Michigan Consumer Guide to Health Insurance

DIFS
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES

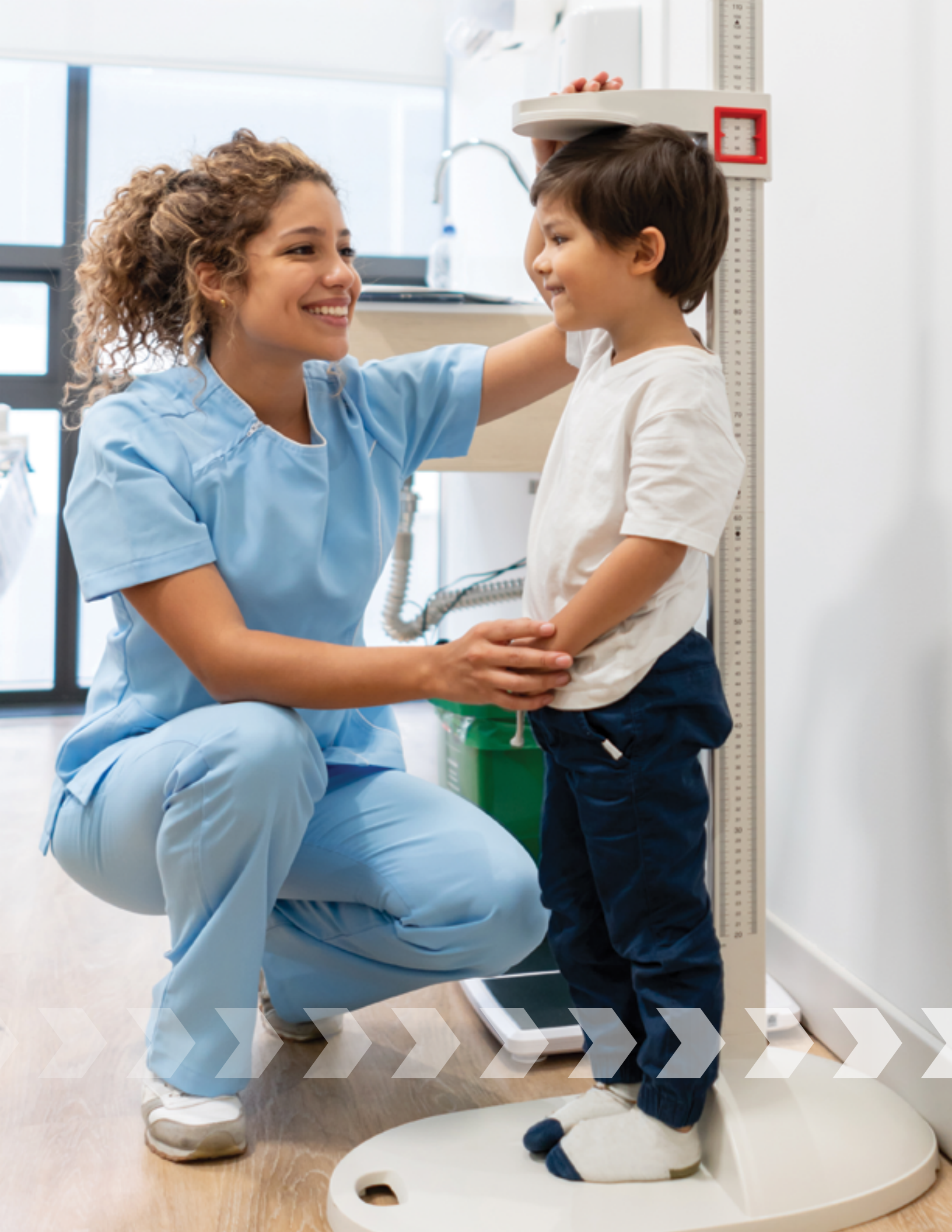


Table of Contents

Employer Group Coverage **3**

Individual Coverage **7**

Costs for Individual Health Plans **12**

Types of Health Plans **16**

Filing a Complaint With DIFS **19**

Appealing a Decision Made by Your Health Insurer ... **20**

Additional Resources **23**

Glossary of Health Coverage and Medical Terms ... **23**

Important Contact Information **26**

About DIFS

The mission of the Michigan Department of Insurance and Financial Services is to ensure access to safe and secure insurance and financial services fundamental for the opportunity, security and success of Michigan residents, while fostering economic growth and sustainability in both industries.

This guide provides consumers with health insurance basics to assist Michigan residents in making informed decisions regarding their health coverage.

Employer Group Coverage

Employers with 50 or more employees are required to provide health coverage to employees and their dependents. Failure to offer affordable coverage may subject an employer to a tax penalty and allow the employee to obtain a tax credit in the Health Insurance Marketplace.

Employers with fewer than 50 employees are not required to provide health coverage. However, if they choose to offer health coverage, they may be eligible for a small business health care tax credit.

The Employer Is the Policyholder

The employer is the master policyholder and the employees are certificate holders in an employer group health plan. The master policyholder:

- Negotiates the terms of the group policy with the health insurer.
- May reduce or change the plan's benefits.
- May increase the employees' premium contribution.
- Is permitted to switch health insurers.
- May allow the employees to choose from more than one plan.
- Can stop providing coverage entirely.

EMPLOYEE PREMIUMS

Coverage and rates may change annually. The employee contribution – what you pay – is determined by your employer.

Employer Group Coverage

Enrollment

Employees should be aware of the employer's group health coverage enrollment policies and deadlines. Employers can require up to a 90-day waiting period before new employees are eligible to enroll in coverage.

Employers have an annual open enrollment period for employees to apply, change or disenroll in coverage. Any benefit changes or premium adjustments in the group plan are communicated to employees during the annual open enrollment period.

Special enrollment periods (SEPs) are allowed when certain life events occur (i.e., birth/adoption, marriage/divorce). Check with the employer's human resources department for more information about SEPs.

Benefits of Employer Group Health Plans

Employer group health plans typically offer:

- Limits on out-of-pocket maximums.
- No annual or lifetime dollar limits on essential health benefits.
- Free preventive services.
- Dependent coverage to age 26.
- Specific minimum benefits required by Michigan law.

Small Business Requirement

Employers with 50 or fewer employees are not required to provide health coverage; however, they are required to provide information about the Marketplace to their employees, whether they offer health coverage or not. If they offer health coverage to their employees, they must offer it to all eligible employees within 90 days of their employment start date.

Small business employers can explore offering health and/or dental insurance to their employees through the Small Business Health Options Program (SHOP). An employer purchasing SHOP coverage may be eligible for a small business health care tax credit. To review plans and enroll in coverage, contact an insurer or an insurance agent licensed with DIFS and registered with SHOP. SHOP health plans can be reviewed at **www.healthcare.gov/Small-Businesses** or by contacting the SHOP Call Center at 800-706-7893.

Wellness Plans

Employers may offer wellness plans to encourage employee participation in a healthy behavior, maintenance or improvement program. If a health insurer bases their health insurance rates on tobacco use, they must offer a wellness program for any group policy. For participation in the wellness plan, the insurer may provide the employees with:

- A rebate or reduction in premium.
- A reduction in co-payments, co-insurance and deductibles.
- A combination of these incentives.

Self-Funded Health Plans

If you work for a large employer or a government agency, there is a good chance your health plan is self-funded or self-insured. Self-funded 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 self-funded plan.

A self-funded plan will not use the term "insurance" in its benefit information package. Instead, the word "plan" or "summary plan description" will be used.

Employers may contract with insurance companies and third-party administrators to manage a self-funded health plan.

DIFS does not have authority over employers or self-funded plans. DIFS may, however, have authority over the administrator of a self-funded plan. Self-funded plans fall under the authority of the United States Department of Labor's Employee Benefit Security Administration. They can be reached at **www.dol.gov/Agencies/EBSA** or 866-444-3272.

Losing Employer Group Coverage

If you lose group health coverage through your employer, you may have federal COBRA rights, be eligible for Medicaid or the Healthy Michigan Plan or be able to purchase health insurance through a special enrollment period.

The following options are available to those losing employer group coverage:

- Temporarily continue the same group health plan under COBRA. COBRA is available to health plans of employers with more than 20 employees.
- Purchase individual coverage through the Health Insurance Marketplace, from a licensed insurance agent or health insurer. You can still go to the Marketplace and check to see if the rates offered there are more suited for your needs even if your employer has more than 20 employees. You may be eligible for a subsidy.
- Enroll in another group health plan you may be eligible for through a new employer or a spouse's plan.
- Purchase a short-term limited duration plan to bridge the gap between coverage during a period of transition. See page 17 for more information regarding short-term plans.
- Enroll in Medicare, Medicaid or the Healthy Michigan Plan if you are eligible.

Consolidated Omnibus Reconciliation Act (COBRA)

COBRA is a federal law that allows you the right to continue employer group health coverage on a temporary basis after you, your spouse or your parent leaves an employer with 20 or more employees.

The employer must notify the former employee of their COBRA rights within 30 days after employment has ended. Once notified, the former employee has 60 days to apply for COBRA coverage and is responsible for paying the entire premium, including any part the employer paid, plus up to an additional 2% for administrative expenses.

COBRA Coverage Is Available For:

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

COBRA is complicated! The employer's human resources office should have a booklet explaining the details. Additional questions can be addressed by the U.S. Department of Labor, Employee Benefits Security Administration at 866-444-3272 or **www.dol.gov/Agencies/EBSA**.

Moving From One Employer Group Plan to Another Employer Group Plan

The federal Health Insurance Portability and Accountability Act (HIPAA) applies when you are covered by an employer's group health plan and you move to a different employer also offering health coverage.

If the new employer's group health plan offers dependent coverage, it must offer coverage to your dependents who were covered under your previous plan.

The 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 to add a dependent because of marriage, birth, adoption or loss of other coverage. As with individual health plans, group health plans may not impose pre-existing condition exclusions.

Employers with 20 or more employees must comply with COBRA, except health plans sponsored by the federal government and some church-related organizations.

Individual Coverage

If you are a Michigan resident without access to a group health plan and are ineligible for the Healthy Michigan Plan, Medicaid or Medicare, you may purchase an individual major medical health plan through a licensed agent, directly from a health insurer or through the Health Insurance Marketplace (Marketplace).

You are the policyholder on an individual health plan. The plan can cover you and your eligible dependents and cannot deny coverage based on pre-existing conditions.

Open Enrollment

The annual open enrollment period provides an opportunity for you to enroll in an individual health plan. Plans may be purchased outside of open enrollment through a special enrollment period under certain qualifying events.

To find out which options may be available to you, call DIFS at 877-999-6442 or visit **www.michigan.gov/HICAP**

Required Benefits

Individual policies must include specific minimum health care benefits required by Michigan and federal law. More information regarding these requirements can be found at **www.michigan.gov/HICAP**.

Premiums

The monthly premium is the cost for your health plan and depends on the following:

- The type of plan chosen.
- Your age.
- Where you live.
- The number of eligible dependents covered under your plan.
- Tobacco use.

Premiums may 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. Individuals may be eligible for the Healthy Michigan Plan if they:

- Are age 19-64 years.
- Do not qualify for Medicaid.
- Are ineligible for or enrolled in Medicare.
- Are not pregnant when applying for the Healthy Michigan Plan.
- Earn up to 133% of the federal poverty level (adjusted annually).
- Are residents of Michigan.

Visit **www.healthymichiganplan.org** or call 855-789-5610 for more information.

Health Insurance Marketplace

Health Insurance Marketplace (Marketplace) is a federally operated insurance marketplace where individuals and families can purchase and compare health plans. The Marketplace is primarily accessed at **www.healthcare.gov** or by telephone at 800-318-2596.

An individual health plan may be purchased for you and your family during the annual open enrollment period with the Marketplace.

For information on how to purchase a health plan outside of the Marketplace, please refer to **www.michigan.gov/HICAP**.

When purchasing health coverage through the Marketplace, it's beneficial to understand the following:

- Advance premium tax credits
- Cost-sharing reductions
- Marketplace participation

Advance Premium Tax Credits (APTC)

An APTC is a federal tax credit that is used to lower the monthly cost of a Marketplace health plan. Eligibility for an APTC is available for those with a household income between 100% to 400% of the federal poverty level. The federal poverty level is adjusted annually. The Marketplace will determine your eligibility for an APTC.

Cost-Sharing Reductions (CSR)

CSRs allow you to save money when you receive health care services. A health plan with a CSR includes lower out-of-pocket costs, such as a lower deductible, co-payment, co-insurance and out-of-pocket maximum. To qualify for a CSR, you must purchase a silver level health plan on the Marketplace and have a household income between 100% to 250% of the federal poverty level. The federal poverty level is adjusted annually.

Marketplace Participation

Not all health insurers choose to participate in the federal Marketplace. Prior to selling plans on the Marketplace, an insurer's qualified health plan and rates must be certified by DIFS and the federal government.

Types of Qualified Health Plans (QHP) on the Marketplace

QHPs are divided into five metal levels. Each metal level represents how the cost for health care services are split between you and the health plan.

The five metal levels are: platinum, gold, silver, bronze, and expanded bronze. Insurers selling health plans on the Marketplace are not required to offer plans in every metal level, or in all counties.

- **Platinum Level** – These plans must cover 90% of expected health care costs and you are financially responsible for the remaining 10%.
- **Gold Level** – These plans must cover 80% of expected health care costs and you are financially responsible for the remaining 20%.
- **Silver Level** – These plans must cover 70% of expected health care costs and you are financially responsible for the remaining 30%.
- **Bronze Level** – These plans must cover 60% of expected health care costs and you are financially responsible for the remaining 40%.
- **Expanded Bronze Level** – These plans must cover between 56% and 62% of expected health care costs.

  If an expanded bronze plan covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, it must cover between 56% and 65% of expected health care costs.

Qualified Health Plan (QHP): a health plan that's certified by the Health Insurance Marketplace and DIFS. QHPs provide essential health benefits, follow established limits on cost-sharing (i.e., deductibles, co-payments, and out-of-pocket maximum amounts), and meet other requirements under the ACA.

Catastrophic Health Plans

In addition to the metal level plans described, catastrophic health plans are also available on the Marketplace. However, these plans are available only to those under age 30 or of any age who have received certain hardship exemptions through the Marketplace. Eligibility for a hardship exemption can be obtained through **www.healthcare.gov**.

Catastrophic plans purchased through the Marketplace generally:

- Have lower premiums and higher deductibles.
- Cover three annual primary care visits prior to the deductible being met.
- Cover preventive services at no cost.
- Are not eligible for federal tax credits.

Costs for Individual Health Plans

There is more to shopping for health insurance than just finding the lowest premium. Considering your financial status and family needs, the bottom line on your health insurance may not be the monthly premium you pay. A policy with a lower monthly premium may seem like a better deal, but a lower monthly premium could mean you'll have less coverage – or that you'll pay more out-of-pocket when you need health care services.

Premiums for individual health plans on and off the Marketplace are rated based on:

- Type of plan chosen
- Age
- Gender
- Geographic location
- Family size
- Tobacco use

Each year, DIFS publishes the names of the insurers selling on the Marketplace, along with their rates and changes in the rates. To view the health plans available in your area and review anticipated costs, visit **www.michigan.gov/DIFS**.

By completing an application through the Marketplace, you can review plans and rates available to you. Assistance signing up for a Marketplace plan is available from navigators, certified application assisters and licensed health insurance agents who have completed training and registration with the Marketplace. Health insurance agents must also be licensed with DIFS. These individuals cannot charge you for their assistance. Visit localhelp.healthcare.gov to find assistance in your area. You may also visit **www.michigan.gov/DIFS** to locate a licensed agent.

DIFS' role in the Health Insurance Marketplace includes reviewing health plan rates and policies prior to the policies being available to sell in the Marketplace.

Example: **How You and Your Insurer Share Costs Annually**

Your Plan Deductible: $1,500 | **Co-insurance:** 20% | **Out-of-Pocket Limit:** $5,000

1	2	3
You have not reached your $1,500 deductible yet. Your plan does not pay any of the costs.	**You have reached your $1,500 deductible; co-insurance begins.** You have seen a doctor several times and paid $1,500 total. Your plan pays some of the costs of your next visit.	**You have reached your $5,000 out-of-pocket limit.** You have seen the doctor often and paid $5,000 total. Your plan pays the full cost of your covered health care services for the rest of the year.
Office visit cost: $125 **You pay:** $125 **Your plan pays:** $0	**Office visit cost:** $75 **You pay:** 20% of $75 = $15 **Your plan pays:** 80% of $75 = $60	**Office visit cost:** $200 **You pay:** $0 **Your plan pays:** $200
You pay 100% Your plan pays 0%	You pay 20% Your plan pays 80%	You pay 0% Your plan pays 100%

Plan year starting Jan. 1 and ending Dec. 31

What's Covered

Health insurance helps pay for provider visits, hospital services and medications. But remember, insurance isn't just for when you get sick – it can also help you stay healthy. Most plans cover preventive services like immunizations, annual visits, screenings and more for free.

For more information on what your plan covers, review the "Summary of Benefits and Coverage." If you don't have one, ask your insurance company for a copy. The Summary of Benefits and Coverage explains the plan's key features like:

- Covered health care services.
- Your share of the costs for a covered service.
- Health care services the plan does not cover.

Paying Medical Bills

Both the insured and insurer share the financial responsibility of health care services covered by a health plan, otherwise known as cost-sharing. The health plan explains exactly who pays for what.

It is the insured's responsibility to understand the benefits of the health plan and how the plan works. Contact the insurer's customer service department if there are questions about the plan's benefits. The insurer's customer service number can be located on the back of the insurance card.

To better understand the basics of health insurance, review the following example of how an insured would use their health plan:

- The insured person gives their insurance card to the provider at the time health care services are received.
- The co-payment is paid to the provider at the time health care services are received.
- Usually, the provider submits a claim to the health plan to receive payment for the health care services. The insured is responsible for submitting the claim if the provider doesn't do it. This typically occurs if services are received from an out-of-network provider.
- The insurer sends an Explanation of Benefits (EOB) to the insured if there is a financial responsibility for the treatment received. The EOB lists the date of service, the amount the provider charged, the amount the insurer will pay for the service(s) and your financial responsibility (deductible, co-payment, co-insurance, non-covered benefit).

The individual is responsible for their portion of the bill when an invoice is received from the provider. It is important to keep a copy of the EOB from the insurer to compare what the EOB says you owe and what the provider is billing you.

Coordination of Benefits (COB)

If you are covered by two or more comprehensive health insurance policies, you may be familiar with the term "coordination of benefits" (COB). Comprehensive health insurance was designed to help cover the cost of health care treatment; however, it was never intended to pay more than 100% of that cost.

For this reason, COB rules were established to address situations where an individual has more than one health plan and makes sure insurance companies don't duplicate or pay benefits that exceed 100% of the cost for treatment.

For policies issued In Michigan, the COB Act of 1984 specifies how benefits are to be coordinated.

How Does COB Work?

The most common question when two or more comprehensive health insurance policies are involved is "Who pays first?" The COB Act provides guidelines for the general order by which the primary plan, the plan that pays first, and the secondary plan, the plan that pays second, is determined.

The primary plan pays its share of the costs first, then the secondary plan pays up to 100% of the total cost of care. The plans will not duplicate benefits or pay more than 100% of the cost for treatment.

It is important to note that COB rules for an employee/subscriber/member differ from the rules for dependent children.

Specific questions about coordination of benefits may be directed to DIFS at 877-999-6442.

Types of Health Plans

It is important to know the different types of health plans to make the best use of your benefits and money.

Not all plans offer Minimum Essential Coverage (MEC), as defined under the Affordable Care Act. MEC may be an individual or group health plan, Medicaid, the Healthy Michigan Plan and Medicare. The most common major medical plans providing MEC are described below.

For more information related to MEC health plans, visit www.healthcare.gov.

Health Plans
Minimum Essential Coverage

- **Health Maintenance Organization (HMO)**
  An HMO is a type of health plan that usually limits coverage to their network of providers. It generally won't cover out-of-network care except in an emergency. An HMO may require you to live or work in the service area to be eligible for coverage. All care is coordinated through the member's primary care physician (PCP); therefore, you must designate a PCP.

- **HMO Point-of-Service Plan**
  An HMO Point-of-Service plan offers in-network and out-of-network benefits. There may be higher out-of-pocket costs for health care services received outside the HMO's network.

- **Preferred Provider Organization (PPO)**
  A PPO is a contract between an insurer and a network of providers agreeing to provide health care services at a negotiated rate. PPOs may be less restrictive than HMOs because they do not require a referral to see other providers. There are also out-of-network benefits with a higher financial responsibility.

- **Preferred Provider Arrangement (PPA)**
  A PPA is an optional feature of a health plan. The plan includes a network of participating providers available to the insured to obtain cost-effective medical services.

- **High Deductible Plans**
  These major medical plans are often sold in conjunction with Health Savings Accounts. They pay the cost of inpatient hospital care and outpatient medical bills with high deductibles. The financial responsibility under these plans changes annually and is paid from a federally tax-exempt Health Savings Account.

Visit www.michigan.gov/HICAP for more information on the annual limits under this plan.

Health Plans
Limited Benefits

- **Short-Term Limited Duration Plan**
  In Michigan, short-term limited duration plans are limited to a coverage period of 185 days out of any 365-day period. These policies are not required to cover pre-existing conditions, cannot be renewed or extended for more than 185 days and do not satisfy the requirement to have health insurance. They also do not have to comply with Affordable Care Act protections, including prohibitions on annual or lifetime limits, essential health benefits, protections against rescissions and cost-sharing limitations.

- **Limited Benefit Plans**
  Limited benefit plans provide reduced benefits intended to supplement comprehensive health insurance, not to be an alternative to them. These types of plans limit the amount of coverage the company will pay per episode of injury or illness.

  » **Accident Only**
  Accident only plans provide a cash payment in the event of injury or death resulting from a covered accident. For example, the policy may pay a $200 benefit for each covered accident.

  » **Hospital Indemnity**
  Hospital indemnity plans pay a cash benefit in the event of hospitalization and/or surgery resulting from a covered illness or injury. For example, the policy may pay a $100 per-day benefit while the insured is hospitalized.

- **Specified (Dread) Disease Plan**
  A specified disease plan provides benefits for specified causes of illness, disease or injury, such as a heart attack, stroke or cancer diagnosis. For example, the policy may pay a $30,000 benefit for an initial cancer diagnosis while the policy is in force.

- **Incidental Policies**
  Individual policies for dental and/or vision benefits pay for care not covered by typical comprehensive health insurance and may be available on a limited basis. Stand-alone dental plans can be purchased through the Health Insurance Marketplace during open enrollment and off the Marketplace directly from an insurer at any time throughout the year.

Health Plans
Medical Expense Reimbursement

- **Health Savings Account (HSA)**
  HSAs are tax-exempt accounts set up by an employer or individual to pay expenses including deductibles, co-payments and other out-of-pocket prescribed medical expenses. An HSA must be established with a high deductible health plan. The HSA is used to pay routine expenses and the health plan is used to pay more significant expenses. HSAs allow employers and consumers to set aside funds on a tax-free basis to pay health care expenses, including expenses that may not be covered by traditional health coverage. For example, HSAs may be used for vision and dental services, prescription drugs, over-the-counter drugs (if you have a prescription for them), long-term care services and certain health insurance premiums during retirement.

- **Health Reimbursement Account (HRA)**
  HRAs are employer-funded group health plans from which employees are reimbursed tax-free for qualified medical expenses up to a fixed dollar amount per year. Unused amounts may be rolled over to be used in subsequent years. The employer funds and owns the account. Health Reimbursement Accounts are sometimes called Health Reimbursement Arrangements.

- **Individual Coverage Health Reimbursement Account (ICHRA)**
  Effective January 1, 2020, employers can begin offering employer funded ICHRAs as an alternative to traditional group health plan coverage. ICHRAs are arrangements under which employees are reimbursed tax-free for qualified medical care expenses and premiums paid for individual health insurance you've chosen, up to a certain dollar amount for the plan year. Unused funds can be rolled over to be used in subsequent years. If you enroll in an ICHRA, you must also be enrolled in an individual health insurance plan purchased on or off the Exchange, or Medicare (Part A and B, or C) for each month you're enrolled in the ICHRA.

- **Excepted Benefit Health Reimbursement Account (EBHRA)**
  Effective January 1, 2020, employers can begin offering employer-funded EBHRAs in conjunction with a traditional group health plan. The annual EBHRA employer contribution is limited to $1,800 (indexed for inflation beginning in 2021). Employees may enroll in the EBHRA even if they do not enroll in the traditional group health plan or any other coverage. EBHRAs are arrangements under which employees are reimbursed tax-free for qualified medical care expenses and premiums paid for excepted benefits, such as dental and vision coverage, as well as for short-term limited duration insurance (STDLI). EBHRAs cannot be used to reimburse individual health insurance premiums, group health plan premiums (other than COBRA), or Medicare premiums. Unused funds can be rolled over to be used in subsequent years.

For more information on HSAs and HRAs, visit www.irs.gov.

Filing a Complaint With DIFS

You do not always need an attorney to resolve most claim disputes with an insurer. Start with contacting the insurer's customer service department. Most insurers have toll-free telephone numbers located on the back of your insurance card.

If a satisfactory resolution is not received, ask about the insurer's appeal process or file a written complaint with the Michigan Department of Insurance and Financial Services (DIFS).

DIFS will send the insurer a copy of the complaint and ask them to explain its position. Insurers are required by law to respond to DIFS. We will review the facts to ensure the health insurer has complied with your contract language and all rules and regulations.

How to File a Complaint With DIFS

Complaints can be submitted as follows:

- **Online:** www.michigan.gov/DIFScomplaints
- **Email:** DIFScomplaints@michigan.gov
- **Fax:** 517-284-8837 or 517-284-8853
- **Mail:** The Department of Insurance and Financial Services
  Office of Consumer Services
  PO Box 30220
  Lansing, MI 48909
- Contact DIFS toll-free at 877-999-6442 to request a complaint form be sent to you via mail, email or fax.

Health Care Provider Complaints

DIFS regulates the business of insurance transacted in Michigan. Our authority pertains to contracts issued in Michigan. DIFS accepts complaints from parties involved in the contract, such as the insured, policyholder or certificate holder. Because a health care provider is usually not a party to the health plan, DIFS generally does not accept complaints from providers. There are some exceptions to this rule.

DIFS will pursue appropriate complaints from providers acting as the authorized representative of a patient; however, written authorization from the patient or their legal representative must be included with the complaint.

DIFS will accept complaints from providers having problems with receiving timely payment for submitted claims without any errors or other issues. These claims are referred to as "clean claims" and must be paid within 45 days after they are received by the health plan. For more information on clean claims and to obtain the Clean Claim Report form, visit **www.michigan.gov/DIFS**.

If you have a provider-related billing dispute, these complaints can be submitted to the Michigan Attorney General Consumer Protection Division for review. The office can be reached toll-free at 877-765-8388 or **www.michigan.gov/AG**.

Appealing a Decision
Made by Your Health Insurer

Internal Grievance Process

If you disagree with a decision your health insurer made regarding your health care claim, you have the right to appeal the decision. There are two levels of appeal – an internal appeal with your health insurer and an external review with the Department of Insurance and Financial Services (DIFS).

The external review process should be initiated only if:

1. The covered person has exhausted the health carrier's internal grievance process.
2. The health carrier fails to provide a determination within the timeframe dictated by law.

Internal Appeal Process

Michigan law provides you the right to file an internal appeal if you disagree with your health insurer's claim determination, also known as an adverse determination.

An adverse determination means that an admission, availability of care, continued stay or other health care service that is a covered benefit has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a claim determination is also an adverse determination.

When you receive an adverse determination notice, you must notify your health insurer in writing that you want to appeal its decision.

The adverse determination notice will provide the timeframe in which you are required to submit your written appeal. Once you file an appeal, the health insurer is required to complete the internal grievance process within:

- 30 calendar days for a pre-service denial.
- 60 calendar days for a post-service denial.

External Review Process

If you do not agree with the health insurer's final adverse determination, you have 127 days to file an external review under the Patient's Right to Independent Review Act (PRIRA).

To request an external review, you or your authorized representative must complete the Health Care Appeals-Request for External Review form. In addition to the form, the external review request should include a copy of the final adverse determination from your health insurer, the reason(s) why you are appealing the decision and any documentation to support your position.

If the external review concerns a denial based on an experimental and/or investigational service, your treating provider must complete the Treating Provider Certification for Experimental/ Investigational Denials form and submit it with your request.

For additional information related to DIFS' external review process and to access the required forms, visit **www.michigan.gov/DIFS** or contact DIFS at 877-999-6442. Upon receipt, DIFS will examine your external review request to determine if it meets the requirements under PRIRA.

If your request is accepted and involves a contractual dispute, the external review is conducted by DIFS. If your request is accepted and involves issues of medical necessity or clinical review, it is referred for review to an independent review organization. In both instances, the Director of DIFS will issue an order with the decision of the review.

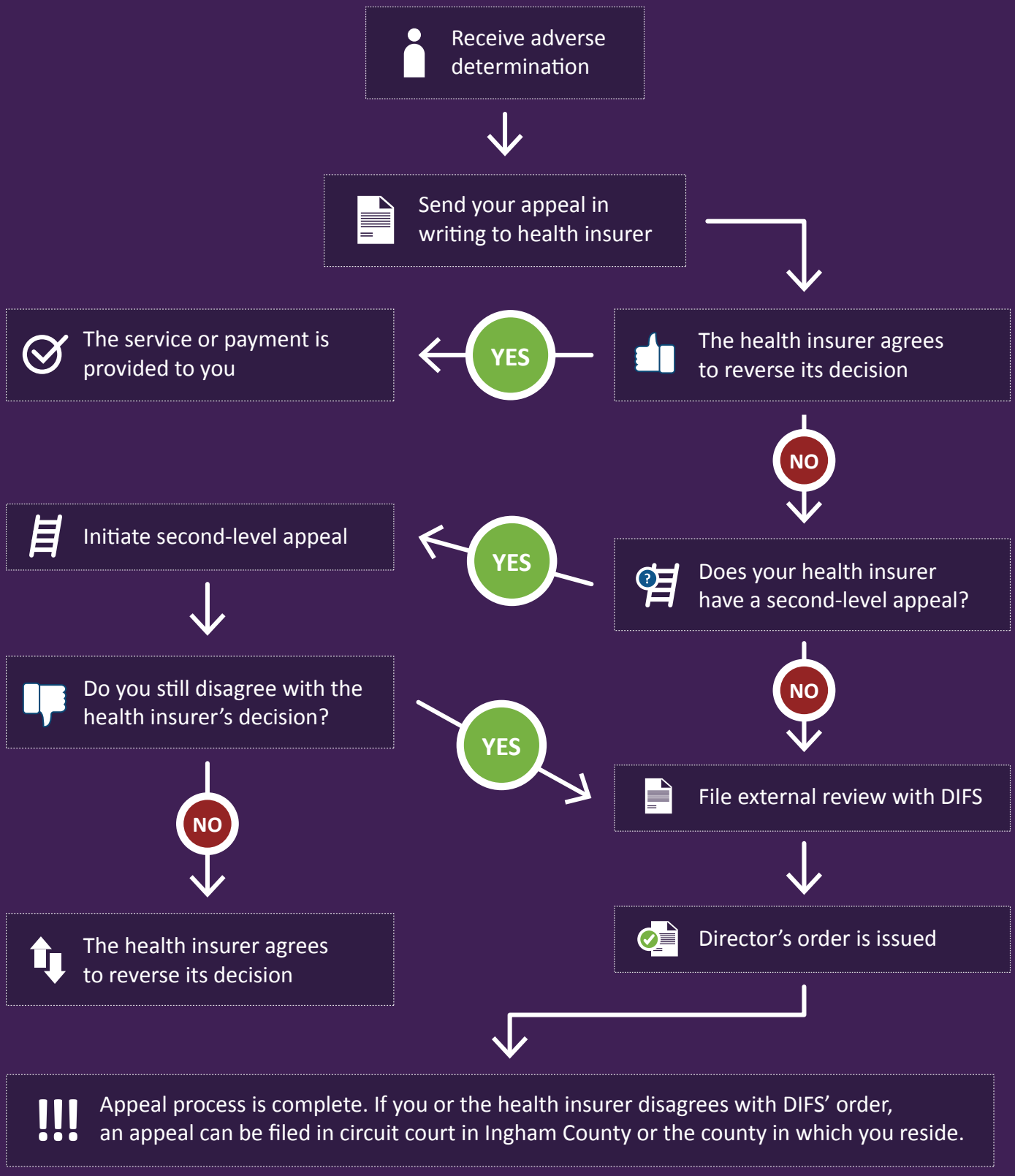
Appointment of Authorized Representative

You may authorize in writing any person, such as a doctor, attorney, parent or spouse, to represent you in the internal grievance process and/or the PRIRA external review process. In the PRIRA external review process, this person is called an authorized representative. The Health Care Appeals-Request for External Review form provides space to authorize a representative, who will be DIFS' sole contact in the PRIRA external review process.

Expedited External Review

You have the right to request an expedited external review in situations where the normal PRIRA review timeframe would seriously jeopardize your life, health, or ability to regain maximum function. An expedited external review is conducted within 72 hours and requires your treating physician to verify, orally or in writing, the necessity of an expedited review. You are not eligible for an expedited external review if it concerns a health care service that has already been received.

Appeal Process Flow Chart



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 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 documents.)

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 charges not paid by your health insurance because the charges are higher than the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you the $30 difference.

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.

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 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 covered health care services 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. 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 service for an emergency medical condition.

Emergency Room Care
Treatment you receive 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.

Habilitative 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
Service 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
Treatment 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
The 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. – doctor of medicine 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
A health insurance benefit that helps pay for prescription drugs and medications.

Prescription Drugs
A drug that by law requires a medical prescription.

Primary Care Physician
A physician (M.D. – doctor of medicine 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. – doctor of medicine 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. – doctor of medicine 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 condition.

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

Updated Contact Information 6/2022

Important Contact Information

Michigan Department of Insurance and Financial Services (DIFS)

- Michigan.gov/DIFS
- Phone: 877-999-6442

Health Insurance Marketplace

- Healthcare.gov
- Phone: 800-318-2596

SHOP Marketplace

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

- Healthcare.gov/Small-Business
- Phone: 800-706-7893

Michigan Department of Health & Human Services (MDHHS)

Apply for Michigan health care programs like Medicaid, Healthy Michigan Plan and MiChild at:

- Michigan.gov/MiBridges
- Phone: 855-276-4627
- Michigan.gov/MDHHS
- Phone: 855-789-5610
- Michigan.gov/HealthyMiPlan
- Phone: 855-789-5610

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 in Michigan.

- FCOMi.org
- Phone 248-635-8695

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

The USDOL regulates self-funded health plans and the Consolidated Omnibus Budget Reconciliation Act (COBRA).

- DOL.gov/Agencies/EBSA
- Phone: 866-444-3272

Michigan Attorney General – Consumer Protection

Handles complaints and answers questions regarding provider billing issues.

- Michigan.gov/AG
- Phone: 877-765-8388

Don’t Know Where to Turn?

Health Insurance Consumer Assistance Program (HICAP)

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

- www.michigan.gov/HICAP
- Telephone: 877-999-6442

Medicare

Medicare provides health insurance for people age 65 or older, some under age 65 with disabilities, and those experiencing kidney failure.

- www.medicare.gov
- Telephone: 800-MEDICARE (800-633-4227)

Michigan Medicare/Medicaid Assistance Program (MMAP)

MMAP provides free education and personalized assistance to people with Medicare and Medicaid, their families and caregivers.

- www.mmapinc.org
- Telephone: 800-803-7174

www.michigan.gov/DIFS

This Consumer Guide was created by the State of Michigan, Department of Insurance and Financial Services (DIFS) and supported by Funding Opportunity Number PR-PRP-18-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies.