claims records if you think they are wrong or not complete. We may say “no” to requests. If we do, we will tell you why in writing within 60 days.

Ask for private communications. You can ask us to reach you in a specific way, such as home or office phone. You can ask us to send mail to a different address. We will think about all fair requests. We must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share. You can ask us not to use or share certain health information for care, payment, or our operations. We do not have to agree to these requests. We may say “no” if it would change your care or for certain other reasons.

Get a list of who we have shared information with. You can ask how many times we’ve shared your health information. This is only up to six years before the date you asked. You can ask who we shared it with and why. We will include all the disclosures except for those about:

- Care;
- Amount paid;
- Health care operations, and;
- Other disclosures that you asked us to make.

We will give you one list each year for free. We will charge a fair, cost-based fee if one is asked for within 12 months.

Get a copy of this privacy notice. You can ask for a paper copy of this notice at any time. You can ask even if you agreed to get the notice electronically. We will give you a paper copy as soon as possible.

Allow HAP CareSource to speak to someone on your behalf. You can allow HAP CareSource to talk about your health information with someone else on your behalf. Legal guardians can make choices about your health information. HAP CareSource will give health information to the legal guardian. We will make sure a legal guardian has this right and can act for you before we take any action.

File a complaint if you feel your rights are violated. You can complain if you feel we have violated your rights by contacting the HAP CareSource Privacy Office at the information provided at the end of this notice or the HAP CareSource Compliance Hotline at 1-844-784-9583 (TTY: 711). When calling the hotline, you have the option to stay anonymous.

You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

- Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201
- Calling 1-877-696-6775, or
- Visiting https://www.hhs.gov/ocr/complaints/index.html

We will not take action against you for filing a complaint. We cannot ask you to give up your right to file a complaint as a condition of:

- Care
- Payment
- Enrolling in a health plan
- Eligibility for benefits

Your Choices

For certain health information, you can choose what we share. You should tell HAP CareSource how you want this information shared. We will follow these orders. In these cases, you have the right and choice to tell us to:

- Share information with your family, close friends, or others who pay for your care.
- Share information in a disaster relief situation.

If you can't tell us your choice, such as if you are unconscious, we may share your information if we believe it is in your best interest. We may also share if we need to reduce a serious and close threat to health or safety. We cannot share your information unless you have given us written consent for:

- Marketing uses
- Sale of your information
- Sharing your therapy notes

You may revoke your authorization at any time, but it will not affect information that we have already used or disclosed.

Consent to Share Health Information

HAP CareSource shares your health information, including Sensitive Health Information (SHI). SHI can be information related to drug and/or alcohol treatment, genetic testing results, HIV/AIDS, mental health, sexually transmitted diseases (STD), or communicable/other diseases that are a danger to your health. This information is shared to handle your care and treatment or to help with benefits. This information is shared with your past, current, and future treating providers. It is also shared with Health Information Exchanges (HIE). An HIE lets providers view information that HAP CareSource has about members. You have the right to tell HAP CareSource you do not want your health information (including SHI) shared. If you do not agree to share your health information, it will not be shared with providers to handle your care and treatment or to help with benefits. It will be shared with the provider who treats you for the specific SHI. If you do not approve sharing, all providers helping care for you may not be able to manage your care as well as they could if you did approve sharing.

To the extent we collect or process substance use treatment-related records under 42 U.S.C. §290dd-2 and 42 C.F.R. Part 2 ("Part 2"), we follow the confidentiality protections of Part 2.

Other Uses and Disclosures

We use or share your health information in these ways (we have included some examples, but we have not listed every permissible use or disclosure):

- **Help you get health care.** We can use your health information and share it with experts who are treating you. *Example: A doctor sends us your diagnosis and care plan so we can arrange more care.*
- **Pay for your health care.** We can use and give out health information when we pay for health care. *Example: We share information about your dental plan to pay for dental work.*
- **Operate the plan.** We may use or share your health information to run our health plan. *Example: We may use your information to make the quality of health care better. We may give your health information to outside groups so they can help us run the health plan. Outside groups are lawyers, accountants, consultants, and others. They keep your health information private, too.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways. This is often for the public good, such as public health and research. We have to meet many rules in the law

before we can share your information for these reasons. To learn more, see https://www.hhs.gov/hipaa/index.html.

- To help with public health and safety issues. This is to:
  - Prevent disease
  - Help with product recalls
  - Report harmful reactions to drugs
  - Report suspected abuse, neglect, or domestic violence
  - Prevent or reduce a serious threat to anyone's health or safety
- To do research. We can use or share your information for health research. We can do this as long as certain privacy rules are met.
- To obey the law. We will share information if state or federal laws call for it. This involves the Department of Health and Human Services if it wants to see that we are obeying federal privacy laws.
- To react to organ and tissue donation requests and work with a medical examiner or funeral director. We can share health information with organ donation organizations. We can also share with a coroner, medical examiner, or funeral director if you die.
- To address workers' compensation, law enforcement, and other government orders. We can use or share health information for:
  - Workers' compensation claims
  - Law enforcement purposes or with a police official
  - Health oversight offices for actions allowed by law
  - Special roles such as military, national safety, and presidential protective services
- To react to lawsuits and legal actions. We can share health information due to a court or legal order. We may also make a group of "de-identified" information that cannot be traced back you.

Further Uses and Disclosures. Please be aware that health information that the law permits or requires us to disclose may be further shared by recipients and is no longer protected by law or the safeguards and restrictions in place when it is in our possession.

Part 2 Records. To the extent we collect or process any Part 2 records, in a civil, criminal, administrative, or legislative proceeding against an individual, we will not use or share information about your Part 2 records unless a court order requires us to do so or you give us your written permission.

Our Responsibilities

- We protect your health information in many ways. This includes information that is written, spoken, or available online using a computer.

  - HAP CareSource employees are trained on how to protect member information.
  - Member information is spoken in a way so that it is not inappropriately overheard.
  - HAP CareSource makes sure that computers used by employees are safe by using firewalls and passwords.
  - HAP CareSource limits who can access member health information. We make sure that only those employees with a business reason to access information use and share that information.
- We are required by law to keep the privacy and security of your protected health information. We are required to give you a copy of this notice.
- We will let you know quickly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice. We must give you a copy of it.
- We will not use or share your information other than as listed here unless you tell us we can in writing. You may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Effective date and changes to the terms of this notice

This privacy notice is effective October 1, 2023. We must follow the terms of this notice as long as it is in effect. If we change the notice, the new one would apply to all health information we keep. If this happens, HAP CareSource will put the new notice on our website, and we will mail a copy in the next annual mailing. You can also ask our HAP CareSource Privacy Office for it by:

Mail: HAP CareSource
Attn: Privacy Officer
P.O. Box 8738
Dayton, OH 45401-8738

Email: HIPAAPrivacyTeam@CareSource.com

Phone: **1-833-230-2091** (TTY: 711)

Member Consent/HIPAA Authorization Form

This form lets HAP CareSource share your health care information as described below. All of this form must be filled out. Mail or fax it to the address listed at the end of this form. You may also fill out this form online at **HAPCareSource.com**.

Section 1: Your Information

Last Name	MI	First Name		Date of Birth
Street Address		City	State	Zip Code
Phone Number		HAP CareSource Member ID Number		

By giving your cell phone number, you are saying that HAP CareSource may use it to reach you.

Section 2: Consent

This form gives your consent to share your health care information with others or on your own health care apps. It may be shared with your past, current, or future providers. It also may be shared with Health Information Exchanges (HIE). An HIE lets providers view the health care information that HAP CareSource has about you. You can ask for a list of people who were given your health care information by HAP CareSource.

☐ Check this box if you **want** your health care information shared with your past, current, or future providers or on health care apps. It will be shared for treatment, to manage your care, and to help with benefits. It includes sensitive health information. This includes treatment for substance use and HIV/AIDS. You have more control over what is shared on health care apps.

Or –

☐ Check this box if you **do not want*** your health care information shared with your past, current, or future providers. It will not be shared with your providers except:

- Your provider may see the physical and behavioral health treatment you have received. Treatment for substance use or HIV/AIDS will not be shared.
- Your health care information may be shared with a HIE. Treatment for substance use or HIV/AIDS will not be shared.

**Your providers may not be able to care for you as well as they could if you do not approve sharing.*

Section 3: Representative Designation

Fill out the lines below to name someone that HAP CareSource can speak to on your behalf. Your health care information will also be shared with this person.

Your Representative

Last Name	MI	First Name	
Entity Name (if law firm or other)			
Street Address	City	State	Zip Code
Phone Number			

Section 4: Review and Approval

By signing my name, I agree: To let HAP CareSource share my health care information as marked in Sections 2 and/or 3. The person or entity receiving the health care information could share it again. Federal privacy laws may no longer protect it. Treatment for substance use is private and cannot be shared again without my permission.

Signing this form is my choice. I may cancel this consent at any time. I must send a written letter to HAP CareSource to cancel. I may mail or fax the letter to the address at the bottom of this form. I may also cancel on **HAPCareSource.com**. Cancelling this consent will not change the actions HAP CareSource took before I cancelled. My treatment, payment, enrollment or benefits do not depend on whether I sign this form. ***Please sign below.***

Your Signature (Parent/Guardian for Minors or Legal Representative*)	Date:
Date this Consent Ends: *Consent ends on the date above or when a minor turns 18 years old. If no date is provided it will end five years after the date of the form.*	

**You must have a copy of the Power of Attorney or court papers if this is signed by a legal representative*. The lines below must also be filled out.

Legal Representative

First and Last Name	Choose one: ☐ Power of Attorney ☐ Court-Appointed Guardian or Custodian ☐ Other:		
Street Address	City	State	Zip Code

Please send this form to:

Mail: *HAP CareSource*
Attn: Privacy Office
P.O. Box 8738
Dayton, OH 45401-8738

Fax: 1-833-334-4722 (TTY: 711)

Online: HAPCareSource.com

Original effective date: April 13, 2003

Revisions: February 2005, November 2007, September 2013, September 2014, March 2015, October 2015, October 2018, October 2023, December 2023, August 2024, October 2025, February 2026, June 2026, October 2026

Reviewed: November 2008, November 2009, October 2011, January 2019, August 2020, September 2021, October 2022, October 2025, June 2026, October 2026

Want one-on-one help to understand your coverage?

1-833-230-2053 (TTY: 711)

HAPCareSource.com

MyLife.CareSource.com

Get free help in your language with interpreters and other written materials. Get free aids and support if you have a disability. Call **1-833-230-2053** (TTY: 711).

HAP CareSource™

Obtenga ayuda gratuita en su idioma a través de intérpretes y otros materiales en formato escrito. Obtenga ayudas y apoyo gratuitos si tiene una discapacidad.
Llame al: **1-833-230-2053** (TTY: 711).

Jwenn èd gratis nan lang ou ak entèprèt ansanm ak lòt materyèl ekri. Jwenn èd ak sipò gratis si w gen yon andikap. Rele **1-833-230-2053** (TTY: 711).

احصل على مساعدة مجانية بلغتك من خلال المترجمين الفوريين والمواد المكتوبة الأخرى. إذا كنت من ذوي الاحتياجات الخاصة، ستحصل على المساعدات والدعم مجانًا. اتصل على الرقم **1-833-230-2053** (TTY "الهاتف النصيّ للصم وضعاف السمع": 711).

通过口译员和其他书面材料，获得您所使用语言的免费帮助。 如果您有残疾，可以获得免费的辅助设备和支持。 请致电：**1-833-230-2053**（听语障人士专用电话：711）。

Erhalten Sie kostenlose Hilfe in Ihrer Sprache durch Dolmetscher und andere schriftliche Unterlagen. Beziehen Sie kostenlose Hilfsmittel und Unterstützung, wenn Sie eine Behinderung haben. Rufen Sie folgende Telefonnummer an: **1-833-230-2053** (TTY: 711).

Obtenez une aide gratuite dans votre langue grâce à des interprètes et à d'autres documents écrits. Si vous souffrez d'un handicap, vous bénéficiez d'aides et d'assistance gratuites. Appelez le **1-833-230-2053** (ATS : 711).

Nhận trợ giúp miễn phí bằng ngôn ngữ của quý vị với thông dịch viên và các tài liệu bằng văn bản khác. Nhận trợ giúp và hỗ trợ miễn phí nếu quý vị bị khuyết tật.
Gọi **1-833-230-2053** (TTY: 711).

Grick Helfe mitaus Koscht in dei Schprooch mit Iwwersetzer un annere schriftliche Dinge. Grick Aids un Helfe mitaus Koscht wann du en Behinderung hoscht. Ruf **1-833-230-2053** (TTY: 711).

आपकी भाषा के इंटरप्रेटर तथा आपकी भाषा में अन्य लिखित सामग्रियों संबंधी फ्री मदद पाएं। यदि आपको कोई डिसएबिलिटी हो, तो मुफ्त सहायता और सपोर्ट प्राप्त करें। कॉल करें **1-833-230-2053** (TTY: 711)

통역사와 기타 서면 자료의 도움을 귀하의 언어로 무료로 받으세요. 장애가 있을 경우, 보조와 지원을 무료로 받으세요. **1-833-230-2053** (TTY: 711) 로 문의하세요.

በአስተርጓሚዎች እና በሌሎች የጽሑፍ ቁሳቁሶች በቋንቋዎ ከክፍያ ነፃ እርዳታ ያግኙ። የአካል ጉዳት ካለብዎት ከክፍያ ነፃ እርዳታ እና ድጋፍ ያግኙ። ወደ **1-833-230-2053** (TTY 711) ይደውሉ።
Gba ìrànlọ́wọ́ ọ̀fẹ́ ní èdè rẹ pẹ̀lú àwọn ògbifọ̀ àti àwọn ohun èlò míràn tí a kọ sílẹ̀. Gba àwọn ìrànlọ́wọ́ àti àtìlẹ́yìn ọ̀fẹ́ bí o bá ní àìlera kan. Pe **1-833-230-2053** (TTY: 711).

Makakuha ng libreng tulong sa wika mo gamit ang mga interpreter at mga ibang nakasulat na materyales. Makakuha ng mga libreng pantulong at suporta kung may kapansanan ka. Tumawag sa **1-833-230-2053** (TTY: 711).

په خپله ژبه کې د ژباړونکو او نورو لیکلي شوو موادو له لاري وړیا مرسته ترلاسه کړئ. که تاسو معلولیت لرئ نو وړیا ملاتړ او مرستې ترلاسه کړئ. دې شمېرې ته زنګ ووهئ **1-833-230-2053** (TTY: 711).

వ్యాఖ్యాతలు మరియు ఇతర రాతపూర్వక మెటీరియల్స్‌తో మీ భాషలో ఉచిత సహాయాన్ని పొందండి. ఒకవేళ మీకు వైకల్యం ఉంటే, ఉచిత ఉపకరణాలు మరియు మద్దతు పొందండి. కాల్ చేయండి: **1-833-230-2053** (TTY: 711).

दोभाषे र अन्य लिखित सामग्रीहरूको माध्यमद्वारा आफ्नो भाषामा निःशुल्क मद्दत प्राप्त गर्नुहोस्। तपाईंलाई अशक्तता छ भने निःशुल्क सहायता र समर्थन प्राप्त गर्नुहोस्। **1-833-230-2053** (TTY: 711) मा कल गर्नुहोस्।

သင့်ဘာသာစကားအတွက် စကားပြန်များနှင့် အခြားပုံနှိပ်စာရွက်များကို အခမဲ့အကူအညီရယူပါ။ သင်သည် မသန်စွမ်းသူတစ်ဦးဖြစ်ပါက အခမဲ့အကူအညီများနှင့် အထောက်အပံ့များ ရယူပါ။ ဖုန်းခေါ်ရန် - **1-833-230-2053** (TTY: 711)

Bōk jibañ ilo an ejjelok wōnāān ikkijjien kajin eo am ibbān rukok ro im wāween ko jet ilo jeje. Bōk jerbalin jibañ ko ilo an ejjelok wōnāer im jibañ ko ñe ewōr am nañinmejin utamwe. Kalle **1-833-230-2053** (TTY: 711).

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HAP CareSource™

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Mail: HAP CareSource
Attn: Civil Rights Coordinator
P.O. Box 1947
Dayton, OH 45401

Phone: 1-844-539-1732 (TTY: 711)

Fax: 1-844-417-6254

Email: CivilRightsCoordinator@CareSource.com

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights.

Mail: U.S. Department of Health and Human Services 200 Independence Ave., S.W. Room 509F, HHH Building Washington, D.C. 20201. Mail the complaint form found at www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf.

Phone: 1-800-368-1019 (TTY: 1-800-537-7697)

Online: ocrportal.hhs.gov

You can find this notice at **HAPCareSource.com**.

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