

# Michigan Consumer Guide to Health Insurance



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**Find more information at [www.michigan.gov/difs](http://www.michigan.gov/difs).**

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# Introduction

The Michigan Department of Insurance and Financial Services (DIFS) is the agency responsible for regulating Michigan's financial industries, including health insurance companies, products and agents.

This guide provides consumers with information about the basics of health coverage so Michigan residents can make informed decisions. There are several types of health insurance policies and health care plans with many different features available. Individual coverage can be purchased directly by the consumer or group health coverage can be obtained through an employer.

Health carriers provide health coverage through several different entity types, the most common are health insurance companies or health maintenance organizations (HMOs). **Throughout this guide “health carrier” will mean any one of these entity types. When there is a difference between entities, the health carrier type will be specified.**

In addition to educating consumers about the industries it regulates, DIFS licenses health carriers and agents, makes sure the carriers are financially sound, reviews policies for consumer protections, and investigates potential violations of insurance law by companies and agents. DIFS reviews health coverage rates for individual health plans, small employer group plans, HMOs and other types of coverage.

DIFS investigates complaints against health carriers or insurance agents to ensure that they have followed their contract language and complied with all insurance rules and laws. Additionally, under the Patient's Right to Independent Review Act (PRIRA), DIFS provides policyholders with appeal rights due to adverse decisions made by health carriers regarding a denial, reduction, or termination of health care services.



# Employer Group Coverage

An employer is not required to provide health coverage to employees or their dependents. However, under the Affordable Care Act, starting in tax year 2015, an employer with 100 or more employees may be assessed a tax penalty for coverage not offered to its full-time employees and their dependent children. Additionally, the employer may have to pay a tax penalty if they don't offer affordable coverage that provides "minimum value" for at least 70 percent of their full-time employees and their dependents in 2015. In 2016 the required percentage is 95 percent of covered employees and the requirement to provide coverage or pay a penalty applies to employers with 50 or more employees.

Additionally under the Affordable Care Act, there are requirements for non-grandfathered employer health plans, including limits on out-of-pocket expenditures and waiting periods, no annual or lifetime dollar limits on coverage of essential health benefits, no cost-sharing for preventive services, and offering coverage to adult children up to age 26.

In group coverage, the employer is the master policyholder and the employees are certificate holders. The master policyholder negotiates the terms of the group policy with the health carrier. The master policyholder can reduce or change the benefits and coverage, increase the employee share of the premium cost, switch health carriers or stop providing coverage entirely. The master policyholder determines who has coverage and makes requests to the health carrier for additions or deletions of employees from the plan.

Some employers offer more than one plan for coverage and the employees may choose which plan best meets

their needs or is most cost-effective for their situation. All group health care contracts must include specific minimum benefits required by Michigan law. For more information, see page 14 in this guide.

## Employee Premiums

Coverage and rates may change annually. The employer decides what portion of the coverage is paid by the employees. In some cases, the health carrier may require that the employer pay a minimum percentage of the premium. However, under the Affordable Care Act for the employer-based coverage to be considered affordable, the employee's premiums for the plan's employee-only option must be less than nine and a half percent of the employee's annual household income. To offer "minimum value," the plan must pay at least 60 percent of the medical costs for services the plan covers. If either one of the above does not apply, then the employee may receive a tax credit toward the purchase of insurance in the Health Insurance Marketplace and the employer may be subject to a tax penalty.

## Enrollment

Employees should be aware of the employer's group enrollment policies. Employers can require a waiting period not longer than 90 days before group coverage is first effective for new employees or before they can enroll in the coverage. Employees should be aware of any deadline when first applying for the group coverage. Employers have an annual open enrollment period for employees to add or change coverage. Employer changes in the group plan are also communicated to the employees at this time. Special enrollment periods are allowed when certain events occur such as a birth, adoption, marriage, death, or loss of a job, etc.



# Employer Group Coverage *cont'd*

## Wellness Plans

Michigan law allows health carriers to offer wellness programs. A workplace wellness program consists of tools such as a health risk assessment and a biometric assessment, both of which measure health-risk factors, and programs designed to address those health-risk factors. Many employer group plans include wellness programs as an option.

Under the Affordable Care Act, health carriers must offer a wellness program if the carrier is using tobacco rating on any group or individual policy.

## Self-funded Health Care Plans

If you work for a large employer or a government agency, there is a good chance your health care plan is self-funded or self-insured. This means that the employer accepts the risk rather than transferring the risk to an insurer. It is not insurance, although a self-funded health care plan may look like insurance to the employee.

Self-funded health care plans may work best for employers that are large enough to offer substantial coverage and pay expensive claims for medical services. As long as claims are being paid, you may not notice whether your employer has provided coverage through a fully insured plan or a self-funded health care plan.

Employers contract with entities such as insurance companies and third party administrators to administer the self-funded health care plan. Administering the plan means the contracted

entity collects premiums and processes claims on behalf of the employer.

DIFS does not have authority over the contracts for self-funded health care plans created by employers, but DIFS does have authority over the administrators of these plans. In the case of local government plans, such as cities, counties, state colleges and universities and the State of Michigan, DIFS handles external appeals, or requests by a consumer for an independent review of a denial, reduction or termination of a health service, for these plans, regardless of whether the plan is fully insured or self-funded.

The easiest way to find out if your health care plan is self-funded or fully insured is to ask your employer. You may also find the answer in the benefit information provided by your employer. Often the word “plan” or “Summary Plan Description” is included as part of the name of the coverage if it is a self-funded health care plan. Most large employers provide health care benefits through self-funded health care plans.

## Losing Employer Coverage

If you lose group health coverage through your employer, you may have federal COBRA rights, group conversion rights and/or you may be eligible to purchase coverage in the Health Insurance Marketplace. For more information on your options, see page 20 in this guide.



# Individual Coverage

If you do not have access to group health coverage and are not eligible for the Healthy Michigan Plan, Medicaid or Medicare, individual health coverage may be purchased through a licensed agent, directly from the health carrier or through the Health Insurance Marketplace. A list of carriers that sell individual policies is available at the “Are you shopping for insurance?” tab at [www.michigan.gov/hicap](http://www.michigan.gov/hicap).

You are the policyholder on an individual policy. Your policy can cover you and your eligible dependents. With the implementation of the Affordable Care Act, an insurance company cannot decline your application for coverage based on a pre-existing condition. If you are a Michigan resident and do not have access to group coverage, you may want to visit the Health Insurance Marketplace at [www.healthcare.gov](http://www.healthcare.gov) or call the Marketplace toll free at 800-318-2596 or contact an agent or carrier directly to obtain coverage.

## Open Enrollment

Generally speaking for coverage in 2014, most individual plans were only available for purchase during the open enrollment period of October 1, 2013 through March 31, 2014. For coverage in 2015, the open enrollment period is November 15, 2014 through February 15, 2015. To find out what options may be available outside of open enrollment, call DIFS at 877-999-6442.

## Health Coverage Requirement

Beginning in 2014, the “individual mandate” provision of the Affordable Care Act requires that people obtain health insurance or pay a federal tax penalty. If you currently have coverage through the Healthy Michigan Plan, Medicare, Medicaid or an employer, you are considered covered and will not pay a federal tax penalty. If you currently purchase an individual plan that has major medical coverage you are likely considered covered and will not pay a federal tax penalty.

Those who do not have or do not obtain coverage will pay a federal tax penalty. The amount of the penalty for an individual is as follows:

- In 2014 — the greater of \$95 per adult or one percent of taxable income
- In 2015 — the greater of \$325 per adult or two percent of taxable income
- In 2016 — the greater of \$695 per adult or two and a half percent of taxable income

You may be exempt from paying the penalty for not having coverage if you have a financial hardship, religious objection, belong to a health care sharing ministry, if your 2013 individual policy was canceled or if it would cost more than eight percent of your income to purchase coverage. Visit [www.irs.gov/aca](http://www.irs.gov/aca) for more information on the federal tax penalty.

## Required Benefits

Individual policies must include specific minimum health care benefits required by Michigan and federal law, including essential health benefits. Individual plans, including health plans used in conjunction with Health Savings Accounts with high deductibles, can have varying copayments, co-insurance and deductibles. These deductibles are subject to limits set by the Internal Revenue Service. For more information see page 14 in this guide.

## Premiums

The monthly premium cost for your individual coverage depends on the type of plan chosen, your age, where you live, the number of eligible family members or eligible dependents covered under your plan and tobacco use. Premiums can increase each plan year to reflect the increasing cost of health care.

## Healthy Michigan Plan

If you are uninsured and looking for coverage, you may be eligible for the Healthy Michigan Plan, a new program passed by the Michigan legislature and signed into law by Governor Snyder that began on April 1, 2014. To be eligible for the Healthy Michigan Plan, you must be:

- Ages 19-64.
- Not currently eligible for Medicaid.
- Not eligible for or enrolled in Medicare.
- Not pregnant when applying for the Healthy Michigan Plan.
- Earning up to 133 percent of the federal poverty level (The federal poverty level is adjusted annually. In 2013, 133 percent of the poverty level for an individual was approximately \$16,000 or \$33,000 for a family of four.)
- A resident of Michigan.

Visit [www.HealthyMichiganPlan.org](http://www.HealthyMichiganPlan.org) or call 855-789-5610 for more information.



# Medicare, Medicare Supplement & Medicare Advantage Coverage

This section is dedicated to products that are generally considered to be “senior” health coverage products. The information in this section includes Medicare, Medicare Supplement, and Medicare Advantage. Individuals that have reached the age of 65 usually purchase coverage related to Medicare. However, the information is also relevant to persons who are under the age of 65 and are on Medicare.

## Medicare

Medicare is a federal government program that provides health coverage to persons age 65 or over, persons who are disabled, persons who have been receiving Social Security benefits for 24 months, and persons who are receiving kidney dialysis treatments (who are eligible for Part B of Medicare).

Medicare is divided into two main parts:

- **Part A hospital coverage:** Part A is hospital coverage for which most people are automatically eligible upon turning 65. It is financed by taxes on employers and employees. Part A has a deductible that you must pay before Medicare will begin paying for health care services. The Part A deductible will be charged each time there is a hospitalization as long as there are 60 days between hospitalizations. Once the deductible is paid, Medicare will pay a share of the covered health care expenses and you will be responsible for a share of the covered health care expenses. Part A also provides coverage for hospice care, limited skilled nursing care and home health care.

- **Part B medical coverage:** Part B is doctor and outpatient coverage, and is optional to purchase. It is financed by individual monthly premiums, usually deducted from a person’s Social Security check. Part B also has a deductible, but the Part B deductible is an annual deductible. Under Part B, Medicare will pay 80 percent of covered health care costs and you will be responsible for 20 percent of the covered health care costs that Medicare does not pay. Under the Affordable Care Act, Part B now covers some preventive services, including a yearly wellness visit without a deductible or coinsurance.

Medicare deductibles and coinsurance amounts are adjusted on an annual basis.

## More Information on Medicare

For more information on the Medicare program, what is covered, and the changes that have recently been made to the program, please visit [www.medicare.gov](http://www.medicare.gov). The website has a lot of information, including a “Frequently Asked Questions” section that covers many topics. You may also want to review the publication “Your Medicare Rights and Protections,” which is available at [www.medicare.gov](http://www.medicare.gov).

## Medicare Supplement Policies

A Medicare supplement policy is designed to help pay for the costs that are not paid by Medicare for covered health care costs (i.e., deductibles and coinsurance amounts). Medicare supplement policies are often referred to as “Medigap” policies. You should consider purchasing a Medicare supplement policy if you do not have employer or retiree health care coverage and can afford to pay a monthly

Medicare supplement premium. A Medicare supplement policy must provide benefits that are designed to cover cost-sharing amounts under Medicare and will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. A Medicare supplement policy is guaranteed renewable. Medicare supplement policies can be terminated only for nonpayment of premium or material misrepresentation only.

### Medicare Supplement Plans Basic Core Benefits

Every Medicare supplement plan includes all of the following:

- Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end;
- Medical Expenses: Part B coinsurance (generally 20 percent of Medicare-approved expenses) for hospital out-patient services;
- Medicare Part A and B blood coverage: first three pints of blood per calendar year; and
- Medicare Part A Hospice coinsurance.

### Medicare Supplement Standardized Plans

- Plan A includes only the basic core benefits.
- Plan B includes the basic core benefits and the Medicare Part A deductible.
- Plan C includes the core benefits, the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, and medically necessary emergency care in a foreign country.
- Plan D includes the core benefits, the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country.
- Plan F includes the core benefits, the Medicare Part A deductible, skilled nursing facility care, Medicare Part B deductible, 100 percent of the Medicare Part B excess charges, and medically necessary emergency care in a foreign country. Plan F also offers a high deductible option. The deductible increases every year and premiums are typically lower than other Medicare supplement policies. However, you must meet the deductible before the policy will cover your health claims. In 2014, the deductible for this plan is \$2,140.
- Plan G includes the core benefits, the Medicare Part A deductible, skilled nursing facility care, 100 percent of the Medicare Part B excess charges and medically necessary emergency care in a foreign country.

- Plan K includes the core benefits. Plan K only provides 50 percent of the cost sharing for Medicare Part A covered hospice expenses and the first three pints of blood. It also only pays 50 percent of the Part B coinsurance after you meet your annual deductible. Once you meet your annual out-of-pocket spending limit, Plan K will pay 100 percent of all Part A and B deductibles, copayments and coinsurance. In 2014, the out-of-pocket limit for Plan K is \$4,940.
- Plan L includes the core benefits. Plan L only provides 75 percent of the cost sharing for Medicare Part A covered hospice expenses and the first three pints of blood. It also only pays 75 percent of the Part B coinsurance after you meet your annual deductible. Once you meet your annual out-of-pocket spending limit, Plan L will pay 100 percent of all Part A and B deductibles, copayments and coinsurance. In 2014, the out-of-pocket limit for Plan L is \$2,470.
- Plan M includes the core benefits, 50 percent of the Medicare Part A deductible, skilled nursing facility care and medically necessary emergency care in a foreign country.
- Plan N includes the core benefits, Medicare Part A deductible, skilled nursing facility care, and medically necessary emergency care in a foreign country. Plan N pays 100 percent of the Part B coinsurance, except up to \$20 copayment for office visits and up to \$50 for emergency department visits.

### Medicare Select

A Medicare select policy is a Medicare supplement policy (Plan A through N) that conditions the payment of benefits, in whole or in part, on the use of network providers. Network providers are providers of health care, or a group of providers of health care, which have entered into a written agreement with the insurance company to provide benefits under a Medicare select policy. A Medicare select policy cannot restrict payment for covered services provided by non-network providers if the services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury, or condition and it is not reasonable to obtain such services through a network provider. A Medicare select policy must provide payment for full coverage under the policy for covered services that are not available through network providers.

# Medicare, Medicare Supplement & Medicare Advantage Coverage *cont'd*

## **Your Right to Return a Medicare Supplement Policy**

The policy is your contract. You must read the policy itself to understand all of the rights and duties of both you and your health carrier. If you find that you are not satisfied with your policy, you may return it to the health carrier. If you send the policy back within 30 days after you receive it, the health carrier will treat it as if it had never been issued and return all of your premium payments.

## **Replacing Your Existing Medicare Supplement Policy with one from a Different Company**

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it. Any agent selling a Medicare supplement policy that will replace another Medicare supplement policy with a different health carrier must provide you with a notice regarding replacement of Medicare supplement coverage.

## **Medicare Supplement Open Enrollment Period**

The best time to purchase a Medicare supplement policy is during the open enrollment period. The open enrollment period begins on the first day of the month in which you are both: age 65 or older and enrolled in Medicare Part B. The open enrollment period lasts six months, during which you can purchase any Medicare supplement plan that any company offers, even if you have health problems. If you apply for a Medicare supplement policy after your six month open enrollment period, unless you meet certain qualifying circumstances, you may not be able to buy a Medicare supplement policy if you don't meet a carrier's medical underwriting requirements. For more information about your options after the open enrollment period, contact 800-MEDICARE or the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800-803-7174.

## **Becoming Eligible for Medicaid while You Have a Medicare Supplement Policy**

Benefits and premiums under a Medicare supplement policy will be suspended at your request for a period not to exceed 24 months. You must notify the health carrier within 90 days after you become eligible for Medicaid. The health carrier must return to you the portion of the premium attributable to the period of Medicaid eligibility, subject

to adjustment for paid claims. If you lose your entitlement to Medicaid, the policy shall be automatically reinstated effective as of the date of termination of the eligibility.

## **Treatment of Pre-Existing Conditions under Medicare Supplement Policies**

A claim filed under a Medicare supplement policy cannot be denied as a pre-existing condition if the condition was last treated more than six months prior to the effective date of the Medicare supplement policy. The policy cannot define a pre-existing condition more restrictively than to mean a condition for which medical advice was given or treatment was recommended by or received from a physician within six months prior to the effective date of coverage. A Medicare supplement policy cannot use riders or endorsements to exclude, limit, or reduce coverage or benefits for specifically named or described pre-existing diseases or physical conditions. If a Medicare supplement policy replaces another Medicare supplement policy, the replacing health carrier must waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, and probationary periods in the new Medicare supplement policy for similar benefits to the extent such time was spent under the original coverage.

## **Medicare Advantage (MA) Plans**

Medicare Advantage plans are offered by private companies approved by the federal government. These plans are sometimes called "Part C" or "MA plans." Medicare Advantage plans actually replace original Medicare coverage and will provide all of Part A and Part B coverage and must cover all of the services that original Medicare covers except for hospice care. Medicare Advantage plans may require the use of network providers and may pay different copayments, coinsurance and deductibles than original Medicare. They may also offer extras, including vision, hearing or dental coverage. Many MA plans include Medicare prescription drug coverage. Medicare Advantage plans are not Medicare supplement policies even though they cover many of the same benefits as Medicare supplement policies. For this reason, individuals do not need a Medicare Advantage plan and Medicare supplement plan at the same time.

Medicare Advantage plans are under the sole authority of the Center for Medicare and Medicaid Services, a federal agency. The Department of Insurance and Financial Services (DIFS) does not have authority over Medicare Advantage plans, but DIFS does license most of the health carriers that issue Medicare Advantage plans in Michigan. This means that DIFS does not review or approve the contract language or the rates for Medicare Advantage plans.

### **Open Enrollment for Medicare Advantage Plans**

You may only enroll, switch or drop a Medicare Advantage plan during certain times of the year. Once enrolled in a Medicare Advantage plan, you must stay enrolled for the calendar year starting the date your coverage begins. There are limited circumstances during which you may be able to change your coverage. For more information, call 800-MEDICARE or the Michigan Medicare/Medicaid Assistance Program (MMAP) at 800-803-7174.

### **Medicare Prescription Drug Coverage (Part D)**

Prescription drug coverage is available to everyone with Medicare and is offered by Medicare prescription drug plans or Medicare Advantage Plans. Medicare prescription drug plans are voluntary. If you want prescription drug coverage under Medicare, you must choose a plan offering the coverage that best meets your needs and then enroll. Health carriers will offer a variety of options, with different covered prescriptions, and different costs. You may only join, switch or drop Medicare prescription drug coverage during certain times. Once enrolled, you generally must stay enrolled for the calendar year starting the date your coverage begins. Medicare prescription drug plans will charge a monthly premium that varies by plan. This premium is in addition to the Medicare Part B premium. Medicare Advantage plans that include prescription drug coverage may include an amount for the prescription drug coverage in their monthly premium. The amount you pay for Medicare prescription drug coverage may be higher based on your income.

Medicare prescription drug plans may have yearly deductibles that must be met before the plan begins to pay its share of your covered drugs. They may also have copayments and coinsurance that must be paid after the deductible has been met. Medicare prescription drug plans also have a coverage gap commonly known as the “donut hole.” This means after you and your Medicare prescription drug plan have spent a certain amount of money, you then have to pay all of the out-of-pocket costs for your prescriptions up to a yearly

limit. If you reach the coverage gap or “donut hole” in one year, you will get a certain discount on covered, brand name prescription drugs. In 2014, this discount is 52.5 percent. The Affordable Care Act will reduce and eventually eliminate the coverage gap in Medicare prescription drug plans.

If you have retiree health coverage or are covered under an employee group health plan, please watch for any information that is sent by the employer. You may not have to make any changes. If you do not understand the information you receive from your current or former employer, contact the company’s human resources department or use the contact number provided on any written communication you receive.

The Department of Insurance and Financial Services (DIFS) does not have authority over Medicare prescription drug plans. Medicare prescription drug plans are solely under the authority of the Center for Medicare and Medicaid Services, a federal agency. This means that DIFS does not review or approve the contract language, the list of covered prescription drugs or the rates for Medicare prescription drug plans.

### **Michigan Medicare/Medicaid Assistance Program (MMAP)**

The Michigan Medicare/Medicaid Assistance Program (MMAP) provides free counseling services for Medicare and Medicaid beneficiaries and their caregivers. MMAP can assist in making health benefit decisions. For free senior health insurance counseling, visit [www.mmapinc.org](http://www.mmapinc.org) or call 800-803-7174.





# Types of Health Plans

Whether you get health coverage at work or buy a plan on your own, understanding how your policy works will help you make the best use of your benefits.

## Traditional

In the past, most individual health coverage consisted of “traditional” fee-for-service plans where the patient had a great deal of freedom in choosing their doctors and other providers and medical expenses were incurred and then reimbursed by the health carrier. “Traditional” fee-for-service plans are different from managed care plans. Fewer traditional types of individual plans exist now as managed care plans have become more common.

## Managed Care

Managed care is mostly seen in employer group health plans, but many individual plans now have varying elements of managed care. Features of managed care include carrier control of access to providers, risk sharing of providers, utilization and quality management and preventive care. Managed care can be seen in several types of plans and variations of plans, including those described below.

- **Health Maintenance Organizations (HMOs)** — A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in its service area to be eligible for coverage. HMOs often provide integrated care and focus on prevention and wellness.
- **HMO Point-of-Service Plan** — These HMO plans are a hybrid arrangement that combine aspects of traditional insurance coverage and HMO coverage. At the time of medical treatment, the HMO member can elect whether to receive treatment for specified services within the HMO's network of contracted

health care providers or outside of the network. There may be higher member out-of-pocket costs for health care services received outside of the HMO network.

- **Preferred Provider Organization (PPO)** — A PPO is not a specific type of health coverage; instead, it is a contract between a health carrier and a PPO or network of providers such as selected hospitals, physicians, and others who agree to provide services at an agreed-upon rate. PPOs may be less restrictive than HMOs in that PPOs allow members or enrollees to receive benefits for services rendered by any provider (with increased benefits or lower out-of-pocket costs if a network provider is used).
- **Preferred Provider Arrangement (PPA)** — A PPA is not a specific type of health coverage but rather an optional feature of a health benefit plan. The plan makes an identified network of participating providers or selected providers available to the insured in order to obtain cost-effective medical services.



## Medical and Hospital Plans

While there are many types of plans approved for use in Michigan, not all plans will meet the “minimum essential coverage” requirements under the Affordable Care Act that would exempt someone from paying the federal tax penalty for not obtaining health coverage. For more information on what constitutes minimum essential coverage, visit [www.healthcare.gov](http://www.healthcare.gov). The following are the types of medical and hospital plans available in Michigan:

- **Major Medical Coverage** — Although not defined in Michigan law, major medical coverage usually pays the cost of inpatient hospital care and outpatient medical bills, such as lab tests, office visits, physical therapy, and x-rays, and may include prescription coverage. You pay any appropriate copayments and deductibles. The policy covers only the eligible expenses listed in the contract or certificate of coverage. Make sure you read the contract carefully to determine your deductibles, copayments, coinsurance, covered benefits and exclusions. The maximum out-of-pocket cost limit (deductibles, copayments, and coinsurance) for any individual plan for 2014 can be no more than \$6,350 for an individual plan and \$12,700 for a family plan.
- **Basic Hospital-Surgical Expense Coverage** — This coverage usually pays only expenses directly related to inpatient hospital care as defined in the certificate of coverage or policy. Inpatient hospital care includes the cost of surgery, doctors’ services and treatments you receive after you are admitted to the hospital.
- **Short-Term Coverage** — This coverage is limited to a specified period of time, but for no longer than 180 days. For example, you might buy a six-month policy with major medical coverage for the months that you are between jobs and therefore without group health coverage. These policies do not cover pre-existing conditions.
- **Catastrophic Health Coverage** — A medical expense coverage that provides benefits only after a certain amount of medical expenses, sometimes as high as \$6,350, has been incurred and paid for by the policyholder. In the Marketplace, catastrophic plans are available only to people under age 30 and some low-income people who are exempt from paying the federal tax penalty because other insurance is considered unaffordable or because they have received hardship exemptions. Visit <https://www.healthcare.gov/can-i-buy-a-catastrophic-plan/> for more information.
- **High Deductible Plans** — These plans are major medical expense plans, but are often sold in conjunction with Health Savings Accounts. They pay the cost of inpatient hospital care and outpatient

medical bills but have high deductibles, currently more than \$1,200 (or \$2,400 for a family), that are paid from your federally tax exempt Health Savings Account. High deductible plans also have a maximum out-of-pocket amount that is paid in deductibles, copayments, and coinsurance. For 2014, the maximum out-of-pocket amount for an individual is \$6,350 or \$12,700 for a family.

## Limited Purpose Indemnity Plans

While these types of plans are approved for use in Michigan, they do not meet the minimum coverage requirements under the Affordable Care Act that would exempt one from paying the federal tax penalty for not obtaining health coverage in 2014. The following are the types of limited purpose indemnity plans available in Michigan:

- **Accident Only Policy** — This is a policy that provides cash payments in the event of injury or death resulting from a covered accident within a specified period of time. This type of policy pays only when you are treated for an accidental injury or if an accident causes death.
- **Hospital Indemnity Policy** — This is a policy of limited medical coverage that pays cash benefits in the event of hospitalization and/or surgery resulting from an illness or injury. This type of plan pays you a flat cash amount, such as \$100 per day when you are hospitalized.
- **Specified (Dread) Disease Policy** — This policy provides per day, per service, expense-incurred, and/or lump-sum benefit payments upon the occurrence of medical events or diagnoses related to the treatment of a disease named in the policy. These are sometimes sold as “cancer policies.”
- **Incidental Policies** — Individual policies for dental and/or vision benefits pay for care not covered by typical major medical policies and may be available on a limited basis.



# Shopping for Health Coverage or Comparing Health Plans

## Health Coverage Requirement

Beginning in 2014, the “individual mandate” provision of the Affordable Care Act requires that people obtain health insurance or pay a federal tax penalty.

For more information on the tax penalty or exemptions to the penalty, see page 22 or visit: [www.irs.gov/aca](http://www.irs.gov/aca) or call 800-829-1040.

## Open Enrollment for Individual Coverage

Generally speaking, for coverage in 2014, most individual plans were only available for purchase within the open enrollment period of October 1, 2013 through March 31, 2014. For coverage in 2015, the open enrollment period is November 15, 2014 through February 15, 2015. During open enrollment, individuals can shop for coverage in the Health Insurance Marketplace or outside in the overall market. The Health Insurance Marketplace, or Health Insurance Exchange, is a new, optional place to shop for and compare health coverage. To access the Marketplace or to learn more, visit: [www.healthcare.gov](http://www.healthcare.gov) or call 800-318-2596 or see page 24. To find out what options may be available outside of open enrollment, call DIFS at 877-999-6442.

## Special Enrollment Periods Outside of Open Enrollment

Certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other job-based health coverage entitle a person to a special enrollment period (outside of the standard open enrollment period) in the Health Insurance Marketplace or in the overall market.

## Ways You Can Buy a Plan

- Through the Health Insurance Marketplace. Visit: [www.healthcare.gov](http://www.healthcare.gov) or call 800-318-2596.
- Directly from an insurance company.
- With the help of a licensed agent.
- With the help of a federally trained navigator or certified application counselor. Navigators and certified application counselors can help you sign up for a Marketplace plan.
- From an online health insurance seller.

Some insurance companies, agents, and online insurance sellers can sell you plans through the Marketplace. All of

them must sign agreements with the Marketplace in order to sell Marketplace plans. In order to receive a tax credit to help with the cost of coverage, you must apply through the Marketplace.

## Things to Think About When Shopping for Coverage

Before shopping, you may wish to view page 10, “Types of Health Plans” to learn more about different types of policies available to consumers, certain minimum coverage requirements and explanations of many key terms. Consider the following when shopping for health coverage:

- **Do your best to balance the cost (monthly premium) of a policy with the protection it offers.** It is important to understand that what you pay as a monthly premium alone does not indicate the total cost you pay for your health care. Generally speaking, the lower your monthly premium, the greater your portion of health care costs will be when you seek medical treatment.
- **Determine what you will have to pay for covered services in a deductible, coinsurance, copayments, and out-of-pocket limit.** To see a definition and explanation of those terms, review the Glossary of Health Coverage and Medical Terms on page 29 of this guide. If you buy a plan for your family, determine if the deductible amount is per person or a combined family total. An individual plan purchased for 2014 must limit out-of-pocket costs to \$6,350 for an individual and \$12,700 for a family.
- **Determine what benefits are covered without having to meet the deductible in advance.** All new plans must cover certain preventive care services free of charge and without having to pay a portion towards the deductible. In addition, some plans may exempt a certain number of physician visits or prescription drugs from the deductible. Some plans may not exempt any services from the deductible other than the required preventive services. You may also want to determine what copayments are required before and after a deductible is met.
- **Determine the access to care.** You may want to find out if you would need to designate a

primary care physician, if you would need a referral to see a specialist and what providers would require a prior approval. If you have a doctor or hospital that you prefer, you may want to pick a plan that participates with that provider.

## Questions to Ask Before Choosing Coverage:

### Costs and Coverage Limits

- What will your premiums cost and how often are they paid?
- How much is the annual deductible, copayment, or coinsurance?
- How often will you have to pay the deductible or copayment (e.g., yearly or each time you use a service)?
- Is the annual deductible per person or per family and how much?
- Are there separate deductibles for medical and prescription costs?
- Are there limits on the number of visits for certain types of care?
- In the worst-case scenario, what is the most you will pay in a calendar year for covered services (the out-of-pocket maximum)? (Don't overlook any non-covered services that you will have to pay.)

### Benefits

- What does the plan pay for?
- What does the plan exclude?
- Does the plan cover prescriptions?
- Are your prescriptions on the list of covered drugs?
- Are there tiers, or pricing levels, for prescription drug coverage?
- Does the plan cover services you might need? (For example, pregnancy, psychiatric care, physical therapy, chiropractic care, acupuncture, infertility treatment, morbid obesity weight management, etc.?)

### Doctor Choice

- Can you keep your current doctor(s)?
- Does the plan require you to pick a primary care doctor out of a specific group of doctors or can you choose your own doctor?
- If you need to choose a doctor, are the doctors in the network taking new patients?
- Does the plan require referrals for specialists?
- Does the plan require prior authorization for certain services?

- Does the plan have doctors, pharmacies, and hospitals near your home or work?
- If you travel frequently, what kind of coverage can you expect in those areas outside of the health carrier's service area?
- If you have dependents living outside of the plan's service area, what kind of coverage is provided?
- If you want to choose a doctor or provider outside of the network, will your plan pay any portion of the cost?

### Quality and Service

- How long does it take to reach a person when you call the company?
- Does the health carrier get a significant number of consumer complaints? (You can view health carrier complaint ratios at DIFS' website: [www.michigan.gov/difs](http://www.michigan.gov/difs)).
- Is the insurance agent and/or health carrier licensed in Michigan? (You can look up a license at DIFS' website, [www.michigan.gov/difs](http://www.michigan.gov/difs)).

### Optional Methods to Compare Health Carriers

Note: The Department of Insurance and Financial Services does not rate or recommend health carriers.

### Private Rating Firms

Several private firms specialize in evaluating the finances and services of insurance companies or health maintenance organizations. Each of these agencies has its own methods and standards and gives grades to the companies based on their judgment of how well the company is doing.

Contact information for some of the most popular rating firms is listed below. There may be a charge for some reports. Several of these rating firms publish books with their ratings, so you may also be able to find what you need at your local library. Before you rely on any report, make sure you understand the rating system because each firm has its own. For example, one firm may use "A+" as its top grade, while another may go all the way up to "A+++."

A.M. Best Company  
Phone: 908-439-2200  
[www.ambest.com](http://www.ambest.com)

Fitch Investor's Service  
Phone: 800-853-4824  
[www.fitchibca.com](http://www.fitchibca.com)

Moody's Investor Service  
Phone: 212-553-0377  
[www.moody.com](http://www.moody.com)

Standard & Poor's  
Phone: 212-438-1000  
[www.standardandpoors.com](http://www.standardandpoors.com)



# What Medical Care Must My Health Carrier Pay For?

Health carriers pay for the medical treatments defined in your policy. They do not pay for the medical treatments listed in the policy exclusions. Health carriers only pay for medical treatments that are medically necessary. “Medically necessary” is defined in your insurance policy or certificate of coverage. Health carriers often do not pay for medical treatments that are considered experimental or investigational.

Health carriers may require that you get prior approval for medical treatment from the carrier before the carrier will pay for the treatment. This is generally referred to as “prior authorization” and may be required for certain procedures, surgeries, or to see a specialist or non-contracted health care provider.

A health carrier cannot deny payment for emergency health services because of the diagnosis or the fact that prior authorization was not given before the emergency services were provided. Health carriers must give you a written explanation about coverage for emergency medical treatment.

Under the Affordable Care Act, most new health plans must cover specific preventive care services without cost-sharing to consumers. This means you will not have copays, coinsurance, or deductibles for certain services as long as they are provided by in-network doctors or medical staff. Some examples of preventive services are:

- breast and colon cancer screenings,
- screenings for diabetes, high cholesterol, and high blood pressure,
- routine vaccines,
- regular pediatrician visits,

- vision and hearing screening, and
- counseling to address obesity.

For a more comprehensive list of covered preventive services, visit: [www.healthcare.gov/prevention](http://www.healthcare.gov/prevention).

## Coverage Requirements under State Law

Under state law, there are certain benefits that most health coverage contracts issued in Michigan must include. There are other benefits that are not required to be included in a policy, but if the coverage is included in the policy, the health carrier has certain responsibilities concerning that coverage. The minimum coverage benefits are listed below. The information below only applies to policies that are written on an “expense incurred” basis. This type of policy pays for the actual expenses that were incurred for health care services received. The other type of policy is referred to as an “indemnity” based policy. This type of policy pays a pre-set amount for health care services received, regardless of the actual amount charged for those services. The information below does not apply to limited purpose indemnity policies.

### 1) Diabetes Treatment

The health carrier must establish a program to prevent the onset of clinical diabetes and the contract must include coverage for equipment, supplies, and educational training for the treatment of diabetes.

This mandate includes coverage for:

- Blood glucose monitors and blood glucose monitors for the legally blind;
- Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices;

- Syringes;
- Insulin pumps and medical supplies required for the use of an insulin pump; and
- Diabetes self-management training.

If the policy includes prescription coverage directly or by rider, the health carrier must include the following coverage for the treatment of diabetes, if determined to be medically necessary:

- Insulin, if prescribed by an allopathic or osteopathic physician;
- Non-experimental medication for controlling blood sugar, if prescribed by an allopathic or osteopathic physician; and
- Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by an allopathic, osteopathic, or podiatric physician.

“Diabetes” includes gestational diabetes, insulin-dependent diabetes, and non-insulin-dependent diabetes.

## 2) Breast Cancer Diagnostic Services

The health carrier must offer or include coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

Breast screening mammography must be allowed using the following schedule:

- (a) For a woman 35 years of age or older and under 40 years of age, coverage for one screening mammography examination during that 5-year period.
- (b) For a woman 40 years of age or older, coverage for one screening mammography examination every calendar year.

## 3) Mastectomy

The health carrier must offer benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This includes medical care for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device.

## 4) Hospice Care

If the health carrier provides coverage for inpatient hospital care, it must also offer coverage for hospice care and include a description of the coverage in the contract.

## 5) Chemotherapy (Cancer Treatment)

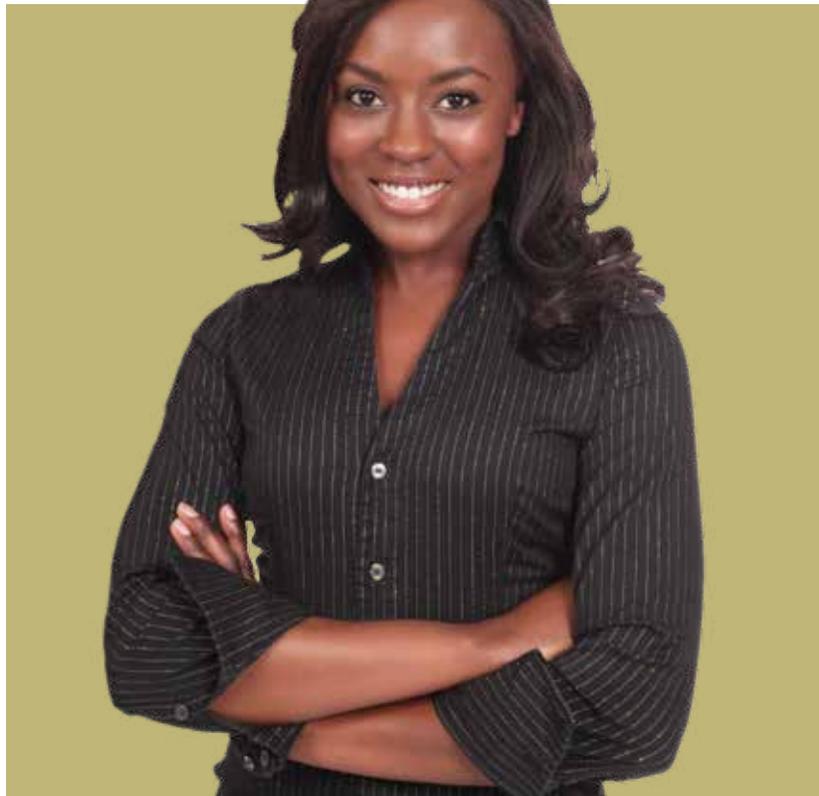
In Michigan, a health carrier must provide coverage for a drug used in antineoplastic therapy (cancer treatment) and the reasonable cost of its administration. Coverage must be provided for any FDA-approved drug regardless of whether the specific cancer for which the drug is being used as

treatment is the specific cancer for which the drug has received approval by the FDA if all of the following conditions are met:

- (a) The drug is ordered by a physician for the treatment of a specific type of cancer.
- (b) The drug is approved by the FDA for use in cancer treatment.
- (c) The drug is used as part of any cancer drug regimen.
- (d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.
- (e) The physician has obtained informed consent from the patient for the treatment regimen which includes FDA-approved drugs for off-label indications.

## 6) Emergency Health Services

If the policy provides coverage for emergency health services, it must provide coverage for medically necessary services for the sudden onset of a medical condition with signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual’s health (or to a pregnancy in the case of a pregnant woman), serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.



# What Medical Care Must My Health Carrier Pay For? *cont'd*

A health carrier cannot deny payment for emergency health services because of the diagnosis or the fact that prior authorization was not given before the emergency services were provided.

## 7) Ambulance

If the policy covers benefits for emergency services, it must provide coverage for ambulance services.

## 8) Obstetrician-Gynecologist and Mid-Wife

If the health coverage requires you to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services, the woman must be allowed to have these treatments performed by an obstetrician-gynecologist or a nurse mid-wife, as long as these providers are acting within the scope of their license.

## 9) Pediatrician

If a health carrier requires a designation of a primary care provider and provides coverage for dependents, the health carrier must allow the dependents to receive care from a pediatrician.

## 10) Prescription Drug

If the contract includes prescription drug coverage and the prescription drug coverage is limited to drugs included in a formulary, the health carrier must provide the formulary restrictions. It must also provide for exceptions when a non-formulary medication is medically necessary and is an appropriate alternative.

## 11) Off-Label Use of Approved Drug

If the contract provides prescription coverage, the health carrier must provide coverage for an off-label use of an FDA-approved drug and the reasonable cost of supplies medically necessary to administer the drug. "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the FDA.

## 12) Substance Abuse

The health carrier must include coverage for intermediate and outpatient care for substance abuse treatment. The contract must provide a minimum dollar amount for coverage of substance abuse. The minimum amount is adjusted each year based on the Consumer Price Index.

## 13) Autism Spectrum Disorders (ASD)

Most policies that are issued, amended or renewed after October 15, 2012 must provide coverage for diagnosis and treatment of ASDs. Health carriers may not:

- Limit the number of visits a member, insured, or enrollee may use for treatment of ASDs covered under the act,
- Deny or limit coverage on the basis that it is educational or habilitative in nature, or
- Subject autism coverage to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally.



Coverage for treatment of ASDs may be limited to an individual through age 18. Carriers may impose certain restrictions on ASD coverage, subject to state law, federal mental health parity laws and the Affordable Care Act.

### Coverage Requirements under Federal Law (Essential Health Benefits)

The Affordable Care Act requires that, as of January 1, 2014, health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services known as essential health benefits. Essential health benefits must include items and services within the following ten categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.



**TIP: Always read the health insurance contract or certificate of coverage and ask questions if you do not understand any provisions.**

**TIP: There is no such thing as “Full Coverage.” Full coverage is not defined in Michigan statute, nor health coverage contracts. You should be cautious if someone tries to sell you a plan claiming to be “Full Coverage.”**





# Paying Medical Bills

You and your health carrier may share the costs of care covered by your policy. Your policy explains exactly who pays for what. Read your summary of benefits to find out how your policy works. If you need more information, you may wish to read your contract or certificate of coverage, or call the customer service number on your health carrier's membership card.

Here is an example of how health coverage typically works:

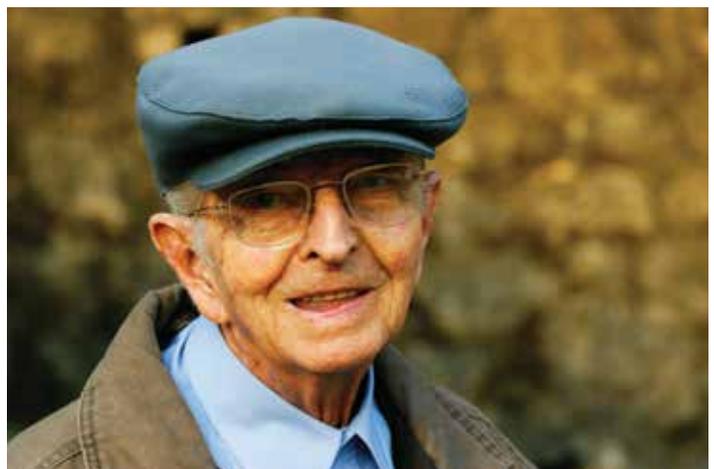
- 1) You give the doctor or hospital your health carrier's membership card at the time you seek medical care.
- 2) You pay the doctor or hospital any copayment required by the plan.
- 3) Usually, the doctor submits a claim for payment to your health carrier. You must submit a claim if the doctor doesn't do this for you.
- 4) The health carrier sends you an explanation of benefits. It lists what the doctor or hospital charged, the maximum amount the health carrier allows for that procedure, what the health carrier paid as its share, and any amount you may owe as a balance.  
**Note:** If you have more than one group health insurance plan, health carriers coordinate payment of benefits. This means that the carriers determine how much each of them will pay toward your medical treatment.
- 5) You pay your share of the bills.

## Coordination of Benefits (COB) or What Health Plan Pays First?

If you or your family members have coverage from more than one group health plan you may be familiar with the term coordination of benefits, or "COB." If a person has more than one group health plan, COB rules determine which group health plan pays first, which pays second, and so on. COB rules were created to make sure that together the group health plans do not pay more than 100 percent of the claim for that person.

Having coverage under more than one health plan does not mean that you will not have to pay a portion of a claim. Each health plan's contractual copayments, coinsurance, deductibles, exceptions, limitations, and prior authorization and in-network requirements still apply. Coordination of benefits rules do not override these contractual provisions.

In Michigan, the Coordination of Benefits Act specifies how benefits are to be coordinated by health carriers issuing group health coverage in the state. These rules do not apply



to individual or non-group coverage. If you have individual coverage, you should review your contract to determine how it pays when you have other health coverage in effect.

### **Who Pays First? Second?**

The first question when there are two or more group health plans involved is which plan is primary and which plan is secondary. The primary health coverage is the health plan that pays first, the secondary health coverage pays second after the primary coverage pays, and so on down the line. The Coordination of Benefits Act, MCL 550.251 to 550.255, dictates how to determine which coverage is primary and which coverage is secondary. While these are not the only scenarios in which it is necessary to determine the order of payment by multiple group health plans, the following are common scenarios in which the coordination of benefits is determined:

**Please note for these explanations, it is assumed that the health plans were issued in Michigan and that no covered person is eligible for Medicare.**

- The health plan that covers you as an employee, member, or subscriber is primary over a health plan that covers you as a dependent. This means that each spouse has primary coverage from his or her own employer's group health plan.
- The plan that covers you as an active employee or dependent of an active employee (not as a laid-off employee or retiree) is primary over the plan that covers you as a laid-off employee or retiree or dependent of a laid-off employee or retiree.
- If you are covered as an employee, member, or subscriber under more than one plan, and neither the first or second scenario applies, then the plan that has covered you for the longest period of time is primary, back to your original effective date under your employer group, whether or not the health carrier has changed over the course of coverage.
- If you are covered as an employee, member, subscriber, or dependent of an employee under more than one health plan, but are covered under COBRA on one of the health plans, then the COBRA plan is secondary to the other plan.

### **Dependents and Minor Children of Parents Not Separated or Minor Children of Divorced Parents with Joint Physical Custody**

- The health plan covering the parent whose birthday falls earlier in the year is the primary carrier. This is referred to as the "birthday rule." Birthday refers only to the month and day in a calendar year, not the year in which the person was born.
- If both parents have the same birthday, then the health plan that has provided coverage for the longer period of time is the primary health plan.

### **Dependent Minor Children of Legally Separated, Divorced, or Never Married Parents Living Separately**

If a child is covered by more than one group health plan and the parents are legally separated or divorced from the other parent or live apart and were never married, the plans must pay in the following order:

- First, the health plan of the parent with physical custody of the child;
- Second, the health plan of the spouse of the parent with physical custody of the child;
- Finally, the health plan of the parent or spouse of the parent without physical custody of the child.

However, if a court decree such as a divorce, states that one parent is financially responsible for the health care expenses of the child, and the health plan has been advised of that legal responsibility, then that health plan is the primary health plan for the child and the health plan of the other parent is secondary. If a court decree states that both parents are responsible for providing health coverage, then the two health plans would be of the same priority level and the "birthday rule" would apply.

**In unique circumstances or when Medicare, out-of-state health plans, or self-funded health care plans are involved, there may be exceptions to the preceding rules.**

For specific questions about coordination of benefits, call DIFS at 877-999-6442.

# Switching from One Health Plan to Another

When you are changing jobs, losing your job, leaving a job, or taking an early retirement, there are many questions you may have about how it will affect your health care coverage. Educating yourself on your rights and options will ensure you make the best decisions for your situation.

## If you are losing employer coverage, you will generally have three options:

- Convert to an individual policy with the same insurer that provided the Michigan employer group coverage;
- Temporarily continue the same group plan under COBRA; or
- Purchase individual coverage from a health carrier either through the Health Insurance Marketplace or directly from the carrier.

## Group Conversion Rights

If your Michigan employer-provided group health coverage is not a self-funded health care plan and you were continuously covered under the policy for at least three months, you may have the right to convert your group health coverage into individual coverage provided by the group's health carrier. This is called group conversion. Your Michigan employer must give you written notice of your right to the group conversion option and you must apply for group conversion coverage within 30 days of losing the employer group coverage. Your coverage under group conversion may not be the same coverage as the employer group coverage. The group conversion policy must be issued with no

pre-existing condition exclusions. Premiums will likely be higher and benefits are likely to be less robust. However, you can keep the group conversion coverage as long as you pay premiums.

You have the right to convert your Michigan employer group policy to an individual policy with the same health carrier if you have been continuously insured for at least three months in the employer group plan and:

- You leave the employer, the group policy has been discontinued for all employees or for a specific class of employees, you are involuntarily terminated for reasons other than gross misconduct; or
- You are a covered family member of a certificate holder who has died; or
- You have reached the age limit for coverage under your parent's group coverage; or
- You divorce or separate from the certificate holder or you cease to be a qualified family member under a group plan.

Please note: Insurance companies will no longer be required to offer conversion policies as of January 1, 2015.

## Consolidated Omnibus Reconciliation Act (COBRA)

COBRA is a federal law that may give you the right to continue employer-provided group health coverage on a temporary basis after you, your spouse, or your parent leave an employer with 20 or more employees. Employers



of 20 or more workers must comply, including employers who provide coverage through self-funded health care plans. However, COBRA does NOT apply to plans sponsored by the federal government and some church-related organizations.

Your former employer must notify you of your COBRA rights within 30 days after you leave the employer. Once notified, you have 60 days to apply for the COBRA coverage. If you choose to purchase the COBRA coverage, you are insured from the date the employer group coverage ended, even if you wait until the 59th day to apply. You must pay the entire premium, including any part your employer had been paying, plus up to an additional two percent for administrative expenses.

#### You can purchase COBRA coverage for:

- 18 months, or
- 29 months if you became eligible for Social Security disability during the first 60 days of COBRA coverage, or
- 36 months if you were insured through your spouse's or parent's employer and the spouse or parent has become eligible for Medicare, died, divorced, or separated or if you are a dependent child who has reached the age beyond eligibility.

COBRA is not simple! Your employer's personnel office should have a booklet that explains all of the details. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

#### Other Than COBRA Continuation of Coverage

If you lose your employer group coverage and the Michigan employer has fewer than 20 employees, you do not have COBRA rights. However, you do have the following options for continuation of health coverage:

- Convert to an individual policy with the same insurer that provided the Michigan employer group coverage, or
- Purchase individual coverage from a health carrier either through the Health Insurance Marketplace or directly from the carrier.

#### Moving From One Employer Group Plan to Another Employer Group Plan

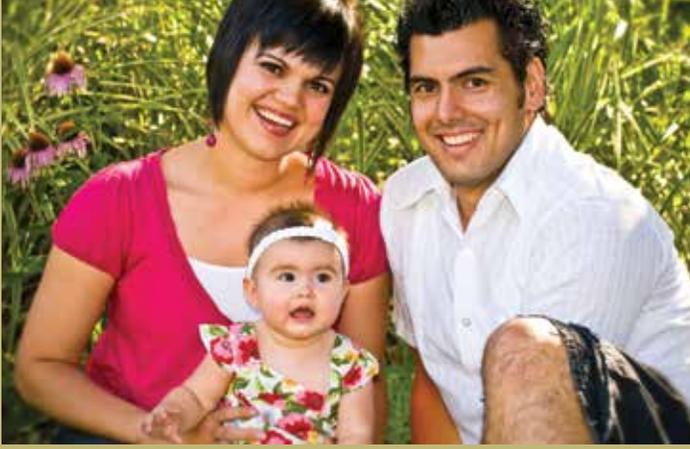
The federal Health Insurance Portability and Accountability Act (HIPAA) applies if you are covered by your employer's group health plan and you move to a different employer that also offers health coverage. Your new employer's group health plan must cover any dependent that was covered under the plan with the old employer, if the new employer's group plan provides dependent coverage. Your new employer's group health plan may cost more and provide different coverage. If the new employer health plan offers dependent coverage, it must have a special enrollment period for you to add a dependent because of marriage, birth, adoption, or loss of other coverage. **Note:** Under the ACA, group health plans may not impose pre-existing condition exclusions. This includes grandfathered and transitional plans.

#### Affiliation Period

If you work for a small employer (from 2–50 employees), and coverage is provided by an insurance company, the law allows an affiliation waiting period of not more than 90 days, at the employer's option before coverage is effective.

#### Moving from an Employer Group Plan to an Individual Plan

In Michigan, if you have lost your employer group coverage and still want to maintain health coverage, you can purchase individual coverage from a health carrier either through the Health Insurance Marketplace or directly from the carrier. The Health Insurance Marketplace has an annual open enrollment period. However, loss of employer group coverage outside of open enrollment would qualify you for a special enrollment period of 60 days during which you could purchase coverage in the Marketplace. For more information on shopping for coverage, see page 12 of this guide.



# Understanding the New Health Care Law

The Patient Protection and Affordable Care Act is a federal statute which was signed into law in 2010. It is often referred to as the Affordable Care Act, ACA, “Obamacare,” or “health care reform.”

## New Health Coverage Exchange called the Health Insurance Marketplace

If you are uninsured, purchase individual coverage or believe your employer provided coverage is inadequate or unaffordable, you may be able to shop for coverage directly in the federal Health Insurance Marketplace — a new marketplace where you can shop for and compare health benefit plans. For more information, please see page 24 of this guide.

## Healthy Michigan Plan:

A new Michigan law allows for the creation of the Healthy Michigan Plan on April 1, 2014. To be eligible for the Healthy Michigan Plan, you must be:

- Ages 19–64
- Not currently eligible for Medicaid
- Not eligible for or enrolled in Medicare
- Not pregnant when applying for the Healthy Michigan Plan
- Earning up to 133 percent of the federal poverty level (The federal poverty level is adjusted annually. In 2013, 133 percent of the poverty level for an individual was approximately \$16,000 or \$33,000 for a family of four)
- A resident of Michigan

Visit [www.HealthyMichiganPlan.org](http://www.HealthyMichiganPlan.org) for more information, or call 855-789-5610.

## Financial Help to Purchase Health Care Coverage

Federal tax credits to assist with the cost of health coverage in the Health Insurance Marketplace may be available for those with income between 100 percent and 400 percent of the federal poverty level who are not eligible for other affordable coverage. (The federal poverty level is adjusted annually. In 2013, 400 percent of the poverty level for Michigan residents was about \$45,960 for an individual or \$94,200 for a family of four.) Visit the Health Insurance Marketplace: [www.healthcare.gov](http://www.healthcare.gov) to apply for the tax credit.

## Health Coverage Requirement

In 2014 and beyond, the “individual mandate” provision of the Patient Protection and Affordable Care Act (ACA) requires that people obtain health insurance or pay a federal tax penalty. If you currently have coverage from the Healthy Michigan Plan, Medicare, Medicaid, or an employer, you are considered covered and will not pay a tax penalty.



Those who do not have or do not obtain coverage will pay a tax penalty. The amount of the penalty for an individual is phasing in as follows:

- In 2014 — the greater of \$95 per adult or one percent of taxable income
- In 2015 — the greater of \$325 per adult or two percent of taxable income
- In 2016 — the greater of \$695 per adult or two and a half percent of taxable income

You may be exempt from paying the penalty for not having coverage if you have a financial hardship, religious objection, belong to a health care sharing ministry, if your 2013 individual policy was canceled or if it would cost more than eight percent of your income to purchase coverage. Visit [www.irs.gov/aca](http://www.irs.gov/aca) for more information on federal tax penalty.

### **No Denial for People with an Illness or Chronic Condition**

Beginning in 2014, no insurance company can turn you down, charge you more or impose a waiting period for coverage because you have a pre-existing medical condition.

### **No-Cost Preventive Care**

New health plans must eliminate any cost-sharing for certain preventive services. Health carriers cannot charge a deductible, copay, or coinsurance for preventive care measures such as flu shots and other immunizations, mammograms and other cancer screenings, diabetes screenings, and more. For a more comprehensive list of covered preventive services, visit: [www.healthcare.gov/prevention](http://www.healthcare.gov/prevention).

### **Ban on Health Policy Rescissions**

Health carriers are prohibited from rescinding or retroactively canceling your health coverage unless you committed fraud or made an intentional misrepresentation of an important fact on your application.

### **No Lifetime Dollar Limits on Your Health Care Costs**

For new plans, health carriers will be prohibited from setting lifetime dollar limits on significant benefits, such as hospitalization and emergency services. As of 2014, the ACA now also eliminates the annual dollar limits a health plan can place on most of your benefits.

### **Extended Coverage for Young Adults**

Most health carriers and employers providing dependent coverage to children are required to make coverage available to adult children up to age 26. This applies to adult children who do not have access to coverage from their

own job and regardless of whether or not they are students, financially dependent on their parents, live with their parents, or are married.

### **Medicare Prescription Drug Discounts**

Seniors who are in the Medicare prescription drug coverage gap known as the “donut hole” will receive discounts on covered prescription drugs. The donut hole will be phased out by 2020.

### **Help for Small Business**

Some small businesses may qualify for a small business tax credit to help offset the costs of providing health insurance for employees. To be eligible for the credit in 2014, the small business would have to purchase coverage in the SHOP Marketplace. Small businesses may wish to contact an agent or carrier to assist with purchasing coverage from the SHOP Marketplace because the SHOP website has been delayed until 2015. For more information visit [www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses).



# Health Insurance Marketplace

The Health Insurance Marketplace is a federally operated insurance marketplace (or “exchange”) where individuals and small businesses shop for and compare health coverage. The Marketplace is primarily accessed as a website: [www.healthcare.gov](http://www.healthcare.gov). However, a paper application and consumer assistance is available at the Health Insurance Marketplace Call Center: 800-318-2596.

## Purchasing Coverage in the Health Insurance Marketplace

Any individual or family may buy coverage in the Marketplace. Illegal or undocumented immigrants and incarcerated people cannot purchase coverage in the Marketplace. For those who do not want to purchase in the Marketplace, coverage will continue to be sold outside of the Marketplace. However, new federal tax credits will be available to help with the cost of coverage only for plans sold within the Marketplace.

If you currently have health coverage through an employer, the Healthy Michigan Plan, Medicare or Medicaid, you don’t need to do anything with the Marketplace. However, if you are uninsured, purchase individual coverage, or believe your employer coverage is inadequate or unaffordable, you may wish to apply to the Health Insurance Marketplace to find out if you qualify for tax credits to help with the cost of coverage.

## Health Coverage Requirement

In 2014 and beyond, the “individual mandate” provision of the Patient Protection and Affordable Care Act (ACA) requires that people obtain health insurance or pay a federal tax penalty. For more information on the federal health coverage requirement, see page 22 in this guide.

## Open Enrollment for the Health Insurance Marketplace

Open enrollment for coverage in 2014 was October 1, 2013 through March 31, 2014. Open enrollment for coverage in 2015 is November 15, 2014 through February 15, 2015.

## Cost of Coverage in the Health Insurance Marketplace

Go to [www.healthcare.gov](http://www.healthcare.gov) to officially apply for coverage and tax credits and to view the plans sold in the Marketplace.

Visit <https://www.healthcare.gov/see-plans/> to get an estimate of what your premiums might be. However, the premium estimates do not represent an offer of coverage on the Marketplace.

## Help with the Cost of Coverage in the Health Insurance Marketplace

Federal tax credits to assist with the cost of health coverage in the Health Insurance Marketplace may be available for those with income between 100 percent and 400 percent of the federal poverty level who are not eligible for other affordable coverage. (The federal poverty level is adjusted annually. In 2013, 400 percent of the poverty level for Michigan residents was \$45,960 for an individual or \$94,200 for a family of four.) The Marketplace will also assess one’s eligibility for state run programs like the Healthy Michigan Plan and MICHild and refer your application to the state. For information about the Healthy Michigan Plan, please see page 5 of this guide.



### Types of Plans Available in the Marketplace:

Four tiers of coverage are available through the Marketplace:

- Bronze Level — These plans must cover 60 percent of expected health care costs.
- Silver Level — These plans must cover 70 percent of expected health care costs.
- Gold Level — These plans must cover 80 percent of expected health care costs.
- Platinum Level — These plans must cover 90 percent of expected health care costs.

One additional level of coverage is available in the Marketplace: a catastrophic plan. Catastrophic plans are available only to people under age 30 and to people who have received certain hardship exemptions. For more information, see <https://www.healthcare.gov/exemptions/>. Catastrophic plans will generally have lower premiums and higher deductibles. Marketplace catastrophic plans cover three annual primary care visits and preventive services at no cost. People with catastrophic plans are not eligible for federal tax credits to lower their monthly premiums.

### Plans for Sale in the Marketplace:

Visit <https://www.healthcare.gov/see-plans/> to get a listing of plans sold in the Marketplace by geographic area and sample prices.

### Cost for Marketplace Coverage for People with Pre-Existing Conditions:

Beginning in 2014, new plans cannot deny you coverage, charge you more, or impose a waiting period on your coverage because of a pre-existing medical condition. As of 2014, individual health insurance premiums (both on and off the Marketplace) can only vary based on: whether the policy to be sold will be for an individual person or for a whole family; the geographic area in which you live; your age; and tobacco use.

### Help Signing up for Coverage

Assistance is available from “navigators” and “certified application counselors.” Visit: <https://localhelp.healthcare.gov/> to find a navigator or certified application counselor in your area. Health insurance agents may be able to assist you as well.

### Michigan’s role in the Health Insurance Marketplace:

The federal government operates Michigan’s Health Insurance Marketplace. Michigan reviewed the rates and forms for carriers that sell products in the Marketplace.





# What to Do if Your Health Care Claim is Denied

You do not need a lawyer to resolve most claim disputes with a health carrier. Start with contacting your health carrier's customer service staff. Most companies have toll-free telephone numbers for quick service and the number may be indicated on the back of your health carrier's membership card.

If you do not receive a satisfactory resolution, ask about the health carrier's grievance procedures for appealing decisions and/or file a written complaint with the Department of Insurance and Financial Services (DIFS).

## How to File a Complaint with DIFS

You can obtain a complaint form and instructions for filing a written complaint at our website: [www.michigan.gov/difs](http://www.michigan.gov/difs). You can also call DIFS toll-free at 877-999-6442 or use the form on page 33 in this guide.

DIFS will send the health carrier a copy of your complaint and ask it to explain its position. Health carriers are required by law to respond to DIFS. DIFS will review all of the facts to make sure the health carrier has followed its contract with you and that it has also complied with Michigan laws.



# Health Coverage Grievances and Appeals

## Internal Grievance Process

Under Michigan law, each health carrier must establish an internal formal grievance process. This process provides the covered person or their authorized representative an avenue to seek resolution when there has been an adverse determination. An adverse determination is a determination that an admission, availability of care, continued stay, or other health care service has been reviewed and denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

With any claims decision, the health carrier is required to provide you with information on the internal grievance process and your right to an external review. The health carrier is required to provide the address to submit the written grievance and any special forms, as well as information on how to begin the internal grievance process.

The covered person may authorize a representative, such as a doctor or spouse, to act on their behalf in the internal grievance and/or the external review process.

The authorization must be in writing and there is space provided on the Health Care Request for External Review Form to designate such a representative.

## Beginning the Internal Grievance Process

The first step in the internal grievance process is to provide the health carrier with a written grievance, which consists of a written statement regarding the facts of the issue and the covered person's position.

Once a request for review under the internal process has been submitted, the carrier must make sure all steps in the internal grievance process are completed within 35 calendar days. This does not include the time the covered person takes to decide to go from one step to the next step in the process, or the ten additional business days the health carrier can request to obtain necessary medical information. The health carrier is required to notify the covered person of its determination in writing and the right to proceed to the next step(s) in the grievance process if the covered person disagrees with the determination.

At the conclusion of the internal grievance process, the health carrier is required to notify the covered person of its determination, in writing, and of the applicable external review process. The external review process

could be either a review of the adverse determination by the Department of Insurance and Financial Services (DIFS) under the Patient's Right to Independent Review Act (PRIRA) or a process administered by the federal government.

## Patient's Right to Independent Review Act — External Review Process

PRIRA is a Michigan law that provides a covered person with appeal rights due to an adverse determination made by a health carrier.

The PRIRA external review process should only be initiated if: 1) the covered person has exhausted the health carrier's internal grievance process or, 2) the health carrier fails to provide a determination within the 35-day timeframe (plus any additional days allowed in the internal process for obtaining medical records, etc.).

## Required Information for PRIRA External Review

The covered person or their authorized representative must complete the Health Care Request for External Review Form. The request should also include a copy of the final adverse determination from the health carrier along with any information and documentation to support the covered person's position. The request must be submitted within 60 days of the covered person's receipt of the health carrier's final adverse determination. A covered person or their authorized representative is not required to have an attorney represent them in the PRIRA external review process.

## Preliminary Review of Request for PRIRA External Review

DIFS conducts a preliminary review to determine if the request meets the following requirements:

- 1) The issue involves an adverse determination.
- 2) The coverage involved is subject to PRIRA.
- 3) The covered person was a covered person at the time the health care service was provided or requested.
- 4) The health care service in question reasonably appears to be a covered service under the contract or policy.
- 5) The covered person exhausted the internal grievance process of the health carrier.

# Health Coverage Grievances and Appeals *cont'd*

## Acceptance for External Review

DIFS will notify the covered person or their authorized representative in writing if the request is accepted or not accepted for external review under the PRIRA. Occasionally requests are determined to be incomplete, in which case DIFS advises the person of the information needed to make the request complete. If the request is not accepted, DIFS will explain the reason why the request does not qualify for an external review under PRIRA or may refer the case to another Office within DIFS for review as a complaint.

If the request is accepted and involves only contractual provisions of the policy, the review is conducted by the Director of DIFS. If the request is accepted and involves issues of medical necessity or clinical review criteria, it is referred to an independent review organization (IRO) to provide a recommendation.

## Investigation and Obtaining Medical Records

DIFS staff will not investigate, contact medical sources, or seek out information to support a covered person's position. It is the covered person's responsibility to provide the pertinent documents such as bills, explanations of benefits, medical records, correspondence, statements from doctors, and research material to support their own position.

If the issue in the review is referred to an IRO, the health carrier is required to provide the IRO with the medical records and other documents it used in making its determination. The IRO will use this information as part of its research into the issue.



## Decision Issuance

If the PRIRA external review is conducted by the Director and does not require review by an IRO, the law requires that the Director issue a decision within 14 calendar days after the request is accepted for review.

If the review requires referral to an IRO, the IRO is required to provide DIFS with its recommendation within 14 calendar days after it is assigned the review. The law requires that the Director issue a decision within seven business days after receiving the recommendation of the IRO.

## Right to Appeal Director's Decision

If the covered person or the health carrier disagrees with the Director's decision, either party has the right to appeal to circuit court in the county where the covered person resides or in Ingham County within 60 days from the date of the decision. If the decision overturns the health carrier's determination and the health carrier appeals to circuit court, DIFS will not represent the covered person in circuit court or pay any associated court costs.

## PRIRA Expedited External Review

A PRIRA expedited external review is available when an adverse determination involves a medical condition for which the time frame for completion of the PRIRA external review would seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function. To qualify for an expedited review, a physician must verify, in writing, the seriousness of the covered person's condition.

The same form is used to request both expedited and non-expedited reviews under the Patient's Right to Independent Review Act. The Health Care Request for External Review Form is on page 34 of this guide.

# Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- **Bold blue** text indicates a term defined in this Glossary.
- See page 4 for an example showing how **deductibles**, **co-insurance** and **out-of-pocket limits** work together in a real life situation.

## Allowed Amount

Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your **provider** charges more than the allowed amount, you may have to pay the difference. (See **Balance Billing**.)

## Appeal

A request for your health insurer or **plan** to review a decision or a **grievance** again.

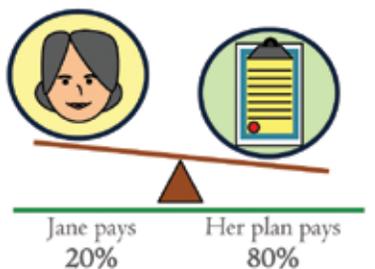
## Balance Billing

When a **provider** bills you for the difference between the provider's charge and the **allowed amount**. For example, if the provider's charge is \$100 and the allowed amount is \$70, the provider may bill you for the remaining \$30. A **preferred provider** may **not** balance bill you for covered services.

## Co-insurance

Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the **allowed amount** for the service.

You pay co-insurance **plus** any **deductibles** you owe. For example, if the **health insurance** or **plan's** allowed amount for an office visit is \$100 and you've met your deductible, your co-insurance payment of 20% would be \$20. The health insurance or plan pays the rest of the allowed amount.



(See page 4 for a detailed example.)

## Complications of Pregnancy

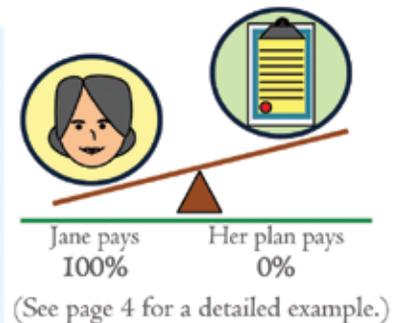
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

## Co-payment

A fixed amount (for example, \$15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

## Deductible

The amount you owe for health care services your **health insurance** or **plan** covers before your health insurance or plan begins to pay. For example, if your deductible is \$1,000, your plan won't pay anything until you've met your \$1,000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



## Durable Medical Equipment (DME)

Equipment and supplies ordered by a health care **provider** for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

## Emergency Medical Condition

An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

## Emergency Medical Transportation

Ambulance services for an **emergency medical condition**.

## Emergency Room Care

**Emergency services** you get in an emergency room.

## Emergency Services

Evaluation of an **emergency medical condition** and treatment to keep the condition from getting worse.

### Excluded Services

Health care services that your **health insurance** or **plan** doesn't pay for or cover.

### Grievance

A complaint that you communicate to your health insurer or **plan**.

### Habilitation Services

Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

### Health Insurance

A contract that requires your health insurer to pay some or all of your health care costs in exchange for a **premium**.

### Home Health Care

Health care services a person receives at home.

### Hospice Services

Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

### Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

### Hospital Outpatient Care

Care in a hospital that usually doesn't require an overnight stay.

### In-network Co-insurance

The percent (for example, 20%) you pay of the **allowed amount** for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-insurance usually costs you less than **out-of-network co-insurance**.

### In-network Co-payment

A fixed amount (for example, \$15) you pay for covered health care services to **providers** who contract with your **health insurance** or **plan**. In-network co-payments usually are less than **out-of-network co-payments**.

### Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

### Network

The facilities, **providers** and suppliers your health insurer or **plan** has contracted with to provide health care services.

### Non-Preferred Provider

A **provider** who doesn't have a contract with your health insurer or **plan** to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your **health insurance** or **plan**, or if your health insurance or **plan** has a "tiered" **network** and you must pay extra to see some providers.

### Out-of-network Co-insurance

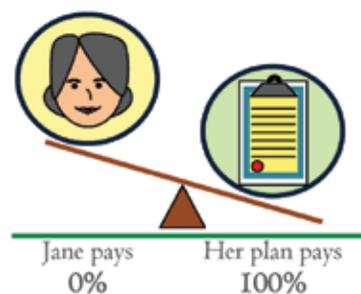
The percent (for example, 40%) you pay of the **allowed amount** for covered health care services to providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-insurance usually costs you more than **in-network co-insurance**.

### Out-of-network Co-payment

A fixed amount (for example, \$30) you pay for covered health care services from providers who do **not** contract with your **health insurance** or **plan**. Out-of-network co-payments usually are more than **in-network co-payments**.

### Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your **health insurance** or **plan** begins to pay 100% of the **allowed amount**. This limit never includes your **premium**, **balance-billed** charges or health care your health



insurance or **plan** doesn't cover. Some health insurance or **plans** don't count all of your **co-payments**, **deductibles**, **co-insurance** payments, out-of-network payments or other expenses toward this limit.

### Physician Services

Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

## Plan

A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

## Preauthorization

A decision by your health insurer or **plan** that a health care service, treatment plan, **prescription drug** or **durable medical equipment** is **medically necessary**. Sometimes called prior authorization, prior approval or precertification. Your **health insurance** or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

## Preferred Provider

A **provider** who has a contract with your health insurer or **plan** to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your **health insurance** or plan has a "tiered" **network** and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

## Premium

The amount that must be paid for your **health insurance** or **plan**. You and/or your employer usually pay it monthly, quarterly or yearly.

## Prescription Drug Coverage

**Health insurance** or **plan** that helps pay for **prescription drugs** and medications.

## Prescription Drugs

Drugs and medications that by law require a prescription.

## Primary Care Physician

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

## Primary Care Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

## Provider

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

## Reconstructive Surgery

Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

## Rehabilitation Services

Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

## Skilled Nursing Care

Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

## Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a **provider** who has more training in a specific area of health care.

## UCR (Usual, Customary and Reasonable)

The amount paid for a medical service in a geographic area based on what **providers** in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the **allowed amount**.

## Urgent Care

Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require **emergency room care**.

# How You and Your Insurer Share Costs - Example

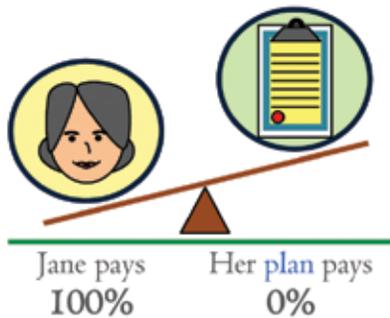
Jane's Plan Deductible: \$1,500

Co-insurance: 20%

Out-of-Pocket Limit: \$5,000

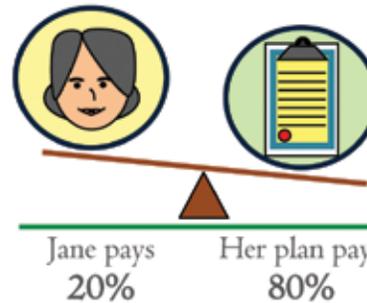
January 1<sup>st</sup>  
Beginning of Coverage  
Period

December 31<sup>st</sup>  
End of Coverage  
Period



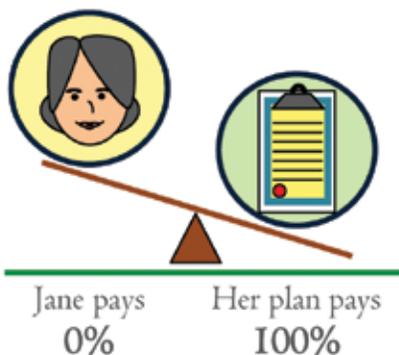
**Jane hasn't reached her \$1,500 deductible yet**  
Her plan doesn't pay any of the costs.  
Office visit costs: \$125  
Jane pays: \$125  
Her plan pays: \$0

→  
more costs



**Jane reaches her \$1,500 deductible, co-insurance begins**  
Jane has seen a doctor several times and paid \$1,500 in total. Her plan pays some of the costs for her next visit.  
Office visit costs: \$75  
Jane pays: 20% of \$75 = \$15  
Her plan pays: 80% of \$75 = \$60

→  
more costs



**Jane reaches her \$5,000 out-of-pocket limit**  
Jane has seen the doctor often and paid \$5,000 in total. Her plan pays the full cost of her covered health care services for the rest of the year.  
Office visit costs: \$200  
Jane pays: \$0  
Her plan pays: \$200



## Health Care-Request for External Review

You are eligible to request an External Review if ALL the following apply:

- You have exhausted the Health Carrier's internal grievance process. (unless waived because the health carrier did not complete their review within the required time).
- The request is within 60 days of receipt of a Final Adverse Determination.
- The patient was covered on the date of service.
- The health care service appears to be a covered benefit.

The following types of policies are NOT eligible for review: Medicare supplement, disability income, hospital indemnity, specified accident, credit, long term care, and self-funded plans.

### You are responsible for submitting:

- A copy of the Final Adverse Determination from the health carrier
- Pertinent documentation, such as bills, explanations of benefits, medical records, correspondence, statements from doctors, research material that supports your position, etc.

Note: It is your responsibility to submit medical records. The Department of Insurance and Financial Services does not contact medical sources.

**Always send copies. Never send original documents.**

1. Patient Name | Name of INSURED person

Name of Health Carrier (HMO, BCBSM, Health Insurer)

Policy number | Group number (if applicable) | Claim number (if applicable)

Dates service was received or requested ◀ If service was received, enter date received. If not, enter date service was requested.

Physician and medical facility involved.

2. Statement of request: Provide a brief explanation of the problem and the resolution you are seeking. Describe the medical service or requested service.

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4. This request is being filed by (choose one)

- The patient-provide patient's contact information in part 5
- The patient's parent (if patient is a minor child); or the patient's legal guardian- provide parent or legal guardian's contact information in part 5
- A representative authorized by the patient-provide authorized representative's contact information in part 5.

5. Contact information for person filing this form

Name of Patient, Parent, Legal Guardian or Authorized Representative

Address

City | State | Zip

Daytime phone number | Evening phone number

If you are not the patient, what is your relationship to the patient?

If person filing is NOT the patient or the patient's parent or the patient's legal guardian, the patient must designate the representative by reading and signing statement in part 6 below:

6. Patient authorization statement

I authorize the person named in Part 5, to act as my authorized representative in this External Review.

Signature of Patient | Date

7. Authorization to review medical information

I authorize the Department of Insurance and Financial Services (DIFS), the Independent Review Organization, the health carrier involved, and any other health care provider needed to review protected health information and records pertaining to this external review.

Signature of Patient | Date

8. Send your Request for External Review to

DIFS - Office of General Counsel - Appeals Section

(by mail)

P.O.Box 30220  
Lansing, MI 48909-7720

Fax: 517-241-4168

(by courier/delivery)

611 W. Ottawa Street, 3rd Floor  
Lansing, MI 48933-1070

Phone: 877-999-6442

3. EXPEDITED External Review Requirements (if you are not requesting an expedited external review, or your request doesn't meet the conditions below, skip to Part 4)

The following conditions must be met:

- An expedited INTERNAL review has been requested AND
- The request is filed within 10 days of receipt of adverse determination AND
- A physician substantiates the medical condition involved in the adverse determination is serious enough to jeopardize the life or health of the covered person.

My request meets these requirements. By completing items (3a.) and (3b.) below, I am requesting an Expedited External Review.

(3a.) Date you requested an expedited INTERNAL review \_\_\_\_\_

(3b.) Name and phone number of substantiating physician: \_\_\_\_\_

P.A. 251 of 2000 as amended, authorizes the Director to review requests for external review. Submission of this form is required to request an external review by the Director of the Department of Insurance and Financial Services.



Michigan Department of Insurance and Financial Services

DIFS is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities. Visit DIFS online at: [www.michigan.gov/difs](http://www.michigan.gov/difs) Phone DIFS toll-free at: 877-999-6442

# Important Contact Information

## State Health Programs

### Health Care Coverage

(i.e., the Healthy Michigan Plan, Medicaid, MICHild, etc.) is available to individuals and families who meet certain eligibility requirements. The state also offers several programs for prescription assistance.

Phone: 855-275-6424  
[www.michigan.gov/mdch](http://www.michigan.gov/mdch)

### County Health Plans & Other County Health Services

Depending on which county you reside in, there may be county health coverage or medical services available.

### Free Health Clinics

Free Clinics of Michigan (FCOM) is a network of volunteer-staffed free clinics that provide health care services to the uninsured or medically underserved within the state of Michigan.

Phone: 248-677-2273  
Website: [www.fcomi.org](http://www.fcomi.org)

## Key Insurance Contacts

### Health Insurance Marketplace

The Health Insurance Marketplace is a new federally operated insurance marketplace (or “exchange”) where individuals may shop for and compare health coverage.

Phone: 800-318-2596  
[www.healthcare.gov](http://www.healthcare.gov)

### SHOP Marketplace

The Small Business Health Options Program (SHOP) Marketplace is a new federally operated insurance marketplace where small businesses may shop for and compare group health coverage.

Phone: 800-706-7893  
[www.healthcare.gov/small-businesses](http://www.healthcare.gov/small-businesses)

# Important Contact Information *cont'd*

## Key Insurance Contacts

### State of Michigan Department of Insurance and Financial Services (DIFS)

This state department protects consumers through regulation of the insurance industry amongst other industries. Insurance Analysts can answer general insurance questions and help you file a complaint against an insurance company, agency, or agent.

Phone: 877-999-6442  
[www.michigan.gov/difs](http://www.michigan.gov/difs)

### U.S. Department of Labor (Employee Benefits Security Administration)

Information and rules for people whose employers are self-insured.

Phone: 866-444-3272  
[www.dol.gov/ebsa](http://www.dol.gov/ebsa)

### Internal Revenue Service

Information on the federal tax implications of the Affordable Care Act.

Phone: 800-829-1040  
[www.irs.gov/aca](http://www.irs.gov/aca)

## Senior Health Insurance Resources

### Medicare

Health insurance for people age 65 or older, some people under age 65 with disabilities, and people with kidney failure.

Phone: 800-MEDICARE  
(800-633-4227)  
[www.medicare.gov](http://www.medicare.gov)

### Michigan Medicare/Medicaid Assistance Program

The Michigan Medicare/Medicaid Assistance Program (MMAP) has provided free education and personalized assistance to people with Medicare and Medicaid, their families and caregivers.

Phone: 800-803-7174  
[www.mmapinc.org](http://www.mmapinc.org)

## Don't Know Where to Turn?

### Health Insurance Consumer Assistance Program (HICAP)

The Health Insurance Consumer Assistance Program is federally funded and operated by the Department of Insurance and Financial Services to help Michigan consumers with health insurance issues.

Phone: 877-999-6442  
[www.michigan.gov/hicap](http://www.michigan.gov/hicap)



# Health Insurance Got You Confused?



## Michigan's Health Insurance Consumer Assistance Program (HICAP) can help you:

- Find out about your health coverage options
- Learn about your rights under federal and state law
- Resolve a complaint against a health plan or insurer
- Appeal a health plan's denial of a service or treatment today

**We can help. Contact HICAP:**  
**Toll-free: 877-999-6442**  
**[www.michigan.gov/HICAP](http://www.michigan.gov/HICAP)**  
**[DIFS-HICAP@michigan.gov](mailto:DIFS-HICAP@michigan.gov)**



DIFS is an equal opportunity employer/program.

Quantity: 10,000; Cost: \$6,794.20; Unit Cost: \$0.68; Paid for with federal funds.