Michigan Civil Service Commission Regulation 5.18
Complaints About Benefits

SPDOC 26-09, effective August 4, 2026 (replaces Reg. 5.18, SPDOC 26-05)

1. Purpose

This regulation provides the exclusive procedures for all classified employees to file (1) complaints about benefits under group insurance plans, (2) HIPAA privacy complaints about self-insured state health-insurance plans, and (3) complaints under regulation 5.16, § 4.E.2 over compensation corrections ordered by civil service.

2. CSC Rule References

5-11 Group-Insurance Plans

5-11.1 Plans

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(e) Administration. The director shall implement and administer approved group-insurance plans.

(1) Complaints. The director shall provide an expedited administrative review of employee complaints over group-insurance benefits. The director's process is the exclusive procedure for employee complaints over group-insurance benefits. An employee aggrieved by the director's final decision may appeal to the commission as provided in the civil service rules and regulations.

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3. Definitions

A. CSC Rule Definition.

1. **Group insurance benefits** means eligibility, enrollments, premiums, coverages, exclusions, costs, reimbursements, payments, copayments, deductibles, coinsurance, out-of-pocket maximums, coordination of benefits, or other benefits authorized under the group insurance plans.

B. Definitions in This Regulation.

1. **Group insurance plans** means all the following:

   a. The group insurance plans authorized in the compensation plan for employee health, dental, vision, disability, and life for which the state retains the responsibility to pay the cost of eligible claims.

   b. COBRA and other insurance continuation programs authorized by law or the compensation plan.

2. **Qualified pretax plan** means health-care and dependent-care flexible spending accounts and qualified transportation fringe benefits reimbursement plans authorized by law and the commission.
3. **Third-party administrator (TPA)** means an organization under contract with the state to administer claims under a group-insurance plan.
4. **Voluntary benefits plan (VBP)** means a benefit or insurance plan for which (1) the state does not pay any portion of the costs or benefits and (2) the employee pays all premium costs.

4. Standards

A. Complaints About Third-Party Administrator (TPA) Decisions. A TPA processes claims for the state for some state group-insurance plans, but civil service retains responsibility to review some of these decisions; others may be subject to external review through another state agency as provided in state or federal law. A classified employee with a complaint over a group-insurance-plan benefit must complain under the exclusive procedure in this regulation.

1. **Plans and third-party administrators.** As of this regulation's effective date, the following TPAs are responsible for the corresponding plans:
   - **a.** Blue Cross Blue Shield of Michigan: State Health Plan PPO, State High Deductible Health Plan with HSA, and State Behavioral Health & Substance Use Disorder Plan.
   - **b.** Delta Dental Plan of Michigan: State Dental Plan and Preventive Dental Plan.
   - **c.** EyeMed: State Vision Plan
   - **d.** OptumRx: State Prescription Drug Plan.
   - **e.** Securian Financial Group: State Group Life Insurance Plan.
   - **f.** Sedgwick: Long-Term Disability Plan.
   - **g.** HealthEquity: Health-Care and Dependent-Care Flexible Spending Account Plans.
2. **Initial complaints to TPA.** If an employee has a complaint about a plan decision made by a TPA (e.g., coverage, exclusion, or payment decision over a specific service), the employee must first file a complaint with the TPA and exhaust all appeal mechanisms provided by the TPA. All documentation that an employee wants considered in any appeal must be provided by the final appeal available with the TPA; records newly submitted with an appeal to the Employee Benefits Division (EBD) will not be considered.

3. **Appeal or review of final TPA decision.** After exhausting the TPA's complaint and appeal process, the presence of further appeal or review rights depends on the plan. For final TPA decisions from state health, dental, vision, behavioral health & substance abuse, or prescription drug plans, the decision of the TPA cannot be appealed to the EBD but external review can be sought as described in the TPA's processes. For final TPA decisions of a life, long-term disability, or flexible-spending-account plan, an employee who disagrees with a TPA's final decision must file any appeal in writing to the EBD as follows:

   a. **How to file**. The appeal must be filed with the EBD by email to MCSC-EBDAppeal@mi.gov or through the Civil Service Connect portal at https://www.michigan.gov/mdcs/csconnect.

   b. **Time limit.** The EBD must receive the appeal within 28 days after the date of the TPA's final decision. If an employee fails to timely appeal, the TPA's decision is final and cannot be further appealed.

   c. **Contents.** An appeal must include (a) a clear, concise statement of relief sought and why the TPA's decision is in error and (b) a copy of the final TPA decision appealed. The EBD will obtain the record from the TPA for its review.

   d. **Review and decision.** If a timely appeal is filed, the EBD shall review the record from the TPA, the employee's filing, and any other information the EBD deems necessary to evaluate the appeal. The EBD shall then issue a written decision.

B. **Direct Complaint to Civil Service.** If an employee has a complaint about a group-insurance-benefit or qualified-pretax-plan decision made by someone other than a TPA (e.g., a plan enrollment decision, back-pay award, etc.), or a complaint over corrections ordered by Civil Service under regulation 5.16, the employee must file any complaint in writing directly with the EBD by email to MCSC-EBDAppeal@mi.gov or through the Civil Service Connect portal at https://www.michigan.gov/mdcs/csconnect.

   1. **Complaint.** The EBD must receive the complaint within 28 days after the employee knew of or, in exercising reasonable diligence, should have known of the circumstances giving rise to the complaint.

   2. **Contents.** A complaint must include (a) a clear, concise statement of relief sought and (b) copies of all relevant information and evidence needed to consider the complaint.

   3. **Review and decision.** The EBD shall review the appeal and issue a written decision.

C. **Further Appeal to Commission.** An employee who disagrees with a decision of the EBD, either as an appeal of a TPA decision or after a direct complaint, may appeal the decision to the commission under regulation 8.05.

D. HMOs, DMOs, and VBPs. Health Maintenance Organizations (HMOs), Dental Maintenance Organizations (DMOs), and Voluntary Benefit Plans (VBPs) are not covered by this regulation. VBPs include accident, accidental death & dismemberment, identity theft, legal, term-life, universal-life, long-term-care, critical-illness, home, automobile, and other insurance programs where the employee pays the full premium cost. If HMOs, DMOs, or VBPs are responsible for a group-insurance-benefit decision, an employee must file any complaint directly with the applicable HMO, DMO, or VBP carrier. The carrier's final decision cannot be appealed to the EBD or commission.

E. Qualified Pretax Plans. Complaints about qualified pretax plans arising under or related to regulation 5.16 must be filed with Civil Service exclusively under §§ 4.B or 4.C.

F. Involuntary Payroll Deductions by Civil Service. Complaints against Civil Service about involuntary payroll deductions to recover overpayments under regulation 5.16 must be filed with Civil Service under § 4.B. Complaints against an agency about involuntary payroll deductions must be filed under the grievance process.

G. Privacy Complaints.

1. **Complaint filing.** An eligible classified employee enrolled in a self-insured health-insurance plan administered by the EBD who believes that the plan has improperly used or disclosed personal health information may file a complaint with the plan's privacy official. The complaint must be filed on the HIPAA Privacy Complaint Form (CS-1782) and must identify the alleged violation of privacy rights with sufficient specificity to allow review. Privacy complaints over HMOs, DMOs, VBPs, long-term-disability plans, or life-insurance plans must be directed to the plan's TPA or carrier.

2. **Privacy official review.** Under plan privacy policies, the privacy official or a designee shall review the complaint and make written findings on the alleged violations. This decision is final. The privacy official shall send the complainant and any other relevant party copies of the written findings. The privacy official shall continuously evaluate complaints to seek improvements to existing privacy procedures. An appointing authority shall consider all appropriate discipline of an employee found by the privacy official or designee to have violated privacy procedures.

Contact: Direct questions on this regulation to Employee Benefits Division, Civil Service Commission, P.O. Box 30002, 400 South Pine Street, Lansing, Michigan 48909; at 800-505-5011; or MCSC-EBDAppeal@mi.gov. Direct questions on privacy complaints to the privacy official at the same address and phone number or MCSC-HIPAA@mi.gov.