

The Michigan Consumer Guide to Health Insurance serves as a comprehensive resource for residents, detailing health insurance options, including employer group coverage and individual plans. In employer group coverage, the employer is the master policyholder, negotiating terms with insurers and having the authority to modify benefits, adjust employee premium contributions, or discontinue coverage. Employers with 50 or more employees are required to provide health coverage, while those with fewer than 50 are not mandated but may qualify for tax credits if they choose to offer coverage. Employees should be aware of enrollment policies, which may include waiting periods and annual open enrollment periods for changes in coverage. Benefits typically include limits on out-of-pocket expenses, no annual or lifetime limits on essential health benefits, and coverage for dependents up to age 26.

For individuals without access to group plans, individual major medical health plans are available, which cannot deny coverage based on pre-existing conditions. Premiums for these plans are influenced by factors such as plan type, age, location, and tobacco use, and may increase annually. The Healthy Michigan Plan provides coverage for uninsured individuals aged 19-64 who do not qualify for Medicaid or Medicare and earn up to 133% of the federal poverty level. The Health Insurance Marketplace allows individuals to compare and purchase health plans, with options for advance premium tax credits and cost-sharing reductions based on income levels. Qualified Health Plans (QHPs) are certified by the Marketplace and must cover essential health benefits while adhering to cost-sharing limits mandated by the Affordable Care Act (ACA). QHPs are categorized into five metal levels: platinum (90% coverage), gold (80% coverage), silver (70% coverage), bronze (60% coverage), and expanded bronze (56% to 62% coverage).

The guide emphasizes the importance of understanding enrollment periods, required benefits, and the implications of premium payments for both employer and individual health plans. Cost-sharing is a key aspect of health insurance, where both the insured and insurer share financial responsibilities. The insured must understand their plan's benefits and can contact customer service for inquiries.

When receiving care, the insured presents their insurance card, pays any co-payment, and the provider typically submits a claim to the insurer. An Explanation of Benefits (EOB) is sent to the insured detailing service costs and their financial responsibility, which should be kept for reference against provider bills.

Coordination of Benefits (COB) applies when an individual has multiple health insurance policies, ensuring total payments do not exceed 100% of treatment costs. The primary plan pays first, followed by the secondary plan. The guide also outlines various types of health plans, including Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and High Deductible Plans, as well as limited benefit plans that do not meet ACA requirements. Medical Expense Reimbursement options such as Health Savings Accounts (HSAs) and Health Reimbursement Accounts (HRAs) are also discussed, providing tax-exempt accounts for out-of-pocket medical expenses.

The process for filing complaints with the Department of Insurance and Financial Services (DIFS) in Michigan is detailed, allowing insured parties to submit complaints regarding timely payment of clean claims, which must be paid within 45 days. If a health insurer makes an adverse determination regarding a claim, policyholders have the right to appeal through an internal grievance process, with specified timeframes for pre-service and post-service denials. An external review can be requested if the internal appeal does not resolve the issue.

The guide includes a glossary of common health insurance terms, providing clarity on terminology used in health insurance policies. It also emphasizes the importance of considering factors beyond just premiums when shopping for health insurance, as lower premiums may result in less coverage or higher out-of-pocket costs. Overall, the document serves as a vital resource for understanding health insurance options, complaint processes, and key terms relevant to consumers in Michigan, while also providing important contact information for various health insurance resources and

assistance programs.