

STATE OF MICHIGAN  
DEPARTMENT OF INSURANCE AND FINANCIAL SERVICES  
Before the Director of Insurance and Financial Services

In the matter of:

██████████  
Petitioner

v  
Blue Cross Blue Shield of Michigan  
Respondent

File No. 146710-001

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Issued and entered  
this 31<sup>st</sup> day of March 2015  
by Joseph A. Garcia  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On March 9, 2015, ██████████ filed a request with the Director of Insurance and Financial Services for an external review under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* On March 16, 2015, after a preliminary review of the information submitted, the Director accepted the request.

The Petitioner and her dependents receive health care benefits under a group plan underwritten by Blue Cross Blue Shield of Michigan (BCBSM). The Director notified BCBSM of the external review request and asked for the information it used to make its final adverse determination. The Director received BCBSM's response on March 24, 2015.

This case presents an issue of contractual interpretation. The Director 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's employer, Midwest Anesthesia Consultants, provides health insurance to its employees through BCBSM. Between January 1, 2014 and November 30, 2014, the benefits were governed by BCBSM's *Community Blue Group Benefits Certificate* and related riders. Effective December 1, 2014, Midwest Anesthesia Consultants changed coverage to BCBSM's *Simply Blue Group Benefits Certificate SG*. As a consequence of the change, employee out-of-pocket maximums increased, in the Petitioner's case from \$3,000.00 to \$7,000.00 for a family

and from \$1,500.00 to \$3,500.00 for an individual. (The out-of-pocket maximum is the maximum amount a covered individual or family can be required to pay in deductibles, copayments, and coinsurance in a given year. There are separate maximums for services received from in-network and out-of-network providers.)

By November 30, 2014, the Petitioner's son had satisfied his out-of-pocket maximum of \$1,500.00 required by the *Community Blue* certificate of coverage. In December 2014, after the change to the *Simply Blue* coverage, the Petitioner's son received a number of medical services from participating providers. BCBSM covered the services but applied the larger out-of-pocket maximum under the *Simply Blue* plan and imposed deductibles, copayments and coinsurance requirements totaling \$1,150.13.

The Petitioner appealed BCBSM's processing of the claim through its internal grievance process. At the conclusion of that process, BCBSM issued a final adverse determination dated February 26, 2015, affirming its benefit decision. The Petitioner now seeks a review of that adverse determination from the Director.

### III. ISSUE

Was BCBSM correct to apply the larger out-of-pocket maximum in the *Simply Blue* certificate of coverage to the December 2014 claims of the Petitioner's son?

### IV. ANALYSIS

#### Petitioner's Argument

In her January 26, 2015 appeal letter to BCBSM, the Petitioner wrote:

BCBS was contacted on 11/25/14; I was told that my deductible and coinsurance was based on the calendar year. And that I had reached my out of pocket in October and that it would not restart in December even though our policy renewed December 1, 2014.

I am asking that my increased coinsurance out of pocket be waived for the month of December 2014. BCBSM was not clear and/or our representative at Kapnick [the insurance agency or benefit manager of Petitioner's employer].

In her request for an external review, the Petitioner stated:

I was covered by a policy that had annual deductibles and out-of-pocket maximums. We met the limits in October. My company switched policies effective December 1, 2014. When I called BCBS they told me my coinsurances would apply until the end of the year. My EOB statements back this up.

Instead on December 1, 2014 the coinsurance was raised by \$2,000 for 1 month. We were sold an “annual policy” that was good for 11 months and then 1 month. I want to be reimbursed for the coinsurance I was billed for in December 2014.

### BCBSM’s Argument

In its final adverse determination, BCBSM wrote to the Petitioner:

I confirmed that effective December 1, 2014 your family was covered under the *Simply Blue Group Benefits Certificate SG*. Under the *Simply Blue Group Benefits Certificate SG*, the annual out-of-pocket maximum for one member is \$3,500. Prior to December 1, 2014, your family was covered under the *Community Blue Group Benefits Certificate. Rider CB-CM-P \$1500 Community Blue Copayment Maximum For Panel Services* amended this Certificate and your annual out-of-pocket maximum for one member was \$1,500. Although the out-of-pocket maximum was previously met under the Community Blue Group coverage, the out-of-pocket maximum increased to \$3,500 when your coverage started under the *Simply Blue Group Benefits Certificate SG* on December 1, 2014.

To ensure all consideration was given I reviewed the telephone call placed to BCBSM on November 25, 2014. After review, the customer service representative correctly informed you that your son’s deductible was satisfied and would not be restarted until January 1, 2015. However, there was no discussion regarding the out-of-pocket maximum.

### Director’s Review

The Petitioner asserts that on November 25, 2014, a BCBSM representative advised her that she had met her out-of-pocket maximum for the 2014 calendar year and that it would not restart in December 2014 under her new coverage. BCBSM states that their records show no discussion of out-of-pocket maximums when the Petitioner called on November 25. Under the Patient’s Right to Independent Review Act the Director’s role is limited to determining whether BCBSM properly administered benefits under the terms of the relevant policy and any applicable law. The Director has no authority to amend the terms of an insurance policy on the basis of oral representations by an insurer’s employees, even when there is no dispute as to what the employee said.

The Petitioner argues that the December 1, 2014 change in policies means she did not receive the benefits (the \$1,500.00 individual out-of-pocket maximum) she should have received for a full 12 months. The decision to change coverage was made by the Petitioner’s employer,

not BCBSM. Once the coverage had changed, BCBSM was obliged to apply the terms of the new policy.

The Director finds that BCBSM correctly applied the terms of the *Simply Blue* certificate, the policy that was in force beginning December 1, 2014.

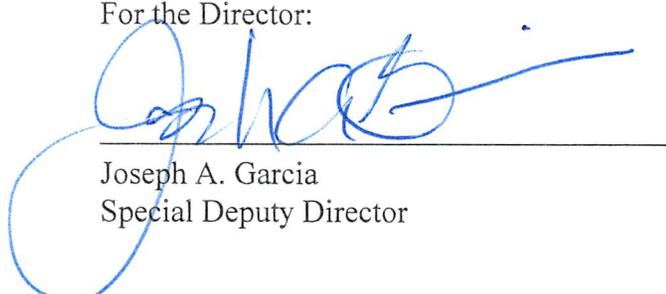
**V. ORDER**

The Director upholds BCBSM's final adverse determination of February 26, 2015. BCBSM is not required to apply the out-of-pocket maximums of the *Community Blue* certificate after November 30, 2014.

This is a final decision of an administrative agency. 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 Michigan county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1). A copy of the petition for judicial review should be sent to the Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Annette E. Flood  
Director

For the Director:



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Joseph A. Garcia  
Special Deputy Director