

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

In the matter of:

██████████  
Petitioner

v

File No. 150433-001

United Healthcare Community Plan, Inc.  
Respondent

---

Issued and entered  
this 12<sup>th</sup> day of November 2015  
by Randall S. Gregg  
Special Deputy Director

**ORDER**

**I. PROCEDURAL BACKGROUND**

On October 20, 2015, ██████████ (Petitioner) 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.* After a preliminary review of the material received, the Director accepted the request on October 27, 2015.

The Petitioner receives health benefits through an individual plan through United Healthcare Community Plan, Inc. (United), a health maintenance organization. The benefits are described in United's *Gold Compass 500* individual medical policy. The Director notified United of the external review request and asked for the information it used to decide the Petitioner's claims.

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**

Between May 13 and June 24, 2015, the Petitioner received prenatal care and physician services from ██████████ Hospital and Dr. ██████████. ██████████ Hospital and Dr. ██████████ are not in United's network of providers. United denied coverage for the services.

The Petitioner appealed United's benefit determination through its internal grievance process. At the conclusion of that process, on August 17, 2015, United issued two final adverse determinations affirming its denial of coverage for each provider's services. The Petitioner now seeks a review of those final adverse determinations from the Director.

### III. ISSUE

Did United correctly deny coverage for the services the Petitioner received from non-network providers between May 13 and June 24, 2015?

### IV. ANALYSIS

#### Respondent's Argument

In its final adverse determination for Dr. [REDACTED] claim, United wrote:

In your health plan documents, section entitled Schedule of Benefits, subsection entitled Accessing Benefits it says:

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

The claim was processed correctly because the provider is out of network with your health plan and your health plan does not offer out of network benefits.

In its final adverse determination for the [REDACTED] Hospital claims, United wrote:

In your health plan documents, section entitled Schedule of Benefits, subsection entitled Accessing Benefits it says:

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this Scheduled of Benefits, Benefits are not available for services provided by non-Network providers. This benefit plan does not provide a Non-Network level of Benefits.

The [claims were] processed correctly because network gap was not requested for the above mentioned dates of services. Your health plan does not have benefits for out of network providers. If a network provider is not available in your area to provide the required service(s), your primary care physician may contact United Healthcare's Care Coordination department at the phone number on the back of your identification card and request a network gap review. An approved network

gap would allow the requested service(s) you will receive from the approved out of network provider to be processed at your network level of benefits....

### Petitioner's Argument

In her request for external review the Petitioner wrote:

I was sent to [REDACTED] for my ultrasounds, unaware that this facility was "out of network." I didn't find out until I received a bill a month or so after. I am appealing because I feel this should be considered "in network" because the closest "in network" facility I can go to is over 30 miles away from my home, which is absurd. Not only is [REDACTED] facility not considered "in network," neither are two other major hospitals, [REDACTED] in [REDACTED], MI or [REDACTED] in [REDACTED], MI; which are also within a 5-10 mile radius of my home. After being billed for these "out of network" ultrasounds, my doctor was able to get a Gap Exception for my future labor at this [REDACTED], the same hospital my doctor is affiliated with and now with the Gap Exception, will be covered and considered "in network." However, United Healthcare still refuses to accept my appeal to have the previous charges for these ultrasounds taken care of. Since my doctor nor I was aware a Gap Exception was needed before my ultrasounds, I am being stuck with over \$2,000 in bills for procedures that were medically necessary for the health of my baby. This has been an ongoing battle between myself, [REDACTED], [REDACTED], and my Dr.'s office since July. Up until even last week, I was still going back and forth with [REDACTED]. [REDACTED] was still making me believe that they were working on this and it could be corrected without this appeal having to be done. I'm at my wits end though because whoever I talk to and is supposedly taking care of this for me, disappears every time and I have to start the whole process over. Even supervisors at [REDACTED] have never called me back when they said they would. This has caused me an overwhelming amount of stress and I am already considered a high risk pregnancy. I'm hoping someone at your office will understand that UHC should cover these ultrasounds because they were medically necessary and they are already willing to cover the labor at the same hospital....

### Director's Review

Ultrasounds and laboratory are covered services under the Petitioner's coverage. However, it is also true that such services must be obtained from a UHCCP network provider in order to be covered.

Page 1 of the *Gold Compass 500* policy's Schedule of Benefits states:

Compass offers a limited Network of providers. To obtain Network Benefits, you must receive Covered Health Services from a CompassNetwork provider within the Network Area. You can confirm that your provider is a CompassNetwork provider by calling Customer Care at the telephone number on your ID card or you can access a directory of providers online at [www.myuhc.com](http://www.myuhc.com).

You must see a Network Physician in order to obtain Benefits. Except as specifically described in this Schedule of Benefits, Benefits are not available for services provided by non-Network providers. This Benefit plan does not provide a Non-Network level of Benefits.

Page 19 of the Schedule of Benefits includes this provision:

**Provider Network**

We arrange for health care providers to participate in a Network...Before obtaining services you should always verify the Network status of a provider. A provider's status may change. You can verify the provider's status by calling *Customer Care*. A directory of providers is available online at [www.myuhc.com](http://www.myuhc.com) or by calling *Customer Care* at the telephone number on your ID card to request a copy. It is possible that you might not be able to obtain services from a particular Network provider. The network of providers is subject to change. Or you might find that a particular Network provider may not be accepting new patients. If a provider leaves the Network or is otherwise not available to you, you must choose another Network provider to get Benefits.

The medical services the Petitioner received were provided by non-network providers. The Petitioner's policy requires that medical services be provided by in-network providers in order to be covered. Apparently, the Petitioner has now received permission to complete her maternity care at a non-network hospital. The fact that United has offered this coverage exception does not require United to extend that exception to cover the Petitioner's earlier medical care.

United has identified seven in-network medical laboratories within 20 miles of the Petitioner's home and has identified three hospitals within 30 miles of her home. While the hospitals are not as conveniently located as the hospitals the Petitioner says she would prefer to use, they are not so far away as to be unavailable to the Petitioner.

The Director finds that United's denial of the laboratory and ultrasound services provided by Dr. [REDACTED] and [REDACTED] Hospital between May 13 and June 24, 2015 is consistent with the terms and conditions of the United *Gold Compass 500* policy.

**V. ORDER**

The Director upholds United's final adverse determinations of August 17, 2015.

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 Michigan 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 Department of Insurance and Financial Services, Office of General Counsel, Post Office Box 30220, Lansing, MI 48909-7720.

Patrick M. McPharlin  
Director

For the Director:

A handwritten signature in black ink, appearing to read 'RS Gregg', is written over a horizontal line.

Randall S. Gregg  
Special Deputy Director