Filing is **REQUIRED** for: Commercial insurers, HMOs, and AFDSs licensed for Health whether they write it or not.	**DUE** April 15, 2021 for 2020 calendar year

Complaint and Grievance Summary

Complete each section based on complaints/grievances resolved (closed) during the calendar year.

File via SERFF:

Commercial Insurers use:

- TOI H21 Health Other **and** SubTOI H21.000 Health-other.

HMO or AFDS use:

- TOI HOrg03 Health Other **and** SubTOI HOrg03.000 Health-other.

All must use: Filing Type "FIS 0318 Complaint and Grievance Summary Form"

Company Name:	NAIC Group Number:	Select Company Type
		☐ Commercial Insurer ☐ HMO or AFDS

Internal Reviews: Instructions for Table 1:

- Provide the number of Complaints/Grievances by decision type for each step, including Expedited Reviews. If the company has only one step for Standard reviews, enter NA under Step 2.
- Compile data based on the full calendar year.
- Use Adverse Determination as defined in MCL 550.1903(a) and Grievance as defined in MCL 500.2213(5)(b).

Table 1	Complaints/Grievances NOT resulting from Adverse Determination or Denial of Service	Upheld	Overturned	Compromise Resolution	Total Decisions
	Step* 1				
	Step 2				
	Complaints/Grievances resulting from Adverse Determination or Denial of Service	**Upheld**	**Overturned**	**Compromise Resolution**	**Total Decisions**
	Step* 1				
	Step 2				
	Expedited				

*Step, as used in Table 1, is described in MCL 500.2213(1)(k)

Internal Reviews exceeding the time allowed by statute: (MCL 500.2213(1)(k))

Number of Complaints/Grievances per category **NOT** completed within the statutory time.

_____ Pre-service: *(Maximum 30 days)* _____ Post-service *(Maximum 60 days)*

For each Internal Complaint/Grievance NOT completed within the statutory time, include a report containing the following: ***(Note-**this report will be public. **DO NOT** include any personally identifiable information)***

1. Whether Complaint/Grievance was pre- or post-service.
2. Company's Complaint/Grievance identification number.
3. Date of final decision.
4. Number of calendar days beyond statutory allowance. *(Do not include any tolled days.)*
5. Reason the time limit was exceeded.
6. For each reason listed in item 5 provide a description of the steps being taken to resolve the issue.

In addition to the above, please provide DIFS with a brief description of any trends, including increases or decreases in either number or type of Complaints/Grievances.

Certification:
I certify that I am an officer of the company named in this report, and that I have authority to prepare and file this report. I have examined this report thoroughly, and it is true, complete and correct to the best of my knowledge and belief.

Signature:	Date:	Preferred Contact Person: (if different)
Name and Title: (printed or typed)		Phone:
Phone:	E-mail:	E-mail:

MCL 500.2213(1)(g) requires submission of this form by **ALL** licensed health carriers. Failure to properly complete and submit this form by April 15, may result in compliance action, or revocation of the company's authority to do business in Michigan.

For questions regarding this form please contact the Office of Rates and Forms at 517-284-8715.

All forms must be filed via SERFF under the filing type:
"FIS 0318 Complaint and Grievance Summary Form"

Commercial Insurers use:
- TOI H21 Health Other **and** SubTOI H21.000 Health-other.

HMO or AFDS use:
- TOI HOrg03 Health Other **and** SubTOI HOrg03.000 Health-other.

Any form filed under the wrong filing type, or TOI/SubTOI **will be** returned without review.