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

500.2212a Health insurance policy; written summary requirements; style, arrangement and appearance of policy; electronic copy permissible; "board certified" defined.

Sec. 2212a. (1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall provide a written summary of the health insurance policy in plain English to insureds. The written summary must provide a clear, complete, and accurate description of all of the following, as applicable:

(a) Uniform definitions of standard insurance terms and medical terms so that a consumer may compare health coverage and understand the terms of, or exceptions to, the consumer's coverage, in accordance with the most recent guidance issued by the United States Department of Health and Human Services.

(b) A description of the coverage, including cost sharing, for each category of benefits in the most recent guidance issued by the United States Department of Health and Human Services.

(c) The exceptions, reductions, and limitations of the health insurance policy.

(d) The cost-sharing provisions of the coverage, including deductible, coinsurance, and copayment obligations.

(e) The renewability and continuation of coverage provisions.

(f) Coverage examples.

(g) A statement about whether the health insurance policy provides minimum essential coverage as defined under section 5000A(f) of the internal revenue code of 1986, 26 USC 5000A, and whether the health insurance policy's share of the total allowed costs of benefits provided under the health insurance policy meets applicable requirements.

(h) A statement that the summary is only a summary and that the health insurance policy should be consulted to determine the governing contractual provisions of the coverage.

(i) Contact information for questions.

(j) An internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained.

(k) For insurers that maintain 1 or more networks of providers, instructions for obtaining a list of network providers.

(*l*) For insurers that use a formulary in providing prescription drug coverage, instructions for obtaining information on prescription drug coverage.

(m) Instructions for obtaining the uniform glossary, as described in subdivision (c), and a contact telephone number to obtain a paper copy of the uniform glossary, and a disclosure that paper copies are available.

(2) An insurer, or a group health plan to the extent the group health plan has contractually agreed to distribute the written summary under subsection (1), shall provide the written summary under subsection (1) as follows:

(a) To the applicant not later than 7 business days after the date of the receipt of the application.

(b) By the first date of coverage if the information provided at the time of application has changed.

(c) To the insured not later than 30 days after the effective date of a renewal of the policy.

(d) On request of the insured, not later than 7 days after the request.

(3) An insurer shall provide on request to insureds covered under a policy issued under section 3405 a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the service area, including names and locations of affiliated or participating providers by specialty or type of practice, a statement of limitations of accessibility and referrals to specialists, and a disclosure of which providers will not accept new subscribers.

(b) The professional credentials of affiliated or participating providers, including, but not limited to, affiliated or participating providers who are board certified in the specialty of pain medicine and the evaluation and treatment of pain and have reported that certification to the insurer, including all of the following:

(*i*) Relevant professional degrees.

(*ii*) Date of certification by the applicable nationally recognized boards and other professional bodies.

(*iii*) The names of licensed facilities on the provider panel where the provider currently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the department of licensing and regulatory affairs that can be accessed for information as to whether any disciplinary actions or open formal complaints have been taken or filed against a health care provider in the preceding 3 years.

(d) Any prior authorization requirements and any limitations, restrictions, or exclusions, including, but not limited to, drug formulary limitations and restrictions by category of service, benefit, and provider, and, if

applicable, by specific service, benefit, or type of drug.

(e) The financial relationships between the insurer and any closed provider panel, 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.

(f) A telephone number and address to obtain from the insurer additional information concerning the items described in subdivisions (a) to (e).

(4) On request, any of the information provided under subsection (3) must be provided in writing. An insurer may require that a request under subsection (2) be submitted in writing.

(5) A health insurer shall not deliver or issue for delivery a policy of insurance to any person in this state unless all of the following requirements are met:

(a) The style, arrangement, and overall appearance of the policy do not give undue prominence to any portion of the text. Every printed portion of the text of the policy and of any endorsements or attached papers must be plainly printed in light-faced type of a style in general use, the size of which must be uniform and not less than 10-point with a lowercase unspaced alphabet length, not less than 120-point in length of line. As used in this subdivision, "text" includes all printed matter except the name and address of the insurer, name or title of the policy, the brief description, if any, and captions and subcaptions.

(b) Except as otherwise provided in this subdivision or except as provided in sections 3406 to 3452, exceptions and reductions of indemnity are set forth in the policy and are printed, at the insurer's option, with the benefit provision to which they apply or under an appropriate caption such as "EXCEPTIONS" or "EXCEPTIONS AND REDUCTIONS". If an exception or reduction of indemnity specifically applies only to a particular benefit of the policy, a statement of the exception or reduction must be included with the benefit provision to which it applies.

(c) Each form, including riders and endorsements, is identified by a form number in the lower left-hand corner of the first page of the form.

(d) The policy contains no provision that purports to make any portion of the charter, rules, constitution, or bylaws of the insurer a part of the policy unless the portion is set forth in full in the policy. This subdivision does not apply to the incorporation of or reference to a statement of rates, classification of risks, or short-rate table filed with the director.

(6) Subject to section 2266, the information required under this section may be provided electronically.

(7) As used in this section, "board certified" means certified to practice in a particular medical or other health professional specialty by the American Board of Medical Specialties, the American Osteopathic Association Bureau of Osteopathic Specialists, or another appropriate national health professional organization.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997;—Am. 1998, Act 424, Eff. Apr. 1, 1999;—Am. 2001, Act 235, Imd. Eff. Jan. 3, 2002;—Am. 2016, Act 276, Imd. Eff. July 1, 2016;—Am. 2023, Act 161, Eff. Feb. 13, 2024.

Compiler's note: Enacting section 1 of Act 235 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 2212a(4) to the insurance code of 1956, 1956 PA 218, MCL 500.2212a, shall not be construed as creating a new mandated benefit for any coverages issued under the insurance code of 1956, 1956 PA 218, MCL 500.100 to 500.8302."

Popular name: Act 218