Health Insurance
What to Do When Things Go Wrong

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Who We Are
Who We Regulate
Who We Regulate

Uh....
Khakis?
Why It Matters
Health Insurance is complicated
Sources of coverage

- Your employer
- A government program
- Purchased for yourself
Self Funded vs. Fully Insured
How to be a savvy health insurance customer
Read and Review Everything
<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$500 person / $1,000 family</td>
<td>You must pay all the costs up to the <strong>deductible</strong> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>Yes, $300 for prescription drug coverage. There are no other specific deductibles.</td>
<td>You must pay all of the costs for these services up to the specific <strong>deductible</strong> amount before this plan begins to pay for these services.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For participating providers $2,500 person / $5,000 family For non-participating providers $4,000 person / $8,000 family</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit.</strong></td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.%5Binsert">www.[insert</a>] or call 1-800-[insert] for a list of participating providers.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. See the chart starting on page 2 for how this plan pays different kinds of <strong>providers</strong>.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don’t need a referral to see a specialist.</td>
<td>You can see the <strong>specialist</strong> you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 4. See your policy or plan document for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

Questions: Call 1-800-[insert] or visit us at www.[insert]. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

*This is not a cost estimator.*

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby

(normal delivery)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

- Deductibles: $700
- Copays: $30
- Coinsurance: $1,320
- Limits or exclusions: $0

**Total:** $2,050

### Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount owed to providers</td>
<td>$5,400</td>
</tr>
<tr>
<td>Plan pays</td>
<td>$3,520</td>
</tr>
<tr>
<td>Patient pays</td>
<td>$1,880</td>
</tr>
</tbody>
</table>

#### Sample care costs:

- Prescriptions: $2,900
- Medical Equipment and Supplies: $1,300
- Office Visits and Procedures: $700
- Education: $500
- Laboratory tests: $100
- Vaccines, other preventive: $100

**Patient pays:**

- Deductibles: $800
- Copays: $500
- Coinsurance: $500
- Limits or exclusions: $80

Note: These numbers assume the patient is participating in our diabetes wellness program. If you have diabetes and do not participate in the wellness program, your costs may be higher. For more information about the diabetes wellness program, please contact [insert].

Questions: Call 1-800-[insert] or visit us at www.[insert]. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.[insert] or call 1-800-[insert] to request a copy.
Ask Questions
DIFS can help.
Billing Issues
Claim Denials
Provider Networks
GUIDE TO RESOLVING HEALTH INSURANCE PROBLEMS

State of Michigan
Rick Snyder, Governor

Health Insurance Complaint Form

My Name: ____________________________
Name of Health Carrier: ____________________________
Address: ____________________________
Name of AGENT or AGENCY (if applicable): ____________________________
City: ____________________________ State: ____________________________ Zip Code: ____________________________
Name of ARMED person on insurance card: ____________________________
My Email Address: ____________________________ Date of healthcare service: ____________________________

Emergency phone number: ____________________________ Alternate phone number: ____________________________ Type of Plan: ____________________________

- Health Insurance - HMO
- HMO of Michigan
- Medigap (Medicare Supplement)
- Medicare Advantage
- Medicare Part D
- Other

Type of Coverage: ____________________________
Group Plan: ____________________________

- Individual Plan
- Group Plan
- Medicare

Reason for complaint:
- Claims Issue
- Rate Issue
- Other

Date of Incident: ____________________________
Details of my complaint: ____________________________
Additional information 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 in reviewing your complaint. This includes your insurance policy, bills, receipts, claim denials or other records that support or refute your complaint.

Always send copies. Never send original documents.

Desired outcome: ____________________________

Please mail your complaint to:
DIFS Consumer Services
P.O. Box 100238
Lansing, MI 48909-0238
Or call 1-877-999-4442
Or Email to: difs.consumer@michigan.gov

Michigan Department of Insurance and Financial Services
Department of Insurance and Financial Services (DIFS) is required to review and release any information to any company, agency, or person involved in this matter. I authorize the health carrier to release all records (including protected health information) relating to this complaint to DIFS in order to resolve this complaint. I represent that I have the proper authority to execute this release.

Signature: ____________________________ Date signed: ____________________________
DIFS Consumer Complaint Form

Before You Begin:

We encourage consumers to first attempt to resolve disputes directly with their insurance and/or financial service entity. If a resolution cannot be reached, our department can help try to resolve your dispute.

If you choose to file your complaint online you will need to have a valid email address and the ability to include relevant documentation as attachments. If you do not have a valid email address or the means to provide documents electronically we recommend filing your complaint by fax or mail.

For more information regarding mail-in submissions please visit DIFS How to File a Complaint to download the appropriate form.

Types of Complaints We Assist With:

DIFS is able to assist in resolving complaints across several industries including insurance, banking, credit union, mortgage and other consumer financial products.

*At this time our system does not allow for the online submission of the following types of complaints: Business-to-Business, Health External Reviews, Provider Clean Claims, and Proof of Claim Against a Mortgage Company Bond.
Complaint Process

1. Complaint received and assigned to an analyst
2. Complaint forwarded to the company
3. Analyst receives a response from company
4. Analyst makes file determination
5. Consumer receives response
Complaint received and assigned to an analyst
Complaint forwarded to the company
Analyst receives a response from the company
Analyst makes a file determination
Consumer receives a response from DIFS
$10 million
Internal Appeal Process

1. Consumer submits written appeal regarding a denial to the company
2. Company reviews the claim
3. Company notifies consumer in writing of decision and next steps
Consumer submits written appeal regarding a denial to the company
Company reviews the claim
Company notifies consumer in writing of decision and next steps
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.

1. Patient Name ___________________________ Name of INSURED person ___________________________

Name of Health Carrier (HMO, BC/BS, etc. 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 does not 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/Patient, Legal Guardian or Authorized Representative ___________________________

Address ___________________________ City ___________________________ State ___________________________ Zip ___________________________

Daytime phone number ___________________________ Evening phone number ___________________________

6. Patient authorization statement

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

Signature of Patient ___________________________ Date ___________________________

7. Authorization to review medical information

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

Signature of Patient ___________________________ Date ___________________________

8. Send your Request for External Review to

DIFS - Office of General Counsel - Appeals Section
P.O. Box 303200
811 W. Ottawa St., 3rd Floor
Lansing, MI 48909-7700
Fax: 517-438-1070
Phone: 877-999-6442

Visit DIFS online at: www.michigan.gov/difs Phone DIFS toll-free at: 877-999-6442

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

Michigan Department of Insurance and Financial Services

DIFS is an equal opportunity employment program.

Auxiliary aids and services are available upon request to individuals with disabilities.

Visit DIFS online at: www.michigan.gov/difs Phone DIFS toll-free at: 877-999-6442
External Appeal Process

1. Consumer has completed the internal appeal process
2. Consumer submits written appeal to DIFS
3. Appeal received and assigned to a specialist
4. Appeal is reviewed & may include an IRO
5. Director issues a decision. Either party may appeal in court.
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Consumer submits written appeal to DIFS
Appeal received and assigned to a specialist
Appeal is reviewed and may include an Independent Review Organization (IRO)
Director issues a decision. Either party may appeal in court.