Michigan Consumer Guide to Health Insurance
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Find more information at www.michigan.gov/healthinsurance.

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This guide was printed October 2012. Portions of the text may be out of date; be sure to check with specific agencies or programs for the most current information.
# Table of Contents

- Introduction .................................................................................................................. 2
- Employer Group Coverage ............................................................................................ 3
- Individual Coverage ....................................................................................................... 5
- Types of Health Plans .................................................................................................... 6
- Shopping For or Comparing Health Coverage .............................................................. 8
- What Medical Care Must My Insurer Pay For? ............................................................ 11
- Paying Medical Bills ..................................................................................................... 15
- Switching from One Health Plan to Another ............................................................... 17
- Understanding the New Health Care Law ................................................................... 21
- What to Do if Your Claim is Denied ............................................................................ 23
- Health Coverage Grievances and Appeals ................................................................. 24
- Glossary of Health Coverage and Medical Terms ....................................................... 28
- Complaint Form ........................................................................................................... 32
- External Review Form ................................................................................................... 33
- Important Contact Information .................................................................................... 34
- County Health Plan Contact Information .................................................................... 38
The Office of Financial and Insurance Regulation (OFIR) is the State of Michigan agency responsible for regulating Michigan’s financial industries, including health insurance companies, products and agents.

This guide educates consumers about the basics of health coverage. There are several types of health insurance policies and health care plans with many different features available to consumers in Michigan. Individual coverage can be purchased on your own 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, Health Maintenance Organizations (HMOs), and non-profit health care corporations such as Blue Cross Blue Shield of Michigan. Throughout this guide “health carrier” will mean any one of these entity types. When specific differences occur for a given entity, the health carrier type will be specified.

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

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

NOTE: This guide does not explain government-sponsored health coverage programs such as Medicare or Medicaid. For information on these programs you may wish to visit:

- [www.medicare.gov](http://www.medicare.gov)
- [www.michigan.gov/helpinghand](http://www.michigan.gov/helpinghand)

or contact the Michigan Medicare Medicaid Assistance Program (MMAP) at 1(800) 803-7174.
Currently, an employer is not required to provide health coverage to employees or their dependents. However, if an employer offers group health coverage to employees and dependents, the coverage must be made available to all eligible employees. In most cases the employer determines which employees and categories of employees are eligible for the health coverage but the health carrier may have requirements as well.

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 have a choice in 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 11 in this guide.

**Premiums**
Coverage and rates may change annually and 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. Employers can make acceptance of the employer group coverage mandatory in which case the employee would be required to pay their portion of the cost.

**Enrollment**
Employees should be aware of the employer's group enrollment policies. Employers can require a waiting period 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 enrollments are allowed when certain events occur such as a birth, adoption, marriage, death, loss of a job, etc.

**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 are including wellness programs as an option.
The health carrier may offer a rebate or reduction in premium, copayments, coinsurance or deductibles or a combination of these incentives in exchange for employees’ participation in any health behavior wellness, maintenance or improvement program offered by the employer.

The employer and health carrier must determine and agree to certain indicators of employees’ health status. The employer must then provide the health carrier with evidence of improvement or maintenance of the employees’ health status and health behaviors under the program.

Once started, health carriers are not required to continue wellness programs or any incentive associated with the program.

**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. The employer is at 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 Blue Cross Blue Shield of Michigan, 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.

OFIR does not have authority over the contracts for self-funded health care plans created by employers, but OFIR 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, OFIR 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 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.
Individual Coverage

If you do not have access to group health coverage and are not eligible for Medicaid or Medicare, individual health coverage may be purchased through a licensed agent or directly from the health carrier. A list of individual health coverage carriers is available at www.michigan.gov/healthinsurance.

You are the policyholder on an individual policy. Your policy can cover you and your eligible dependents.

An insurance company **can** decline your application for coverage on an individual insurance policy if you are over age 19 with a pre-existing medical condition. If you are accepted for coverage, an insurance company may impose a waiting period for coverage on pre-existing conditions of up to 12 months or a Health Maintenance Organization (HMO) may impose a waiting period for coverage on pre-existing conditions for up to six months.

If you are a Michigan resident and do not have access to group coverage, Blue Cross Blue Shield of Michigan cannot deny you coverage based on a medical condition. Blue Cross Blue Shield of Michigan is the alternative mechanism to provide health coverage to individuals in Michigan, regardless of their health. All Blue Cross Blue Shield of Michigan individual plans have a 180-day waiting period for coverage on pre-existing conditions for those over age 19 which can be waived if you meet certain criteria. Visit: www.michigan.gov/healthinsurance and under the “Understanding Health Coverage” tab, click on “Blue Cross Blue Shield of Michigan” for more information.

Most HMOs are required to offer a 30 day open enrollment period each year to those seeking individual coverage. During the annual open enrollment period HMOs cannot deny you coverage based on your medical condition, but they can deny you coverage if they have reached enrollment capacity. A list of HMOs and their annual open enrollment periods is available at www.michigan.gov/healthinsurance.

Individual contracts must include specific minimum health care benefits required by Michigan law. For more information see page 11 in this guide. Individual plans can have varying copayments, coinsurance and deductibles including health plans used in conjunction with Health Savings Accounts with high deductibles. These deductibles are subject to limits set by the Internal Revenue Service.

**Premiums**

The monthly premium cost for your coverage depends on the type of plan chosen, your age, your gender, where you live, the industry you work in, and the number of eligible family members or eligible dependents covered under your plan.

Premiums can increase each plan year and would reflect the increasing cost of health care. Rates can also change as you move from one age bracket to another.
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 member or enrollee 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 not managed care plans. Fewer and fewer traditional types of individual plans exist now as managed care has become more common.

Managed Care
The growth of 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 control in 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 explained below.

- **HMOs—Health Maintenance Organizations** The HMO provides a comprehensive array of medical services on a prepaid basis to members who live or work within a specific geographic region. An HMO plan usually requires you to choose a primary care provider from a list of in-network providers. Your primary care provider manages most of your health care. Except for emergencies, if you need care from another provider or specialist, your primary care provider may need to give you a referral.

- **HMO Point-of-Service Plan** These HMO plans are a hybrid arrangement that combines aspects of traditional insurance coverage, with HMO coverage. At the time of medical treatment, the HMO member or enrollee 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.

- **PPO — Preferred Provider Organization:** A PPO is not a specific type of health coverage, rather 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 a discounted rate. PPOs may be less restrictive than an HMO in that it allows 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). There is usually no specialist or service referral requirement, and utilization controls are less stringent.

- **PPA — Preferred Provider Arrangement:** 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. The providers may or may not bear a financial risk for the utilization and cost of health services that is reflected in the payments the providers receive under the plan.
Medical and Hospital Plans

- **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, covered benefits and exclusions.

- **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 admittance to the hospital.

- **Short-Term Coverage:** This coverage is only for a specified length 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 are not renewable and do not cover pre-existing conditions.

- **Catastrophic Health Coverage:** A medical expense coverage that provides benefits after an extraordinary amount of medical expenses has been incurred, sometimes as high as $25,000. This type of coverage is sometimes called an excess major medical policy.

- **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 is paid from a federally tax exempt Health Savings Account (HSA). High deductible plans also have a maximum out-of-pocket amount that is paid in deductibles, copayments and coinsurance. The maximum out-of-pocket amount for an individual is $6,500, or $12,250 for a family.

Limited Purpose Indemnity Plans

- **Accident Only Policy:** This is a policy of limited medical coverage that provides cash payments in the event of injury or death resulting from a covered accident within a specified period. This type of policy pays only when you are treated for an accidental injury or if an accident causes death.

- **Hospital Indemnity Plan:** This is a policy of limited medical coverage featuring 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 Policy:** Individual policies for dental and vision benefits pay for care not covered by typical major medical policies and may be available on a limited basis.
Not all health plans are the same. The benefits, costs, and access to care differ from plan to plan. Here are some questions you might ask to help you compare health coverage plans if you are buying individual coverage or have a choice of employer group plans.

**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 (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 dollar limits, such as daily or annual benefit caps?
- 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: 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?
- Do you need 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 OFIR’s website, just go to: www.michigan.gov/ofir).

Is the insurance agent and/or health carrier licensed in Michigan? (You can look up a license at OFIR’s website, www.michigan.gov/ofir).

Health Carriers that Sell Health Coverage in Michigan

In general, if you are shopping for individual health coverage in Michigan, you have the choice of purchasing coverage from:

- Health Maintenance Organizations (HMOs), or
- Health insurance companies, or
- Blue Cross Blue Shield of Michigan — a non-profit health care corporation

Contact information for these health carriers may be found at: www.michigan.gov/healthinsurance, click on “Shopping for Health Coverage.”

Shopping for Coverage with a Pre-Existing Medical Condition

In Michigan, a health carrier, except for Blue Cross Blue Shield of Michigan or an HMO during its annual open enrollment, can refuse to issue an individual contract if you have a pre-existing condition. A pre-existing condition is a condition for which medical advice, diagnosis, care, or treatment was recommended prior to the application for health coverage. The health carrier can issue a policy with an exclusion or limitation for a pre-existing condition but the limitation or exclusion cannot be for more than 12 months (six months for Blue Cross Blue Shield of Michigan). With the implementation of the Affordable Care Act, children under 19 cannot be denied coverage for a pre-existing condition, but adults can still be denied coverage for pre-existing conditions until 2014.

Now through 2013, adults who have a pre-existing medical condition and have gone without coverage for six months may qualify to purchase coverage through a new program called HIP Michigan. HIP Michigan sells coverage to people who are otherwise unable to purchase health coverage due to pre-existing conditions. It is part of a federal program established by the U.S. Department of Health and Human Services (HHS) in response to the Affordable Care Act. The plan is administered by Physicians Health Plan. For more information, or to apply, visit: www.hipmichigan.org or call: 1(877) 459-3113.
Limited-benefit Plans

If you watch late-night television, you may see ads for low-cost, affordable health insurance. You may wonder if these offers are right for you. Often, these ads are for limited benefit plans—bare-bones policies with reduced benefits and higher costs for you.

A limited-benefit plan, for example, might limit the amount of coverage the company will pay per episode of illness. This sometimes is as low as $1,500 to $5,000 (not counting coinsurance and deductibles paid out-of-pocket by you). These policies also provide limited surgical, preventive care, testing, and emergency benefits. Low benefit limits called “caps” may leave you with a big bill.

Discount Plans

Medical discount plans are not health insurance. They simply offer a discount from participating doctors, pharmacists, and other health care providers who contract with the company.

Non-Licensed Risk Sharing Plans

You may receive offers to join a group or association that will take your monthly payments, put them in a savings account (or trust) with other participants’ money, and then help pay some of your health care costs, as needed. Such arrangements are not insurance and the participants do not have the protections available to purchasers of licensed insurance plans or health carriers. The Office of Financial and Insurance Regulation strongly recommends that you thoroughly investigate such plans before joining.
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.

Certain (non-grandfathered) plans under the Affordable Care Act 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. Grandfathered plans, which do not have to meet this requirement, are plans that existed before the Affordable Care Act took effect and meet other criteria.

Until 2014, if you are age 19 or older, health carriers may deny payment for treatment of pre-existing medical conditions for up to 12 months depending on whether you have group or individual health coverage and not more than 180 days for Blue Cross Blue Shield of Michigan.

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 emergency medical treatment.

Minimum Coverage Requirements

Michigan requires some health carriers to pay for specific medical treatments, commonly referred to as minimum coverage requirements. (Minimum coverage requirements do not apply to self-funded health care plans or to indemnity policies. For more information on self-funded plans, see page 4. For more information on indemnity plans, see page 7.)

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
- 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
- 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.

Blue Cross Blue Shield of Michigan plans must include this coverage regardless of whether or not prescription drug coverage is included in the plan.

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) A woman 35 years of age or older and under 40 years of age — coverage for one screening mammography examination during that five-year period.

(b) A woman 40 years of age or older — coverage for one screening mammography examination every calendar year.

3) Mastectomy Benefit Coverage: 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. 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 Coverage: If the policy covers benefits for emergency services it must provide coverage for ambulance services.

8) Obstetrician-Gynecologist and Mid-Wife Coverage: If the health policy 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 Coverage:
If the contract includes prescription drug coverage and the prescription drug coverage is limited to drugs included in a formulary (or list of approved drugs), the health carrier must provide the formulary restrictions. It must also provide for exceptions when a non-formulary medication is medically necessary and 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 Coverage:
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 dollar amount is adjusted each year based on the Consumer Price Index. To review the current substance abuse minimum benefit amount, see www.michigan.gov/ofir and click on “Publications” and then “Reports.”
13) Autism Spectrum Disorder (ASD):
Beginning October 15, 2012, most health coverage policies that are issued, amended or renewed, 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 bills.
- deny or limit coverage on the basis that it is educational or habilitative in nature.
- 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 maximum annual benefits on ASD coverage, subject to federal mental health parity laws and the Affordable Care Act.

This does not apply to self-funded plans but many self-funded plans have voluntarily agreed to provide this coverage.

**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.”
You and your health carrier may share the costs of care covered by your policy and 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. (See COB below.)

5) You pay your share of the bills.

**TIP:** Put your summary of benefits provided to you by your health carrier in a convenient place so that you can access it whenever you have questions about what is covered by your health plan.

The provision of COB was 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 would 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 the 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 is the primary coverage?” “Which is the secondary coverage?” and so on. The primary health coverage is the health plan that pays first; the secondary health coverage pays second or after the primary coverage pays; and so on down the line. The Coordination of Benefits Act provides guidelines for the general order by which the primary health coverage and secondary health coverage is determined as follows:

1. 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 person would have primary coverage from their own employer’s group health plan.

2. 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.

**Please note for these explanations, it is assumed that the health plans were issued in Michigan and 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 person would have primary coverage from their 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.
Paying Medical Bills cont’d

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 health plan covering you as an employee, member, subscriber or dependent of an employee, member or subscriber is primary over the health plan covering you under COBRA.

If you are covered as an employee, member or subscriber under more than one plan, and none of the above rules apply, 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.

Coverage for 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;
- Then, 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 would be 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 OFIR at 1 (877) 999-6442.
Switching from One Health Carrier to Another

When you, or a loved one, are changing jobs, losing your job, leaving a job for other adventures 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.

You will generally have five options:

- Conversion to an individual policy with the same health carrier that provided the Michigan employer group coverage,
- Temporary continuation of the same group plan under COBRA,
- Purchase of an individual policy with Blue Cross Blue Shield of Michigan if you are a Michigan resident,
- Enrollment in coverage with a Health Maintenance Organization (HMO) during its annual open enrollment period if you live in the service area,
- Purchase of individual coverage from an insurance company.

**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 will 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. 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 from employment 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 health coverage, or
- You divorce or separate from the certificate holder or you cease to be a qualified family member under a group health plan.

Under Michigan law, if you convert your group policy to an individual (group conversion) policy with a health carrier other than Blue Cross Blue Shield of Michigan, you are no longer considered a Health Insurance Portability and Accountability Act (HIPAA) eligible individual and you will lose protections provided under HIPAA for health coverage in Michigan. If you have a pre-existing condition you may want to choose coverage with Blue Cross Blue Shield of Michigan or an HMO during the annual open enrollment rather than group conversion coverage.

**Temporary Continuation of Coverage**

**Consolidated Omnibus Budget Reconciliation Act (COBRA):**

COBRA is a federal law that gives you the right to continue employer provided group health coverage on a temporary basis after you or your spouse or parent leave an employer with 20 or more employees. Employers with 20 or more employees 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 whole group premium including any part your employer had been paying, plus up to an additional two percent for administrative expenses. COBRA coverage ends after either:

- 18 months,
- 29 months, if you became eligible for Social Security disability during the first 60 days of COBRA continuation 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 this 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 1 (866) 444-3272 or on the Internet at www.dol.gov/ebsa.

Other than COBRA Continuation of Coverage: If you lose your employer group coverage and the Michigan employer has less than 20 employees, you do not have COBRA rights. Michigan does not have a “mini COBRA law.” However, you do have the following options for continuation of health coverage:

- You have the right to a group conversion policy with the Michigan employer’s group health carrier, or
- You can apply for an individual policy with Blue Cross Blue Shield of Michigan, if you are a Michigan resident and are not eligible for group coverage elsewhere, or
- You can apply for coverage with an HMO that has a service area where you live during the HMO’s annual open enrollment period. The HMO cannot turn you down during its annual open enrollment period, unless it has reached enrollment capacity. If you have more than six months of creditable coverage the HMO cannot institute a pre-existing condition exclusion, or
- If coverage for a pre-existing condition is not an issue, you can apply for coverage with any health carrier that sells individual coverage in Michigan.
Health Insurance Portability and Accountability Act (HIPAA):

HIPAA is a federal law that makes it easier for you to stay insured and covered for pre-existing conditions when you move from one employer group health plan to another employer group plan. HIPAA establishes rules that identify HIPAA eligible individuals. The “Portability” part of HIPAA is the ability to move from one employer group health plan to another employer group health plan without pre-existing condition exclusion waiting periods when you arrive at your new employer group health plan.

Moving from One Employer Group Plan to Another Employer Group Plan

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. You cannot be turned down or charged higher premiums simply because of a dependent’s medical condition. 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.

Pre-Existing Condition Waiting Periods When Moving from One Employer Group to Another:

A pre-existing condition waiting period is the amount of time that the covered person must wait from the beginning of the coverage period before coverage for treatment for pre-existing conditions is provided.

According to Michigan law:

- No health carrier providing coverage to a small employer group of two to 50 employees can require a pre-existing condition waiting period.
- Blue Cross Blue Shield of Michigan (BCBSM) and HMOs cannot require pre-existing condition waiting periods for any size of employer group.
- Health carriers, other than BCBSM and HMOs, may require a pre-existing condition waiting period of no more than six months for large groups of 51 or more employees.

Creditable Coverage When Moving From One Employer Group to Another:

The concept of “creditable coverage” is that individuals should be given credit for having previous health coverage when moving from one employer group health plan to another employer group health plan, from an employer group health plan to an individual policy, or from certain kinds of individual coverage to an employer group health plan. Generally, most health coverage is considered “creditable coverage,” including prior coverage under a group health plan (including a governmental or church plan), individual health coverage, Medicare, Medicaid, and other government sponsored health coverage.

Certificate of Creditable Coverage:

HIPAA provides that your former employer or health carrier must issue you an automatic certificate of creditable coverage within a “reasonable” period after your health coverage ends. In addition, within 24 months after coverage ends and upon your written request the employer or health carrier must issue you a certificate of creditable coverage whether or not you already received an “automatic” certificate of coverage.

HIPAA Eligibility:

Federal law considers you a HIPAA eligible individual if you meet all of the following requirements:

- Have 18 months of creditable coverage,
- Were most recently covered by an employer group health plan,
- Were not terminated from your group plan due to nonpayment of premium or fraud,
- Do not have a gap in coverage of more than 62 days,
- Are not eligible for Medicare, Medicaid, or any other group health coverage.
- Have exhausted all COBRA coverage, and
- You do not have any other health coverage.
HIPAA eligibility does not however, prevent a health carrier from denying you individual coverage in Michigan because, under Michigan law, Blue Cross Blue Shield of Michigan is the “alternate mechanism” or insurer of last resort to provide coverage to individuals in Michigan. If you are a Michigan resident and are not eligible for group coverage elsewhere, Blue Cross Blue Shield of Michigan cannot turn you down regardless of your HIPAA eligibility and your medical condition. Blue Cross Blue Shield of Michigan does have a contractual 180-day waiting period on coverage for pre-existing conditions for those over age 19, but it will waive the 180-day waiting period on coverage for pre-existing conditions if the applicant provides a certificate of creditable coverage from their most recent group health plan and meets all of the following:

- Must be eligible by having at least 18 months of continuous health coverage,
- Most recent health coverage was group employment related,
- Have accepted and exhausted all COBRA coverage to which they are entitled, and
- Cannot have more than a 62-day gap in coverage.

If you have creditable coverage from the prior health carrier, the number of months that you had that coverage will be used to eliminate all or a portion of the 180-day pre-existing condition waiting period.

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 have options. You can apply for individual coverage through any health carrier. However, health carriers, except for Blue Cross Blue Shield of Michigan and HMOs during the annual open enrollment period, can medically underwrite your application meaning they can refuse to provide coverage based on your pre-existing health conditions even if you are a HIPAA eligible individual. If the health carrier agrees to provide you with coverage, it can still apply up to a 12-month waiting period on coverage for pre-existing conditions until 2014.

In accordance with HIPAA and under Michigan law, Blue Cross Blue Shield of Michigan is the “alternate mechanism” or insurer of last resort to provide coverage to individuals in Michigan. If you are a Michigan resident and are not eligible for group coverage elsewhere, Blue Cross Blue Shield of Michigan cannot turn you down regardless of your HIPAA eligibility and your medical condition. Blue Cross Blue Shield of Michigan does have a contractual 180-day waiting period on coverage for pre-existing conditions but it will waive this waiting period under certain conditions. If you have creditable coverage from the prior health carrier, the number of months that you had that coverage will be used to eliminate all or a portion of the 180-day pre-existing condition waiting period.
Understanding the New Health Care Law

In 2010, the U.S. Congress passed, and the President signed, the new health care law. While the proper title of the legislation is the Patient Protection and Affordable Care Act or PPACA, it is now more commonly referred to as the Affordable Care Act or ACA.

What you can expect now:
The Affordable Care Act of 2010 made some changes to health coverage beginning in 2010. Here are some of these key reforms that are in effect:

- Health carriers and employer plans that offer dependent coverage to children must cover adult children up to age 26. (This provision does not apply to health plans that provide coverage to retirees only.)

- Health carriers can no longer deny coverage to children under age 19 who have pre-existing conditions and who apply during open enrollment periods. Also, the health carrier cannot make children wait for coverage for pre-existing conditions.

- Most health carriers must provide coverage for certain preventive benefits (such as immunizations and cancer screenings) to you without any cost sharing.

- Policies may not include lifetime dollar limits on how much they will pay to cover essential benefits. Essential health benefits are a set of health care service categories that must be covered by certain plans, starting in 2014, including items and services within at least the following 10 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.

- Annual dollar limits on essential benefits will be phased out by 2014.

- Rescissions, or the retroactive cancellation of a policy, are limited to cases of fraud and intentional misrepresentation of material fact (if you intentionally misrepresent or omit information on your application, for example).

- Health carriers and employer plans cannot require you to get a referral for pregnancy or gynecological care, as long as you go to a provider who contracts with your health carrier.

- Now through 2013, adults who have a pre-existing medical condition and have gone without coverage for six months may qualify to purchase coverage through a new federal program called HIP Michigan (administered by Physicians Health Plan). For more information, call 1 (877) 459-3113.
Understanding the New Health Care Law cont’d

What you can expect in 2014:

- The Medicaid program which provides health coverage for lower income people, families, the elderly and people with disabilities, may be expanded. Individuals who earn less than $14,856 a year (or $30,657 for a family of four) may be eligible to enroll in Medicaid.

- A new competitive insurance marketplace, or health insurance exchange, will be established where millions of Americans and small businesses will be able to shop for and compare health coverage based on price and benefits.

- Tax credits will be available for those with income of $44,000 or less ($88,000 or less for a family of four) who are not eligible for other affordable coverage.

- Most individuals who can afford it will be required to obtain basic health coverage or pay a fee to help offset the cost of caring for uninsured Americans. If affordable coverage is unavailable to an individual, he or she will be eligible for an exemption.

- Health carriers will no longer be able to deny coverage or charge a higher premium to an adult with a pre-existing condition.

The information provided in this guide is only intended to be general summary information to the public. It is not intended to take the place of either the written law or regulations. If you have questions about whether a provision applies to your plan, contact your health carrier, plan administrator, employer or the Office of Financial and Insurance Regulation (OFIR-HICAP@michigan.gov). Or for more information on the law, visit the federal website: www.healthcare.gov.
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 Office of Financial and Insurance Regulation (OFIR).

How to File a Complaint with OFIR

- You can obtain a complaint form and instructions for filing a written complaint from our website www.Michigan.gov/OFIR or by calling OFIR toll-free at 1 (877) 999-6442 or use the form on page 32 in this guide.

- OFIR 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 OFIR.

- OFIR 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 member or their authorized representative an avenue to seek resolution when there has been an adverse determination. An adverse determination is an admission, availability of care, continued stay, or other health care service that has been reviewed and has been denied, reduced, or terminated. Failure to respond in a timely manner to a request for a determination constitutes an adverse determination.

The health carrier is required to make sure all steps in the internal grievance process are completed within 35 calendar days after the written request has been submitted. This does not include the time the patient takes to decide to go from one step in the process to the next step in the process. The health carrier can request an additional 10 business days to obtain necessary medical information.

Beginning the Internal Grievance (or Internal Review) 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 your position. 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 health carrier is required to notify you of its determination in writing and to advise you of your right to the next step(s) in the grievance process if you disagree with the determination.

The internal grievance process must give the patient the right to appear before a board of directors or designated committee or the right to a managerial-level conference to complete the grievance.

Next, the health carrier is required to notify the patient of its determination in writing and to advise the patient of the external review process and the right to an external review with the Office of Financial and Insurance Regulation (OFIR) under the Patient’s Right to Independent Review Act; or, other external review processes that may be available to the patient.

Patient’s Right to Independent Review Act (PRIRA) — External Review Process
The Patient’s Right to Independent Review Act (PRIRA) is a Michigan law that provides patients with appeal rights due to adverse decisions made by health carriers regarding a denial, reduction, or termination of health care services.

The PRIRA external review process applies after the patient has exhausted the health carrier’s internal grievance process.
Required Information for PRIRA External Review

The member or enrollee or their authorized representative must complete the Health Care Request for External Review Form on page 33 of this guide. The request should also include a copy of the final adverse determination from the health carrier along with information and documentation to support the member or enrollee’s position.

The request must be submitted within 60 days of the member or enrollee’s receipt of the health carrier’s final adverse determination.

The member or enrollee may authorize in writing any person such as a doctor, attorney, parent or spouse to represent them in the internal grievance process and/or the PRIRA external review process. The Health Care Request for External Review Form provides space to authorize a representative who will act on behalf of the member or enrollee with respect to a request for external review and will be OFIR’s sole contact in the PRIRA external review process.

Member or enrollees and their authorized representative are not required to have an attorney represent them through the PRIRA external review process.

Preliminary Review of Request for PRIRA External Review

OFIR has five business days to conduct a preliminary review to determine if the member or enrollee is eligible for the PRIRA external review process.

OFIR notifies the health carrier of the request and obtains pertinent information to help decide if the member or enrollee and health care service is eligible for a PRIRA external review.

OFIR makes sure the request meets the following requirements:

1) The issue must involve an adverse determination.
2) The coverage involved must be subject to the Patient’s Right to Independent Review Act.
3) The member or enrollee must have been a covered person at the time the health care service was provided or requested.
4) The health care service in question must reasonably appear to be a covered service under the contract or policy.
5) The covered person must have exhausted the internal grievance process of the health carrier.
Acceptance for External Review

OFIR will notify the member or enrollee 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 OFIR advises the person of the information needed to make the request complete. If the request is not accepted, OFIR will explain the reason why the request does not qualify for a PRIRA external review.

If the request is accepted and involves only contractual provisions of the policy, the review is conducted by the Commissioner of OFIR.

If the request is accepted and involves issues of medical necessity or clinical review criteria, it is referred to an independent review organization (IRO). An IRO is an independent entity that has a contract with OFIR to conduct medical reviews under PRIRA. The contracted entities reviewing the issues have staff with medical expertise in the health care service at issue in the review.

Investigation and Obtaining Medical Records

OFIR staff will not investigate, contact medical sources or seek out information to support the member or enrollee’s position. It is the member or enrollee’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 Commissioner and does not require review by an IRO, the law requires that the Commissioner 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 OFIR with its recommendation within 14 calendar days after it is assigned the review. The law requires that the Commissioner issue a decision within seven business days after it receives the recommendation of the IRO.

Right to Appeal Commissioner’s Decision

If the member or enrollee (or authorized representative) or the health carrier disagrees with the Commissioner’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, OFIR will not represent the member or enrollee in circuit court.
PRIRA Expedited External Review

A PRIRA expedited external review is a faster review process 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 member or enrollee or would jeopardize the member or enrollee’s ability to regain maximum function.

A PRIRA expedited external review is completed within 72 hours after your request (which OFIR prefers in writing) has been accepted for expedited external review.

To qualify for a PRIRA expedited external review, the member or enrollee must have a physician verify, orally or in writing, that the time frame for a non-expedited PRIRA external review would seriously jeopardize the life or health of the covered person.

A PRIRA expedited external review is only granted when the issue involves health care services that have not already been provided to the member or enrollee and the issue involves medical necessity.

The same form is used to request an expedited external review under the Patient’s Right to Independent Review Act. The Health Care Request for External Review Form is on page 33 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.

**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 cesarean 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 $1000, your plan won’t pay anything until you’ve met your $1000 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

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January 1st
Beginning of Coverage Period

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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

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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

---

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 Insurance Complaint Form

**My Name**

**Name of Health Carrier**

*Please include a copy of the front and back of insurance card*

**Address**

**Name of AGENT or AGENCY (if applicable)**

**City**

**Name of INSURED person on insurance card**

**State**

**My Email Address**

**Zip Code**

**Date of healthcare service**

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<tr>
<th>Daytime phone number</th>
<th>Alternate phone number</th>
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**Type of Plan**

- [ ] Individual plan
- [ ] Group Plan

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<tr>
<th>Policy #</th>
<th>Name of group/employer</th>
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<tr>
<th>Group Contract #</th>
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**Type of coverage my complaint is about:**

- [ ] Health Insurance
- [ ] HMO
- [ ] Medicare Supplement
- [ ] Medicare Advantage
- [ ] BCBS of Michigan
- [ ] Medicare RX Part D
- [ ] Vision
- [ ] Denial
- [ ] Other

**Reason for complaint:**

- [ ] Claims issue
- [ ] Dependent Coverage
- [ ] Rate Issue
- [ ] Coverage for Health Service
- [ ] Premium Billing
- [ ] Refusal to Insure
- [ ] Customer Service
- [ ] Other

**Please list events in the order they happened. Attach additional pages if needed. If possible please use letter size paper (8 1/2 x 11”) for all attachments.**

**Details of my complaint:**

- [ ] Misrepresentation of Coverage
- [ ] Refusal to Insure
- [ ] Other

**Desired outcome:**

**Please mail your complaint to:**

OFIR Consumer Services
P.O. Box 30220
Lansing, MI 48909-7720

Or fax to: (517) 241-3991
Or Email to: ofir-hicap@michigan.gov

**Signature**

**Date signed**

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**Documentation relating to your complaint is important. This information helps us to understand details of your complaint.**

**Please attach copies of letters or other documents that will help us review your complaint. This includes your insurance cards, bills, receipts, claim documents or other items that relate to your complaint.**

**Always send copies. Never send original documents.**
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 Office of Financial and Insurance Regulation does not contact medical sources. Always send copies. Never send original documents.

1. Patient Name
   Name of INSURED person

   Name of Health Carrier (HMO, HCBISM, 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.

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:

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 Office of Financial and Insurance Regulation (OFIR), 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
   OFIR Health Plans Division -- Appeals Section
   (by mail)  (by courier/delivery)
   P.O. Box 30220  611 W Ottawa Street, 3rd Floor
   Lansing, MI 48909-7720  Lansing, MI 48933-1070
   Fax: 1-517-241-4168  Phone: 1-877-999-6442

P.A. 251 of 2003 as amended, authorizes the Commissioner to review requests for external review. Submission of this form is required to request an external review by the Commissioner of the Office of Financial & Insurance Regulation.

Michigan Department of Licensing and Regulatory Affairs
LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities. Visit OFIR online at: www.michigan.gov/ofir  Phone OFIR toll-free at: 1-877-999-6442
State Health Programs

Health care coverage is available to individuals and families who meet certain eligibility requirements. The goal of these health care programs is to ensure that essential health care services are made available to those who otherwise do not have the financial resources to purchase them. Some of the available programs are listed below. If you believe that you are eligible for Medicaid please contact the Department of Human Services.

MIChild

If you have children under age 19, you may be able to get health and dental care for them through MIChild. To qualify, your children must:

» Be under age 19
» Have no comprehensive health insurance, including Medicaid
» Have a Social Security number (or have applied for one)
» Live in Michigan, even for a short time
» Be a U.S. citizen or qualified immigrant
» Meet monthly family income limits

Healthy Kids

You may be able to get health and dental services for you and your children through Healthy Kids. To qualify, you or your children must:

» Be under age 19, or pregnant
» Have a Social Security number (or have applied for one)
» Live in Michigan, even for a short time
» Be a U.S. citizen or a qualified immigrant
» Meet monthly family income limits

Children’s Special Health Care Services

If you have a child (20 or younger) with a qualifying medical condition or an adult dependent with cystic fibrosis or other medical condition, they may qualify.

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<tr>
<th>Phone: 1(800) 359-3722</th>
<th>Phone: 1(888) 988-6300</th>
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<tbody>
<tr>
<td>Website: <a href="http://www.michigan.gov/dhs">www.michigan.gov/dhs</a></td>
<td>Website: <a href="http://www.healthcare4mi.com">www.healthcare4mi.com</a></td>
</tr>
<tr>
<td>Website to apply for Medicaid: <a href="http://www.michigan.gov/mibridges">www.michigan.gov/mibridges</a></td>
<td>Website: <a href="http://www.michigan.gov/dhs">www.michigan.gov/dhs</a></td>
</tr>
</tbody>
</table>
**Plan First!**

Decide when to have a baby. You may be able to get family planning services through Plan First! To qualify, you must:

» Not be pregnant or receiving Medicaid
» Be age 19–44 years old
» Not have health insurance that covers family planning services
» Have a Social Security number (or have applied for one)
» Live in Michigan
» Be a U.S. citizen or a qualified immigrant
» Meet monthly family income limits

*Phone: 1(800) 343-7320
Website: www.michigan.gov/mdch*

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**County Health Plans and Other County Health Services**

Depending on which county you reside in, there may be county health coverage or medical services available. (See page 38 for a listing of county health plans.)

*Phone: 1(517) 373-3740
Website: www.michigan.gov/mdch*

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**Free or Low Cost Prescription Medication**

The State of Michigan offers several programs for prescription assistance.

*Phone: 1(517) 373-3740
(General information)
Website: www.michigan.gov/mdch
MIRx Hotline: 1(800) 259-8016*

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**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: 1(269) 491-0493
Website: www.fcomi.org*
**Important Contact Information cont’d**

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### Turned Down for Health Insurance?

**Michigan High Risk Pool (HIP Michigan)**

HIP Michigan provides affordable health coverage for people who are otherwise unable to purchase health coverage due to pre-existing conditions and have been uninsured for six months. It’s part of a federal program established by the U.S. Department of Health and Human Services (HHS) in response to the Affordable Care Act. The plan is administered by Physicians Health Plan.

- **Phone:** 1(877) 459-3113
- **Website:** [www.hipmichigan.com](http://www.hipmichigan.com)

**Contact Blue Cross Blue Shield of Michigan**

BCBSM cannot deny coverage to a Michigan resident but may impose a 180-day waiting period for coverage on pre-existing conditions.

- **Phone:** 1(877) 469-2583
- **Website:** [www.bcbsm.com](http://www.bcbsm.com)

**Visit www.healthcare.gov**

To explore healthcare coverage options in Michigan that are available to you.

- **Website:** [www.healthcare.gov](http://www.healthcare.gov)

### Key Insurance Contacts

**U.S. Department of Health and Human Services (HHS)**

This agency provides a website that lists private and public insurance options to make it easier for you to find affordable coverage.

- **Phone:** 1(877) 696-6775
- **Website:** [www.hhs.gov](http://www.hhs.gov)

**State of Michigan Office of Financial and Insurance Regulation (OFIR)**

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

- **Phone:** 1(877) 999-6442
- **Website:** [www.michigan.gov/ofir](http://www.michigan.gov/ofir)

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

Information and rules for people whose employer group health plans are self-insured.

- **Phone:** 1(866) 444-3272
- **Website:** [www.dol.gov/ebsa](http://www.dol.gov/ebsa)
### Senior Health Insurance Resources

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<th>Resource</th>
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<th>Contact Info</th>
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<td><strong>Medicare</strong>:</td>
<td>Health insurance for people age 65 or older, some people under age 65 with disabilities, and people with kidney failure.</td>
<td>Phone: 1(800) MEDICARE 1(800) 633-4227 Website: <a href="http://www.medicare.gov">www.medicare.gov</a></td>
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<tr>
<td><strong>Michigan Medicare/Medicaid Assistance Program (MMAP)</strong></td>
<td>The Michigan Medicare/Medicaid Assistance Program (MMAP) provides free education and personalized assistance to people with Medicare and Medicaid, their families and caregivers.</td>
<td>Phone: 1(800) 803-7174 Website: <a href="http://www.mmapinc.org">www.mmapinc.org</a></td>
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<tr>
<td><strong>Centers for Medicare and Medicaid Services</strong></td>
<td>Federal government agency that regulates Medicare and Medicaid. Provides useful options and information in regard to healthcare.</td>
<td>Phone: 1(800) 633-4227 Website: <a href="http://www.cms.gov">www.cms.gov</a></td>
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<tr>
<td><strong>Health Insurance Consumer Assistance Program (HICAP)</strong></td>
<td>The Health Insurance Consumer Assistance Program is federally funded and operated by the State of Michigan — Office of Financial and Insurance Regulation to help Michigan consumers with health insurance issues.</td>
<td>Phone: 1(877) 999-6442 Website: <a href="http://www.michigan.gov/hicap">www.michigan.gov/hicap</a></td>
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</table>
Don’t know where to turn?

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

Get help today! Contact HICAP:
Toll-free: 1(877) 999-6442
www.michigan.gov/HICAP
OFIR-HICAP@michigan.gov

LARA is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities. State of Michigan, Department of Licensing and Regulatory Affairs, Office of Financial and Insurance Regulation
Quantity: 5,000; Cost: $5,254.50; Unit Cost: $1.05; Paid for with federal funds.