Your right to file a grievance regarding a decision about your benefits

Most questions or concerns about how we processed your claim or request for benefits can be resolved through a phone call to one of our Customer Service Representatives. However, Michigan Public Act 350, as amended by Public Act 516 of 1996 and Public Act 250 of 2000, protects you by providing a grievance procedure, including a managerial-level conference, if you believe that we have violated Section 402 or 403 of Public Act 350. You will find the specific provisions of those two parts of the act at the end of this section.

A. Standard Grievance Procedure

Under the standard grievance procedure, we must provide you with our final written determination within 35 calendar days of our receipt of your written grievance. However, that time frame may be suspended for any amount of time that you are permitted to take to file your grievance and for a period of up to 10 days if we have not received information we have requested from a health care provider, such as your doctor or hospital. The standard grievance procedure is as follows:

1. You or your authorized representative must send us a written statement explaining why you disagree with our determination on your request for benefits or payment and request a managerial-level conference. Mail your request to:

   Appeals Unit
   Blue Cross Blue Shield of Michigan
   P.O. Box 2459
   Detroit, MI 48231-2459

   You can ask that the conference be conducted in person or over the telephone. If in person, the conference can be held at our headquarters in Detroit, during regular business hours. Our written proposed resolution will be our final determination regarding your grievance.

In addition to the information found above, you should also know:

a. You may authorize in writing another person, including but not limited to a physician, to act on your behalf at any stage in the standard grievance procedure.
b. Although we have 35 days within which to give you our final determination, you have the right to allow us additional time if you wish.
c. You may obtain copies of information relating to our denial, reduction, or termination of coverage for a health care service for a reasonable copying charge.
d. You may include other documents for us to consider, such as medical or benefit documents, notarized statements, declarations, or testimony, but these are not required.

B. Expedited Grievance Procedure

If a physician substantiates, verbally or in writing, that adhering to the time frame for the standard internal grievance would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, you may file a request for an expedited internal

grievance. You may file a request for an expedited grievance only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service or if you believe we have failed to respond timely to a request for benefits or payment.

The procedure is as follows:

> You may submit your expedited grievance request by telephone. The required physician's substantiation that your condition qualifies for an expedited grievance can also be submitted by telephone at (313) 225-6800. We must provide you with our decision within 72 hours of receiving both your grievance and the physician's substantiation.

In addition to the information found above, you should also know:

a. You may authorize in writing another person, including but not limited to a physician, to act on your behalf at any stage in the expedited grievance procedure.
b. If our decision is communicated to you verbally, we must provide you with written confirmation within 2 business days.

Sections 402 and 403 of Public Act 350

What We May Not Do

The sections below provide the exact language in the law.

Section 402(1) provides that we may not do any of the following:

- Misrepresent pertinent facts or certificate provisions relating to coverage.
- Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
- Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
- Refuse to pay claims without conducting a reasonable investigation based upon the available information.
- Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
- Fail to attempt in good faith to make a prompt, fair and equitable settlement of a claim for which liability has become reasonably clear.
- Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
- Attempt to settle a claim for less than the amount which a reasonable person would believe was due under a certificate, by making reference to written or printed advertising material accompanying or made part of an application for coverage.

- Make known to the member a policy of appealing from administrative hearing decisions in favor of members for the purpose of compelling a member to accept a settlement or compromise in a claim.
- Attempt to settle a claim on the basis of an application which was altered without notice to, knowledge or consent of, the subscriber under whose certificate the claim is being made.
- Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.
- Fail to promptly provide a reasonable explanation of the basis for a denial of a claim or for the offer of a compromise settlement.
- Fail to promptly settle a claim where liability has become reasonably clear under one portion of the certificate in order to influence a settlement under another portion of the certificate.

Section 402(2) provides that there are certain things that we cannot do in order to induce you to contract with us for the provision of health care benefits, or to induce you to lapse, forfeit or surrender a certificate issued by us or to induce you to secure or terminate coverage with another insurer, health maintenance organization or other person.

The things we cannot do under this section are:

- Issue or deliver to a person, money or other valuable consideration.
- Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.
- Offer to give or pay, directly or indirectly, a rebate or part of a premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.
- Make, issue or circulate, or cause to be made, issued or circulated, any estimate, illustration, circular or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits there under, or the true nature thereof.
- Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization or other person.

What We Must Do

Section 403 provides that we must, on a timely basis, pay to you or a participating provider benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to you will bear simple interest from a date 60 days after we have received a satisfactory claim form at a rate of 12 percent interest per year. The interest will be paid in addition to the claim at the time of payment of the claim.

We must specify in writing the materials which constitute a satisfactory claim form no later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not

supplied as to the entire claim, the amount supported by the claim form will be considered to be paid on a timely basis if paid within 60 days after we receive the claim form.

External Reviews

C. Standard External Review Procedure

Once you have exhausted our standard internal grievance procedure, you or your authorized representative have the right to request an external review from the Commissioner. The standard external review process is as follows:

1. Within 60 days of the date you received, or should have received, our final determination, send a written request for an external review to the Commissioner. Mail your request, including the required forms that we will supply to you, to:

   OFIR – Health Plans Division
   Appeals Section
   Post Office Box 30220
   Lansing, MI 48909-7720

2. If your request for external review concerns a medical issue, and is otherwise found to be appropriate for external review, the Commissioner will assign an IRO, consisting of independent clinical peer reviewers, to conduct the external review.

   You will have an opportunity to provide additional information to the Commissioner within 7 days after you submit your request for an external review. We must provide documents and information considered in making our final determination to the Independent Review Organization within 7 business days after we receive notice of your request from the Commissioner. We will also provide this information to you. The assigned Independent Review Organization will recommend within 14 days whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within 7 business days whether or not to accept the recommendation and will notify you.

   The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.

3. If your request for external review is found by the Commissioner to be appropriate for external review and related to non-medical issues, the Commissioner's staff will conduct the external review. The Commissioner's staff will recommend whether the Commissioner should uphold or reverse our determination. The Commissioner will notify you of the decision, and the Commissioner's decision is your final administrative remedy under Public Act 350.

D. Expedited External Review Procedure

If a physician substantiates verbally or in writing that you have a medical condition for which the timeframe for completion of an expedited internal grievance would seriously jeopardize your life

or health, or would jeopardize your ability to regain maximum function, and if you have filed a request for an expedited internal grievance, you may request an expedited external review from the Commissioner. You may file a request for an expedited external review only when you think that we have wrongfully denied, terminated, or reduced coverage for a health care service prior to your having received that health care service.

The expedited external review process is as follows:

1. Within 10 days of your receipt of our denial, termination, or reduction in coverage for a health care service, you or your authorized representative may request an expedited external review from the Commissioner. To do so in writing, mail your request, including the required forms that we will supply to you, to the address indicated for the standard External review.

   You can also request an expedited external review by telephone at the following toll-free number: 1-877-999-6442.

2. Immediately after receiving your request, the Commissioner will decide if it is appropriate for external review and assign an Independent Review Organization (IRO) to conduct the expedited external review. If the IRO decides that you do not have to first complete the expedited internal grievance procedure, it will review your request and recommend within 36 hours whether the Commissioner should uphold or reverse our determination. The Commissioner must decide within 24 hours whether or not to accept the recommendation and will notify you.

   The Commissioner's decision is the final administrative remedy under the Patient's Right to Independent Review Act.