THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

CHAPTER 34
DISABILITY INSURANCE POLICIES

500.3400 Definitions; scope of chapter, exemptions, exceptions.

Sec. 3400. (1) As used in this chapter:

(a) "Affiliated provider" means a health professional, licensed hospital, licensed pharmacy, or other person that has entered into a participating provider contract, directly or indirectly, with a health maintenance organization to render 1 or more health services to an enrollee. Affiliated provider includes a person described in this subdivision that has entered into a written arrangement with another person, including, but not limited to, a physician hospital organization or physician organization, that contracts directly with a health maintenance organization.

(b) "Disability insurance policy" includes an insurance policy or insurance contract that insures against loss resulting from sickness or from bodily injury or death by accident, or both, including also the granting of specific hospital benefits and medical, surgical, and sick-care benefits to an individual, family, or group, subject to the exclusions provided in this section.

(2) This chapter does not apply to or affect any of the following:

(a) A liability or worker's disability compensation insurance policy, regardless of whether supplementary expense coverage is included.

(b) A reinsurance policy or contract.

(c) Life insurance, endowment, or annuity contracts, or contracts supplemental to life insurance, endowment, or annuity contracts, that only contain provisions relating to disability insurance that do any of the following:

(*i*) Provide additional benefits in case of death or dismemberment or loss of sight by accident.

(*ii*) Operate to safeguard the contracts against lapse or to give a special surrender value, special benefit, or annuity in the event that the insured or annuitant becomes totally and permanently disabled, as defined by the contract or supplemental contract. A supplemental contract described in this subparagraph must be issued under the authority of section 602.

(3) An insurer may omit the provisions required under sections 3407, 3411, and 3420 from ticket policies sold only to passengers by common carriers.

(4) Section 3475 applies to group, blanket, or family expense disability insurance contracts and the remaining provisions of this chapter apply to group, blanket, or family expense disability insurance contracts only as provided in this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1963, Act 56, Eff. Sept. 6, 1963;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3401 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to purpose and short title of chapter.

Popular name: Act 218

500.3401a Group disability insurance; issuance; filing and approval of form.

Sec. 3401a. (1) An insurer authorized to write disability insurance in this state may issue group disability insurance policies.

(2) Except as otherwise provided in section 2236(8)(d), an insurer shall not deliver or issue for delivery in this state a group disability insurance policy unless a copy of the form has been filed with and approved by the director.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.3402 Disability insurance policy; provisions required.

Sec. 3402. An insurer shall not deliver or issue for delivery in this state a disability insurance policy for an individual or family unless all of the following requirements are met:

(a) The entire money and other considerations for the policy are expressed in the policy.

(b) The time at which the insurance takes effect and terminates is expressed in the policy.

(c) The policy purports to insure only 1 individual, except that a policy may insure, originally or by subsequent amendment, upon the application of an adult member of a family who is considered to be the policyholder, any 2 or more eligible members of that family, including husband, wife, dependent children, any children under a specified age, and any other individual dependent upon the policyholder, if coverage is made available to any dependent child at least until the child turns 26 years of age for a health insurance policy or 19 years of age for a policy of disability insurance, a policy providing pediatric dental benefits, or a policy providing pediatric vision benefits.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402a Group disability insurance policy; provisions required.

Sec. 3402a. An insurer shall include all of the following provisions in a group disability insurance policy:

(a) That the policy, application of the employer or of an executive officer or trustee of an association, and the individual applications, if any, of the employees or members insured, constitute the entire contract between the parties. The insurer's identification of what constitutes the entire contract creates a rebuttable presumption that the identified items are the entire contract.

(b) That a statement made by the employer, the executive officer or trustee of an association, or an individual employee or member, in the absence of fraud, is a representation and not a warranty. An insurer shall not use a statement made by the employer, the executive officer or trustee of an association, or an individual employee or member as a defense to a claim under the policy, unless the statement is contained in a written application.

(c) That the insurer will issue to the employer or the executive officer or trustee of an association, for delivery to an employee or member who is insured under the policy, an individual certificate that states the insurance protection to which the employee or member is entitled and to whom benefits are payable.

(d) That new employees or members, as applicable, who are eligible and who apply will be added to the group or class originally insured.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402b Group or nongroup disability insurance policy; coordination of benefits; provision; limitation; "other coverage" defined; payment by each insurer.

Sec. 3402b. (1) Subject to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255, an insurer may include in a group or nongroup disability insurance policy a provision for the coordination of benefits otherwise payable under the policy with benefits payable for the same loss under other group or nongroup disability insurance. An insurer that does not include in a group or nongroup disability insurance policy a provision for the coordination of benefits as described in this subsection shall coordinate benefits under the policy in the manner prescribed in the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(2) Subject to subsection (1), an insurer may include a provision in a group or nongroup disability insurance policy that benefits payable by the policy may be limited if there is other valid coverage with another insurer that provides benefits for the same loss on an expense-incurred basis. The insurer may provide that if it is not given written notice on the application for coverage that the other valid coverage exists, or if other coverage is acquired after the effective date of the coverage, the only liability under any expense-incurred coverage of the policy is the amount of the covered claim that exceeds the benefits payable by the other coverage. An insurer shall apply benefits paid or payable by the primary insurer to satisfy any deductibles, coinsurance, and copayments with the policy. An insurer shall not apply payments made by a primary insurer to reduce the policy maximum limits on the policy. As used in this subsection, "other coverage" includes a plan that provides coverage under a health insurance policy, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program. Other coverage does not include Medicaid, hospital daily indemnity plans, specified disease only policies, or limited occurrence policies that provide only for intensive care or coronary care at a hospital, first aid outpatient medical expenses resulting from accidents, or specified accidents such as travel accidents.

(3) If there are more than 1 group or nongroup disability insurance policies that cover the same loss and contain a provision described in subsection (2), and the insurers each pay a share of the covered expenses for the claim, neither insurer is required to pay more than it would have paid had it been the primary insurer.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402c Family expense insurance policy.

Sec. 3402c. (1) For purposes of this chapter, family expense insurance is accident and health insurance that is written under 1 policy issued to the head of a family who may be either spouse and that insures the head of the family and 1 or more dependents, including a nondependent spouse. Benefits under a family expense insurance policy, except as applied to the head of the family, do not include indemnification for loss of time from any cause.

(2) An insurer authorized to write accident and health insurance in this state may issue family expense insurance policies.

(3) An insurer shall not deliver or issue for delivery in this state a family expense insurance policy unless a copy of the form of the policy is filed with and approved by the director.

(4) An insurer shall include in a family expense insurance policy the applicable provisions of sections 3406 to 3466 and all of the following provisions:

(a) That the policy and the application signed by the individual acting as the head of the family for the purpose of family expense insurance constitute the entire contract between the parties. The insurer's identification of what constitutes the entire contract creates a rebuttable presumption that the identified items are the entire contract.

(b) That a statement made by the head of the family, in the absence of fraud, is a representation and not a warranty. An insurer shall not use a statement made by the head of the family as a defense to a claim under the policy, unless the statement is contained in a written application.

(c) That new members of the family who are eligible, on application of the head of the family, will be added to the family group originally insured.

(5) A family expense insurance policy is subject to sections 3474 and 3474a.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.3402d Blanket disability insurance; coverage.

Sec. 3402d. (1) For purposes of this chapter, blanket disability insurance is disability insurance that covers special groups of individuals, as follows:

(a) A policy issued to a common carrier as the policyholder and that covers a group defined as all individuals who are passengers of the common carrier.

(b) A policy issued to an employer as the policyholder and that covers all employees or any group of employees defined by reference to exceptional hazards incidental to the employment.

(c) A policy issued to a university, college, school, or other educational institution, or to the head or principal of the university, college, school, or institution as the policyholder, that covers students or teachers.

(d) A policy issued to a volunteer fire department, first aid group, or other volunteer group as the policyholder that covers all of the members of the department or group.

(e) A policy issued to a creditor as the policyholder that insures debtors of the creditor.

(f) A policy issued to a sports team or camp as the policyholder that covers members or campers.

(2) In the discretion of the director, blanket disability insurance may be issued to any other special group of individuals that is substantially similar to a group described in subsection (1).

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402e Blanket disability insurance policies; issuance.

Sec. 3402e. (1) An insurer authorized to write disability insurance in this state may issue blanket disability insurance policies.

(2) An insurer shall not deliver or issue for delivery in this state a blanket disability insurance policy unless a copy of the form of the policy is filed with and approved by the director.

(3) A blanket disability insurance policy is subject to sections 3474 and 3474a.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 3 of Act 276 of 2016 provides:

"Enacting section 3. On the effective date of this amendatory act, an insurer may submit to the director of the department of insurance

and financial services for approval any modification to policies and certificates that were approved before or on the effective date of this amendatory act, to conform with amendments made to the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302, by this amendatory act. This enacting section does not apply to rates and rating methodologies."

Popular name: Act 218

500.3402f Blanket disability insurance policy; provisions.

Sec. 3402f. An insurer shall include in a blanket disability insurance policy the applicable provisions of sections 3406 to 3466 and all of the following provisions:

(a) That the policy and the application signed by the policyholder constitute the entire contract between the parties. The insurer's identification of what constitutes the entire contract creates a rebuttable presumption that the identified items are the entire contract.

(b) That a statement made by the policyholder, in the absence of fraud, is a representation and not a warranty. An insurer shall not use a statement made by the policyholder as a defense to a claim under the policy, unless the statement is contained in a written application.

(c) That individuals who are eligible for coverage, on application of the policyholder, will be added to the group or class originally insured.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402g Blanket disability insurance policy; certificate; payment of benefits.

Sec. 3402g. (1) An insurer shall not require an individual application from an individual covered under a blanket disability insurance policy. The director may require the insurer to furnish a certificate to each individual insured under a blanket disability policy.

(2) Except as otherwise provided in this subsection, an insurer shall pay benefits under a blanket disability insurance policy to the insured or to the insured's designated beneficiary or estate. If the insured is a minor or developmentally disabled, an insurer may pay benefits under a blanket disability insurance policy to the insured's parent, guardian, or other person to which the insured is a dependent. An insurer may provide in a blanket disability insurance policy that, with the consent of the insured, the benefits may be paid directly to a person that legally furnishes hospital, medical, surgical, or sick-care services to the insured, within the limits under the policy and without other preference as to creditors.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3402h Legal liability of policyholder.

Sec. 3402h. Sections 3402d to 3402g do not affect the legal liability of a policyholder for the death of or injury to an employee, member, or other individual insured under the blanket disability insurance policy.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3403 Health insurance policy offering dependent coverage; required provisions; denial prohibited; grounds.

Sec. 3403. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that makes dependent coverage available under the health insurance policy shall do all of the following:

(a) Make available dependent coverage, at the option of the policyholder, until the dependent has attained 26 years of age.

(b) Provide the same health insurance benefits to a dependent child that are available to any other covered dependent.

(c) Provide health insurance benefits to a dependent child at the same rate or premium applicable to any other covered dependent.

(d) Include both of the following provisions in the health insurance policy:

(*i*) That the health insurance benefits applicable for children are payable with respect to a newly born child of the insured from the moment of birth.

(*ii*) That the coverage for newly born children consists of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

(2) A health insurance policy that offers dependent coverage shall not deny enrollment to an insured's child on any of the following grounds:

(a) The child was born out of wedlock.

(b) The child is not claimed as a dependent on the insured's federal income tax return.

(c) The child does not reside with the insured or in the insurer's service area.

(3) This section does not require an insurer or plan to make coverage available for a child of a child receiving dependent coverage.

History: Add. 1975, Act 20, Imd. Eff. Apr. 3, 1975;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2023, Act 158, Eff. Feb. 13, 2024.

Compiler's note: Section 2 of Act 20 of 1975 provides: "The requirements of this act shall apply to all insurance policies delivered or issued for delivery in this state more than 120 days after the effective date of the act."

Popular name: Act 218

500.3404 Insurance policy issued for delivery to nonresident.

Sec. 3404. The director may require that a policy issued by an insurer domiciled in this state for delivery to a person residing in another state meet the standards prescribed in sections 2212a, 3402, and 3406 to 3466 if the official that is responsible for the administration of the insurance laws of the other state advises the director that the policy is not subject to approval or disapproval by the official.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3405 Prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services; rates; discrimination prohibited; optometry, chiropractic, and physical therapy service.

Sec. 3405. (1) For the purpose of doing business as an organization under the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63, an insurer authorized in this state to write health insurance may enter into prudent purchaser agreements with providers of hospital, nursing, medical, surgical, or sick-care services pursuant to this section and the prudent purchaser act, 1984 PA 233, MCL 550.51 to 550.63.

(2) An insurer may offer health insurance policies under which the insured persons shall be required, as a condition of coverage, to obtain health care services exclusively from health care providers who have entered into prudent purchaser agreements.

(3) An insurer may offer health insurance policies under which insured persons who elect to obtain health care services from health care providers who have entered into prudent purchaser agreements realize a financial advantage or other advantage by selecting providers who have entered into prudent purchaser agreements. Policies offered under this subsection shall not, as a condition of coverage, require insured persons to obtain hospital, nursing, medical, surgical, or sick-care services exclusively from health care providers who have entered into prudent purchaser agreements.

(4) An insurer shall not charge rates for coverage under policies issued under this section that are unreasonably lower than what is necessary to meet the expenses of the insurer for providing the coverage or that have an anticompetitive effect or result in predatory pricing in relation to prudent purchaser agreement coverages offered by other organizations.

(5) An insurer shall not discriminate against a class of health care providers when entering into prudent purchaser agreements with health care providers for its provider panel. This subsection does not do any of the following:

(a) Prohibit the formation of a provider panel consisting of a single class of providers if a service provided for in the specifications of a purchaser may legally be provided only by a single class of providers.

(b) Prohibit the formation of a provider panel that conforms to the specifications of a purchaser of the coverage authorized by this section if the specifications do not exclude any class of health care providers who may legally perform the services included in the coverage.

(c) Require an organization that has uniformly applied the standards filed under section 3(3) of the prudent purchaser act, 1984 PA 233, MCL 550.53, to contract with any individual provider.

(6) Notwithstanding any provision of this act to the contrary, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of optometry, an insurer is not required to provide coverage or reimburse for a practice of optometry service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, 1978 PA 368, MCL 333.17401, as of May 20, 1992.

(7) Notwithstanding any provision of this act to the contrary, if coverage under a prudent purchaser agreement provides for benefits for services that are within the scope of practice of chiropractic, an insurer is not required to provide coverage or reimburse for a practice of chiropractic service unless that service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(8) Notwithstanding any provision of this act to the contrary, if coverage under a prudent purchaser agreement provides for benefits for services that are provided by a licensed physical therapist or physical

therapist assistant under the supervision of a licensed physical therapist, an insurer is not required to provide coverage or reimburse for services provided by a physical therapist or a physical therapist assistant unless that service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

History: Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 1989, Act 137, Eff. Jan. 3, 1990;—Am. 1994, Act 438, Eff. Mar. 30, 1995;—Am. 2009, Act 227, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 263, Imd. Eff. July 1, 2014;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Senate Bill No. 493 was not enacted into law by the 87th Legislature.

Popular name: Act 218

500.3405a Use of most favored nation clause.

Sec. 3405a. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

(2) Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on February 1, 2013, unless the most favored nation clause has been filed with and approved by the director. Subject to subsection (3), beginning February 1, 2013, an insurer or a health maintenance organization shall not enforce a most favored nation clause in any provider contract without the prior approval of the director.

(3) Beginning January 1, 2014, an insurer or a health maintenance organization shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

(4) As used in this section, "most favored nation clause" means a clause that does any of the following:

(a) Prohibits, or grants a contracting insurer or health maintenance organization an option to prohibit, a provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(b) Requires, or grants a contracting insurer or health maintenance organization an option to require, a provider to accept a lower payment or reimbursement rate if the provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(c) Requires, or grants a contracting insurer or health maintenance organization an option to require, termination or renegotiation of an existing provider contract if a provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the contract with the insurer or health maintenance organization.

(d) Requires a provider to disclose, to the insurer or health maintenance organization or the insurer's or health maintenance organization's designee, the provider's contractual payment or reimbursement rates with other parties.

(5) As used in this section, after December 31, 2016, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406 Disability insurance policy; provisions required, captions, omissions, substitutions.

Sec. 3406. (1) Except as provided in subsection (2) of this section, each such policy delivered or issued for delivery to any person in this state shall contain the provisions specified in sections 3407 through 3424 in the words in which the same appear in such sections: Provided, however, That the insurer may, at its option, substitute for 1 or more of such provisions corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary. Such provisions shall be preceded individually by the caption appearing in the pertinent section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

(2) If any such provision is in whole or in part inapplicable to or inconsistent with the coverage provided by a particular form of policy the insurer, with the approval of the commissioner, shall omit from such policy any inapplicable provision or part of a provision, and shall modify any inconsistent provision or part of the provision in such manner as to make the provision as contained in the policy consistent with the coverage provided by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3406a Reconstructive surgery following mastectomy; prosthetic device.

Sec. 3406a. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall offer benefits for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy. This coverage must provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device are covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage required under this section.

History: Add. 1982, Act 527, Eff. Mar. 30, 1983;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406b Coverage for mental health services by mental health care provider.

Sec. 3406b. A policy or certificate which provides coverage for mental health services shall provide coverage for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health provider meets the standards set by the insurer for all other providers of the type.

History: Add. 1984, Act 280, Imd. Eff. Dec. 20, 1984.

Popular name: Act 218

500.3406c Hospice care; definition; description of coverage.

Sec. 3406c. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for inpatient hospital care shall offer to include coverage for hospice care. As used in this section, "hospice" means a health care program that provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

(2) If hospice care coverage is provided, an insurer shall include a description of the hospice coverage in communications sent to the insured.

History: Add. 1984, Act 368, Eff. Jan. 1, 1986;—Am. 1994, Act 233, Imd. Eff. June. 30, 1994;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406d Coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions.

Sec. 3406d. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall offer or include coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall offer or include the following coverage for breast cancer screening mammography:

(a) If performed on a woman 35 years of age or older and under 40 years of age, coverage for 1 screening mammography examination during that 5-year period.

(b) If performed on a woman 40 years of age or older, coverage for 1 screening mammography examination every calendar year.

(3) As used in this section:

(a) "Breast cancer diagnostic services" means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathologic examination and interpretation.

(b) "Breast cancer rehabilitative services" means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to reconstructive plastic surgery, physical therapy, and psychological and social support services.

(c) "Breast cancer screening mammography" means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

(d) "Breast cancer outpatient treatment services" means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

History: Add. 1989, Act 59, Eff. Nov. 1, 1989;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406e Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.

Sec. 3406e. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage in each policy for a drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage must be provided for any United States Food and Drug Administration approved drug regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the United States Food and Drug Administration if all of the following conditions are met:

(a) The drug is ordered by a physician for the treatment of a specific type of neoplasm.

(b) The drug is approved by the United States Food and Drug Administration for use in antineoplastic therapy.

(c) The drug is used as part of an antineoplastic drug regimen.

(d) Current medical literature substantiates its efficacy and recognized oncology organizations generally accept the treatment.

(e) The physician has obtained informed consent from the patient for the treatment regimen that includes United States Food and Drug Administration approved drugs for off-label indications.

History: Add. 1989, Act 59, Imd. Eff. June 16, 1989;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406f Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to excluded or limited coverage and examination of issue of crediting prior continuous health care coverage.

Popular name: Act 218

500.3406g Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to prohibition against denying coverage to dependent child under certain conditions.

Popular name: Act 218

500.3406h Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; duties of insurer; court or administrative order and notice required.

Sec. 3406h. (1) If a parent is eligible for dependent coverage through an insurer, the insurer shall:

(a) Permit the parent to enroll, under the dependent coverage, a child who is otherwise eligible for coverage without regard to any enrollment season restrictions.

(b) If the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under dependent coverage upon application by the friend of the court or by the child's other parent through the friend of the court.

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the policy or certificate or the insurer is provided with satisfactory written evidence of either of the following:

(*i*) The court or administrative order is no longer in effect.

(*ii*) The child is or will be enrolled in comparable health coverage through another insurer, health care corporation, health maintenance organization, or self-funded health coverage plan that will take effect not later than the effective date of the cancellation of the existing coverage.

(2) If a child has health coverage through an insurer of a noncustodial parent, that insurer shall do all of the following:

(a) Provide the custodial parent with information necessary for the child to obtain benefits through that coverage.

(b) Permit the custodial parent or, with the custodial parent's approval, the provider to submit a claim for covered services without the noncustodial parent's approval.

(c) Make payment on claims submitted under subdivision (b) directly to the custodial parent or medical

provider.

(3) This section applies only if a parent is required by a court or administrative order to provide health coverage for a child and the insurer is notified of that court or administrative order.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406i Individual eligible under title XIX of social security act; assignment of rights of insured to department of social services.

Sec. 3406i. (1) An insurer shall not consider whether an individual is eligible for or has available medical assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments under its plan for eligible insureds.

(2) If an insurer has a legal liability to make payments, and payment for covered expenses for medical goods or services furnished to an individual has been made under the medical assistance program established under section 105 of the social welfare act, Act No. 280 of the Public Acts of 1939, being section 400.105 of the Michigan Compiled Laws, the department of social services has the rights of the individual to payment by the insurer to the extent payment was made by the department of social services's medical assistance program for those medical goods or services.

(3) If the department of social services has been assigned the rights of an insured who is eligible for medical assistance under section 105 of Act No. 280 of the Public Acts of 1939 and is covered by an insurer, the insurer shall not impose requirements on the department of social services that are different from requirements that apply to an agent or assignee of any other covered insured.

History: Add. 1995, Act 237, Eff. Mar. 28, 1996.

Popular name: Act 218

500.3406j Insured or applicant as victim of domestic violence; refusal to provide coverage prohibited; liability; "domestic violence" defined.

Sec. 3406j. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not rate, cancel coverage on, refuse to provide coverage for, or refuse to issue or renew a health insurance policy solely because an insured or applicant for insurance is or has been a victim of domestic violence.

(2) An insurer is not civilly liable for any cause of action that may result from compliance with this section.

(3) As used in this section, "domestic violence" means inflicting bodily injury on, causing serious emotional injury or psychological trauma to, or placing in fear of imminent physical harm by threat or force a person who is a spouse or former spouse of, has or has had a dating relationship with, resides or has resided with, or has a child in common with the person committing the violence.

History: Add. 1998, Act 136, Imd. Eff. June 24, 1998;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406k Emergency health services; medically necessary coverage; "stabilization" defined.

Sec. 3406k. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for emergency health services shall provide coverage for medically necessary services provided to an insured for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. An insurer shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. An insurer shall not deny payment for emergency health services up to the point of stabilization provided to an insured under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization not being given by the insurer before emergency health services were provided.

(2) As used in this section, "stabilization" means the point at which no material deterioration of a condition is likely, within reasonable medical probability, to result from or occur during transfer of the patient.

History: Add. 1998, Act 125, Imd. Eff. June 10, 1998;—Am. 2004, Act 7, Imd. Eff. Feb. 20, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406*l* Medical transportation services; reimbursement; exception.

Sec. 3406*l*. (1) Except as otherwise provided in subsections (2) and (3), an insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides benefits for emergency services shall provide for direct reimbursement to any provider of covered medical transportation services or shall provide that payment be made jointly to the insured and the provider, if the provider has not received payment for those services from any other source.

(2) Subsection (1) does not apply to a transaction between an insurer and a medical transportation service provider if the parties have entered into a contract providing for direct payment.

(3) An insurer for a policy issued under section 3405 does not have to provide for direct reimbursement to any nonaffiliated or nonparticipating provider for medical transportation services that were not emergency health services as described in section 3406k.

(4) This section does not apply to a health maintenance organization contract.

History: Add. 2004, Act 171, Imd. Eff. June 24, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406m Access by insured to obstetrician-gynecologist.

Sec. 3406m. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that requires an insured to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services shall permit a female insured to access an obstetrician-gynecologist for annual well-woman examinations and routine obstetrical and gynecologic services.

(2) An insurer shall not require prior authorization or referral for access under subsection (1) to an obstetrician-gynecologist who is participating with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating obstetrician-gynecologist.

(3) An insurer shall include a description of the coverage required under this section in a communication sent to the insured or group purchaser of coverage.

History: Add. 1998, Act 402, Eff. Mar. 23, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406n Access to pediatric care services.

Sec. 3406n. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that requires an insured to designate a participating primary care provider and provides for dependent care coverage shall permit a dependent minor insured to select and access a pediatrician for general pediatric care services.

(2) An insurer shall not require prior authorization or referral for access under subsection (1) to a pediatrician who participates with the insurer. An insurer may require prior authorization or referral for access to a nonparticipating pediatrician.

History: Add. 1999, Act 179, Imd. Eff. Nov. 16, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406o Insurer providing prescription drug coverage; formulary restrictions; expedited review of coverage for nonformulary alternative; determination; subject to 500.3406w.

Sec. 3406o. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:

(a) Provide for participation of participating physicians, dentists, and pharmacists in the development of the formulary.

(b) Disclose to health care providers and upon request to insureds the nature of the formulary restrictions.

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent an insurer from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives.

(2) On a request for an expedited review of coverage for a nonformulary alternative based on exigent circumstances, an insurer shall make a determination and notify the enrollee or the enrollee's designee and the prescribing physician, or other prescriber, as appropriate, of the determination within 24 hours after the insurer receives all information necessary to determine whether the exception should be granted. For purposes

of this subsection, exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a nonformulary drug.

(3) If subsection (2) does not apply, an insurer shall make a determination on coverage for a nonformulary alternative and notify the enrollee or the enrollee's designee and the prescribing physician, or other prescriber, as appropriate, of the determination within 72 hours after the insurer receives all information necessary to determine whether the exception should be granted.

(4) This section is subject to section 3406w.

History: Add. 1999, Act 177, Imd. Eff. Nov. 16, 1999;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2020, Act 322, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.3406p Establishment of program to prevent onset of clinical diabetes required; survey; coverages; "diabetes" defined.

Sec. 3406p. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall establish and provide to insureds, enrollees, and affiliated providers a program to prevent the onset of clinical diabetes. This program for affiliated providers must emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

(2) An insurer that provides a program under subsection (1) shall regularly measure the effectiveness of the program by regularly surveying individuals covered by the health insurance policy.

(3) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall include coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

(c) Syringes.

(d) Insulin pumps and medical supplies required for the use of an insulin pump.

(e) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

(4) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides outpatient pharmaceutical coverage directly or by rider shall include the following coverage for the treatment of diabetes, if determined to be medically necessary:

(a) Insulin, if prescribed by an allopathic or osteopathic physician.

(b) Nonexperimental medication for controlling blood sugar, if prescribed by an allopathic or osteopathic physician.

(c) Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes, if prescribed by an allopathic, osteopathic, or podiatric physician.

(5) Coverage under subsection (3) for diabetes self-management training is subject to all of the following:

(a) The training is limited to completion of a certified diabetes education program if either of the following applies:

(*i*) The training is considered medically necessary upon the diagnosis of diabetes by an allopathic or osteopathic physician who is managing the patient's diabetic condition and is needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.

(*ii*) An allopathic or osteopathic physician has diagnosed a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in the patient's self-management or a significant change in medical protocol or treatment modalities.

(b) The training must be provided by a diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the department of community health. Training provided under this subdivision must be conducted in group settings whenever practicable.

(6) Coverage under this section is not subject to dollar limits, deductibles, or copayment provisions that are greater than those for physical illness generally.

(7) As used in this section, "diabetes" includes all of the following:

(a) Gestational diabetes.

(b) Insulin-dependent diabetes.

(c) Non-insulin-dependent diabetes.

History: Add. 2000, Act 425, Eff. Mar. 28, 2001;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406q Off-label use of approved drug; coverage; conditions; compliance; use of copayment, deductible, sanction, or utilization control; limitation; definitions.

Sec. 3406q. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides pharmaceutical coverage shall provide coverage for an off-label use of a United States Food and Drug Administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

(2) Coverage for a drug under subsection (1) applies if all of the following conditions are met:

(a) The drug is approved by the United States Food and Drug Administration.

(b) The drug is prescribed by an allopathic or osteopathic physician for the treatment of either of the following:

(*i*) A life-threatening condition if the drug is medically necessary to treat the condition and the drug is on the plan formulary or accessible through the insurer's formulary procedures.

(*ii*) A chronic and seriously debilitating condition if the drug is medically necessary to treat the condition and the drug is on the plan formulary or accessible through the insurer's formulary procedures.

(c) The drug has been recognized for treatment for the condition for which it is prescribed by 1 of the following:

(*i*) The American Medical Association drug evaluations.

(*ii*) The American Hospital Formulary Service drug information.

(*iii*) The United States Pharmacopoeia Dispensing Information, Volume 1, "Drug Information for the Health Care Professional".

(*iv*) Two articles from major peer-reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer-reviewed medical journal.

(3) Upon request, the prescribing allopathic or osteopathic physician shall supply to the insurer documentation supporting compliance with subsection (2).

(4) This section does not prohibit the use of a copayment, deductible, sanction, or mechanism for appropriately controlling the utilization of a drug that is prescribed for a use different from the use for which the drug has been approved by the United States Food and Drug Administration. This may include prior approval or a drug utilization review program. Any copayment, deductible, sanction, prior approval, drug utilization review program, or mechanism described in this subsection must not be more restrictive than for prescription coverage generally.

(5) As used in this section:

(a) "Chronic and seriously debilitating" means a disease or condition that requires ongoing treatment to maintain remission or prevent deterioration and that causes significant long-term morbidity.

(b) "Life-threatening" means a disease or condition as to which the likelihood of death is high unless the course of the disease is interrupted or that has a potentially fatal outcome and as to which the end point of clinical intervention is survival.

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the United States Food and Drug Administration.

History: Add. 2002, Act 538, Eff. Jan. 22, 2003;—Am. 2003, Act 88, Eff. Jan. 23, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016
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Popular name: Act 218

500.3406r Coverage for obstetrical and gynecological services by physician or nurse midwife.

Sec. 3406r. (1) As used in this section, "nurse midwife" means an individual licensed as a registered professional nurse under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan board of nursing under section 17210 of the public health code, 1978 PA 368, MCL 333.17210.

(2) An insurer that delivers, issues for delivery, or renews in this state a policy of health insurance that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification or shall do 1 or both of the following:

(a) Offer to provide coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

(b) Offer to provide coverage for maternity services and gynecological services rendered during pre- and

post-natal care whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

History: Add. 2004, Act 375, Imd. Eff. Oct. 11, 2004;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3406s Diagnosis and treatment of autism spectrum disorders; coverage; prohibition; availability of other benefits; conditions; qualified health plan offered through American health benefit exchange pursuant to federal law; short-term or 1-time limited duration policy or certificate; prescription drug plan; coordinated benefits; definitions.

Sec. 3406s. (1) Except as otherwise provided in this section, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders. An insurer shall not do any of the following:

(a) Terminate coverage or refuse to deliver, execute, issue, amend, adjust, or renew coverage solely because an individual is diagnosed with, or has received treatment for, an autism spectrum disorder.

(b) Limit the number of visits an insured or enrollee may use for treatment of autism spectrum disorders covered under this section.

(c) Deny or limit coverage under this section on the basis that treatment is educational or habilitative in nature.

(d) Except as otherwise provided in this subdivision, subject coverage under this section to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally. An insurer may limit coverage under this section for treatment of autism spectrum disorders to an insured or enrollee through 18 years of age and may subject the coverage to a maximum annual benefit as follows:

(*i*) For a covered insured or enrollee through 6 years of age, $50,000.00.

(*ii*) For a covered insured or enrollee from 7 years of age through 12 years of age, $40,000.00.

(*iii*) For a covered insured or enrollee from 13 years of age through 18 years of age, $30,000.00.

(2) This section does not limit benefits that are otherwise available to an insured or enrollee under a policy, contract, or certificate. An insurer shall utilize evidence-based care and managed care cost-containment practices pursuant to the insurer's procedures if the care and practices are consistent with this section. An insurer may subject coverage under this section to other general exclusions and limitations of the policy, contract, or certificate, including, but not limited to, coordination of benefits, affiliated provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

(3) If an insured or enrollee is receiving treatment for an autism spectrum disorder, an insurer may, as a condition to providing the coverage under this section, do all of the following:

(a) Require a review of the treatment consistent with current protocols and may require a treatment plan. If requested by the insurer, the cost of treatment review must be borne by the insurer.

(b) Request the results of the autism diagnostic observation schedule that has been used in the diagnosis of an autism spectrum disorder for the insured or enrollee.

(c) Request that the autism diagnostic observation schedule be performed on the insured or enrollee not more frequently than once every 3 years.

(d) Request that an annual development evaluation be conducted and the results of the annual development evaluation be submitted to the insurer.

(4) A qualified health plan offered through an American health benefit exchange established in this state pursuant to the federal act is not required to provide coverage under this section to the extent that it exceeds coverage that is included in the essential health benefits as required pursuant to the federal act. As used in this subsection, "federal act" means the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(5) This section does not apply to a short-term or 1-time limited duration policy or certificate of no longer than 6 months as described in section 2213b.

(6) This section does not require the coverage of prescription drugs and related services unless the insured or enrollee is covered by a prescription drug plan. This section does not require an insurer to provide coverage for autism spectrum disorders to an insured or enrollee under more than 1 of its health insurance policies. If an insured or enrollee has more than 1 health insurance policy that covers autism spectrum disorders, the benefits provided are subject to the limits of this section when coordinating benefits.

(7) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental

modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism diagnostic observation schedule" means the protocol available through Western Psychological Services for diagnosing and assessing autism spectrum disorders or any other standardized diagnostic measure for autism spectrum disorders that is approved by the director, if the director determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

(c) "Autism spectrum disorders" means any of the following pervasive developmental disorders as defined by the Diagnostic and Statistical Manual:

(*i*) Autistic disorder.

(*ii*) Asperger's disorder.

(*iii*) Pervasive developmental disorder not otherwise specified.

(d) "Behavioral health treatment" means evidence-based counseling and treatment programs, including applied behavior analysis, that meet both of the following requirements:

(*i*) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual.

(*ii*) Are provided or supervised by a board certified behavior analyst or a licensed psychologist if the services performed are commensurate with the psychologist's formal university training and supervised experience.

(e) "Diagnosis of autism spectrum disorders" means assessments, evaluations, or tests, including the autism diagnostic observation schedule, performed by a licensed physician or a licensed psychologist to diagnose whether an individual has 1 of the autism spectrum disorders.

(f) "Diagnostic and Statistical Manual" means the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association or another manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the director, if the director determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the manual published by the American Psychiatric Association on April 18, 2012.

(g) "Pharmacy care" means medications prescribed by a licensed physician and related services performed by a licensed pharmacist and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(h) "Psychiatric care" means evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(i) "Psychological care" means evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(j) "Therapeutic care" means evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

(k) "Treatment of autism spectrum disorders" means evidence-based treatment that includes the following care prescribed or ordered for an individual diagnosed with 1 of the autism spectrum disorders by a licensed physician or a licensed psychologist who determines the care to be medically necessary:

(*i*) Behavioral health treatment.

(*ii*) Pharmacy care.

(*iii*) Psychiatric care.

(*iv*) Psychological care.

(*v*) Therapeutic care.

(*l*) "Treatment plan" means a written, comprehensive, and individualized intervention plan that incorporates specific treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the treatment of an autism spectrum disorder is first prescribed or ordered by a licensed physician or licensed psychologist as described in subdivision (k).

History: Add. 2012, Act 100, Imd. Eff. Apr. 18, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 1 of Act 100 of 2012 provides:

"Enacting section 1. This amendatory act applies to policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 180 days after the date this amendatory act is enacted into law."

Popular name: Act 218

500.3406t Synchronizing insured's or enrollee's multiple maintenance prescription drugs.

Sec. 3406t. (1) An insurer that delivers, issues for delivery, or renews in this state an expense-incurred hospital, medical, or surgical group or individual policy or certificate that provides prescription drug coverage, or a health maintenance organization that offers a group or individual contract that provides prescription drug coverage, shall provide a program for synchronizing multiple maintenance prescription drugs for an insured or enrollee if both of the following are met:

(a) The insured or enrollee, the insured's or enrollee's physician, and a pharmacist agree that synchronizing the insured's or enrollee's multiple maintenance prescription drugs for the treatment of a chronic long-term care condition is in the best interests of the insured or enrollee for the management or treatment of a chronic long-term care condition.

(b) The insured's or enrollee's multiple maintenance prescription drugs meet all of the following requirements:

(*i*) Are covered by the policy, certificate, or contract described in this section.

(*ii*) Are used for the management and treatment of a chronic long-term care condition and have authorized refills that remain available to the insured or enrollee.

(*iii*) Except as otherwise provided in this subparagraph, are not controlled substances included in schedules 2 to 5 under sections 7214, 7216, 7218, and 7220 of the public health code, 1978 PA 368, MCL 333.7214, 333.7216, 333.7218, and 333.7220. This subparagraph does not apply to anti-epileptic prescription drugs.

(*iv*) Meet all prior authorization requirements specific to the maintenance prescription drugs at the time of the request to synchronize the insured's or enrollee's multiple maintenance prescription drugs.

(*v*) Are of a formulation that can be effectively split over required short fill periods to achieve synchronization.

(*vi*) Do not have quantity limits or dose optimization criteria or requirements that will be violated when synchronizing the insured's or enrollee's multiple maintenance prescription drugs.

(2) An insurer or health maintenance organization described in subsection (1) shall apply a prorated daily cost-sharing rate for maintenance prescription drugs that are dispensed by an in-network pharmacy for the purpose of synchronizing the insured's or enrollee's multiple maintenance prescription drugs.

(3) An insurer or health maintenance organization described in subsection (1) shall not reimburse or pay any dispensing fee that is prorated. The insurer or health maintenance organization shall only pay or reimburse a dispensing fee that is based on each maintenance prescription drug dispensed.

History: Add. 2016, Act 38, Imd. Eff. Mar. 15, 2016.

Compiler's note: Enacting section 1 of Act 38 of 2016 provides:

"Enacting section 1. This amendatory act applies to policies, certificates, and contracts delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 365 days after the date this amendatory act is enacted into law."

Popular name: Act 218

500.3406u Coverage for prescription eyedrops; requirements; "prescriber" defined.

Sec. 3406u. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription eyedrops shall not deny coverage for a refill of the prescription if all of the following apply:

(a) For a 30-day supply, the amount of time has passed within which the insured should have used 75% of the dosage units of the drug according to the prescriber's instructions, or 23 days have passed after either of the following:

(*i*) The original date the prescription was distributed to the insured.

(*ii*) The date the most recent refill was distributed to the insured.

(b) The prescriber indicates on the original prescription that additional quantities are needed.

(c) The prescription eye drops prescribed by the prescriber are covered under the health insurance policy.

(2) As used in this section, "prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

History: Add. 2019, Act 139, Imd. Eff. Dec. 5, 2019.

Compiler's note: Enacting section 1 of Act 139 of 2019 provides:

"Enacting section 1. This amendatory act applies to health insurance policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning 90 days after the date this amendatory act is enacted into law."

Ninety days after the enactment date of Act 139 of 2019 is March 4, 2020.

Popular name: Act 218

500.3406v Coverage for emergency supply of insulin.

Sec. 3406v. Beginning on the effective date of the amendatory act that added this section, an insurer that

delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs shall provide coverage for any emergency supply of insulin that is covered under an insured's health insurance policy and that is dispensed to the insured by a pharmacist as provided in section 17744f of the public health code, 1978 PA 368, MCL 333.17744f.

History: Add. 2021, Act 37, Imd. Eff. July 1, 2021.

Popular name: Act 218

500.3406w Temporary emergency and early refills for prescription drugs; inapplicable after March 31, 2021.

Sec. 3406w. (1) Beginning on the effective date of the amendatory act that added this section, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs shall do both of the following:

(a) Provide coverage for an emergency refill of up to a 60-day supply of any covered maintenance prescription drug.

(b) Provide coverage for an early refill of any 30-day or 60-day covered maintenance prescription drug to allow for up to a 90-day supply, without regard to whether the pharmacy is mail order or in person.

(2) This section does not apply after March 31, 2021.

(3) As used in this section:

(a) "Emergency refill" means a refill where, in the pharmacist's professional judgment, failure to refill the prescription may interrupt the patient's ongoing care and have a significant adverse effect on the patient's well-being as provided in section 17713 of the public health code, 1978 PA 368, MCL 333.17713.

(b) "Maintenance prescription drug" means a prescription drug that meets the requirements under section 3406t(1)(b)(*i*) to (*iii*).

History: Add. 2020, Act 322, Imd. Eff. Dec. 29, 2020.

Popular name: Act 218

500.3406x Nonopioid directive form; website.

Sec. 3406x. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall make available to the insurer's insureds a nonopioid directive form on the insurer's internet website. As used in this section, "nonopioid directive form" means that term as defined in section 9145 of the public health code, 1978 PA 368, MCL 333.9145.

History: Add. 2022, Act 43, Imd. Eff. Mar. 23, 2022.

Compiler's note: Enacting section 1 of Act 43 of 2022 provides:

"Enacting section 1. This amendatory act applies to policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, after March 31, 2022."

Popular name: Act 218

500.3406y Nonopioid directive form; enrollment.

Sec. 3406y. An insurer that delivers, issues for delivery, or renews in this state a policy of health insurance shall provide a nonopioid directive form to insureds upon enrollment. As used in this section, "nonopioid directive form" means that term as defined in section 9145 of the public health code, 1978 PA 368, MCL 333.9145.

History: Add. 2022, Act 42, Imd. Eff. Mar. 23, 2022.

Compiler's note: Enacting section 1 of Act 42 of 2022 provides:

"Enacting section 1. This amendatory act applies to policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, after June 30, 2022."

Popular name: Act 218

500.3406z Essential health benefit coverage; annual and lifetime dollar limits; prohibition; applicability to grandfathered health plan coverage.

Sec. 3406z. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not institute either of the following:

(a) Lifetime limits on the dollar value of essential health benefit coverage under section 3406bb(1).

(b) Annual limits on the dollar value of essential health benefit coverage under section 3406bb(1).

(2) This section does not prevent an insurer from placing annual or lifetime dollar limits with respect to any individual on specific covered benefits that are not essential health benefits to the extent that the limits are otherwise permitted under applicable federal or state law.

(3) This section does not apply to grandfathered health plan coverage, as that term is defined in 45 CFR 147.140, or to a short-term or 1-time limited duration policy or certificate of not longer than 6 months.

History: Add. 2023, Act 159, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406z[1] Disability insurance policies; discrimination against living donors; prohibition; definitions.

Sec. 3406z. (1) This section applies to disability insurance policies or certificates delivered or issued for delivery after December 31, 2023.

(2) Unless there is an additional actuarial risk, as determined in accordance with sound actuarial principles as well as the individual's actual and reasonably anticipated experience, an insurer shall not do any of the following with respect to a disability insurance policy or certificate based solely on the individual's status as a living donor:

(a) Deny coverage.

(b) Cancel coverage.

(c) Refuse to issue the policy or certificate.

(d) Determine the price or premium for the policy or certificate.

(e) Otherwise vary a term or condition of the policy or certificate.

(3) As used in this section:

(a) "Living donor" means an individual who is not deceased and has donated any of the following:

(*i*) All or part of an organ.

(*ii*) A tissue.

(b) "Organ" means a human kidney, liver, heart, lung, pancreas, esophagus, stomach, or small or large intestine, a portion of the human gastrointestinal tract, or another part of the human body designated by the department by rule.

(c) "Tissue" means a portion of the human body other than an organ, including, but not limited to, an eye, skin, bone, bone marrow, a heart valve, a spermatozoon, an ova, an artery, a vein, a tendon, a ligament, blood, blood derivatives, a pituitary gland, or fluid.

History: Add. 2023, Act 192, Imd. Eff. Nov. 7, 2023.

Compiler's note: Section 3406z, as added by Act 192 of 2023, was compiled as 500.3406z[1] to distinguish it from another section 3406z, deriving from Act 159 of 2023 and pertaining to a prohibition on lifetime and annual dollar limits.

Popular name: Act 218

500.3406aa Third party access; dental provider network; requirements; exceptions; definitions.

Sec. 3406aa. (1) A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided under a provider network contract, if both of the following requirements are met:

(a) At the time the provider network contract is entered into or renewed, or when there are material modifications to a contract relevant to granting access to a provider network contract to a third party, the contracting entity allows a provider that is part of the carrier's provider network to choose to not participate in third-party access to the provider network contract or to enter into a contract directly with the health insurer that acquired the provider network. If a provider chooses not to participate in third-party access, the contracting entity must not cancel or otherwise end a contractual relationship with the provider. When initially contracting with a provider, a contracting entity must accept a qualified provider if a provider rejects participation in third-party access. This subdivision does not apply to a contracting entity that is not a health insurer or dental carrier. As used in this subdivision, "qualified provider" means a provider who meets the contracting entity's criteria to enter into the provider network.

(b) All of the following are met:

(*i*) The provider network contract specifically states that the contracting entity may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and if the contracting entity is a dental carrier, the provider chose to participate in third-party access at the time the provider network contract was entered into or renewed. If the contracting entity is an insurer, the third-party access provision of a provider network contract must specifically state that the provider network contract grants third-party access to the provider network and, for provider network contracts with dental carriers, that the dentist has the right to choose not to participate in third-party access.

(*ii*) The third party accessing the contract agrees to comply with all of the provider network contract's terms.

(*iii*) The contracting entity identifies, in writing or in electronic form to the provider, all third parties that

would have access to the dental services or contractual discounts of the provider network as of the date the contract is entered into or renewed.

(*iv*) The contracting entity identifies all third parties in existence in a list on its website that is updated at least once every 30 days and displays the date the list was last updated.

(*v*) The contracting entity requires a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken. This subparagraph does not apply to electronic transactions mandated by the health insurance portability and accountability act of 1996, Public Law 104-191.

(*vi*) The contracting entity notifies the third party of the termination of a provider network contract not later than 30 days after the termination date with the contracting entity.

(*vii*) A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract.

(*viii*) The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days after a request from the provider.

(2) A provider is not bound by or required to perform dental treatment or services under a provider network contract that has been granted by a contracting entity to a third party if the contracting entity does not meet the requirements under subsection (1).

(3) This section does not apply if any of the following apply:

(a) Access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity. A list identifying each of the contracting entity's affiliates as affiliates must be made available to a provider on the contracting entity's website.

(b) Access to a provider network contract is granted by a dental carrier that retains the responsibility for administering the dental benefit plan in accordance with its applicable provider network contracts, including all fee schedules and processing policies.

(c) A provider network contract for dental services provided to beneficiaries under health care coverage that is established or maintained by a local, state, or federal government including any of the following:

(*i*) Medicaid established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

(*ii*) The state children's health insurance program established under title XXI of the social security act, 42 USC 1397aa to 1397mm.

(*iii*) Medicare advantage as that term is defined in section 3801.

(4) As used in this section:

(a) "Contracting entity" means a person that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a third-party administrator and a dental carrier.

(b) "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered or issued for delivery by or through a dental carrier on a stand-alone basis.

(c) "Dental carrier" means a nonprofit dental care corporation or other entity authorized to provide dental benefits, or a health benefits plan that includes coverage for dental services.

(d) "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. Dental services does not include services delivered by a provider that are billed as medical expenses under a health benefits plan.

(e) "Dentist" means that term as defined in section 2701 of the public health code, 1978 PA 368, MCL 333.2701.

(f) "Provider" means a person that, acting within the scope of licensure or certification, provides dental services or supplies defined by the health benefits or dental benefit plan. Provider does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

(g) "Provider network contract" means a contract between a contracting entity and a provider that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an enrollee.

(h) "Third party" means a person that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. Third party does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

History: Add. 2023, Act 168, Imd. Eff. Oct. 19, 2023.

Popular name: Act 218

500.3406bb Health insurance policy; minimum required coverage; use of in-network and

out-of-network providers; use of reasonable medical management techniques; applicability to short-term or 1-time limited duration policies; effective date.

Sec. 3406bb. (1) An insurer that delivers, issues for delivery, or renews in the individual or small group market in this state a health insurance policy shall provide coverage for all of the following:

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Pregnancy, maternity, and newborn care.

(e) Mental health and substance use disorder services, including behavioral health treatment.

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

(i) Preventive and wellness services and chronic disease management identified by the director as meeting a requirement under this subdivision. Coverage for an item or service is not required under this subdivision unless the item or service is 1 or more of the following:

(*i*) Evidence-based items or services if the United States Preventive Services Task Force has rated the item or service as "A" or "B" for the purposes of its recommendations currently in effect with respect to the individual involved.

(*ii*) An immunization with routine use in children, adolescents, and adults if the Advisory Committee on Immunization Practices of the United States Centers for Disease Control and Prevention has included the immunization for the purposes of its recommendations with respect to the individual involved.

(*iii*) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings if the United States Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.

(*iv*) With respect to women, preventive care and screenings not described in subparagraph (*i*) if the United States Health Resources and Services Administration has included the care or screening for the purposes of its guidelines.

(j) Pediatric services, including oral and vision care. Pediatric oral care, as required under this subdivision, is not required if an insured has dental insurance from another source and provides evidence of the coverage to the insurer.

(2) Except as otherwise allowed under 45 CFR 147.130 (a)(2)(*i*),(*ii*), and (*iii*), an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not impose any cost-sharing requirements for benefits provided under subsection (1)(i).

(3) Benefits provided under subsection (1) are subject to all requirements applicable to those benefits under this chapter.

(4) This section does not limit the requirements to provide additional benefits under this chapter.

(5) This section does not require an insurer that has a network of providers to provide benefits for items or services described in subsection (1) that are delivered by an out-of-network provider or preclude an insurer that has a network of providers from imposing cost-sharing requirements for items or services described in subsection (1) that are delivered by an out-of-network provider. If an insurer does not have in its network a provider who can provide an item or service described in subsection (1), the insurer must cover the item or service when performed by an out-of-network provider, and may not impose cost sharing with respect to the item or service.

(6) This section does not prevent an insurer from using reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service described in subsection (1) to the extent not specified in the relevant recommendation or guideline. To the extent not specified in a recommendation or guideline, an insurer may rely on the relevant clinical evidence base and established reasonable medical management techniques to determine the frequency, method, treatment, or setting for coverage of a recommended preventive health service.

(7) This section does not require an insurer to cover items of the United States Preventive Services Task Force that have been downgraded to a "D" rating, or any item or service during the plan year that is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service.

(8) This section does not apply to a short-term or 1-time limited duration policy or certificate of not more than 6 months as described in section 2213b, or to a grandfathered plan as that term is defined in 45 CFR 147.140.

(9) Any changes to the items and services required under subsection (1)(i) must take effect for the plan

year that begins on or after the date that is 1 year after the date the recommendation or guideline is issued.

History: Add. 2023, Act 160, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406ee Health insurance policies; individual or small group markets; mandatory levels of coverage; actuarial value; compliance; applicability.

Sec. 3406ee. (1) An insurer that delivers, issues for delivery, or renews in this state in the individual or small group market a health insurance policy shall offer health insurance policies that provide at least 1 of the following levels of coverage:

(a) Coverage designed to provide benefits actuarially equivalent to 60% of the full actuarial value of the benefits provided under the policy.

(b) Coverage designed to provide benefits actuarially equivalent to 70% of the full actuarial value of the benefits provided under the policy.

(c) Coverage designed to provide benefits actuarially equivalent to 80% of the full actuarial value of the benefits provided under the policy.

(d) Coverage designed to provide benefits actuarially equivalent to 90% of the full actuarial value of the benefits provided under the policy.

(2) For plan years beginning after the effective date of the amendatory act that added this section, the allowable variation in the actuarial value of a health insurance policy that does not result in a material difference in the true dollar value of the health insurance policy is the de minimis variation as described in 45 CFR 156.140.

(3) For purposes of determining compliance with subsections (1) to (2), an insurer described in subsection (1) must use the actuarial calculator developed and made available by the federal department of health and human services for the applicable plan year. Subject to subsection (4), if the federal department of health and human services has not developed and made available the calculator, an insurer described in subsection (1) may use the most recently issued calculator. If a health insurance policy's design is not compatible with the calculator, the insurer must submit an actuarial certification from an actuary, who is a member of the American Academy of Actuaries, using 1 of the following methodologies:

(a) Calculate the health insurance policy's actuarial value by:

(*i*) Estimating a fit of its plan design into the parameters of the calculator.

(*ii*) Having the actuary certify that the plan design fits appropriately in accordance with generally accepted actuarial principles and methodologies.

(b) Use the calculator to determine the actuarial value for the health insurance policy provisions that fit within the calculator parameters and have the actuary calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the actuarial value identified by the calculator, for plan design features that deviate substantially from the parameters of the calculator.

(4) The calculation methods described in subsection (3) may include only in-network cost-sharing, including multitier networks.

(5) This section does not apply to a short-term or 1-time limited duration policy or certificate of not longer than 6 months as described in section 2213b, a grandfathered plan as that term is defined in 45 CFR 147.140, or a catastrophic plan as described in 45 CFR 156.155.

History: Add. 2023, Act 163, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406ff Financial parity for orally administered, intravenously administered and injected antineoplastic (anticancer) medications.

Sec. 3406ff. (1) A health insurance policy delivered, issued for delivery, or renewed in this state that provides coverage for prescribed orally administered antineoplastic medications and intravenously administered or injected antineoplastic medications must ensure either of the following:

(a) That financial requirements applicable to prescribed orally administered antineoplastic medications are not more restrictive than the financial requirements that apply to intravenously administered or injected antineoplastic medications that are covered by the health insurance policy.

(b) That the co-pay or coinsurance for orally administered antineoplastic medication does not exceed $250.00 per 30-day supply. Beginning January 1, 2026, and each January 1 after that date, the department shall adjust the financial requirement described in this subdivision by an amount determined by the state treasurer that reflects the cumulative annual change in the prescription drug index of the medical care component of the United States Consumer Price Index.

(2) An insurer cannot achieve compliance with this section by increasing cost-sharing requirements,

reclassifying benefits with respect to antineoplastic medications, or imposing more restrictive treatment limitations on prescribed orally administered antineoplastic medications or intravenously administered or injected antineoplastic medications covered under a health insurance policy described in subsection (1).

(3) This section does not prohibit an insurer from applying utilization management techniques, including prior authorization, step therapy, limits on quantity dispensed, and days' supply per fill for any administered antineoplastic medication.

(4) As used in this section:

(a) "Antineoplastic medication" means a medication used to kill, slow, or prevent the growth of cancerous cells.

(b) "Cost-sharing requirement" means deductibles, copayments, coinsurance, out-of-pocket expenses, aggregate lifetime limits, and annual limits.

(c) "Treatment limitation" means limits on the frequency of treatment, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitation does not include the application of utilization management techniques described in subsection (3).

History: Add. 2023, Act 170, Eff. Feb. 13, 2024.

Compiler's note: Enacting section 1 of Act 170 of 2023 provides:

"Enacting section 1. This amendatory act applies to health insurance policies delivered, issued for delivery, or renewed in this state after December 31, 2025."

Popular name: Act 218

500.3406hh Coverage for mental health and substance use disorder services.

Sec. 3406hh. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for mental health and substance use disorder services. All of the following apply to the coverage required under this subsection:

(a) Any financial requirements or quantitative treatment limitations applicable to mental health and substance use disorder benefits in any classification must be no more restrictive than the predominant financial requirements or quantitative treatment limitations applied to substantially all benefits provided for medical/surgical benefits in the same classification and there must be no separate cumulative financial requirements that are applicable only with respect to mental health or substance use disorder benefits.

(b) Except as otherwise provided in subsections (3) and (4), nonquantitative treatment limitations may be imposed on mental health or substance use disorder benefits in any classification only if the processes, strategies, evidentiary standards, or other factors used in developing and applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the same classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in developing and applying the limitation with respect to medical/surgical benefits in the same classification.

(c) The insurer may divide its benefits furnished on an outpatient basis into the following subclassifications:

(*i*) Office visits, such as physician visits.

(*ii*) Any other outpatient benefit, such as outpatient surgery, facility charges for day treatment centers, laboratory charges, and other medical items.

(2) Benefits provided under subsection (1) must meet all applicable federal parity requirements, including, but not limited to, 42 USC 300gg-26 and the regulations promulgated under that section. An insurer that meets the federal parity requirements described in this subsection is considered to meet the requirements under subsection (1) if the federal parity requirements are not less stringent than the requirements under subsection (1).

(3) If a health insurance policy provides benefits through multiple tiers of in-network providers, including an in-network tier of preferred providers with more generous cost-sharing to participants than a separate in-network tier of participating providers, the health plan may divide its benefits provided on an in-network basis into subclassifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the requirements for nonquantitative treatment limits and without regard to whether a provider provides services with respect to medical and surgical benefits or mental health or substance use disorder benefits. After the subclassifications are established, the health insurance policy must not impose any financial requirement or treatment limitation on mental health or substance use disorder benefits in any subclassification that is more restrictive than the predominant financial requirement or treatment limit that applies to substantially all medical and surgical benefits in the subclassification.

(4) If a health insurance policy applies different levels of financial requirements to different tiers of prescription drug benefits that are based on reasonable factors determined in accordance with the

requirements for nonquantitative treatment limits and without regard to whether a drug is generally prescribed with respect to medical and surgical benefits or with respect to mental health or substance use disorder benefits, the health plan satisfies the parity requirements of this section with respect to prescription drug benefits. As used in this subsection, "reasonable factors" include cost, efficacy, generic versus brand name drugs, and mail order versus pharmacy pick-up.

(5) As used in this section:

(a) "Classification" means any 1 of the following:

(*i*) Inpatient in-network.

(*ii*) Inpatient out-of-network.

(*iii*) Outpatient in-network.

(*iv*) Outpatient out-of-network.

(*v*) Emergency services.

(*vi*) Prescription drugs.

(b) "Financial requirements" means deductibles, copayments, coinsurance, and out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

(c) "Nonquantitative treatment limitations" means those limitations that are not expressed numerically but otherwise limit the scope or duration of benefits for treatment under a health insurance policy or coverage and includes, but is not limited to, the limitations described under 45 CFR 146.136. Nonquantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

(d) "Predominant" means that term as defined in 45 CFR 146.136.

(e) "Quantitative treatment limitations" includes limitations that are expressed numerically, such as limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment, and includes, but is not limited to, the limitations described under 45 CFR 146.136. Quantitative treatment limitations do not include a complete exclusion of all benefits for a certain condition or disorder.

(f) "Substantially all" means that term as defined in 45 CFR 146.136.

History: Add. 2024, Act 41, Eff. Apr. 2, 2025.

Popular name: Act 218

500.3406ii Prohibition on the limitation or exclusion of benefits based on preexisting condition; exceptions.

Sec. 3406ii. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not limit or exclude coverage for an individual by imposing a preexisting condition exclusion on the individual.

(2) This section does not apply to any of the following:

(a) Grandfathered health plan coverage, as that term is defined in 45 CFR 147.140.

(b) Insurance coverage that provides benefits for any of the following:

(*i*) Hospital confinement indemnity.

(*ii*) Disability income.

(*iii*) Accident only.

(*iv*) Long-term care.

(*v*) Medicare supplemental.

(*vi*) Limited benefit health.

(*vii*) Specified disease indemnity.

(*viii*) Sickness or bodily injury, or death by accident, or both.

(*ix*) Retiree-only health insurance coverage.

(*x*) Stand-alone dental plans.

(*xi*) Stand-alone vision plans.

(*xii*) Other limited benefit policies.

(3) As used in this section, "preexisting condition exclusion" means a limitation or exclusion of benefits or a denial of coverage based on the fact that a physical or mental condition was present before the effective date of coverage or before the date coverage is denied, whether or not any medical advice, diagnosis, care, or treatment was recommended or received for the condition before the date of coverage or denial of coverage.

History: Add. 2023, Act 157, Eff. Feb. 13, 2024.

Popular name: Act 218

500.3406jj Medical loss ratio rebates; applicability.

Sec. 3406jj. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance

policy shall issue rebates to its insured in accordance with 42 USC 300gg-18 and the regulations promulgated under that section of law if the insurer does not meet the medical loss ratio as required by the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, and the regulations promulgated under that section. An insurer described in this subsection that complies with the applicable federal medical loss ratio calculation and provision of rebates requirements is considered to meet the requirements under this section. An insurer described in this subsection that reports its medical loss ratio calculation and other rebate information to the United States Department of Health and Human Services shall concurrently file that information with the department.

(2) This section does not apply to a health insurance policy that is not required to issue rebates under the patient protection and affordable care act, Public Law 111-148, as amended by the health care and education reconciliation act of 2010, Public Law 111-152, including plans that cover retirees as described in 29 USC 1191a(a).

(3) This section does not apply to grandfathered health plan coverage as that term is defined in 45 CFR 147.140.

History: Add. 2024, Act 254, Eff. Apr. 2, 2025.

Popular name: Act 218

500.3406jj[1] Prohibition on discrimination against health professionals.

Sec. 3406jj. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not discriminate with respect to participation under the health insurance policy against a health professional who is acting within the scope of the health professional's license granted under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

(2) This section does not require that an insurer described in subsection (1) contract with any health professional willing to abide by the terms and conditions for participation established by the insurer.

(3) This section does not prevent an insurer described in subsection (1) from establishing varying reimbursement rates based on quality or performance measures.

(4) As used in this section:

(a) "Discriminate" means that term as described in 42 USC 300gg-5 and the regulations promulgated under that section.

(b) "Health professional" means an individual who is 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.

History: Add. 2024, Act 255, Eff. Apr. 2, 2025.

Compiler's note: Section 3406jj, as added by Act 255 of 2024, was compiled as 500.3406jj[1] to distinguish it from another section 3406jj, deriving from Act 254 of 2024 and pertaining to medical loss ratio rebates.

Popular name: Act 218

500.3406kk Coverage for blood pressure monitors.

Sec. 3406kk. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall cover a blood pressure monitor for a pregnant or postpartum insured subject to applicable cost-sharing including deductible, co-insurance, or co-pay provisions.

History: Add. 2024, Act 245, Eff. Apr. 2, 2025.

Popular name: Act 218

500.3406oo Coverage for mental health screenings during postpartum period.

Sec. 3406oo. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for mental health screenings during the postpartum period as described in section 9137 of the public health code, 1978 PA 368, MCL 333.9137.

History: Add. 2024, Act 247, Eff. Apr. 2, 2025.

Popular name: Act 218

500.3406tt Coverage for certain hormonal contraceptives.

Sec. 3406tt. In addition to any coverage requirements under state or federal law, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides coverage for prescription drugs shall provide coverage for a hormonal contraception patch, self-administered hormonal contraception, or vaginal ring hormonal contraceptive that is covered under an insured health insurance policy and that is prescribed and dispensed by a pharmacist as provided in section 17744g of the public health code, 1978 PA

368, MCL 333.17744g, at a pharmacy in the insurer's network. An insurer described in this section shall also provide coverage for consultation. Coverage required under this section must be consistent with coverage of other prescription drugs under the insured's health insurance policy.

History: Add. 2024, Act 241, Eff. Apr. 2, 2025.

Compiler's note: Enacting section 1 of Act 241 of 2024 provides:

"Enacting section 1. This amendatory act applies to health insurance policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, after December 31, 2025."

Popular name: Act 218

500.3407 Entire contract; changes.

Sec. 3407. Except as otherwise provided in this act, an insurer shall include the following provision in a disability insurance policy:

ENTIRE CONTRACT; CHANGES: This policy, including the applicable riders and endorsements; the application for coverage if specified by the insurer; the identification card if specified by the insurer; and the attached papers, if any, constitutes the entire contract of insurance. No change in this policy is valid until approved by an executive officer of the insurer and unless the approval is endorsed on this policy or attached to this policy. An insurance producer does not have authority to change this policy or to waive any of its provisions.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3407a Conduct on behalf of or information provided to insured by health care provider; prohibition or discouragement by disability insurer.

Sec. 3407a. A disability insurer shall not prohibit or discourage a health care provider from advocating on behalf of an insured for appropriate medical treatment options pursuant to the grievance procedure in section 2213 or from discussing with an insured or provider any of the following:

(a) Health care treatments and services.

(b) Quality assurance plans required by law, if applicable.

(c) The financial relationships between the insurer and the health care provider including all of the following as applicable:

(*i*) Whether a fee-for-service arrangement exists, under which the provider is paid a specified amount for each covered service rendered to the participant.

(*ii*) Whether a capitation arrangement exists, under which a fixed amount is paid to the provider for all covered services that are or may be rendered to each covered individual or family.

(*iii*) Whether payments to providers are made based on standards relating to cost, quality, or patient satisfaction.

History: Add. 1997, Act 66, Imd. Eff. July 15, 1997.

Popular name: Act 218

500.3407b Undergoing genetic testing as condition of issuing, renewing, or continuing policy; disclosure of genetic testing or genetic information; definitions.

Sec. 3407b. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not require an insured or his or her dependent or an asymptomatic applicant for insurance or his or her asymptomatic dependent to do either of the following:

(a) Undergo genetic testing before issuing, renewing, or continuing the policy in this state.

(b) Disclose whether genetic testing has been conducted or the results of genetic testing or genetic information.

(2) As used in this section:

(a) "Clinical purposes" includes all of the following:

(*i*) Predicting risk of diseases.

(*ii*) Identifying carriers for single-gene disorders.

(*iii*) Establishing prenatal and clinical diagnosis or prognosis.

(*iv*) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.

(*v*) Testing for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.

(*vi*) Other testing if the intended purpose is diagnosis of a presymptomatic genetic condition.

(b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

(c) "Genetic test" means the analysis of human DNA, RNA, chromosomes, and those proteins and metabolites used to detect heritable or somatic disease-related genotypes or karyotypes for clinical purposes. A genetic test must be generally accepted in the scientific and medical communities as being specifically determinative for the presence, absence, or mutation of a gene or chromosome to qualify under this definition. Genetic test does not include a routine physical examination or a routine analysis, including, but not limited to, a chemical analysis, of body fluids, unless conducted specifically to determine the presence, absence, or mutation of a gene or chromosome.

(d) After December 31, 2017, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: Add. 2000, Act 27, Imd. Eff. Mar. 15, 2000;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2017, Act 223, Imd. Eff. Dec. 20, 2017.

Popular name: Act 218

500.3408 Time limit on certain defenses; incontestable policy.

Sec. 3408. (1) An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision that consists of both of the following:

(a) One of the following, as applicable:

(*i*) **TIME LIMIT ON CERTAIN DEFENSES:** After 3 years from the date of issue of this policy, the insurer will not use a misstatement, except a fraudulent misstatement, made by the applicant in the application for the policy to void the policy or to deny a claim for loss incurred or disability, as defined in the policy, beginning after the expiration of the 3-year period. This policy provision does not affect a legal requirement for avoidance of a policy or denial of a claim during the initial 3-year period, and does not limit the application of sections 3432, 3434, 3436, 3438, and 3440 if a misstatement with respect to age or occupation or other insurance is made.

(*ii*) Instead of the provision required under subparagraph (*i*), for a policy that the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, for a policy issued after age 44, for at least 5 years after its date of issue, an insurer may include the following in the policy, under the caption **"INCONTESTABLE":**

After this policy has been in force for a period of 3 years during the lifetime of the insured (excluding any period during which the insured is disabled), it becomes incontestable as to the statements contained in the application.

(b) A claim for a loss incurred or disability, as defined in the policy, beginning after 3 years from the date of issue of this policy will not be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss existed before the effective date of coverage of this policy.

(2) For the purpose of permitting insurers to use a uniform policy in several states, the insurer may print in the policy form in the provisions required under subsection (1)(a) and (b) the term of "3 years". Notwithstanding any provision of the contract or law to the contrary, the time limits for the defenses described in this section and included in a disability insurance policy, not including a health insurance policy, that is delivered or issued for delivery in this state must not exceed 2 years.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3409 Disability insurance policy; mandatory notices as to cancellation and refund of premium.

Sec. 3409. (1) Except as otherwise provided in this section, an insurer that delivers, issues for delivery, or renews in this state a disability insurance policy, other than a policy that provides group or blanket insurance, shall include the following notice, in substance printed or stamped on the front page and made a permanent part of the policy:

Cancellation during first 10 days: During a period of 10 days after the date the policyholder receives this policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to this notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it is void from the beginning and the parties are in the same position as if no policy or contract had been issued.

Cancellation after 10 days: A policyholder may cancel this policy after the first 10 days after receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in

the notice. If this policy is canceled under this paragraph, the insurer will promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation under this paragraph is without prejudice to any claim originating before the effective date of cancellation.

(2) An insurer that sells a disability insurance policy through solicitation to a person who is eligible for Medicare shall include the following notice, in substance printed or stamped on the front page and made a permanent part of the policy:

Cancellation during the first 30 days: During a period of 30 days after the date the policyholder receives this policy, the policyholder may cancel the policy and receive from the insurer a prompt refund of any premium paid for the policy, including a policy fee or other charge, by mailing or otherwise surrendering the policy to the insurer together with a written request for cancellation. If a policyholder or purchaser pursuant to this notice returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it is void from the beginning and the parties are in the same position as if no policy or contract had been issued.

Cancellation after 30 days: A policyholder may cancel this policy after the first 30 days after receipt of the policy by giving written notice to the insurer effective upon receipt or on a later date as may be specified in the notice. If this policy is canceled under this paragraph, the insurer will promptly refund to the policyholder the excess of paid premium above the pro rata premium for the expired time. Cancellation under this paragraph is without prejudice to any claim originating before the effective date of cancellation.

(3) If a policyholder cancels a disability insurance policy during the first 30 days after receipt of the policy, the policyholder is responsible for claims paid by the insurer that were incurred before the effective date of cancellation.

History: Add. 1978, Act 144, Eff. Aug. 10, 1978;—Am. 1980, Act 329, Imd. Eff. Dec. 19, 1980;—Am. 1990, Act 170, Imd. Eff. July 2, 1990;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3410 Grace period; provision required.

Sec. 3410. There shall be a provision as follows:

GRACE PERIOD: A grace period of ..... (insert a number not less than "7" for weekly premium policies, "10" for monthly premium policies and "31" for all other policies) days will be granted for the payment of each premium falling due after the first premium, during which grace period the policy shall continue in force.

(A policy which contains a cancellation provision may add, at the end of the above provision, "subject to the right of the insurer to cancel in accordance with the cancellation provision hereof." A policy in which the insurer reserves the right to refuse any renewal shall have, at the beginning of the above provision, "unless not less than 5 days prior to the premium due date the insurer has delivered to the insured or has mailed to his last address as shown by the records of the insurer written notice of its intention not to renew this policy beyond the period for which the premium has been accepted,").

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3411 Reinstatement; provision required.

Sec. 3411. (1) Subject to subsection (2), an insurer shall include the following provision in a disability insurance policy other than a health insurance policy:

REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by an agent duly authorized by the insurer to accept the premium, without requiring in connection with the acceptance of the premium an application for reinstatement, is a reinstatement of the policy. However, if the insurer or its agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy is reinstated upon approval of the application by the insurer or, if not approved by the insurer, on the forty-fifth day after the date of the conditional receipt unless the insurer has previously notified the insured in writing of its disapproval of the application. Under the reinstated policy, the insurer will cover only loss resulting from accidental injury that is sustained after the date of reinstatement and loss due to sickness that begins more than 10 days after that date. In all other respects, the insured and insurer have the same rights under the policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on the policy or attached to the policy in connection with the reinstatement. The insurer will apply any premium accepted in connection with a reinstatement to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

(2) An insurer may omit the last sentence of the provision required under subsection (1) from a policy that

the insured has the right to continue in force subject to its terms by the timely payment of premium until at least age 50 or, for a policy issued after age 44, for at least 5 years after its date of issue.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3412 Notice of claim; provision required.

Sec. 3412. (1) Except as otherwise provided in subsection (2), an insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

NOTICE OF CLAIM: Written notice of claim must be given to the insurer within 20 days after the occurrence or commencement of a loss covered by the policy, or as soon after the loss as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary to the insurer at ..... (insert the location of the office the insurer designates for this purpose), or to any authorized agent of the insurer, with information sufficient to identify the insured, is considered notice to the insurer.

(2) For a policy that provides a loss-of-time benefit payable for at least 2 years, an insurer may at its option insert the following between the first and second sentences of the provision required under subsection (1):

Subject to the qualifications set forth below, if the insured suffers loss of time on account of disability for which indemnity is payable for at least 2 years, the insured will, at least once in every 6 months after having given notice of claim, give to the insurer notice of continuance of the disability, unless the insured is legally incapacitated. The period of 6 months following any filing of proof by the insured or any payment by the insurer on account of the claim or any denial of liability in whole or in part by the insurer is excluded in applying this provision. Delay in giving the notice required under this provision does not impair the insured's right to any indemnity that would otherwise have accrued during the 6 months preceding the date on which the notice is actually given.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3413 Claim forms; provision required.

Sec. 3413. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

CLAIM FORMS: The insurer, upon receipt of a notice of claim, will furnish to the claimant the forms that are usually furnished for filing proofs of loss. If the forms are not furnished within 15 days after the giving of the notice, the claimant is considered to have complied with the requirements of this policy as to proof of loss upon submitting, within the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3414 Proofs of loss; provision required.

Sec. 3414. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its designated office. Proof of loss for a claim for loss for which this policy provides any periodic payment that is contingent upon continuing loss must be furnished within 90 days after the termination of the period for which the insurer is liable. Proof of loss for a claim for any other loss must be furnished within 90 days after the date of the loss. Failure to furnish the proof within the time required under this provision does not invalidate or reduce the claim if it was not reasonably possible to give proof within the time required if the proof is furnished as soon as reasonably possible and, unless the claimant is legally incapacitated, not later than 1 year after the time proof is otherwise required.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3416 Time of payment of claims; provision required.

Sec. 3416. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

TIME OF PAYMENT OF CLAIMS: Indemnities payable under this policy for a loss other than loss for which this policy provides a periodic payment will be paid immediately upon receipt of due written proof of the loss. Subject to due written proof of loss, all accrued indemnities for loss for which this policy provides

periodic payment will be paid ..... (insert period for payment that must not be less frequently than monthly) and any balance remaining unpaid on the termination of liability will be paid immediately upon receipt of due written proof.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3418 Payment of claims; provision required.

Sec. 3418. (1) Except as otherwise provided in subsection (2), an insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

PAYMENT OF CLAIMS: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting the payment, which may be prescribed in this policy, and effective at the time of payment. If a designation or provision is not in effect, the indemnity is payable to the estate of the insured. Other accrued indemnities unpaid at the insured's death may, at the option of the insurer, be paid either to the beneficiary or to the estate. All other indemnities are payable to the insured.

(2) One or more of the following provisions may be included with the provision required under subsection (1) at the option of the insurer:

(a) If indemnity under this policy is payable to the estate of the insured, or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay the indemnity, up to an amount that does not exceed $..... (insert an amount that does not exceed $1,000.00), to any relative by blood or connection by marriage of the insured or beneficiary who is determined by the insurer to be equitably entitled to the indemnity. Payment made by the insurer in good faith pursuant to this provision fully discharges the insurer to the extent of the payment.

(b) Subject to any written direction of the insured in the application or otherwise, all or a portion of any indemnities provided by this policy on account of health care services may, at the insurer's option and unless the insured requests otherwise in writing not later than the time of filing proofs of the loss, be paid directly to the hospital or person rendering the health care services.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3420 Physical examinations and autopsy; provision required.

Sec. 3420. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

PHYSICAL EXAMINATIONS AND AUTOPSY: The insurer at its own expense has the right and must be given the opportunity to examine the insured at reasonable times and as frequently as reasonably required during the pendency of a claim under this policy and to make an autopsy in case of death if not forbidden by law.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3422 Legal actions; provision required.

Sec. 3422. An insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

LEGAL ACTIONS: An insured must not bring an action at law or in equity to recover on this policy before the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of this policy. An insured must not bring an action at law or in equity after the expiration of 3 years after the time written proof of loss is required to be furnished.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3424 Change of beneficiary; provision required.

Sec. 3424. (1) Except as otherwise provided in subsection (2), an insurer shall include in a disability insurance policy, other than a health insurance policy, a provision as follows:

CHANGE OF BENEFICIARY: Unless the insured makes an irrevocable designation of beneficiary, the insured has the right to change the beneficiary under this policy. Consent of a beneficiary is not required to surrender this policy, for the assignment of the policy, to change a beneficiary, or to make any other changes in the policy.

(2) The first clause of the provision required under subsection (1), relating to the irrevocable designation of

beneficiary, may be omitted at the insurer's option.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3425 Health insurance policy; coverage for intermediate and outpatient care for substance use disorder required; charges, terms, and conditions; reduction of coverage; deductibles and copayment provisions; definitions.

Sec. 3425. (1) Except as otherwise provided in this subsection, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide coverage for intermediate and outpatient care for substance use disorder. This section does not apply to limited classification policies.

(2) Charges, terms, and conditions for the coverage required to be provided under subsection (1) must not be less favorable than the maximum prescribed for any other comparable service.

(3) The insurer shall not reduce the coverage required to be provided under subsection (1) by terms or conditions that apply to other items of coverage in a health insurance policy, group or individual. This subsection does not prohibit an insurer from providing in a health insurance policy deductibles and copayment provisions for coverage for intermediate and outpatient care for substance use disorder.

(4) As used in this section:

(a) "Intermediate care" means the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan.

(b) "Limited classification policy" means an accident only policy, a limited accident policy, a travel accident policy, or a specified disease policy.

(c) "Outpatient care" means the use, on both a scheduled and a nonscheduled basis, of any or all of the following therapeutic techniques, as identified in a treatment plan for individuals physiologically or psychologically dependent on or abusing alcohol or drugs:

(*i*) Chemotherapy.

(*ii*) Counseling.

(*iii*) Detoxification services.

(*iv*) Other ancillary services, such as medical testing, diagnostic evaluation, and referral to other services identified in the treatment plan.

(d) "Substance use disorder" means that term as defined in section 100d of the mental health code, 1974 PA 258, MCL 330.1100d.

History: Add. 1980, Act 429, Eff. Jan. 1, 1982;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3426 Offer of wellness coverage by insurer.

Sec. 3426. (1) An insurer that delivers, issues for delivery, or renews in this state a group health insurance policy may offer group wellness coverage. An insurer may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the insureds' or enrollees' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the insurer. Any rebate of premium provided by the insurer is presumed to be appropriate unless credible data demonstrate otherwise, but must not exceed 50% of paid premiums for tobacco cessation programs or 30% of paid premiums for other wellness programs, unless otherwise approved by the director. An insurer shall make available to employers all wellness coverage plans that the insurer markets to employers in this state.

(2) An insurer that delivers, issues for delivery, or renews in this state an individual or family health insurance policy may offer individual and family wellness coverage. An insurer may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the insurer. The insured or enrollee shall provide evidence of

demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the insured and the insurer. Any rebate of premium provided by the insurer is presumed to be appropriate unless credible data demonstrate otherwise, but must not exceed 50% of paid premiums, unless otherwise approved by the director. An insurer shall make available to individuals and families all wellness coverage plans that the insurer markets to individuals and families in this state.

(3) An insurer is not required to continue any health behavior wellness, maintenance, or improvement program or to continue any incentive associated with a health behavior wellness, maintenance, or improvement program.

(4) A health behavior wellness, maintenance, or improvement program under this section may include other requirements in addition to those that are specific to health behavior wellness, maintenance, or improvement, if the program, taken as a whole, meets the intent of this section.

History: Add. 2006, Act 412, Eff. Mar. 30, 2007;—Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Enacting section 2 of Act 412 of 2006 provides:

"Enacting section 2. It is only the intent of this amendatory act to promote the availability of health behavior wellness, maintenance, and improvement programs."

Popular name: Act 218

500.3428 Provider network.

Sec. 3428. An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall establish and maintain a provider network that, at a minimum, satisfies any network adequacy requirements imposed by the director under federal law.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3430 Optional policy provisions; insurance commissioner's approval.

Sec. 3430. Except as provided in subsection (2) of section 3406 (inapplicable or inconsistent provisions), no such policy delivered or issued for delivery to any person in this state shall contain provisions respecting the matters set forth in sections 3432 through 3454 unless such provisions are in the words in which the same appear in such sections: Provided, however, That the insurer may, at its option, use in lieu of any such provision a corresponding provision of different wording approved by the commissioner which is not less favorable in any respect to the insured or the beneficiary. Any such provision contained in the policy shall be preceded individually by the appropriate caption appearing in the pertinent section or, at the option of the insurer, by such appropriate individual or group captions or subcaptions as the commissioner may approve.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3432 Change of occupation; optional provision.

Sec. 3432. An insurer may include in a disability insurance policy, other than a health insurance policy, a provision as follows:

CHANGE OF OCCUPATION: If the insured is injured or contracts an illness after changing his or her occupation to 1 classified by the insurer as more hazardous than the occupation stated in this policy or while doing for compensation anything pertaining to an occupation classified as more hazardous, the insurer will pay only the portion of the indemnities provided in this policy that the premium paid would have purchased at the rates and within the limits fixed by the insurer for the more hazardous occupation. If the insured changes his or her occupation to 1 classified by the insurer as less hazardous than that stated in this policy, the insurer, upon receipt of proof of the change of occupation, will reduce the premium rate accordingly, and will return the excess pro rata unearned premium from the date of change of occupation or from the policy anniversary date immediately preceding receipt of the proof, whichever is the more recent. In applying this provision, the classification of occupational risk and the premium rates must be those that were last filed by the insurer before the occurrence of the loss for which the insurer is liable or before the date of proof of change in the occupation with the state official that supervises insurance in the state where the insured resided at the time this policy was issued. However, if that filing was not required in that state, the classification of occupational risk and the premium rates must be those last made effective by the insurer in that state before the occurrence of the loss or before the date of proof of change in the occupation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3434 Misstatement of age; optional provision.

Sec. 3434. There may be a provision as follows:

MISSTATEMENT OF AGE: If the age of the insured has been misstated, all amounts payable under this policy shall be such as the premium paid would have purchased at the correct age.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3436 Other insurance with same insurer; optional provision.

Sec. 3436. There may be a provision as follows:

OTHER INSURANCE IN THIS INSURER: If an accident or sickness or accident and sickness policy or policies previously issued by the insurer to the insured be in force concurrently herewith, making the aggregate indemnity for ..... (insert type of coverage or coverages) in excess of $..... (insert maximum limit of indemnity or indemnities), the excess insurance shall be void and all premiums paid for such excess shall be returned to the insured or to his estate.

Or, in lieu thereof:

Insurance effective at any one time on the insured under a like policy or policies in this insurer is limited to the one such policy elected by the insured, his beneficiary or his estate, as the case may be, and the insurer will return all premiums paid for all other such policies.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3438 Insurance with other insurers; optional provision; expense incurred benefits.

Sec. 3438. (1) An insurer may include in an individual disability insurance policy a provision as follows:

INSURANCE WITH OTHER INSURERS: If this insurer has not been given written notice before the occurrence or commencement of loss that the insured under this policy has other valid coverage, not with this insurer, and that other valid coverage provides benefits for the same loss on a provision of service basis or on an expense incurred basis, the only liability under any expense incurred coverage of this policy is for the proportion of the loss as the amount that would otherwise have been payable under this policy plus the total of the like amounts under all other valid coverages for the loss of which this insurer had notice bears to the total like amounts under all valid coverages for the loss, and for the return of the portion of the premium paid that exceeds the pro rata portion for the amount so determined. For the purpose of applying this provision when other coverage is on a provision of service basis, the term "like amount" means with respect to the other coverage the amount that the services rendered would have cost in the absence of the coverage.

(2) If the policy provision described in subsection (1) is included in an individual policy of disability insurance that also contains the policy provision described in section 3440, the insurer shall add to the caption of the policy provision the phrase **"—EXPENSE INCURRED BENEFITS"**. The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director, which definition must be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, to coverage provided by hospital or medical service organizations, and to any other coverage the inclusion of which may be approved by the director. In the absence of a definition, the term must not include group insurance, automobile medical payments insurance, or coverage provided by hospital or medical service organizations, by union welfare plans, or by employer or employee benefit organizations.

(3) For the purpose of applying the policy provision under this section to any insured, any amount of benefit provided for the insured under a compulsory benefit statute, including a worker's disability compensation or employer's liability statute, whether provided by a governmental agency or other entity, must in all cases be considered to be other valid coverage of which the insurer has had notice. In applying the policy provision under this section, an insurer shall not include third party liability coverage as other valid coverage.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3439 Repealed. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: The repealed section pertained to provisions concerning insurance with other insurers.

Popular name: Act 218

500.3440 Insurance with other insurers; other benefits.

Sec. 3440. (1) An insurer may include in an individual disability insurance policy a provision as follows:

INSURANCE WITH OTHER INSURERS: If this insurer has not been given written notice before the occurrence or commencement of loss that the insured under this policy has other valid coverage, not with this insurer, and that other valid coverage provides benefits for the same loss on other than an expense incurred basis, the only liability for the benefits under this policy is for the proportion of the indemnities otherwise provided under this policy for the loss as the like indemnities of which the insurer had notice, including the indemnities under this policy, bear to the total amount of all like indemnities for the loss, and for the return of the portion of the premium paid that exceeds the pro rata portion for the indemnities determined under this provision.

(2) If the policy provision described in subsection (1) is included in an individual policy of disability insurance that also contains the policy provision described in section 3438, the insurer shall add to the caption of the policy provision the phrase **"—OTHER BENEFITS"**. The insurer may, at its option, include in this provision a definition of "other valid coverage", approved as to form by the director, which definition must be limited in subject matter to coverage provided by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, and to any other coverage the inclusion of which is approved by the director. In the absence of a definition, the term must not include group insurance or benefits provided by union welfare plans or by employer or employee benefit organizations. For the purpose of applying the policy provision with respect to any insured, any amount of benefit provided for the insured under any compulsory benefit statute, including worker's disability compensation or employer's liability statute, whether provided by a governmental agency or other entity, must in all cases be considered to be "other valid coverage" of which the insurer has had notice, unless the policy contains provisions for the reduction of benefits otherwise payable under the policy by the amount of income from other sources that the insured or the insured's dependents are qualified to receive because of the insured's age or disability from worker's disability compensation or federal social security, if at the time the policy was issued, the premium had been appropriately reduced to reflect the anticipated reduction in benefits. In applying the policy provision, an insurer shall not include third party liability coverage as other valid coverage.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 52, Imd. Eff. June 22, 1987;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Compiler's note: Section 2 of Act 52 of 1987 provides:

"The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act apply to all insurance policies issued on or after January 1, 1957 that were either approved by the commissioner on or after January 1, 1957 or subject to an order of the commissioner exempting policies from filing on or after September 1, 1968. The amendments to sections 2236, 2242, 3440, 3606, 3610, and 4430 of Act No. 218 of the Public Acts of 1956, being sections 500.2236, 500.2242, 500.3440, 500.3606, 500.3610, and 500.4430 of the Michigan Compiled Laws, pursuant to this amendatory act are intended to codify and approve long-standing administrative and commercial practice taken and approved by the commissioner pursuant to his or her legal authority. This amendatory act shall serve to cure and clarify any misinterpretation of the operation of such sections since the effective date of their original enactment. It is the intent of this amendatory act to rectify the misconstruction of the insurance code of 1956 by the court of appeals in Bill v Northwestern National Life Insurance Company 143 Mich App 766 with respect to the power of the insurance commissioner to exempt certain insurance documents from filing requirements and the offsetting of social security benefits against disability income insurance benefits. This amendatory act does not affect the relationship between disability insurance benefits and personal protection insurance benefits as provided in Federal Kemper v Health Insurance Administration Inc. 424 Mich 537."

Popular name: Act 218

500.3444 Relation of earnings to insurance; optional provision.

Sec. 3444. There may be a provision as follows:

RELATION OF EARNINGS TO INSURANCE: If the total monthly amount of loss of time benefits promised for the same loss under all valid loss of time coverage upon the insured, whether payable on a weekly or monthly basis, shall exceed the monthly earnings of the insured at the time disability commenced or his average monthly earnings for the period of 2 years immediately preceding a disability for which claim is made, whichever is the greater, the insurer will be liable only for such proportionate amount of such benefits under this policy as the amount of such monthly earnings or such average monthly earnings of the insured bears to the total amount of monthly benefits for the same loss under all such coverage upon the insured at the time such disability commences and for the return of such part of the premiums paid during such 2 years as shall exceed the pro rata amount of the premiums for the benefits actually paid hereunder; but this shall not operate to reduce the total monthly amount of benefits payable under all such coverage upon the insured below the sum of $200.00 or the sum of the monthly benefits specified in such coverages, whichever is the lesser, nor shall it operate to reduce benefits other than those payable for loss of time. (The foregoing policy provision may be inserted only in a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums (1) until at least age 50, or (2) in the case of a policy issued

after age 44, for at least 5 years from its date of issue. The insurer may, at its option, include in this provision a definition of "valid loss of time coverage", approved as to form by the commissioner, which definition shall be limited in subject matter to coverage provided by governmental agencies or by organizations subject to regulation by insurance law or by insurance authorities of this or any other state of the United States or any province of Canada, or to any other coverage the inclusion of which may be approved by the commissioner or any combination of such coverages. In the absence of such definition such term shall not include any coverage provided for such insured pursuant to any compulsory benefit statute (including any workmen's compensation or employer's liability statute), or benefits provided by union welfare plans or by employer or employee benefit organizations.)

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3446 Unpaid premium; optional provision.

Sec. 3446. There may be a provision as follows:

UNPAID PREMIUM: Upon the payment of a claim under this policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3448 Cancellation; optional provision.

Sec. 3448. There may be a provision as follows:

CANCELLATION: The insurer may cancel this policy at any time by written notice delivered to the insured, or mailed to the insured, stating when, not less than 5 days thereafter, the cancellation shall be effective; and after the policy has been continued beyond its original term the insured may cancel this policy at any time by written notice delivered or mailed to the insurer, effective upon receipt or on a later date as may be specified in the notice. In the event of cancellation, the insurer may retain the pro rata premium for the expired time or $25.00, whichever is greater. Cancellation is without prejudice to any claim originating prior to the effective date of cancellation.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 1987, Act 168, Imd. Eff. Nov. 9, 1987;—Am. 1990, Act 170, Imd. Eff. July 2, 1990.

Popular name: Act 218

500.3450 Conformity with state statutes; optional provision.

Sec. 3450. There may be a provision as follows:

CONFORMITY WITH STATE STATUTES: Any provision of this policy which, on its effective date, is in conflict with the statutes of the state in which the insured resides on such date is hereby amended to conform to the minimum requirements of such statutes.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3452 Illegal occupation or criminal activity; optional provision; definitions.

Sec. 3452. (1) An insurer may include in a disability insurance policy a provision as follows:

ILLEGAL OCCUPATION OR CRIMINAL ACTIVITY: The insurer is not liable for any loss to which a contributing cause was the insured's commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation or other willful criminal activity.

(2) As used in this section:

(a) "Willful criminal activity" includes, but is not limited to, any of the following:

(*i*) Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.

(*ii*) Operating a methamphetamine laboratory. As used in this subdivision, "methamphetamine laboratory" means that term as defined in section 1 of 2006 PA 255, MCL 333.26371.

(b) "Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

History: 1956, Act 218, Eff. Jan. 1, 1957;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3454 Repealed. 1980, Act 429, Eff. Mar. 31, 1981.

Compiler's note: The repealed section pertained to intoxicants and narcotics.

Popular name: Act 218

500.3460 Order of certain policy provisions.

Sec. 3460. The provisions which are the subject of sections 3406 through 3454, or any corresponding provisions which are used in lieu thereof in accordance with such sections, shall be printed in the consecutive order of the provisions in such sections or, at the option of the insurer, any such provision may appear as a unit in any part of the policy, with other provisions to which it may be logically related, provided the resulting policy shall not be in whole or in part unintelligible, uncertain, ambiguous, abstruse, or likely to mislead a person to whom the policy is offered, delivered or issued.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3462 Third party ownership of policy.

Sec. 3462. The word "insured", as used in this chapter, shall not be construed as preventing a person other than the insured with a proper insurable interest from making application for and owning a policy covering the insured or from being entitled under such a policy to any indemnities, benefits and rights provided therein.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3464 Foreign or alien insurers; provision required by other state law; domestic insurers; provision required by other state or country.

Sec. 3464. (1) Any policy of a foreign or alien insurer, when delivered or issued for delivery to any person in this state, may contain any provision which is not less favorable to the insured or the beneficiary than the provisions of this chapter and which is prescribed or required by the law of the state under which the insurer is organized.

(2) Any policy of a domestic insurer may, when issued for delivery in any other state or country, contain any provision permitted or required by the laws of such other state or country.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3466 Filing procedure; insurance commissioner, regulatory powers.

Sec. 3466. The commissioner may make such reasonable rules and regulations concerning the procedure for the filing or submission of policies subject to this chapter as are necessary, proper or advisable to the administration of this chapter. This provision shall not abridge any other authority granted the commissioner by law.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3468 Provisions violating code; construction of noncomplying policies and provisions.

Sec. 3468. (1) No policy provision which is not subject to sections 3406 through 3454 shall make a policy, or any portion thereof, less favorable in any respect to the insured or the beneficiary than the provisions thereof which are subject to this chapter.

(2) A policy delivered or issued for delivery to any person in this state in violation of this insurance code shall be held valid but shall be construed as provided in this code. When any provision in a policy subject to this chapter is in conflict with any provision of this chapter, the rights, duties and obligations of the insurer, the insured and the beneficiary shall be governed by the provisions of this chapter.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3470 Age of insured; provision regulations.

Sec. 3470. If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force subject to any right of cancellation until the end of the period for which premium has been accepted. In the event the age of the insured has been misstated and if, according to the correct age of the insured, the coverage provided by the policy would not have become effective, or would have ceased prior to the acceptance of such premium or premiums, then the liability of the insurer shall be limited to the refund, upon request, of all premiums paid for the period not covered by the policy.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3471 Provision and nondisclosure of large employer group claims utilization and cost information; civil liability immunity; definitions.

Sec. 3471. (1) On request of a large employer group, an insurer shall provide the large employer group with claims utilization and cost information as provided in subsection (3) on presentation of a signed nondisclosure agreement to the insurer. In signing the nondisclosure agreement described in this subsection, the large employer group shall agree to keep confidential all information received under this section other than the information required to be disclosed under subsection (6).

(2) A large employer group that is part of a combined large employer group must be provided with claims utilization and cost information as provided in subsection (3)(a) that is aggregated for all the employees enrolled in the combined large employer group, and the information must not be separated out for any of those employers included in the combined large employer group.

(3) An insurer in this state shall compile, and shall make available to a large employer group in an electronic, spreadsheet-compatible format, complete and accurate claims utilization and cost information for the medical benefit plan in the aggregate and for each large employer group entitled to that information under subsection (1) or (2) and each subgroup of employees of the large employer group if the subgroup has 100 or more employees covered by the medical benefit plan, as follows:

(a) Incurred and paid claims data for the employee group covered by the medical benefit plan, including at least all of the following:

(*i*) For a plan that provides medical benefits, information concerning hospital and medical claims under the plan, presented in a manner that clearly shows all of the following:

(A) Number and total expenditures for inpatient claims for each month.

(B) Number and total expenditures for outpatient claims for each month.

(C) Number and total expenditures for all other medical claims for equipment, devices, and services, including services rendered in the private office of a physician or other health professional, for each month.

(D) The tax identification number or national provider identifier of each provider rendering service or care.

(*ii*) For a plan that provides prescription drug benefits, information concerning prescription drug claims under the plan, presented in a manner that clearly shows all of the following:

(A) Amount paid for prescription drug claims for each month.

(B) Amount paid for brand prescription drug claims for each month.

(C) Amount paid for generic prescription drug claims for each month.

(D) Amount paid for specialty prescription drug claims for each month.

(E) The 50 prescription drugs for which claims were most frequently paid.

(F) The 50 prescription drugs for which expenditures were the largest.

(*iii*) For a plan that provides medical or prescription drug benefits, in addition to the information required under subparagraphs (*i*) and (*ii*), as applicable, information concerning covered individuals with total medical or prescription drug claims, or both, exceeding $25,000.00 for any 12-month period for which claims utilization and cost information are provided, presented in a manner that clearly shows all of the following separately for each covered individual:

(A) Total medical expenditures for the individual.

(B) Total prescription drug expenditures for the individual.

(C) Whether the covered individual is currently covered by the medical benefit plan.

(D) The covered individual's diagnoses.

(*iv*) Fees and administrative expenses for the most recent experience year, reported separately for medical and prescription drug plans, and presented in a manner that clearly shows at least all of the following:

(A) The dollar amounts paid for specific and aggregate stop-loss insurance.

(B) The dollar amount of administrative expenses incurred or paid, reported separately for medical and pharmacy.

(C) The total dollar amount of retentions and other expenses.

(D) The dollar amount for all service fees paid.

(*v*) The dollar amount of any fees or commissions paid to agents, consultants, third party administrators, or brokers by the medical benefit plan or by any large employer group or carrier participating in or providing services to the medical benefit plan, reported separately for medical, prescription drug, and stop-loss.

(*vi*) For medical and prescription drug plans, a benefit summary for the current year's plan and, if benefits have changed during any of the 2 most recent 12-month periods for which claims utilization and cost information are provided, a brief benefit summary for each of those periods for which the benefits were different.

(b) A census of all covered employees, including all of the following:

(*i*) Year of birth of each employee.

(*ii*) Gender of each employee.

(*iii*) Zip code in which each employee resides.

(*iv*) The contract coverage type for each employee, such as single, 2-person, or family, and number of individuals covered by contract.

(*v*) For each month, the total number of covered employees and the number of covered employees in each contract coverage type.

(*vi*) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.

(*vii*) For a plan that provides prescription drug benefits, information concerning enrollment and prescription drugs claims under the plan, presented in a manner that clearly shows all of the following:

(A) For each month, the total number of covered employees and the number of covered employees in each contract coverage type.

(B) For each month, the total number of covered individuals and the number of covered individuals in each contract coverage type.

(C) Other information as required by the director.

(4) Except as otherwise provided in subsection (3) and subject to subsection (5), claims utilization and cost information required to be compiled under this section must be compiled at the request of a large employer group. The large employer group may not request claims utilization and cost information more than once per calendar year. Claims utilization and cost information compiled on the request of a large employer group must be compiled within 30 days after the request.

(5) Claims utilization and cost information compiled under this section must cover a relevant period. For purposes of this subsection, "relevant period" means the 24-month period ending not more than 60 days before the compilation of the information for the medical benefit plan under consideration. However, if the medical benefit plan has been in effect for less than 24 months, the relevant period is that shorter period.

(6) A large employer group or combined large employer group shall disclose the claims utilization and cost information required to be provided under subsections (2) and (3) to any carrier or administrator it solicits to provide benefits or administrative services for its medical benefit plan. A large employer group or combined large employer group shall make the claims utilization and cost information required under this section available within 30 days after the request. In addition, a large employer group or combined large employer group may disclose the claims utilization and costs information required to be provided under subsections (2) and (3) to any carrier or administrator who requests the opportunity to submit a proposal to provide benefits or administrative services for the medical benefit plan during the request for bids or proposals.

(7) On request of a large employer group or combined large employer group, an insurer shall provide the tax identification number or national provider identifier of each provider rendering service or care on presentation of a signed nondisclosure agreement to the insurer.

(8) The claims utilization and cost information required to be produced under subsection (3) must include only health information as permitted under the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164, and must not include any protected health information as defined in the health insurance portability and accountability act of 1996, Public Law 104-191, or regulations promulgated under that act, 45 CFR parts 160 and 164.

(9) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy that provides information in response to a request from a large employer group under this section is immune from civil liability for complying with the request and for the acts or omissions of any person's subsequent use of the data or information.

(10) As used in this section:

(a) "Carrier" means any of the following:

(*i*) An insurer that offers a medical benefit plan.

(*ii*) An employee welfare benefit plan as that term is defined in section 7001.

(*iii*) A person operating a system of health care delivery and financing under section 3573.

(*iv*) A voluntary employees' beneficiary association described in section 501(c)(9) of the internal revenue code of 1986, 26 USC 501.

(b) "Combined large employer group" means either of the following:

(*i*) Two or more employers that are in an arrangement and together have 100 or more employees in medical benefit plans or have a signed letter of intent to enter together 100 or more employees into medical benefit plans.

(*ii*) A medical benefit plan in which the employees of 2 or more employers are enrolled.

(c) "Covered individual" means an employee covered under a medical benefit plan.

(d) "Full-time employees" means the term as used in section 3701.

(e) "Large employer group" means an employer that is issued a policy by a carrier under this chapter with enrollment of 100 or more full-time employees.

(f) "Medical benefit plan" means a plan, established and maintained by a large employer group, that provides for the payment of medical benefits, including, but not limited to, hospital and physician services, prescription drugs, and related benefits, to its employees. Medical benefit plan does not include either of the following:

(*i*) A medical benefit plan as defined in section 3 of the public employees health benefit act, 2007 PA 106, MCL 124.73, that is required to compile and make available claims utilization and cost information under section 15 of the public employees health benefit act, 2007 PA 106, MCL 124.85.

(*ii*) A plan that covers only a specified accident, accident only, credit, dental, disability income, long-term care, or vision benefits.

(g) "National provider identifier" means that term as described in 45 CFR part 162.

(h) "Provider" means provider of services as that term is defined in 42 USC 1395x.

(i) "Specialty prescription drug" means a prescription drug used to treat a rare, complex, or chronic medical condition that meets any of the following requirements:

(*i*) Requires special administration including, but not limited to, inhalation or infusion.

(*ii*) Requires special delivery or special storage.

(*iii*) Requires special oversight, intensive monitoring, or care coordination with a person licensed under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

History: Add. 2022, Act 119, Eff. Sept. 22, 2022.

Popular name: Act 218

500.3472 Open enrollment period; prohibitions; establishment of reasonable periods for health insurance policies; minimum standards for frequency and duration of open enrollment periods; denial of coverage.

Sec. 3472. (1) During an applicable open enrollment period, an insurer that offers, delivers, issues for delivery, or renews in this state a health insurance policy shall not deny or condition the issuance or effectiveness of the policy and shall not discriminate in the pricing of the policy on the basis of health status, claims experience, receipt of health care, or medical condition.

(2) Subject to prior approval of the director, an insurer shall establish reasonable open enrollment periods for all health insurance policies offered, delivered, issued for delivery, or renewed in this state.

(3) The director shall establish minimum standards for the frequency and duration of open enrollment periods established under subsection (2). The director shall uniformly apply the minimum standards for the frequency and duration of open enrollment periods established under this subsection to all insurers.

(4) Subject to approval by the director, an insurer may deny health insurance coverage in the group or individual market if the insurer does not have the network capacity or financial reserves necessary to offer additional coverage. An insurer described in this subsection shall act uniformly with regard to all employers or individuals in the group or individual market. An insurer described in this subsection shall act without regard to the claims experience of an individual or employer and its employees and the employee's dependents and without regard to any health-status-related factor relating to the individual or employer and its employees and the employee's dependents.

(5) Subject to approval by the director, an insurer that denies health insurance coverage to an employer or individual under subsection (4) shall not offer coverage in the group or individual market, as applicable, before the later of the one hundred eighty-first day after the date the insurer denies the coverage or the date the insurer demonstrates to the director that the insurer has sufficient network capacity or financial reserves, as applicable, to underwrite additional coverage.

(6) Subject to approval by the director, subsection (4) does not limit the insurer's ability to renew coverage already in force or relieve the insurer of the responsibility to renew the coverage.

(7) The director may provide for the application of subsection (4) on a service-area-specific basis for health maintenance organizations.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3474 Risk classification; rates; filing requirements.

Sec. 3474. No policy of insurance against loss or expense from the sickness, or from the bodily injury or death from accident of the insured, nor any application, rider or endorsement to be used in connection

therewith, shall be delivered or issued for delivery to any person in this state, until the classification of risks and any premium rates pertaining thereto have been filed with the department of insurance.

History: 1956, Act 218, Eff. Jan. 1, 1957.

Popular name: Act 218

500.3474a Premium rate after January 1, 2014; basis; factors.

Sec. 3474a. The premium rate charged by an insurer, health maintenance organization, or nonprofit health care corporation for health insurance coverage offered through a policy or certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014 in the individual or small group market shall vary based on the following factors only:

(a) Whether the policy or certificate covers an individual or family.

(b) The rating area.

(c) Age, except that the premium rate shall not vary by more than 3 to 1 for adults for all plans other than child-only plans.

(d) Tobacco use, except that the premium rate shall not vary by more than 1.5 to 1.

History: Add. 2013, Act 5, Imd. Eff. Mar. 18, 2013.

Popular name: Act 218

500.3475 Reimbursement for services by licensed psychologist, podiatrist, or chiropractor; section inapplicable to policy involving prudent purchaser agreement.

Sec. 3475. (1) Notwithstanding any provision of a disability insurance policy, if the disability insurance policy provides for reimbursement for any service that is legally performed by a person fully licensed as a psychologist under part 182 of the public health code, 1978 PA 368, MCL 333.18201 to 333.18237; by a podiatrist licensed under part 180 of the public health code, 1978 PA 368, MCL 333.18001 to 333.18058; or by a chiropractor licensed under part 164 of the public health code, 1978 PA 368, MCL 333.16401 to 333.16431, the insurer shall not deny reimbursement under the insurance policy if the service is rendered by a person fully licensed as a psychologist under part 182 of the public health code, 1978 PA 368, MCL 333.18201 to 333.18237; by a podiatrist licensed under part 180 of the public health code, 1978 PA 368, MCL 333.18001 to 333.18058; or by a chiropractor licensed under part 164 of the public health code, 1978 PA 368, MCL 333.16401 to 333.16431, within the statutory provisions provided in his or her individual practice act.

(2) This section does not require coverage for a psychologist in an insurance policy. This section does not require coverage or reimbursement for any of the following:

(a) A practice of chiropractic service unless the service was included in the definition of practice of chiropractic under section 16401 of the public health code, 1978 PA 368, MCL 333.16401, as of January 1, 2009.

(b) A service provided by a physical therapist or physical therapist assistant unless the service was provided by a licensed physical therapist or physical therapist assistant under the supervision of a licensed physical therapist pursuant to a prescription from a health care professional who holds a license issued under part 166, 170, 175, or 180 of the public health code, 1978 PA 368, MCL 333.16601 to 333.16648, 333.17001 to 333.17084, 333.17501 to 333.17556, and 333.18001 to 333.18058, or the equivalent license issued by another state.

(3) This section does not apply to a policy written under section 3405 that involves a prudent purchaser agreement.

History: Add. 1963, Act 56, Eff. Sept. 6, 1963;—Am. 1966, Act 92, Imd. Eff. June 15, 1966;—Am. 1968, Act 182, Eff. Nov. 15, 1968;—Am. 1984, Act 280, Imd. Eff. Dec. 20, 1984;—Am. 2009, Act 227, Imd. Eff. Jan. 5, 2010;—Am. 2014, Act 263, Imd. Eff. July 1, 2014;—Am. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3476 Telemedicine services; provisions; definitions.

Sec. 3476. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the insurer. An insurer described in this subsection shall not require a health care professional to provide services for a patient through telemedicine unless the services are contractually required per the terms of a contract between the insurer and an affiliated provider or a third-party vendor for telemedicine first or telemedicine-only products, and clinically appropriate as determined by the health care professional. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in the health care

professional's health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the health insurance policy agreed on between the policy holder and the insurer, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts. If a service is provided through telemedicine under this section, the insurer shall provide at least the same coverage for that service as if the service involved face-to-face contact between the health care professional and the patient.

(2) As used in this section:

(a) After December 31, 2017, "insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(b) "Telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-191, compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

History: Add. 2012, Act 215, Imd. Eff. June 28, 2012;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2017, Act 223, Imd. Eff. Dec. 20, 2017;—Am. 2020, Act 97, Imd. Eff. June 24, 2020;—Am. 2024, Act 51, Eff. Apr. 2, 2025;—Am. 2024, Act 52, Eff. Apr. 2, 2025.

Compiler's note: Enacting section 1 of Act 52 of 2024 provides:

"Enacting section 1. Section 3476 of the insurance code of 1956, 1956 PA 218, MCL 500.3476, as amended by this amendatory act, applies to health insurance policies delivered, executed, issued, amended, adjusted, or renewed in this state, or outside of this state if covering residents of this state, beginning on the effective date of this amendatory act."

Popular name: Act 218

500.3477 Use of financial incentive or payment to act as inducement to deny, reduce, limit, or delay services; prohibition; exception.

Sec. 3477. (1) An insurer shall not use any financial incentive or make any payment to a health professional that acts directly or indirectly as an inducement to deny, reduce, limit, or delay specific medically necessary and appropriate services.

(2) Subsection (1) does not prohibit payment arrangements that are not tied to specific medical decisions or prohibit the use of risk sharing as otherwise authorized in this chapter.

History: Add. 2016, Act 276, Imd. Eff. July 1, 2016.

Popular name: Act 218

500.3480 Repealed. 1963, Act 127, Eff. Sept. 6, 1963.

Compiler's note: The section imposed penalties for violation of disability insurance provisions.

Popular name: Act 218