

**STATE OF MICHIGAN**  
**DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS**  
**OFFICE OF FINANCIAL AND INSURANCE REGULATION**  
**Before the Commissioner of Financial and Insurance Regulation**

In the matter of

XXXXX

Petitioner

File No. 115211-001

v

American Community Mutual Insurance Company  
Respondent

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**Issued and entered  
this 28<sup>th</sup> day of April 2011  
by R. Kevin Clinton  
Commissioner**

**ORDER**

**I  
PROCEDURAL BACKGROUND**

On August 18, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation (OFIR) under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the information and accepted the request on August 25, 2010.

This appeal can be decided by applying the terms of the contract defining the Petitioner's health care benefits. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

**II  
FACTUAL BACKGROUND**

The Petitioner is covered under American Community Mutual's *Next Generation HSA* policy. The policy provides coverage for both network and non-network services. In May 2010, the Petitioner had knee surgery. In connection with the surgery he received radiology and anesthesia

services. The services were provided by XXXXX Association of XXXXX County and XXXXX. Both are non-network providers. The charges for these services totaled \$1,216.00. American Community Mutual applied the charges to Petitioner's non-network deductible, leaving Petitioner responsible for paying the providers.

The Petitioner appealed American Community Mutual's processing of the claims at the non-network level. American Community reviewed the claims through its internal grievance process but upheld its determination and issued its final adverse determination dated August 3, 2010.

### **III ISSUE**

Did American Community correctly process the Petitioner's claims at the non-network level?

### **IV ANALYSIS**

#### Petitioner's Argument

Petitioner said his lab work was sent to a non-network lab facility without his knowledge. The Petitioner also said he made every attempt to ensure that the services he was to receive pertaining to his knee surgery would be provided by a network provider. Petitioner goes on to say that he had no way of knowing that his anesthesiologist was a non-network provider.

The Petitioner wants American Community Mutual to provide coverage for his lab, MRI and anesthesia services at the network level of benefits and without the application of the non-network deductible.

#### Respondent's Argument

In its final adverse determination American Community Mutual explained its claims decisions:

Your policy provides benefits for services by network *and* non-network providers. Network providers give us a discount in the form of a reduced fee. We are able to pass this discount on to you in the form of a higher level of benefits. You, therefore, increase your benefits and lower your out-of-pocket expenses when you are able to obtain services from a network provider. The network, however, does not guarantee a provider of a given

specialty will be available at all times. No additional benefits will be forthcoming.

We understand circumstances beyond your control may involve a non-network provider providing some of your services. Our intention is to provide our insureds with networks offering a large selection of providers in their geographic area.

The submitted information was reviewed and it has been determined that your claims were processed correctly.

### Commissioner's Review

The Petitioner's policy indicates that there is a calendar year deductible of \$4,200.00 per family member for services received from non-network PPO providers, as was the case here. This deductible is the amount of out-of-pocket expense that must be paid before American Community Mutual begins paying benefits. While diagnostic and anesthesia services are covered under the policy, they are first subject to a deductible based on the network status of the provider.

It is unfortunate that the Petitioner, who made an effort to receive services from network providers, was not able to control the selection of the lab facility or the anesthesiologist. Nevertheless, American Community Mutual is correct – its level of coverage is based on the network status of the provider. There is nothing in American Community Mutual's policy that requires it to cover services from a non-network provider at the network level even if there are no network providers available or even, as here, when the Petitioner did not know that a non-network provider would be providing the services.

The Commissioner finds that American Community Mutual correctly processed Petitioner's claim according to the terms of the certificate.

### **V ORDER**

The Commissioner upholds American Community's adverse determination of September 9, 2010. American Community is not responsible for coverage of Petitioner's claims at the network level.

This is a final decision of an administrative agency. Under MCL 550.1915, any person

aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton  
Commissioner