Notice of Grievance Procedures

In accordance with Section 500.2213 of the Michigan Insurance Code and Public Act 252 - "Patient's Right to Independent Review Act"

Please read this notice carefully for important information about the grievance process available to you.

I. Definitions

"Complaint" means any written correspondence from you, your representatives, or provider expressing a grievance or complaint involving our activities or any aspect, sale or service of this policy.

"Grievance" means a complaint regarding:

(a) the availability, delivery, or quality of health care services, including an adverse determination made due to utilization review;
(b) benefits or claims payment for health care services.
(c) matters pertaining to our contractual relationship.

"Adverse Benefit Determination" means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit. Such determination can be based on eligibility or utilization review, including a determination that a service is not medically necessary or appropriate. Failure to respond in a timely manner to a request for determination can also be considered an adverse determination.

II. Notices

If we make an adverse benefit determination as defined above, we will provide you with the reason in a written statement.

III. Designated Person Responsible For Grievance System, Receiving Complaints, and Serving as Contact for the Michigan Health Plans Division

Name:	Bruce Mieth
	Senior Vice President – Group Operations
Address:	P.O. Box 82657
	Lincoln, NE 68501-2657
Phone:	877-897-4328 (Toll-Free)
Fax:	402-309-2579
E-Mail:	group@employeebenefitservice.com

IV. Levels of Review

The following levels of review are available.

A. Internal Review

The complaint will be fully reviewed by all appropriate internal parties. We will advise you of the status in a timely manner. Our decision will be made no later than 30 calendar days after we receive the written grievance. This period may be extended for a maximum of 10 calendar days if we have not received requested information from your provider.

The written decision will include the following:

1. a statement of our understanding of the grievance;
2. the decision stated in clear terms and the contract basis or medical rationale supporting the decision;
3. a reference to the evidence or documentation used as a basis for the decision; and
4. notice of your right to request an External Review from the Michigan Department of Insurance and Financial Services (“DIFS”), and the External Review Request Form.

All copies of complaints and correspondence will be available at our offices for inspection by the commissioner for at least 2 years following the year the complaint was filed.

You also have the right to present your grievance to an Appeals Panel or managerial level conference for review.

Expedited appeals related to pretreatment estimates for urgent care will be reviewed within 72 hours of receipt by us. If our response is made orally, we will follow it up in writing not more than 2 business days later.

B. External Review

All internal grievance processes should be exhausted prior to requesting an external review. However, if a final determination has not been received within the above time frame without your or your authorized representative’s agreement to the delay, you have the right to request an external review from the Michigan Department of Insurance and Financial Services (DIFS) and you will be considered to have exhausted the internal grievance process. We may also agree to waive our internal grievance process and allow you to request an external review or expedited external review prior to exhausting the internal grievance process.

You will be considered to have exhausted our internal grievance process if we have failed to comply with the requirements of the internal grievance process unless the failure or failures are based on de minimis violations that did not cause, and are not likely to cause, prejudice or harm to the covered person.

Upon written request, the DIFS will review your request for an External Review. This request should be made to DIFS no later than 127 days after our final decision has been received. Expedited requests should be sent within 10 days of your receipt of our expedited grievance decision. When filing a request for an external review, you will be required to authorize the release of any medical records that may be required for the review of the adverse determination. You or your authorized representative may submit additional information that would assist in the review.

The DIFS will review the request and may forward the appeal to an Independent Review Organization to assist in the final determination. The DIFS can be contacted:

In writing:	Michigan Department of Insurance and Financial Services (DIFS) Office of General Counsel, Appeals Section P.O. Box 30220 Lansing, MI 48909-7720
Phone:	1-877-999-6442 (Toll-Free)
Fax:	1-517-284-8838
Website:	https://difs.state.mi.us/Complaints/ExternalReview.aspx

If the time frame for completion of an expedited internal grievance would seriously jeopardize the life or health of the covered person or would jeopardize the covered person’s ability to regain maximum function, as substantiated by a provider either orally or in writing, the covered person or the covered

person's authorized representative may file a request for an expedited external review at the same time the covered person files a request for an expedited internal appeal. The covered person filing a request for external review under these conditions will be considered to have exhausted the internal grievance process.

V. Cultural and Linguistic Support

We want to be sure this information is helpful to you. We are sending it in a culturally and linguistically appropriate manner as described in the Affordable Care Act and 45 CFR 147.136 (e). We can provide interpreting services through our toll-free Customer Service line shown in Section III. For Spanish only, you may call 1-800-487-5553 and speak directly to an employee who is proficient in the Spanish language. Upon request, we will provide certificates of coverage and provider directories in Spanish, or large print materials for the visually impaired. We are prepared to help hearing impaired members who access TDD or TTY "text telephone" systems when contacting us.