

**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**

**XXXXXX**

**Petitioner**

**v**

**File No. 118897-001**

**US Health and Life Insurance Company**

**Respondent**

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**Issued and entered  
this 1<sup>st</sup> day of August 2011  
by R. Kevin Clinton  
Commissioner**

**ORDER**

**I. BACKGROUND**

On January 5, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner accepted the request for external review on January 12, 2011. The issue in this case can be decided by applying the terms of the contract defining the Petitioner's health care benefits.

The Petitioner is covered under a group health plan as a spouse of a retired employee of XXXXX. Her benefits are provided under the XXXXX, underwritten by US Health and Life Insurance Company (USHL). Her benefits are defined in a certificate of group insurance (the certificate). The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

On September 24, 2010, the Petitioner was transported by ambulance to XXXXX in Ann XXXXX after she had a severe reaction to a bee sting. Petitioner does not appeal USHL's coverage for her treatment at the hospital but does challenge the coverage provided for the ambulance transportation. The amount charged by the ambulance service was \$838.20. After applying Petitioner's deductible and copayment, USHL paid \$253.62, leaving Petitioner with a balance due to the ambulance service of \$584.58.

The Petitioner appealed USHL's claims decision through USHL's internal grievance process. USHL affirmed its decision and issued its final adverse determination December 28, 2010.

## II. ISSUE

Did USHL correctly process Petitioner's claim for ambulance care under the terms of the certificate?

## III. ANALYSIS

The Petitioner argues that she had no control over which ambulance company was called as she was unconscious at the time. She believes the claim should be paid at in-network level since it was for a medical emergency and she might have died without the ambulance transportation.

USHL states that the amount it pays on a claim is based on the network status of the provider. In-network and out-of-network benefits are different because of the discounts USHL receives when an insured person receives treatment from an in-network provider. Out-of-network providers do not give USHL such discounts so the proportion of the provider charge paid by USHL is less than it is with in-network providers. In this case, the ambulance provider was not a member of USHL's network so, following the terms of the policy, the claim was processed as an out-of-network benefit.

While Petitioner's situation was serious and left no time to search for an in-network ambulance service, there is nothing in the policy or in state law requiring USHL to handle a claim for services from an out-of-network ambulance provider as an in-network service. The Commissioner finds that USHL correctly processed the ambulance service claim under the terms of the certificate.

## IV. ORDER

The Commissioner upholds USHL's adverse determination of December 28, 2010. USHL is not required to pay an additional amount for the Petitioner's ambulance service.

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 60 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 the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton  
Commissioner