SENATE BILL NO. 245

April 23, 2025, Introduced by Senators IRWIN, CHANG, SHINK, GEISS, MOSS, WOJNO, MCMORROW and SINGH and referred to Committee on Finance, Insurance, and Consumer Protection.

A bill to amend 1956 PA 218, entitled

"The insurance code of 1956,"

by amending sections 2005, 2006, 2026, and 2049 (MCL 500.2005, 500.2006, 500.2026, and 500.2049), section 2005 as amended by 1989 PA 302 and section 2006 as amended by 2017 PA 223, and by adding section 2005b and chapter 30B.

THE PEOPLE OF THE STATE OF MICHIGAN ENACT:

Sec. 2005. **(1)** ~~An~~ **Subject to subsection (2), an** unfair method of competition and an unfair or deceptive act or practice in the business of insurance means the making, issuing, circulating, or causing to be made, issued, or circulated, an estimate,

illustration, circular, statement, sales presentation, or comparison ~~which~~ **that**, by omission of a material fact or incorrect statement of a material fact, does any of the following:

(a) Misrepresents the terms, benefits, advantages, or conditions of an insurance policy.

(b) Misrepresents the dividends or share of the surplus to be received on an insurance policy.

(c) Makes a false or misleading statement as to the dividends or share of surplus previously paid on an insurance policy.

(d) Makes a misleading statement or misrepresentation as to the financial condition of a person engaged in the business of insurance, or as to the legal reserve system ~~upon~~ **on** which a life insurer operates.

(e) Uses a name or title of an insurance policy or class of insurance policies misrepresenting the true nature of that insurance policy or class of insurance policies. A policy approved by the ~~commissioner shall be~~ **director is** conclusively presumed not to misrepresent the true nature of that policy.

(f) Makes a misrepresentation for the purpose of inducing or tending to induce the lapse, forfeiture, exchange, conversion, or surrender of an insurance policy.

(g) Makes a misrepresentation for the purpose of effecting a pledge or assignment of or a loan against an insurance policy.

(h) Misrepresents an insurance policy as being a security. This subdivision ~~shall~~ **does** not apply to an insurance policy ~~which~~ **that** must be registered as a security ~~pursuant to~~ **under** the law of this state or of the United States.

(i) Misrepresents the nature or extent of coverage afforded an insurance policy or annuity contract by the Michigan life and

health insurance guaranty association or the property and casualty guaranty association.

(2) All of the following apply to the conduct described in subsection (1):

(a) Conduct occurring during claims handling and resolution is not precluded from subsection (1).

(b) It is not limited to conduct related to sales and the advertising of policies.

Sec. 2005b. Conduct prohibited under the uniform trade practices act applies to all conduct captured in any insurance policy issued in this state, including, but not limited to, a policy that provides the coverage required under section 3101, unless the applicability of the uniform trade practices act, wholly or partially, is limited to certain types of policies under law.

Sec. 2006. (1) ~~A~~ **Subject to subsection (3), a** person ~~must~~ **shall** pay on a timely basis to its insured, a person directly entitled to benefits under its insured's insurance contract, or a ~~third party~~ **third-party** tort claimant the benefits provided under the terms of its policy. ~~, or, in the alternative, the person must pay to its insured, a person directly entitled to benefits under its insured's insurance contract, or a third party tort claimant 12% interest, as provided in subsection (4), on claims not paid on a timely basis.~~ Failure to pay claims on a timely basis or to pay interest on claims as provided in subsection ~~(4)~~ **(3)** is an unfair trade practice unless the claim is reasonably in dispute.

~~(2) A person shall not be found to have committed an unfair trade practice under this section if the person is found liable for a claim pursuant to a judgment rendered by a court of law, and the person pays to its insured, the person directly entitled to~~

~~benefits under its insured's insurance contract, or the third party tort claimant interest as provided in subsection (4).~~

(2) ~~(3)~~ An insurer shall specify in writing the materials that constitute a satisfactory proof of loss not later than 30 days after receipt of a claim unless the claim is settled within the 30 days. If proof of loss is not supplied as to the entire claim, the amount supported by proof of loss is considered paid on a timely basis if paid ~~within~~ **not later than** 60 days after receipt of proof of loss by the insurer. Any part of the remainder of the claim that is later supported by proof of loss is considered paid on a timely basis if paid ~~within~~ **not later than** 60 days after receipt of the proof of loss by the insurer. If the proof of loss provided by the claimant contains facts that clearly indicate the need for additional medical information by the insurer in order to determine its liability under a policy of life insurance, the claim is considered paid on a timely basis if paid ~~within~~ **not later than** 60 days after receipt of necessary medical information by the insurer. Payment of a claim is not untimely during any period in which the insurer is unable to pay the claim if there is no recipient who is legally able to give a valid release for the payment, or if the insurer is unable to determine who is entitled to receive the payment, if the insurer has promptly notified the claimant of that inability and has offered in good faith to promptly pay the claim on determination of who is entitled to receive the payment.

(3) ~~(4)~~ If benefits are not paid on a timely basis, the benefits paid bear simple interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum, if the claimant is the insured or a person directly entitled to benefits under the insured's insurance

contract. If the claimant is a ~~third party~~ **third-party** tort claimant, the benefits paid bear interest from a date 60 days after satisfactory proof of loss was received by the insurer at the rate of 12% per annum if the liability of the insurer for the claim is not reasonably in dispute, the insurer has refused payment in bad faith, and the bad faith was determined by a court of law. The interest must be paid in addition to and at the time of payment of the loss. If the loss exceeds the limits of insurance coverage available, ~~interest is payable based on the limits of insurance coverage rather than the amount of the loss.~~ **the insurer, regardless of the limits of insurance coverage, is liable for the full amount of the loss.** If payment is offered by the insurer but is rejected by the claimant, and the claimant does not subsequently recover an amount in excess of the amount offered, interest is not due. Interest paid as provided in this section must be offset by any award of interest that is payable by the insurer as provided in the award.

(4) ~~(5)~~ If a person contracts to provide benefits and reinsures all or a portion of the risk, the person contracting to provide benefits is liable for interest due to an insured, a person directly entitled to benefits under its insured's insurance contract, or a ~~third party~~ **third-party** tort claimant under this section if a reinsurer fails to pay benefits on a timely basis.

(5) ~~(6)~~ If there is any specific inconsistency between this section and chapter 31 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941, ~~the provisions of~~ this section ~~do~~ **does** not apply. Subsections ~~(7)~~ **(6)** to ~~(14)~~ **(13)** do not apply to a person regulated under the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941.

Subsections ~~(7)~~ **(6)** to ~~(14)~~ **(13)** do not apply to the processing and paying of Medicaid claims that are covered under section 111i of the social welfare act, 1939 PA 280, MCL 400.111i.

(6) ~~(7)~~ Subsections (1) to ~~(6)~~ **(5)** do not apply and subsections ~~(8)~~ **(7)** to ~~(14)~~ **(13)** do apply to health plans when paying claims to health professionals, health facilities, home health care providers, and durable medical equipment providers, that are not pharmacies and that do not involve claims arising out of chapter 31 or the worker's disability compensation act of 1969, 1969 PA 317, MCL 418.101 to 418.941. This section does not affect a health plan's ability to prescribe the terms and conditions of its contracts, other than as provided in this section for timely payment.

(7) ~~(8)~~ Each health professional, health facility, home health care provider, and durable medical equipment provider in billing for services rendered and each health plan in processing and paying claims for services rendered shall use the following timely processing and payment procedures:

(a) A clean claim must be paid within 45 days after receipt of the claim by the health plan. A clean claim that is not paid within 45 days bears simple interest at a rate of 12% per annum.

(b) A health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider ~~within~~ **not later than** 30 days after receipt of the claim by the health plan of all known reasons that prevent the claim from being a clean claim.

(c) A health professional, health facility, home health care provider, or durable medical equipment provider has 45 days, and any additional time the health plan permits, after receipt of a

notice under subdivision (b) to correct all known defects. The 45-day time period in subdivision (a) is tolled from the date of receipt of a notice to a health professional, health facility, home health care provider, or durable medical equipment provider under subdivision (b) to the date of the health plan's receipt of a response from the health professional, health facility, home health care provider, or durable medical equipment provider.

(d) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) makes the claim a clean claim, the health plan shall pay the health professional, health facility, home health care provider, or durable medical equipment provider within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(e) If a health professional's, health facility's, home health care provider's, or durable medical equipment provider's response under subdivision (c) does not make the claim a clean claim, the health plan shall notify the health professional, health facility, home health care provider, or durable medical equipment provider of an adverse claim determination and of the reasons for the adverse claim determination within the 45-day time period under subdivision (a), excluding any time period tolled under subdivision (c).

(f) A health professional, health facility, home health care provider, or durable medical equipment provider must bill a health plan within 1 year after the date of service or the date of discharge from the health facility in order for a claim to be a clean claim.

(g) A health professional, health facility, home health care provider, or durable medical equipment provider shall not resubmit

the same claim to the health plan unless the time period under subdivision (a) has passed or as provided in subdivision (c).

(h) A health plan that is a qualified health plan for the purposes of 45 CFR 156.270 and that, as required in 45 CFR 156.270(d), provides a 3-month grace period to an enrollee who is receiving advance payments of the premium tax credit and who has paid 1 full month's premium may pend claims for services rendered to the enrollee in the second and third months of the grace period. A claim during the second and third months of the grace period is not a clean claim under this section, and interest is not payable under subdivision (a) on that claim if the health plan has complied with the notice requirements of 45 CFR 155.430 and 45 CFR 156.270.

(8) ~~(9)~~ Notices required under subsection ~~(8)~~ **(7)** must be made in writing or electronically.

(9) ~~(10)~~ If a health plan determines that 1 or more services listed on a claim are payable, the health plan shall pay for those services and shall not deny the entire claim because 1 or more other services listed on the claim are defective. This subsection does not apply if a health plan and health professional, health facility, home health care provider, or durable medical equipment provider have an overriding contractual reimbursement arrangement.

(10) ~~(11)~~ A health plan shall not terminate the affiliation status or the participation of a health professional, health facility, home health care provider, or durable medical equipment provider with a health maintenance organization provider panel or otherwise discriminate against a health professional, health facility, home health care provider, or durable medical equipment provider because the health professional, health facility, home health care provider, or durable medical equipment provider claims

that a health plan has violated subsections ~~(7)~~ **(6)** to ~~(10).~~**(9).**

(11) ~~(12)~~ A health professional, health facility, home health care provider, durable medical equipment provider, or health plan alleging that a timely processing or payment procedure under subsections ~~(7)~~ **(6)** to ~~(11)~~ **(10)** has been violated may file a complaint with the director on a form approved by the director and has a right to a determination of the matter by the director or his or her designee. This subsection does not prohibit a health professional, health facility, home health care provider, durable medical equipment provider, or health plan from seeking court action.

(12) ~~(13)~~ In addition to any other penalty provided for by law, the director may impose a civil fine of not more than $1,000.00 for each violation of subsections ~~(7)~~ **(6)** to ~~(11)~~ **(10)** not to exceed $10,000.00 in the aggregate for multiple violations.

(13) ~~(14)~~ As used in subsections ~~(7)~~ **(6)** to ~~(13):~~**(12):**

(a) "Clean claim" means a claim that does all of the following:

(*i*) Identifies the health professional, health facility, home health care provider, or durable medical equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.

(*ii*) Sufficiently identifies the patient and health plan subscriber.

(*iii*) Lists the date and place of service.

(*iv*) Is a claim for covered services for an eligible individual.

(*v*) If necessary, substantiates the medical necessity and appropriateness of the service provided.

(*vi*) If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.

(*vii*) Identifies the service rendered using a generally accepted system of procedure or service coding.

(*viii*) Includes additional documentation based on services rendered as reasonably required by the health plan.

(b) "Health facility" means a health facility or agency licensed under article 17 of the public health code, 1978 PA 368, MCL 333.20101 to 333.22260.

(c) "Health plan" means ~~all~~ **both** of the following:

(*i*) An insurer providing benefits under a health insurance policy, including a policy, certificate, or contract that provides coverage for specific diseases or accidents only, an expense-incurred vision or dental policy, or a hospital indemnity, Medicare supplement, long-term care, or 1-time limited duration policy or certificate, but not to payments made to an administrative services only or cost-plus arrangement.

(*ii*) A MEWA regulated under chapter 70 that provides hospital, medical, surgical, vision, dental, and sick care benefits.

(d) "Health professional" means an individual licensed, registered, or otherwise authorized to engage in a health profession under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(14) ~~(15)~~ After December 31, 2017, this section applies to a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

Sec. 2026. (1) Unfair methods of competition and unfair or deceptive acts or practices in the business of insurance, other

than isolated incidents, are a course of conduct indicating a persistent tendency to engage in that type of conduct and include:

(a) Misrepresenting pertinent facts or insurance policy **benefits or** provisions relating to coverages at issue.

(b) Failing to acknowledge promptly or to act reasonably and promptly ~~upon~~ **on** communications with respect to claims arising under insurance policies.

(c) Failing to adopt and implement reasonable **written** standards for the prompt investigation**, adjustment, evaluation, and payment** of claims arising under insurance policies.

(d) Refusing to pay claims without conducting a reasonable investigation based ~~upon~~ **on** the available information.

(e) Failing to affirm or deny coverage of claims within ~~a~~ **any of the following periods, as applicable:**

(*i*) ~~reasonable~~ **If subparagraph (*ii*), (*iii*), or (*iv*) does not apply, a reasonable** time after proof of loss statements have been completed.

(*ii*) The time frame required under section 2833(1)(p), if applicable under that section.

(*iii*) The time frame required under section 2836(2), if applicable under that section.

(*iv*) A time frame otherwise specified by law.

(f) Failing to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compelling insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due the insureds.

(h) Attempting to settle a claim for less than the amount to

which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempting to settle claims on the basis of an application ~~which~~ **that** was altered without notice to, or knowledge or consent of, the insured.

(j) Making a claims payment to a policyholder or beneficiary omitting the coverage under which each payment is being made.

(k) Making known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(*l*) Delaying the investigation or payment of claims by requiring an insured, claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submission of formal proof of loss forms, seeking solely the duplication of a verification.

(m) Failing to promptly settle claims where liability has become reasonably clear under 1 portion of the insurance policy coverage **or denying additional living, business interruption, or other expenses owed under the policy** in order to influence settlements under other portions of the insurance policy.

(n) Failing to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(o) Failing to give the interests of insureds at least equal consideration to that of the insurer.

(p) Denying or refusing to acknowledge an insurer's

obligations under this section and other sections of the uniform trade practices act.

(q) Failing to investigate, adjust, and evaluate a claim and the materials and evidence related to a claim for benefits in an objective manner.

(r) Failing to investigate, adjust, and evaluate claims in a manner that gives the insured the reasonable benefit of any doubt and looking for ways under the policy to pay the claim.

(s) Denying or rejecting a claim because of a failure to comply with a policy condition without providing the claimant with written notice of that failure and providing the claimant a reasonable period of time to cure the defect in satisfying the condition.

(t) Construing ambiguous provisions in an insurance contract or policy in favor of the insurer.

(2) The failure of a person to maintain a complete record of all the complaints of its insureds ~~which~~ **that** it has received since the date of the last examination is an unfair method of competition and unfair or deceptive act or practice in the business of insurance. This record ~~shall~~ **must** indicate the total number of complaints, their classification by line of insurance, the nature of each complaint, the disposition ~~thereof,~~ **of the complaint**, and the time it took to process each complaint. For purposes of this subsection, "complaint" means a written communication primarily expressing an allegation of acts ~~which~~ **that** would constitute violation of this chapter. If a complaint relating to an insurer is received by an agent of the insurer, the agent shall promptly forward the complaint to the insurer unless the agent resolves the complaint to the satisfaction of the insured within a reasonable

time. An insurer ~~shall~~ **has** not ~~be deemed to have~~ engaged in an unfair method of competition or an unfair or deceptive act or practice in the business of insurance in violation of this chapter because of the failure of an agent who is not also an employee to forward a written complaint as required by this subsection.

(3) In addition to the legal remedies provided under chapter 30b, repeated violations under subsection (1) may be investigated and penalized by the director in accordance with sections 2028 to 2045.

Sec. 2049. ~~No order of the commissioner under this uniform trade practices act or order of a court to enforce the same shall in any way relieve or absolve any person affected by such order from any liability under any other laws of this state.~~**All of the following apply to an order of the director under this chapter or order of a court to enforce an order of the director as described in this section:**

(a) It must not relieve or absolve any person affected by the order from any liability under any other laws of this state.

(b) Subject to section 3072, it must not limit the right to a civil cause of action provided for under chapter 30b.

CHAPTER 30B

RIGHT TO A CIVIL CAUSE OF ACTION

AGAINST INSURERS FOR CERTAIN CONDUCT

Sec. 3071. As used in this chapter:

(a) "Bad-faith failure to settle" means an insurer's failure to settle a claim when, considering all of the circumstances, the insurer could and should have done so had it acted fairly and reasonably toward its insured and with regard for the insured's interests.

(b) "Claimant" means a first-party claimant, a third-party claimant, or both, and includes the claimant's designated legal representative and a member of the claimant's immediate family designated by the claimant. Claimant includes an insured if the insured is making a first-party claim or otherwise asserting a right to payment under the insured's insurance policy or insurance contract.

(c) "First-party claimant" means a person asserting a right to payment under an insurance policy or insurance contract, or from a person that has obtained permission from a regulatory agency to be self-insured, arising out of the occurrence of a contingency of loss covered by the policy or contract.

(d) "Health facility" means that term as defined in section 2006.

(e) "Health plan" means that term as defined in section 2006.

(f) "Health professional" means that term as defined in section 2006.

(g) "Insurance policy" or "insurance contract" means a contract of insurance, indemnity, suretyship, or annuity issued or proposed or intended for issuance by a person engaged in the business of insurance.

(h) "Insurer" means an insurance company or entity that issued the insurance policy or insurance contract providing insurance coverage to the claimant regardless of whether they are an authorized insurer in this state.

(i) "Third-party claimant" means a person asserting a claim against a person that is insured under an insurance policy or insurance contract and includes a judgment creditor of the insured, or an assignee of the insured, including, but not limited to, a

bankruptcy trustee, personal representative, heir, survivor, receiver, or other successor in interest, including the party injured by the insured.

Sec. 3072. This chapter does not apply to health plans when paying claims to health professionals, health facilities, home health care providers, and durable medical equipment providers, that are not pharmacies.

Sec. 3073. (1) Any of the following people damaged by a violation of section 2006, 2026, or 2027 may file a civil action against the insurer and may recover the damages listed under subsection (2) and, if applicable, subsection (3):

(a) An insured.

(b) A claimant.

(c) Any person directly entitled to benefits under an insurance contract.

(d) A third-party tort claimant asserting a claim for bad-faith failure to settle.

(2) Subject to subsection (6), a person described under subsection (1) may file a civil action and recover the following damages:

(a) The total amount owed under the insurance policy minus any portion already paid.

(b) Any monetary losses caused by a delay in payment and any damage to credit reputation suffered as a reasonably foreseeable result of a delay in payment.

(c) Except as otherwise provided in this subdivision, actual damages, which include all damages available in a negligence tort claim. Actual damages under this subdivision include exemplary damages.

(d) Penalty interest of 12% per annum described under section 2006.

(e) A reasonable attorney fee based on whichever of the following is greater:

(*i*) The amount of time expended by the attorney at a reasonable hourly rate.

(*ii*) A contingent fee representing 33-1/3% of the amount paid or owed by the insurer.

(f) The legal costs incurred, including, but not limited to, expert fees and other expenses incurred in pursuing payments owed by the insurer.

(3) Subject to subsection (6), in addition to the damages under subsection (2), if the court determines that the insurer's violation, as described under subsection (1), was in bad faith or otherwise willful, wanton, reckless, or in conscious disregard of an injured party's rights, the injured party may also recover damages for the following:

(a) Emotional distress, humiliation, and anxiety experienced and reasonably probable to be experienced in the future.

(b) Punitive damages.

(4) For a claim asserted for bad-faith failure to settle, if an insurer fails to make an offer within the policy limits when liability is reasonably clear and it is reasonably clear that damages may exceed the policy limits, the insurer's liability is not limited to the policy limits.

(5) There is a rebuttable presumption that an insurer who violates section 2026 or 2027 has acted in bad faith for purposes of subsection (3).

(6) An action under this section must be treated as a

negligence tort claim and decided under the laws applicable to a negligence tort claim.

Sec. 3074. (1) In addition to a claim described under section 3073, any of the following people may file a civil action against the insurer if the insurer committed any of the conduct listed under subsection (2) and recover the damages listed under subsection (3) and, if applicable, subsection (4):

(a) An insured.

(b) A claimant.

(c) Any person directly entitled to benefits under an insurance contract.

(d) A third-party tort claimant asserting a claim for bad-faith failure to settle.

(2) A person listed under subsection (1) may file a civil action as described under subsection (1) if an insurer commits any of the following conduct:

(a) Misrepresents pertinent facts or insurance policy benefits or provisions relating to coverages at issue.

(b) Fails to acknowledge promptly or to act reasonably and promptly on communications with respect to claims arising under insurance policies.

(c) Fails to adopt and implement reasonable written standards for the prompt investigation, adjustment, evaluation, and payment of claims arising under insurance policies.

(d) Refuses to pay claims without conducting a reasonable investigation based on the available information.

(e) Fails to affirm or deny coverage of claims within any of the following periods, as applicable:

(*i*) If subdivision (*ii*) or (*iii*) does not apply, a reasonable

time after proof of loss statements have been completed.

(*ii*) The time frame required under section 2833(1)(p), if applicable under that section.

(*iii*) The time frame required under section 2836(2), if applicable under that section.

(f) Fails to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear.

(g) Compels insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts due the insureds.

(h) Attempts to settle a claim for less than the amount to which a reasonable person would believe the claimant was entitled, by reference to written or printed advertising material accompanying or made part of an application.

(i) Attempts to settle claims on the basis of an application that was altered without notice to, or knowledge or consent of, the insured.

(j) Makes a claims payment to a policyholder or beneficiary omitting the coverage under which each payment is being made.

(k) Makes known to insureds or claimants a policy of appealing from arbitration awards in favor of insureds or claimants for the purpose of compelling them to accept settlements or compromises less than the amount awarded in arbitration.

(*l*) Delays the investigation or payment of claims by requiring an insured, a claimant, or the physician of either to submit a preliminary claim report and then requiring subsequent submission of formal proof of loss forms, seeking solely the duplication of a verification.

(m) Fails to promptly settle claims where liability has become reasonably clear under 1 portion of the insurance policy coverage or denying additional living, business interruption, or other expenses owed under the policy in order to influence settlements under other portions of the insurance policy.

(n) Fails to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement.

(o) Fails to give the interests of insureds at least equal consideration to that of the insurer.

(p) Denies or refuses to acknowledge an insurer's obligations under this section and other sections of this chapter.

(q) Fails to investigate, adjust, and evaluate a claim and the materials and evidence related to a claim for benefits in an objective manner.

(r) Fails to investigate, adjust, and evaluate claims in a manner that gives the insured the reasonable benefit of any doubt and looks for ways under the policy to pay the claim.

(s) Denies or rejects a claim because of a failure to comply with a policy condition without providing the claimant with written notice of that failure and providing the claimant a reasonable period of time to cure the defect in satisfying the condition.

(t) Construes ambiguous provisions in an insurance contract or policy in favor of the insurer.

(3) Subject to subsection (7), a person described under subsection (1) may file a civil action and recover the following damages:

(a) The total amount owed under the insurance policy minus any

portion already paid.

(b) Any monetary losses caused by a delay in payment and any damage to credit reputation suffered as a reasonably foreseeable result of a delay in payment.

(c) Except as otherwise provided in this subdivision, actual damages, which include all damages available in a negligence tort claim. Actual damages under this subdivision include exemplary damages.

(d) Penalty interest of 12% per annum described under section 2006.

(e) A reasonable attorney fee based on whichever of the following is greater:

(*i*) The amount of time expended by the attorney at a reasonable hourly rate.

(*ii*) A contingent fee representing 33-1/3% of the amount paid or owed by the insurer.

(f) The legal costs incurred, including, but not limited to, expert fees and other expenses incurred in pursuing payments owed by the insurer.

(4) Subject to subsection (7), in addition to the damages allowed under subsection (3), if the court determines that the insurer's violation, as described under subsection (2), was in bad faith or otherwise willful, wanton, reckless, or in conscious disregard of an injured party's rights, the injured party may also recover damages for the following:

(a) Emotional distress, humiliation, and anxiety experienced and reasonably probable to be experienced in the future.

(b) Punitive damages.

(5) For a claim asserted for bad-faith failure to settle, if

an insurer fails to make an offer within the policy limits when liability is reasonably clear and it is reasonably clear that damages may exceed the policy limits, the insurer's liability is not limited to the policy limits.

(6) There is a rebuttable presumption that an insurer who violates section 2026 or 2027 has acted in bad faith for purposes of subsection (4).

(7) An action under this section must be treated as an ordinary negligence tort claim and decided under the laws applicable to an ordinary negligence tort claim.

(8) Conduct in violation of subsection (2) can be, but is not required to be, established through 1 or more incidents of the conduct and through the introduction of evidence, including, but not limited to, an insurer's policies, procedures, practices, business plan, goals, incentives, directives, mandates, guidance, or similar evidence.

Sec. 3075. This chapter does not relieve an insurer from its other duties and responsibilities under this act or case law. The duties and responsibilities of an insurer under this chapter are cumulative to preexisting duties and responsibilities.