THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956
Chapter 22
THE INSURANCE CONTRACT

500.2204 Settlement of action brought by third party against person insured under commercial liability insurance policy; notice to insured required.

Sec. 2204.

Prior to a trial, an insurer shall not settle an action brought by a third party against a person insured under a commercial liability insurance policy issued by the insurer, unless the insurer gives the insured notice of the settlement at least 10 days prior to the settlement. As used in this section, "commercial liability insurance" means insurance which provides indemnification for commercial, industrial, professional, or business liabilities.

History: Add. 1986, Act 173, Imd. Eff. July 7, 1986
Popular Name: Act 218

500.2205 Minor's contracts for insurance.

Sec. 2205.

A contract for life or disability insurance made by a person between the ages of 16 and 18 years for his benefit, or for the benefit of his father, mother, husband, wife, child, brother or sister, or for the surrender of the insurance, or for the discharge of money payable or benefit accruing thereunder, shall be good and of the same force and effect as though the minor had attained his majority at the time of making the contract. This section shall not have the effect of making a promissory note or other evidence of indebtedness given by a minor in payment of premium or premiums on contracts for insurance valid, either in the hands of the original owner or a subsequent purchaser thereof.

History: 1956, Act 218, Eff. Jan. 1, 1957 ;-- Am. 1972, Act 47, Imd. Eff. Feb. 19, 1972
Popular Name: Act 218

500.2206 Repealed. 2014, Act 140, Eff. Mar. 31, 2015.

Compiler's Notes: The repealed section pertained to minor's capacity to receive insurance benefits.

500.2207 Insurable interest; personal insurance; rights of beneficiaries, creditors.

Sec. 2207.

(1) It shall be lawful for any husband to insure his life for the benefit of his wife, and for any father to insure his life for the benefit of his children, or of any one or more of them; and in case that any money shall become payable under the insurance, the same shall be payable to the person or persons for whose benefit the insurance was procured, his, her or their representatives or assigns, for his, her or their own use and benefit, free from all claims of the representatives of such husband or father, or of any of his creditors; and any married woman, either in her own name or in the name of any third person as her trustee, may cause to be insured the life of her husband, or of any other person, for any definite period, or for the term of life, and the moneys that may become payable on the contract of insurance, shall be payable to her, her representatives or assigns, free from the claims of the

representatives of the husband, or of such other person insured, or of any of his creditors; and in any contract of insurance, it shall be lawful to provide that on the decease of the person or persons for whose benefit it is obtained, before the sum insured shall become payable, the benefit thereof shall accrue to any other person or persons designated; and such other person or persons shall, on the happening of such contingency, succeed to all the rights and benefits of the deceased beneficiary or beneficiaries of the policy of insurance, notwithstanding he, she or they may not at the time have any such insurable interest as would have enabled him, her or them to obtain a new insurance; and the proceeds of any policy of life or endowment insurance, which is payable to the wife, husband or children of the insured or to a trustee for the benefit of the wife, husband or children of the insured, including the cash value thereof, shall be exempt from execution or liability to any creditor of the insured; and said exemption shall apply to insurance heretofore or hereafter issued; and shall apply to insurance payable to the above enumerated persons or classes of persons, whether they shall have become entitled thereto as originally designated beneficiaries, by beneficiary designation subsequent to the issuance of the policy, or by assignment (except in case of transfer with intent to defraud creditors).

(2) If a policy of insurance, or contract of annuity (whether heretofore or hereafter issued) is effected by any person on his own life or on another life in favor of a person other than himself, or (except in cases of transfer with intent to defraud creditors) if a policy of life insurance is assigned or in any way made payable to any such person, the lawful beneficiary or assignee thereof (other than the insured or the person so effecting such insurance, or his executors or administrators) shall be entitled to the proceeds and avails (including the cash value thereof) against the creditors and representatives of the insured and of the person effecting the same, (whether or not the right to change the beneficiary is reserved or permitted and whether or not the policy is made payable in the event that the beneficiary or assignee shall predecease such person, to the person whose life is insured or the person effecting the insurance): Provided, That, subject to the statute of limitations, the amount of any premiums for said insurance paid with intent to defraud creditors, with interest thereon, shall inure to their benefit from the proceeds of the policy: Provided further, That proof that such transfer was made and a particular debt or claim existed at the time of such transfer shall be prima facie evidence of intent to defraud said creditor as to said debt or claim; but the company issuing the policy shall be discharged of all liability thereon by payment of its proceeds in accordance with its terms, unless before such payment the company shall have written notice at its home office, by or in behalf of a creditor of a claim to recover for transfer made or premiums paid with intent to defraud creditors, with specification of the amount claimed.

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

500.2209 Insurable interest; married woman; right to proceeds, devise.

Sec. 2209.

(1) It shall be lawful for any married woman, by herself, and in her name or in the name of any third person, with his assent, as her trustee, to cause to be insured for her sole use, the life of her husband or the life of any other person, in any life insurance company of any nature whatever, located in either of the states of the United States of America or in Great Britain, for any definite period, or for the term of his natural life; and in case of her surviving her husband, or such other person insured in her behalf, the sum or net amount of the policy of insurance due and payable by the terms of the insurance, shall be payable to her, to and for her own use, free from the claims of the representatives of her husband, or of such other person insured, or of any of his creditors, but such exemption shall not apply where the amount of premium annually paid shall exceed the sum of $300.00.

(2) In case of the death of the wife before the decease of her husband, or of such other person insured, the amount of the insurance may be made payable after her death to her children, for their use, and to their guardian, if under age, or the amount of the policy may be disposed of by such married woman by a last will and testament.

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

500.2210 Definitions; insurable interest; employer; trust; exemption from claims.

Sec. 2210.

(1) As used in this section:

(a) "Employee benefit plan" means that term as defined by the employee retirement income security act of 1974, Public Law 93-406, 88 Stat. 829.

(b) "Employer" means an individual, sole proprietorship, partnership, firm, corporation, association, or any other legal entity, which has 1 or more employees and is legally doing business in this state.

(c) "Trust" means a trust established by an employer.

(2) Notwithstanding any other section of this act, an employer or a trust has an insurable interest in, and may, with the written consent of the insured, insure on an individual or group basis for its benefit the lives of the employer's directors, officers, managers, nonmanagement employees, and retired employees. An employer or a trust may insure the lives of the employer's nonmanagement employees and its retired employees only if those persons give written consent to be insured and the coverage is limited to an amount reasonably commensurate with the employer's projected unfunded liabilities to nonmanagement and retired employees for employee benefit plans, calculated according to accepted actuarial principles. An employer shall not retaliate in any manner against an employee or a retired employee for refusing consent to be insured.

(3) Notwithstanding any other section of this act, a trust maintained for the purpose of providing for the cost of benefits under an employee benefit plan maintained for employees or retired employees has an insurable interest in, and may, with the acquiescence of the insured, insure on an individual or group basis for its benefit the lives of the employer's directors, officers, managers, nonmanagement employees, and retired employees. A trust may insure the life of a nonmanagement employee and a retired employee only if that person is given written notice of the coverage, he or she has not notified either the employer or the trust in writing that he or she does not want to be insured for the coverage, and the coverage is limited to an amount reasonably commensurate with the employer's projected unfunded liabilities to nonmanagement and retired employees for employee benefit plans, calculated according to accepted actuarial principles. An employer or a trust shall not retaliate in any manner against an employee or a retired employee for providing the written notice that he or she does not want to be insured for the coverage.

(4) The proceeds of any policy or certificate issued pursuant to subsection (2) or (3) are exempt from the claims of any creditor or dependent of the insured.

History: Add. 1990, Act 349, Eff. Mar. 28, 1991 ;-- Am. 1994, Act 227, Imd. Eff. June 27, 1994 ;-- Am. 1998, Act 222, Imd. Eff. July 1, 1998
Popular Name: Act 218

500.2210a Trustee having insurable interest under MCL 700.7114.

Sec. 2210a.

A trustee of a trust has an insurable interest in the life of an individual as provided in section 7114 of the estates and protected individuals code, 1998 PA 386, MCL 700.7114.

History: Add. 2014, Act 7, Imd. Eff. Feb. 11, 2014
Popular Name: Act 218

500.2211 Consent of insured.

Sec. 2211.

(1) Any individual who has an insurable interest in the life of another human being shall not insure that other human being's life for the individual's benefit unless the human being whose life is to be insured consents to be insured in writing. That person's signature on the application for insurance constitutes consent.

(2) This section applies to life insurance policies and certificates of $10,000.00 or more delivered or issued for delivery in this state on and after 30 days after the effective date of this section. This section does not apply if the human being whose life is to be insured is less than 18 years of age.

History: Add. 1998, Act 91, Imd. Eff. May 14, 1998
Popular Name: Act 218

500.2212 Insurable interest in life of individual.

Sec. 2212.

Notwithstanding any other section of this act, an organization described in and qualified under section 501(c)(3) of the internal revenue code of 1986, 26 U.S.C. 501, has an insurable interest in the life of an individual who gives written consent to the ownership or purchase of a policy on his or her life.

History: Add. 1996, Act 572, Imd. Eff. Jan. 16, 1997
Popular Name: Act 218

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 Notes: Enacting section 1 of Act 235 of 2001 provides:â€œEnacting 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.â€

Popular Name: Act 218

500.2212b Policy issued under MCL 550.3405 and to health maintenance organization contract; applicability; termination of affiliation or participation between primary care physician and insurer; notice to insured; effect of termination; definitions.

Sec. 2212b.

(1) This section applies to a policy issued under section 3405 and to a health maintenance organization contract.

(2) If affiliation or participation between a primary care physician and an insurer terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each insured who has chosen the physician as his or her primary care physician. If an insured is in an ongoing course of treatment with any other physician that is affiliated or participating with the insurer and the affiliation or participation between the physician and the insurer terminates, the physician may provide written notice of this termination to the insured within 15 days after the physician becomes aware of the termination. The notices under this subsection may also describe the procedure for continuing care under subsections (3) and (4).

(3) If affiliation or participation between an insured's current physician and an insurer terminates, the insurer shall permit the insured to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days after the date of notice to the insured by the physician of the physician's termination with the insurer.

(b) If the insured is in her second or third trimester of pregnancy at the time of the physician's termination, through postpartum care directly related to the pregnancy.

(c) If the insured is determined to have an advanced illness before a physician's termination or knowledge of the termination and the physician was treating the advanced illness before the date of termination or knowledge of the termination, for the remainder of the insured's life for care directly related to the treatment of the advanced illness.

(4) Subsection (3) applies only if the physician agrees to all of the following:

(a) To continue to accept as payment in full reimbursement from the insurer at the rates applicable before the termination.

(b) To adhere to the insurer's standards for maintaining quality health care and to provide to the insurer necessary medical information related to the care.

(c) To otherwise adhere to the insurer's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations, and treatment plans.

(5) An insurer shall provide written notice to each affiliated or participating physician that if affiliation or participation between the physician and the insurer terminates, the physician may do both of the following:

(a) Notify the insurer's insureds under the care of the physician of the termination if the physician does so within 15 days after the physician becomes aware of the termination.

(b) Include in the notice under subdivision (a) a description of the procedures for continuing care under subsections (3) and (4).

(6) This section does not create an obligation for an insurer to provide to an insured coverage beyond the maximum coverage limits permitted by the insurer's policy or certificate with the insured. This section does not create an obligation for an insurer to expand who may be a primary care physician under a policy or certificate.

(7) As used in this section:

(a) "Advanced illness" means that term as defined in section 5653 of the public health code, 1978 PA 368, MCL 333.5653.

(b) "Physician" means an allopathic physician, osteopathic physician, or podiatric physician.

(c) "Terminates" or "termination" includes the nonrenewal, expiration, or ending for any reason of a participation agreement or affiliated provider contract between a physician and an insurer, but does not include a termination by the insurer for failure to meet applicable quality standards or for fraud.

History: Add. 1999, Act 230, Eff. July 1, 2000 ;-- Am. 2000, Act 486, Imd. Eff. Jan. 11, 2001 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016
Popular Name: Act 218

500.2212c Prescription drug prior authorization workgroup; creation; development of methodology; prior authorization request; definitions.

Sec. 2212c.

(1) By January 1, 2015, the workgroup shall develop a standard prior authorization methodology for use by

prescribers to request and receive prior authorization from an insurer if a health benefit plan requires prior authorization for prescription drug benefits. The workgroup shall include in the standard prior authorization methodology the ability for the prescriber to designate the prior authorization request for expedited review. In order to designate a prior authorization request for expedited review, the prescriber shall certify that applying the review period under section 2212e(10) may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

(2) A prescription drug prior authorization workgroup is created. The department of health and human services and the department shall work together and appoint members to the workgroup. The workgroup must consist of a member who represents the department of health and human services, a member who represents the department, and members who represent insurers, prescribers, pharmacists, hospitals, and other stakeholders as determined necessary by the department of health and human services and the department. The workgroup shall appoint a chairperson from among its members. The chairperson of the workgroup shall schedule workgroup meetings. The department of health and human services and the department shall organize the initial meeting of the workgroup and shall provide administrative support for the workgroup.

(3) In developing the standard prior authorization methodology under subsection (1), the workgroup shall consider all of the following:

(a) Existing and potential technologies that could be used to transmit a standard prior authorization request.

(b) The national standards pertaining to electronic prior authorization developed by the National Council for Prescription Drug Programs.

(c) Any prior authorization forms and methodologies used in pilot programs in this state.

(d) Any prior authorization forms and methodologies developed by the Centers for Medicare and Medicaid Services.

(4) Beginning March 14, 2014, an insurer may specify in writing the materials and information necessary to constitute a properly completed standard prior authorization request if a health benefit plan requires prior authorization for prescription drug benefits.

(5) If the workgroup develops a paper form as the standard prior authorization methodology under subsection (1), the paper form must meet all of the following requirements:

(a) Consist of not more than 2 pages. However, an insurer may request and require additional information beyond the 2-page limitation of this subdivision, if that information is specified in writing by the insurer under subsection (4). As used in this subdivision, "additional information" includes, but is not limited to, any of the following:

(i) Patient clinical information including, but not limited to, diagnosis, chart notes, lab information, and genetic tests.

(ii) Information necessary for approval of the prior authorization request under plan criteria.

(iii) Drug specific information including, but not limited to, medication history, duration of therapy, and treatment use.

(b) Be electronically available.

(c) Be electronically transmissible, including, but not limited to, transmission by facsimile or similar device.

(6) Beginning July 1, 2016, if an insurer uses a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system, the prior authorization methodology described in subsection (5) does not apply. Subsection (4) and section 2212e apply to a prior authorization methodology that utilizes an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system.

(7) Beginning July 1, 2016, except as otherwise provided in subsection (6), an insurer shall use the standard prior authorization methodology developed under subsection (1) if a health benefit plan requires prior authorization for prescription drug benefits.

(8) As used in this section:

(a) "Health benefit plan" means that term as defined in section 2212e.

(b) "Insurer" means any of the following:

(i) An insurer that delivers, issues for delivery, renews, or administers a health benefit plan.

(ii) A health maintenance organization.

(iii) A health care corporation operating pursuant to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704.

(iv) For purposes of this section and section 2212e only, a third party administrator of prescription drug benefits. As used in this subparagraph, "third party administrator" means that term as defined in section 2 of the third party administrator act, 1984 PA 218, MCL 550.902.

(c) "Prescriber" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(d) "Prescription drug" means that term as defined in section 17708 of the public health code, 1978 PA 368, MCL 333.17708.

(e) "Prescription drug benefit" means the right to have a payment made by an insurer for a prescription drug

listed on the applicable formulary in accordance with coverage contained within a health benefit plan delivered, issued for delivery, or renewed in this state.

(f) "Workgroup" means the prescription drug prior authorization workgroup created under subsection (2).

History: Add. 2013, Act 30, Eff. Mar. 14, 2014 ;-- Am. 2022, Act 60, Imd. Eff. Apr. 7, 2022
Popular Name: Act 218

500.2212d National or regional certification of physician; condition of payment or reimbursement by insurer or health maintenance organization; prohibited.

Sec. 2212d.

An insurer that delivers, issues for delivery, or renews in this state a health insurance policy issued under chapter 34 or a health maintenance organization that issues a health maintenance contract under chapter 35 shall not require as the sole condition precedent to the payment or reimbursement of a claim under the policy or contract that an allopathic or osteopathic physician in the medical specialties of family practice, internal medicine, or pediatrics maintain a national or regional certification not otherwise specifically required for licensure under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838.

History: Add. 2018, Act 487, Imd. Eff. Dec. 27, 2018
Popular Name: Act 218

500.2212e Standard electronic prior authorization transaction process; requirements; adverse determination process; denial and appeals; standard report; modification program; definitions.

Sec. 2212e.

(1) For an insurer that delivers, issues for delivery, renews, or administers a health benefit plan in this state, if the health benefit plan requires a prior authorization with respect to any benefit, the insurer or its designee utilization review organization shall, by June 1, 2023, make available a standardized electronic prior authorization request transaction process utilizing an internet webpage, internet webpage portal, or similar electronic, internet, and web-based system. Beginning June 1, 2023, an insurer described in this subsection or its designee utilization review organization and the health professional shall perform a prior authorization utilizing only a standard electronic prior authorization transaction process, which allows the transmission of clinical information, unless the health professional is not able to use the standard electronic prior authorization transaction process because of a temporary technological or electrical failure. The current prior authorization requirements must be described in detail and written in easily understandable language. An insurer described in this subsection or its designee utilization review organization shall make any current prior authorization requirements and restrictions, including the written clinical review criteria, readily accessible and conspicuously posted on its website to insureds, enrollees, health professionals, and health care providers. Content published by a third party and licensed for use by an insurer described in this subsection or its designee utilization review organization may be made available through the insurer or its designee utilization review organization's secure, password-protected website if the access requirements of the website do not unreasonably restrict access to the content. The prior authorization requirements must be based on peer-reviewed clinical review criteria. All of the following apply to clinical review criteria under this subsection:

(a) Unless the criteria are developed as described in subdivision (g), the clinical review criteria must be criteria developed by either of the following:

(i) An entity to which both of the following apply:

(A) The entity works directly with clinicians, either within the organization or outside the organization, to develop the clinical review criteria.

(B) The entity does not receive direct payments based on the outcome of the clinical care decision.

(ii) A professional medical specialty society.

(b) The clinical review criteria must take into account the needs of atypical patient populations and diagnoses.

(c) The clinical review criteria must ensure quality of care and access to needed health care services.

(d) The clinical review criteria must be evidence-based criteria.

(e) The clinical review criteria must be sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

(f) The clinical review criteria must be evaluated and updated, if necessary, at least annually.

(g) For coverage other than prescription drug benefit coverage, before establishing, or substantially or materially altering, its own written clinical review criteria, an insurer or its designee utilization review organization must obtain input from actively practicing licensed physicians representing major areas of the specialty. For coverage of a prescription drug benefit, before establishing, or substantially or materially altering, its own clinical review criteria, an insurer or its designee utilization review organization must obtain input from actively practicing licensed pharmacists or actively practicing licensed physicians. If criteria are developed for a health care service provided by a health professional not licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, an insurer or designee utilization review organization must also seek input from a health professional in the same profession as the health professional providing the health care service.

(2) An insurer described in subsection (1) shall make available on the insurer's public website in a readily accessible format a list of all benefits that are subject to a prior authorization under the health benefit plan.

(3) If an insurer described in subsection (1) implements a new prior authorization requirement or restriction, or amends an existing requirement or restriction, with respect to any benefit under a health benefit plan, the insurer shall ensure that the new or amended requirement or restriction is posted on the insurer's public website before its implementation. For a benefit that does not involve coverage of a prescription drug, an insurer shall notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 60 days before the requirement or restriction is implemented. For coverage of a prescription drug, an insurer shall make available on the insurer's public website or notify contracted health care providers via the insurer's provider portal of the new or amended requirement or restriction not less than 45 days before the requirement or restriction is implemented unless any of the following apply:

(a) The United States Food and Drug Administration has done any of the following:

(i) Issued a statement that calls into question the clinical safety of the drug.

(ii) Required the manufacturers to conduct postmarket safety studies and clinical trials after the approval of the drug.

(iii) Issued any drug safety-related labeling changes.

(iv) Required the manufacturers to implement special risk management programs.

(b) The drug receives a new United States Food and Drug Administration approval and has become available.

(c) The United States Food and Drug Administration has approved expanded use of the drug.

(4) The initial review of information submitted in support of a request for prior authorization may be conducted and approved by a health professional.

(5) For an adverse determination regarding a request for prior authorization for a benefit other than a prescription drug, the adverse determination must be made by a licensed physician. For an adverse determination of a health care service provided by a health professional that is not a licensed physician, a licensed physician may consider input from a health professional who is in the same profession as the health professional providing the health care service. The licensed physician shall make the adverse determination under this subsection under the general direction of the insurer's medical director who oversees the utilization management program. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(6) For an adverse determination regarding a request for prior authorization for a prescription drug, the adverse determination must be made by a licensed pharmacist or licensed physician. The licensed pharmacist or licensed physician shall make the adverse determination under this subsection under the general direction of the insurer's medical director who oversees the utilization management program. Medical directors under this subsection must be licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097, or the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(7) If an insurer described in subsection (1) denies a prior authorization, the insurer or its designee utilization review organization shall, on issuing a benefit denial, notify the health professional and insured or enrollee of all of the following:

(a) The reasons for the denial and related evidence-based criteria.

(b) The right to appeal the adverse determination.

(c) Instructions on how to file the appeal.

(d) Additional documentation necessary to support the appeal.

(8) Subject to subsection (9) an appeal of the denial under subsection (7) must be reviewed by a health professional to which all of the following apply:

(a) The health professional does not have a direct financial stake in the outcome of the appeal.

(b) The health professional has not been involved in making the adverse determination.

(c) The health professional considers all known clinical aspects of the health care services under review, including, but not limited to, a review of all pertinent medical records provided to the insurer or designee utilization review organization by the insured or enrollee's health care provider and any relevant records provided to the insurer or designee utilization review organization by a health care facility.

(d) The health professional may consider input from a health professional who is licensed in the same profession as the health professional providing the health care service or a licensed pharmacist if the adverse decision is regarding a prescription drug.

(9) An insurer or its designee utilization review organization shall not affirm the denial of an appeal under subsection (8) unless the appeal is reviewed by a licensed physician who is board certified or eligible in the same specialty as a health care provider who typically manages the medical condition or disease or provides the health care service. However, if an insurer or its designee utilization review organization cannot identify a licensed physician who meets the requirements described in this subsection without exceeding the applicable time limits imposed under subsection (10), the insurer or its designee utilization review organization may utilize a licensed physician in a similar specialty as considered appropriate, as determined by the insurer or its designee utilization review organization.

(10) Beginning June 1, 2023 through May 31, 2024, a prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 9 calendar days after the date and time of submission of the prior authorization. After May 31, 2024, a prior authorization request under this section that has not been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 7 calendar days after the date and time of submission of the prior authorization. Beginning June 1, 2023 through May 31, 2024, if additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 9 calendar days after the date and time of the submission of additional information. After May 31, 2024, if additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 7 calendar days after the date and time of the submission of additional information.

(11) Beginning June 1, 2023, a prior authorization request under this section that has been certified as urgent by the health care provider is considered granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or require additional information of the health care provider within 72 hours after the date and time of submission of the prior authorization request. If additional information is requested by an insurer or its designee utilization review organization, the prior authorization request is considered to have been granted by the insurer or its designee utilization review organization if the insurer or its designee utilization review organization fails to grant the request, deny the request, or otherwise respond to the request of the health care provider within 72 hours after the date and time of the submission of additional information.

(12) A prior authorization request granted under this section is valid for not less than 60 calendar days or for a duration that is clinically appropriate, whichever is later.

(13) By June 1, 2023, and each June 1 after that date, an insurer shall report to the department, on a form issued by the department, the following aggregated trend data related to the insurer's prior authorization practices and experience for the prior plan year:

(a) The number of prior authorization requests.

(b) The number of prior authorization requests denied.

(c) The number of appeals received.

(d) The number of adverse determinations reversed on appeal.

(e) Of the total number of prior authorization requests, the number of prior authorization requests that were not submitted electronically.

(f) The top 10 services that were denied.

(g) The top 10 reasons prior authorization requests were denied.

(14) By October 1, 2023, and each October 1 after that date, the department shall aggregate and deidentify the data collected under subsection (13) into a standard report and shall not identify the name of the insurer that

submitted the data. The report must be written in easily understandable language and posted on the department's public internet website.

(15) All of the following apply to any data, documents, materials, or other information described in subsection (13) that has not been aggregated, deidentified, and otherwise compiled into the standard report described in subsection (14):

(a) The data, documents, materials, or other information is considered proprietary and to contain trade secrets.

(b) The data, documents, materials, or other information is confidential and privileged and is not subject to disclosure under the freedom of information act, 1976 PA 442, MCL 15.231 to 15.246.

(16) An insurer described in subsection (1) shall adopt a program, developed in consultation with health care providers participating with the insurer, that promotes the modification of prior authorization requirements of certain prescription drugs, medical care, or related benefits, based on any of the following:

(a) The performance of health care providers with respect to adherence to nationally recognized evidence-based medical guidelines, appropriateness, efficiency, and other quality criteria.

(b) Involvement of contracted health care providers with an insurer described in subsection (1) to participate in a financial risk-sharing payment plan, that includes downside risk.

(c) Health provider specialty, experience, or other factors.

(17) As used in this section:

(a) "Adverse determination" means that term as defined in section 2213.

(b) "Evidence-based criteria" means criteria developed using evidence-based standards.

(c) "Evidence-based standard" means that term as defined in section 3 of the patient's right to independent review act, 2000 PA 251, MCL 550.1903.

(d) "Health benefit plan" means an individual or group health insurance policy, an individual or group health maintenance organization contract, or a self-funded plan established or maintained by this state or a local unit of government for its employees. Health benefit plan includes prescription drug benefits. Health benefit plan does not include the Medicaid program. As used in this subdivision, "Medicaid program" means the program for medical assistance established under title XIX of the social security act, 42 USC 1396 to 1396w-6.

(e) "Health care provider" means any of the following:

(i) A health facility as that term is defined in section 2006.

(ii) A health professional.

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

(g) "Insurer" means that term as defined in section 2212c.

(h) "Licensed pharmacist" means either of the following:

(i) A pharmacist licensed to engage in the practice of pharmacy under part 177 of the public health code, 1978 PA 368, MCL 333.17701 to 333.17780.

(ii) A pharmacist licensed in another state.

(i) "Licensed physician" means any of the following:

(i) A physician licensed to engage in the practice of medicine under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17097.

(ii) A physician licensed to engage in the practice of osteopathic medicine and surgery under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556.

(iii) A physician licensed in another state.

(j) "Peer-reviewed" means the clinical review criteria that is approved by a committee comprised of clinicians, including licensed physicians or licensed pharmacists, or both, that meets at regularly-scheduled intervals and evaluates, among other things, pharmaceutical literature or medical literature, or both, and scientific evidence to develop criteria that promotes appropriate, safe, and cost-effective drug utilization.

(k) "Prescription drug" means that term as defined in section 2212c.

(l) "Prescription drug benefit" means that term as defined in section 2212c.

(m) "Prior authorization" means a determination by an insurer or utilization review organization that a requested health care benefit has been reviewed and, based on the information provided, satisfies the insurer or utilization review organization requirements for medical necessity and appropriateness.

(n) "Standardized electronic prior authorization transaction process" means a standardized transmission process, identified by the director and aligned with standards that are nationally accepted, to enable prior authorization requests to be accessible, submitted by health care providers, and accepted by insurers or their designee utilization review organizations electronically through secure electronic transmissions with the goal of maximizing administrative simplification, efficiency, and timeliness. The process must allow health care providers to supply clinical information under the standardized electronic prior authorization process. Standard electronic prior authorization transaction process does not include a facsimile.

(o) "Urgent" means an insured or enrollee is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or could subject the insured or enrollee to severe

adverse health consequences that cannot be adequately managed without the care or treatment that is the subject of the prior authorization.

(p) "Utilization review organization" means that term as defined in section 3 of the patient's right to independent review act, 2000 PA 251, MCL 550.1903.

History: Add. 2022, Act 60, Imd. Eff. Apr. 7, 2022
Popular Name: Act 218

500.2213 Internal formal grievance procedure; approval by director; provisions; person authorized to act on behalf of insured or enrollee; section inapplicable to provider complaint and insurance listed in right to independent review act; written notice to be culturally and linguistically appropriate; definitions.

Sec. 2213.

(1) Except as otherwise provided in subsection (4), an insurer that delivers, issues for delivery, or renews in this state a policy of health insurance shall establish an internal formal grievance procedure for approval by the director for persons covered under the policy that provides for all of the following:

(a) A designated person responsible for administering the grievance system.

(b) A designated person or telephone number for receiving grievances.

(c) A method that ensures full investigation of a grievance.

(d) Timely notification to the insured or enrollee as to the progress of an investigation of a grievance.

(e) The right of an insured or enrollee to appear before a designated person or committee to present a grievance.

(f) Notification to the insured or enrollee of the results of the insurer's investigation of a grievance and of the right to have the grievance reviewed by the director or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(g) A method for providing summary data on the number and types of grievances filed under this section. The insurer or health maintenance organization shall annually file the summary data for the prior calendar year with the director on forms provided by the director.

(h) Periodic management and governing body review of the data to ensure that appropriate actions have been taken.

(i) That copies of all grievances and responses are available at the principal office of the insurer for inspection by the director for 2 years following the year the grievance was filed.

(j) That when an adverse determination is made, a written statement containing the reasons for the adverse determination is provided to the insured or enrollee along with written notifications as required under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(k) That a final determination will be made in writing by the insurer not later than 30 calendar days after a formal preservice grievance is submitted or 60 calendar days after a formal postservice grievance is submitted in writing by the insured or enrollee. The 30-calendar-day period or 60-calendar-day period, as applicable, may be tolled, however, for any period of time the insured or enrollee is permitted to take under the grievance procedure and for a period of time that must not exceed 10 business days if the insurer has not received requested information from a health care facility or health professional. If the insurer's procedure for insureds or enrollees covered under a group policy or plan includes 2 steps to resolve the grievance, the time for the first step must be no longer than 15 calendar days for a preservice grievance or 30 calendar days for a postservice grievance.

(l) That a determination will be made by the insurer not later than 72 hours after receipt of an expedited grievance. Within 10 days after receipt of a determination, the insured or enrollee may request a determination of the matter by the director or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929. If the determination by the insurer is made orally, the insurer shall provide a written confirmation of the determination to the insured or enrollee not later than 2 business days after the oral determination. An expedited grievance under this subdivision applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance under subdivision (k) would seriously jeopardize the life or health of the insured or enrollee or would jeopardize the insured's or enrollee's ability to regain maximum function.

(m) That the insured or enrollee has the right to a determination of the matter by the director or his or her designee or by an independent review organization under the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(2) An insured or enrollee may authorize in writing any person, including, but not limited to, a physician, to act

on his or her behalf at any stage in a grievance proceeding under this section.

(3) This section does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services.

(4) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

(5) A written notice required to be given under this section must be provided in a culturally and linguistically appropriate manner, as required under 45 CFR 147.136(b)(2)(ii)(e).

(6) As used in this section:

(a) "Adverse determination" means any of the following:

(i) A determination by an insurer or its designee utilization review organization that a request for a benefit, on application of any utilization review technique, does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness or is determined to be experimental or investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit.

(ii) The denial, reduction, termination, or failure to provide or make payment, in whole or in part, for a benefit based on a determination by an insurer or its designee utilization review organization of a covered person's eligibility for coverage from the insurer.

(iii) A prospective review or retrospective review determination that denies, reduces, or terminates or fails to provide or make payment, in whole or in part, for a benefit.

(iv) A rescission of coverage determination.

(v) Failure to respond in a timely manner to a request for a determination.

(b) "Grievance" means a formal complaint on behalf of an insured or enrollee submitted by an insured or enrollee concerning any of the following:

(i) The availability, delivery, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review.

(ii) Benefits or claims payment, handling, or reimbursement for health care services.

(iii) Matters pertaining to the contractual relationship between an insured or enrollee and the insurer.

(c) "Insurer" includes a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

(d) "Postservice grievance" means a grievance relating to services that have already been received by the insured or enrollee.

(e) "Preservice grievance" means a grievance relating to services for which the insurer conditions receipt of the services, in whole or in part, on approval of the services in advance of receiving the service.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997 ;-- Am. 2000, Act 252, Imd. Eff. June 29, 2000 ;-- Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002 ;-- Am. 2012, Act 445, Imd. Eff. Dec. 27, 2012 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016
Popular Name: Act 218

500.2213a Expenses incurred by director; calculation; assessment; "insurer" defined.

Sec. 2213a.

(1) The director shall calculate actual and necessary expenses incurred by the director under section 2213 by June 30 of each year for the immediately preceding fiscal year. Except as otherwise provided in subsection (2), the director shall divide these expenses among all insurers that issue a policy or certificate under chapter 34 or 35 in this state on a pro rata basis according to the direct written premiums of each insurer as reported in the insurer's annual statement for the immediately preceding calendar year. An insurer shall pay the assessment within 30 days after receipt of the assessment. The assessment is in addition to the regulatory fee provided for in section 224.

(2) This section does not apply to a policy, certificate, care, coverage, or insurance listed in section 5(2) of the patient's right to independent review act, 2000 PA 251, MCL 550.1905, as not being subject to the patient's right to independent review act, 2000 PA 251, MCL 550.1901 to 550.1929.

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

History: Add. 1996, Act 517, Eff. Oct. 1, 1997 ;-- Am. 2002, Act 707, Imd. Eff. Dec. 30, 2002 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016

500.2213b Renewal or continuation of policy; modification; guaranteed renewal; discontinuing plan or product in nongroup or group market; short-term or 1-time limited duration policy or certificate; reports.

Sec. 2213b.

(1) Except as otherwise provided in this section and section 2213e, an insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall renew the policy or continue the policy in force at the option of the individual or, for a group plan, at the option of the plan sponsor.

(2) At the time of renewal of an individual health insurance policy, the insurer may modify the policy if the modification is consistent with state and federal law and is effective on a uniform basis among all individuals with coverage under the policy.

(3) At the time of renewal of a group health insurance policy issued under chapter 34, the insurer may modify the policy.

(4) Guaranteed renewal of a health insurance policy is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, noncompliance with minimum contribution requirements, or noncompliance with minimum participation requirements, if the insurer no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(5) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy shall not discontinue offering a particular plan or product in the nongroup or group market unless the insurer does all of the following:

(a) Provides notice to the director and to each covered individual or group, as applicable, provided coverage under the plan or product of the discontinuation at least 90 days before the date of the discontinuation.

(b) Offers to each covered individual or group, as applicable, provided coverage under the plan or product the option to purchase any other plan or product currently being offered in the nongroup market or group market, as applicable, by that insurer without excluding or limiting coverage for a preexisting condition or providing a waiting period.

(c) Acts uniformly without regard to any health status factor of enrolled individuals or individuals who may become eligible for coverage in making the determination to discontinue coverage and in offering other plans or products.

(6) An insurer shall not discontinue offering all coverage in the nongroup or group market unless the insurer does all of the following:

(a) Provides notice to the director and to each covered individual or group, as applicable, of the discontinuation at least 180 days before the date of the expiration of coverage.

(b) Discontinues all health benefit plans issued in the nongroup or group market from which the insurer withdrew and does not renew coverage under those plans.

(7) If an insurer discontinues coverage under subsection (6), the insurer shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the insurer withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

(8) Subsections (1) to (7) do not apply to a short-term or 1-time limited duration policy or certificate of not longer than 6 months.

(9) For the purposes of this section, a short-term or 1-time limited duration policy or certificate of not longer than 6 months is an individual health policy that meets all of the following:

(a) Is issued to provide coverage for a period of 185 days or less, except that the health policy may permit a limited extension of benefits after the date the policy ended solely for expenses attributable to a condition for which a covered person incurred expenses during the term of the policy.

(b) Is nonrenewable, provided that the health insurer may provide coverage for 1 or more subsequent periods that satisfy subdivision (a), if the total of the periods of coverage do not exceed a total of 185 days out of any 365-day period, plus any additional days permitted by the policy for a condition for which a covered person incurred expenses during the term of the policy.

(c) Does not cover any preexisting conditions.

(d) Is available with an immediate effective date, without underwriting, upon receipt by the insurer of a completed application indicating eligibility under the insurer's eligibility requirements, except that coverage that includes optional benefits may be offered on a basis that does not meet this requirement.

(10) By March 31 each year, an insurer that delivers, issues for delivery, or renews in this state a short-term or 1-time limited duration policy or certificate of not longer than 6 months shall provide to the director a written annual report that discloses both of the following:

(a) The gross written premium for short-term or 1-time limited duration policies or certificates issued in this state during the preceding calendar year.

(b) The gross written premium for all individual health insurance policies issued or delivered in this state during the preceding calendar year other than policies or certificates described in subdivision (a).

(11) The director shall maintain copies of reports prepared under subsection (10) on file with the annual statement of each reporting insurer.

(12) In each calendar year, an insurer shall not continue to issue short-term or 1-time limited duration policies or certificates if to do so the collective gross written premiums on those policies or certificates would total more than 10% of the collective gross written premiums for all individual health insurance policies issued or delivered in this state either directly by the insurer or through a person that owns or is owned by the insurer.

History: Add. 1996, Act 517, Eff. Oct. 1, 1997 ;-- Am. 1998, Act 457, Imd. Eff. Jan. 4, 1999 ;-- Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013 ;-- Am. 2016, Act 100, Eff. Aug. 1, 2016 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016 ;-- Am. 2023, Act 162, Eff. Feb. 13, 2024
Popular Name: Act 218

500.2213c Disability income insurer; internal grievance procedure; establishment; contents; â€œgrievanceâ€ defined.

Sec. 2213c.

(1) Each disability income insurer shall establish an internal grievance procedure for persons covered under a disability income policy, certificate, or contract.

(2) An internal grievance procedure under subsection (1) shall include all of the following:

(a) Provide for a designated person responsible for administering the grievance procedure.

(b) Provide for a designated person or telephone number for receiving grievances.

(c) Ensure full investigation of a grievance.

(d) Provide for timely notification to the insured as to the progress of an investigation.

(e) Provide for the insured to have the right to have the grievance reviewed by a managerial-level person or group.

(f) Provide for notification to the insured of the results of the insurer's investigation and, if the insurer upholds its prior determination on the grievance, for advising the insured of his or her right to present the grievance to the commissioner for review.

(g) Provide that a final determination will be made in writing by the insurer not later than 45 calendar days after a grievance is submitted in writing by the insured unless the insurer requires an extension of time to obtain additional information to make a determination with respect to the subject of the grievance. The extension may not exceed 45 days from the end of the initial period unless the initial period is extended due to the insured's failure to submit information necessary to decide the claim on appeal. If the extension is due to an insured's failure to submit information, the period for making the determination shall be tolled until the date the insured responds to the request for additional information.

(h) Provide for copies of all grievances and responses to be available at the principal office of the insurer for inspection by the commissioner for 2 years following the year the grievance was filed.

(3) As used in this section, "grievance" means a written complaint by an insured concerning the payment of benefits under a disability income insurance policy.

History: Add. 2002, Act 707, Imd. Eff. Dec. 30, 2002
Popular Name: Act 218

500.2213d Uniform prescription drug information card or other technology.

Sec. 2213d.

(1) A health benefit plan that provides coverage or administers a plan that provides coverage for prescription

drugs or devices and that issues, uses, or requires a card or other technology for prescription claims submission and adjudication shall issue for the plan's insureds, enrollees, members, or participants a uniform prescription drug information card or other technology as provided for in this section.

(2) By July 1, 2003, the commissioner shall develop a uniform prescription drug information card and uniform prescription drug information technology based on the standards and format approved by the national council for prescription drug programs pharmacy ID card implementation guide. The card and technology shall include all of the national council for prescription drug programs standard information required by the health plan for submission and adjudication of claims for prescription drug or device benefits, or at a minimum contain all of the following labeled information:

(a) The card issuer name or logo on the front of the card.

(b) The cardholder's name and identification number, which shall be displayed on the front of the card.

(c) Complete information for electronic transaction claims routing including all of the following:

(i) The international identification number labeled as RxBIN.

(ii) The processor control number labeled as RxPCN, if required for proper routing of electronic claim transactions for prescription benefits.

(iii) The group number labeled as RxGrp, if required for proper routing of electronic claim transactions for prescription benefits.

(d) The name and address of the benefits administrator or other entity responsible for prescription claims submission, adjudication, or pharmacy provider correspondence for prescription benefits claims.

(e) A help desk telephone number that pharmacy providers may call for pharmacy benefit claims assistance.

(3) All information required by subsection (2) that is necessary for submission and adjudication of claims for prescription drug or device benefits, exclusive of information that can be derived from the prescription, shall be included in a clear, readable, and understandable manner on the uniform prescription drug information card or other technology issued by the health plan. The content and format of all information required by subsection (2) shall be in the current content and format required by the health plan for electronic claims routing, submission, and adjudication.

(4) The uniform prescription drug information card or uniform prescription drug information technology developed under this section shall be issued by a health plan upon enrollment and reissued upon any change in coverage that impacts data contained on the card or technology. However, a health plan is not required to issue a new uniform prescription drug information card or other technology more often than once in a calendar year and if a health plan issues stickers or another similar mechanism to the insureds, enrollees, members, or participants to update the cards, then the health plan is not required to issue new uniform prescription drug information cards or other technology more often than once in 3 years from the issuance of the first stickers or other similar mechanisms. This subsection does not prevent a health plan from reissuing updated new uniform prescription drug information cards or other technology on a more frequent basis.

(5) The uniform prescription drug information card or other technology may be used for any and all health insurance coverage. Nothing in this section requires any person issuing, using, or requiring the uniform prescription drug information card or other technology to issue, use, or require a separate card for prescription coverage, provided that the card or other technology can accommodate the information necessary to process the claim as required by subsection (2).

(6) As used in this section, "health plan" means all of the following but does not include a department of community health pharmacy program:

(a) An insurer providing benefits under an expense-incurred hospital, medical, or surgical policy or certificate, but does not include any of the following:

(i) Any policy or certificate that provides coverage only for any of the following:

(A) Vision.

(B) Dental.

(C) Specific diseases.

(D) Accidents.

(E) Credit.

(ii) Hospital indemnity policy or certificate.

(iii) Disability income policy or certificate.

(iv) Coverage issued as a supplement to liability insurance.

(v) Medical payments under automobile, homeowners, or worker's compensation insurance.

(b) A MEWA regulated under chapter 70 that provides hospital, medical, or surgical benefits.

(c) A health maintenance organization licensed or issued a certificate of authority in this state.

(d) A third party administrator licensed under the third party administrator act, 1984 PA 218, MCL 550.901 to 550.962.

History: Add. 2002, Act 708, Eff. Jan. 1, 2003

Compiler's Notes: Enacting section 1 of Act 708 of 2002 provides:â€œEnacting section 1. (1) This amendatory act takes effect January 1,

2003.(2) This amendatory act applies to all health plan coverages issued or renewed on or after July 1, 2005.â€Enacting section 2 of Act 708 of 2002 provides:â€œEnacting section 2. It is the intent of the legislature that pharmacists, by July 1, 2008, be able to obtain information on and submit claims for prescription drug or device benefits by electronic means, including, but not limited to, the internet.â€
Popular Name: Act 218

500.2213e Rescission of health insurance policy; conditions; "rescind coverage" defined; application.

Sec. 2213e.

(1) An insurer that delivers, issues for delivery, or renews in this state a health insurance policy with respect to an individual, including a group to which the individual belongs or family coverage in which the individual is included, shall not rescind coverage under the policy unless both of the following apply:

(a) Either of the following applies:

(i) The individual or a person seeking coverage on behalf of the individual performs an act, practice, or omission that constitutes fraud. For purposes of this subparagraph, a person seeking coverage on behalf of an individual does not include an employee or authorized representative of the insurer or a producer.

(ii) The individual makes an intentional misrepresentation of material fact.

(b) The insurer provides written notice to the individual at least 30 days before the recission.

(2) As used in this section, "rescind coverage" means a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuance of coverage is not a rescission if any of the following apply:

(i) The cancellation or discontinuance of coverage has only a prospective effect.

(ii) The cancellation or discontinuance of coverage is effective retroactively, to the extent it is attributable to a failure to timely pay required premiums or contributions, including COBRA premiums, toward the cost of coverage. As used in this subparagraph, "COBRA" means the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272.

(iii) The cancellation or discontinuance of coverage is initiated by the individual or by the individual's authorized representative and the sponsor, employer, plan, or issuer does not, directly or indirectly, take action to influence the individual's decision to cancel or discontinue coverage retroactively or otherwise take any adverse action or retaliate against, interfere with, coerce, intimidate, or threaten the individual.

(iv) The cancellation or discontinuance of coverage is initiated by an exchange established 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, and any regulations promulgated under those acts.

(3) This section applies to a health insurance policy delivered, issued for delivery, or renewed in this state before, on, or after the date of the effective date of the amendatory act that added this section.

History: Add. 2023, Act 162, Eff. Feb. 13, 2024
Popular Name: Act 218

500.2214 Disability insurance; application, use as evidence.

Sec. 2214.

(1) An insured is not bound by a statement made in an application for a disability insurance policy unless the application is included in the policy when the policy is issued. For purposes of this subsection, an application is not included in a policy unless the policy specifically states that it includes the application.

(2) If a policy described in subsection (1) that was delivered or issued for delivery to a person in this state is reinstated or renewed and the insured or a beneficiary or assignee of the policy makes a written request to the insurer for a copy of any application for reinstatement or renewal, the insurer shall, within 15 days after receiving the request at the home office or a branch office of the insurer, deliver or mail to the person making the request a copy of the application. If the copy is not delivered or mailed as required by this subsection, the insurer is precluded from introducing the application as evidence in an action or proceeding based on or involving the policy or the reinstatement or renewal.

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

500.2216 Life or disability insurance; alteration of application.

Sec. 2216.

No alteration of any written application for any life or disability insurance policy shall be made by any person other than the applicant without his written consent, except that insertions may be made by the insurer, for administrative purposes only, in such manner as to indicate clearly that such insertions are not to be ascribed to the applicant.

History: 1956, Act 218, Eff. Jan. 1, 1957 ;-- Am. 1957, Act 91, Eff. Sept. 27, 1957
Popular Name: Act 218

500.2218 Disability insurance; false statement in application; effect.

Sec. 2218.

The falsity of any statement in the application for any disability insurance policy covered by chapter 34 of this code may not bar the right to recovery thereunder unless such false statement materially affected either the acceptance of the risk or the hazard assumed by the insurer.

(1) No misrepresentation shall avoid any contract of insurance or defeat recovery thereunder unless the misrepresentation was material. No misrepresentation shall be deemed material unless knowledge by the insurer of the facts misrepresented would have led to a refusal by the insurer to make the contract.

(2) A representation is a statement as to past or present fact, made to the insurer by or by the authority of the applicant for insurance or the prospective insured, at or before the making of the insurance contract as an inducement to the making thereof. A misrepresentation is a false representation, and the facts misrepresented are those facts which make the representation false.

(3) In determining the question of materiality, evidence of the practice of the insurer which made the contract with respect to the acceptance or rejection of similar risks shall be admissible.

(4) A misrepresentation that an applicant for life, accident or health insurance has not had previous medical treatment, consultation or observation, or has not had previous treatment or care in a hospital or other like institution, shall be deemed, for the purpose of determining its materiality, a misrepresentation that the applicant has not had the disease, ailment or other medical impairment for which such treatment or care was given or which was discovered by any licensed medical practitioner as a result of such consultation or observation. If in any action to rescind any contract or to recover thereon, any misrepresentation is proved by the insurer, and the insured or any other person having or claiming a right under the contract, shall prevent full disclosure and proof of the nature of the medical impairment, the misrepresentation shall be presumed to have been material.

History: 1956, Act 218, Eff. Jan. 1, 1957 ;-- Am. 1957, Act 91, Eff. Sept. 27, 1957
Popular Name: Act 218

500.2220 Life insurance; solicitor as agent of insurer.

Sec. 2220.

Any person who shall solicit an application for insurance upon the life of another shall, in any controversy between the insured or his beneficiary and the insurer issuing any policy upon such application, be regarded as the agent of the insurer and not the agent of the insured.

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

500.2226 Life insurance; benefits, manner of payment, period, and premiums to be contained in policy.

Sec. 2226.

(1) A life insurer shall not make with or issue to any citizen or resident of this state any contract of life insurance that does not distinctly state the amount of the life benefits, the manner of payment, the period of the continuance, and the amount of the annual, semi-annual, or quarterly premium, or by which the payment of the life benefit assured shall be contingent upon the payment of assessments made upon surviving members and shall be made in accordance with the statutes now or hereafter regulating the business of life insurance. For a universal or variable life insurance contract, the insurer shall clearly and specifically state the amount of benefits or manner in which the benefits are calculated.

(2) Every policy of life insurance hereafter issued or delivered within this state by any life insurer doing business within this state shall contain the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, bylaws, rules, application, or other writing unless the same are endorsed upon or attached to the policy when issued.

(3) For standard provisions required in life insurance contracts see chapters 40, 42, and 44.

History: 1956, Act 218, Eff. Jan. 1, 1955 ;-- Am. 1993, Act 349, Eff. Oct. 1, 1994
Popular Name: Act 218

500.2227 Withholding final settlement amount; notice; escrow procedure to be followed by city, village, or township; disposition of money by local treasurer; commingling funds prohibited; retention of interest to defray expenses; forwarding policy proceeds; proof; effect of failure to provide reasonable proof; demolition of property; civil action for return of policy proceeds; liability; applicability of section; list of cities, villages, and townships; exception to withholding requirements; definitions.

Sec. 2227.

(1) If a claim is filed for a loss to insured real property due to fire, explosion, vandalism, malicious mischief, wind, hail, riot, or civil commotion and a final settlement is reached on the loss to the insured real property, an insurer shall withhold from payment 25% of the actual cash value of the insured real property at the time of the loss or 25% of the final settlement, whichever is less. Until December 31, 2014, for residential property, the 25% settlement or judgment withheld must not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the Consumer Price Index. Beginning January 1, 2015 and before July 1, 2024, for residential property, the 25% settlement or judgment withheld must not exceed $12,000.00 adjusted January 1 of each year in accordance with the Consumer Price Index. Beginning July 1, 2024, for residential property, the 25% settlement or judgment withheld must not exceed $24,000.00 adjusted July 1 of each year in accordance with the Consumer Price Index. The director shall notify annually all insurance companies transacting property insurance in this state as to the new adjusted amount. At the time that 25% of the settlement or judgment is withheld, the insurer shall give notice of the withholding to the treasurer of the city, village, or township in which the insured real property is located, to the insured, and to any mortgagee having an existing lien or liens against the insured real property, if the mortgagee is named on the policy. For a judgment, the insurer shall also provide notice to the court in which judgment was entered. The notice must include all of the following:

(a) The identity and address of the insurer.

(b) The name and address or forwarding address of each policyholder, including any mortgagee.

(c) The location of the insured real property.

(d) The date of loss, policy number, and claim number.

(e) The amount of money withheld.

(f) A statement that the city, village, or township may have the withheld amount paid into a trust or escrow account established for the purposes of this section if within 15 days after the mailing of the notice the city, village, or township states that the money should be withheld to protect the public health and safety; otherwise, the

withheld amount must be paid to the insured 15 days after the mailing of the notice.

(g) An explanation of the provisions of this section.

(2) For a city, village, or township to escrow the amount withheld by the insurer, and to retain that amount, the following procedure must be used:

(a) An authorized representative of the city, village, or township shall request the insurer to pay the withheld amount into an escrow account maintained by the treasurer of the city, village, or township. A final settlement that exceeds 49% of the insurance on the insured real property is prima facie evidence that the damaged insured structure violates existing health and safety standards of the city, village, or township and constitutes cause for the escrowing of the withheld amount as surety for the repair, replacement, or removal of the damaged structure.

(b) For a settlement, the request under subdivision (a) must be sent to the insurer with a copy to the insured and any mortgagees. The copy to the insured must contain the notice required under subdivision (d). On receipt of the request, the insurer shall forward the withheld amount to the treasurer of the city, village, or township, and shall provide notice of the forwarding to the insured and any mortgagees.

(c) For a judgment, the request under subdivision (a) must be sent to the insurer with a copy to the insured, any mortgagees, and the court in which judgment was entered. The copy to the insured must contain the notice required under subdivision (d). On motion of the city, village, or township, the court shall order the withheld amount transmitted to the treasurer of the city, village, or township.

(d) The city, village, or township shall notify the insured that the insured has 10 days from the date of the mailing of the notice to object to the city's, village's, or township's retention of the withheld amount. The notice must identify the authorized representative of the city, village, or township to whom the insured should address his or her objections and must state that the insured may do either of the following:

(i) Seek resolution with the representative of the city, village, or township designated to receive and resolve objections under this section. The city, village, or township shall make a final determination and shall notify the insured of that determination not later than 30 days after receipt of notice that the insured wishes to seek resolution under this subparagraph. This final determination must include notice to the insured that if the insured is still dissatisfied with the city's, village's, or township's determination, the insured may seek relief in circuit court.

(ii) Seek relief in the circuit court.

(3) On receipt of money and information from an insurer as prescribed in subsections (1) and (2), the local treasurer shall record the information and the date of receipt of the money and shall immediately deposit the money in a trust or escrow account established for the purposes of this section. The account may be interest-bearing. If a mortgage on the insured property is in default, the treasurer of the city, village, or township, on written request from the first mortgagee of the property, shall release to the mortgagee all or any part of the policy proceeds received by the city, village, or township not later than 10 days after receipt of the written request by the mortgagee, to the extent necessary to satisfy any outstanding lien of the mortgagee.

(4) Except as provided in subsection (7), money deposited in an account under subsection (3) must not be commingled with city, village, or township funds. Any interest earned on money placed in a trust or escrow account may be retained by the city, village, or township to defray administrative costs incurred under this section.

(5) Except as provided in subdivision (c), the policy proceeds deposited under subsection (3) must immediately be forwarded to the insured when the authorized representative of the city, village, or township designated by the governing body of the city, village, or township receives or is shown reasonable proof of any of the following:

(a) That the damaged or destroyed portions of the insured structure have been repaired or replaced, except to the extent that the amount withheld under this section is needed to complete repair or replacement.

(b) That the damaged or destroyed structure and all remnants of the structure have been removed from the land on which the structure or the remnants of the structure were situated, in compliance with the local code requirements of the city, village, or township in which the structure was located.

(c) That the insured has entered into a contract to perform repair, replacement, or removal services for the insured real property and that the insured consents to payment of money directly to the licensed contractor performing the services on completion. Money released under this subdivision may be forwarded only to a licensed contractor performing services on the insured property.

(6) Reasonable proof required under subsection (5) includes any of the following:

(a) Originals or copies of pertinent verifiable contracts, invoices, receipts, and other similar papers evidencing both the work performed or to be performed and the materials used or to be used by all contractors performing repair, replacement, or removal services for the insured real property, other than a licensed contractor subject to subdivision (b).

(b) An affidavit executed by the licensed contractor that has performed the greatest amount of repair or replacement work on the structure, or that has done most of the clearing and removal work if structure repair or replacement is not to be performed. The licensed contractor shall attach to the affidavit all pertinent contracts, invoices, and receipts and shall swear that these attached papers correctly indicate the nature and extent of the work performed to date by the licensed contractor and the materials used.

(c) An inspection of the insured real property to verify that repair, replacement, or clearing has been completed in accordance with subsection (5).

(7) Except as otherwise provided in this subsection, if, with respect to a loss, reasonable proof is not received by or shown to an authorized representative of the city, village, or township designated by the governing body of the city, village, or township within 120 days after the policy proceeds portion was received by the treasurer, the city, village, or township shall use the retained proceeds to secure, repair, or demolish the damaged or destroyed structure and clear the insured property so that the structure and property comply with local code requirements and applicable ordinances of the city, village, or township. The city, village, or township shall return to the insured any unused portion of the retained proceeds. The city, village, or township may extend the 120-day time period under this subsection. A city, village, or township may retain and use policy proceeds for repairing or demolishing any property if on or before the effective date of the amendatory act that added subsection (16)(g) the authorized representative had not received or been shown reasonable proof within 1 year after the insurer provided notice to the insured under subsection (1). The insured may file a civil action against the city, village, or township for the return of the policy proceeds. An action filed under this subsection must be filed within 3 years after the insurer provided notice to the insured under subsection (1) or 1 year after the effective date of the amendatory act that added subsection (16)(g), whichever is later.

(8) There is no liability on the part of, and a cause of action does not arise against, an insurer or an agent or employee of an insurer for withholding or transferring money in the course of complying or attempting to comply with this section. If there is a dispute with a lienholder concerning the distribution of an amount withheld from payment under this section, the insurer may file an action in circuit court to identify all parties that may have a financial interest in the withheld amount and to determine how the withheld amount should be distributed.

(9) This section applies only to property located in a city, village, or township described in subsection (12) if the city, village, or township under a resolution by its governing body notifies the director in writing that the city, village, or township has established a trust or escrow account to be used as prescribed in this section and intends to uniformly apply this section with respect to all property located within the city, village, or township following written notification to the director. The director shall prepare and distribute a list of all cities, villages, and townships that have elected to apply this section to all insurance companies transacting property insurance in this state.

(10) A city, village, or township may apply to be added to the list prepared under subsection (9) by making a written request for addition to the director. When a written request for addition from a city, village, or township has been received by the director, an amended list must be prepared and distributed indicating the addition. The addition is effective on the date specified by the director in the amendment. The director shall notify the city, village, or township, and the insurance companies, of the effective date of the addition that must be effective not less than 30 days after receipt of notice by the insurance company. A city, village, or township shall not apply this section to any loss that occurred before the effective date of the addition.

(11) A city, village, or township may request to be deleted from the list prepared under subsection (9) or may cease to apply this section for a period of not less than 6 months on not less than 30 days' written notice to the director. After receipt of a request to be deleted from the list, the director shall prepare and distribute an amendment to the list indicating the deletion. The deletion is effective on the date specified by the director in the amendment. The director shall notify the city, village, or township, and the insurance companies, of the effective date of the deletion that must be effective not less than 30 days after receipt of the notice by the insurance company. A city, village, or township shall continue to apply this section to any loss that occurred before the effective date of the deletion, notwithstanding the deletion.

(12) This section applies only to insured real property located in cities, villages, and townships that are located in counties with a population of 425,000 or more and to insured real property located in cities, villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more. This section applies to insured real property located in a city, village, or township that has elected to apply this section as provided in subsection (9) or (10) or that has been included in this section as provided in subsection (13).

(13) Cities, villages, and townships located in counties with a population of 425,000 or more and cities, villages, and townships that are located in counties with a population of less than 425,000 if the city, village, or township has a population of 50,000 or more and that are on the list prepared by the director under section 2845(9) or (10) on October 1, 1998 are automatically included as participants in the procedure established in this section unless the city, village, or township makes a written request to be deleted under subsection (11).

(14) The director shall prepare and distribute to all insurance companies transacting property insurance in this state by November 1, 1998 new lists indicating which cities, villages, and townships are subject to this section and which cities, villages, and townships are subject to section 2845.

(15) The withholding requirements of this section do not apply if all of the following occur:

(a) Within 15 days after agreement on a final settlement between the insured and the insurer, the insured has filed with the insurer evidence of a contract to repair as described in subsection (6).

(b) The insured consents to the payment of money directly to the licensed contractor performing the repair services. Money released under this subdivision may be forwarded only to a licensed contractor performing the repair services on the insured property.

(c) On receipt of the contract to repair, the insurer gives notice to the city, village, or township in which the property is located that there will not be a withholding under this section because of the repair contract.

(16) If the insured and the insurer have agreed on the demolition costs or the debris removal costs as part of the final settlement of the real property insured claim, the insurer shall withhold 1 of the following amounts, whichever is the largest, and shall pay that amount in accordance with this section:

(a) The agreed cost of demolition or debris removal.

(b) Until December 31, 2014, 25% of the actual cash value of the insured real property at the time of loss if this amount for residential property does not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the Consumer Price Index.

(c) Beginning January 1, 2015 and before July 1, 2024, 25% of the actual cash value of the insured real property at the time of the loss if this amount for residential property does not exceed $12,000.00 adjusted January 1 of each year in accordance with the Consumer Price Index.

(d) Beginning July 1, 2024, 25% of the actual cash value of the insured real property at the time of the loss if this amount for residential property does not exceed $24,000.00 adjusted July 1 of each year in accordance with the Consumer Price Index.

(e) Until December 31, 2014, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $6,000.00 adjusted annually beginning June 1, 1999 in accordance with the Consumer Price Index.

(f) Beginning January 1, 2015 and before January 1, 2024, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $12,000.00 adjusted January 1 of each year in accordance with the Consumer Price Index.

(g) Beginning July 1, 2024, 25% of the final settlement of the insured real property claim if this amount for residential property does not exceed $24,000.00 adjusted July 1 of each year in accordance with the Consumer Price Index.

(17) This section applies only to final settlements that exceed 49% of the insurance on the insured real property.

(18) If an insurer withholds payment under a policy in good faith because of suspected arson, fraud, or other question concerning coverage, this section does not apply until the issue or question is resolved and final settlement is made.

(19) As used in this section:

(a) "Consumer Price Index" means that term as defined in section 2080.

(b) "Final settlement" means a determination of the amount due and owing to the insured for a loss to insured real property, but does not include contents damage, losses to personal property, or additional coverage not contained in the building coverage portion of the fire insurance policy, which determination is made by any of the following means:

(i) Acceptance of a proof of loss by the insurer.

(ii) Execution of a release by the insured.

(iii) Acceptance of an arbitration award by both the insured and the insurer.

(iv) Judgment of a court of competent jurisdiction.

(c) "Home insurance" means that term as defined in section 2103.

(d) "Residential property" means property on which home insurance can be issued.

History: Add. 1998, Act 217, Eff. (see compiler's note) ;-- Am. 2014, Act 509, Imd. Eff. Jan. 14, 2015 ;-- Am. 2024, Act 82, Imd. Eff. July 23, 2024

Compiler's Notes: Enacting section 1 of Act 217 of 1998 provides:â€œEnacting section 1. (1) Section 2227(1), (2), (3), (4), (5), (6), (7), (8), (9), (10), (11), (12), (13), (15), (16), (17), (18), and (19) of the insurance code of 1956, 1956 PA 218, MCL 500.2227, as added by this amendatory act, take effect on January 1, 1999 and apply to any loss that occurs on and after January 1, 1999.â€œ(2) Section 2227(14) of the insurance code of 1956, 1956 PA 218, MCL 500.2227, as added by this amendatory act, takes effect October 1, 1998.â€

Popular Name: Act 218

500.2228 Automobile insurance; contents of policy.

Sec. 2228.

(1) No policy of insurance against fire, theft, property damage, collision, and/or liability in connection with automobile coverage shall be issued, unless the premium and amount of coverage is stated in the policy.

(2) For other provisions required in such policies, see chapter 30 of this code (casualty insurance contracts).

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

500.2230 Mutual insurers other than life; contents of policy.

Sec. 2230.

Mutual insurers, other than life insurers, may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance, which are not inconsistent or in conflict with any law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, may conform thereto in substance, if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law, and a copy of such policy and endorsement, if any, shall have been first filed with and shall not have been disapproved by the commissioner.

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

500.2232 Reciprocal insurers; contents of policy.

Sec. 2232.

A reciprocal insurer may insert in any form of policy prescribed by the law of this state any provisions or conditions required by its plan of insurance which are not inconsistent or in conflict with the law of this state. Such policy, in lieu of conforming to the language and form prescribed by such law, shall be held to conform thereto in substance if such policy includes a provision or endorsement reciting that the policy shall be construed as if in the language and form prescribed by such law.

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

500.2235 Written notice to insured under worker's compensation insurance policy.

Sec. 2235.

At least annually, in conjunction with a renewal notice, a bill, or other notice of payment due issued in connection with a policy of worker's compensation insurance, an insurer shall send to each insured a written notice containing all of the following statements:

(a) A description of the insured's right to all pertinent rating information within a reasonable time after making a written request and paying reasonable charges.

(b) A description of the procedures whereby an insured or an insured's representatives may request a review of the way in which the insured's rates and premiums have been determined, including a statement of the insured's right to appeal the result of the review to the commissioner.

(c) Relevant information regarding the right of an insured to obtain a payroll audit under section 2008.

(d) Relevant information regarding the right of an insured to request a conference with a management representative to review reserve or redemption decisions by the insurer under section 2419.

History: Add. 1982, Act 7, Eff. Jan. 1, 1983
Popular Name: Act 218

500.2236 Forms generally; filing; approval; type size; membership in or subscription to rating organization; substitute form; readability score and other requirements; approval of changes or additions; notice of disapproval or withdrawal of approval; prohibition; hearing; separate violation; penalty; applicability of filing requirements; satisfaction of requirement for delivery of form or notice; "exempt commercial policyholder" and "insurer" defined; court review of order.

Sec. 2236.

(1) Except as otherwise provided in this section, an insurer shall not deliver or issue for delivery in this state a basic insurance policy form or annuity contract form; a printed rider or indorsement form or form of renewal certificate; or a group certificate in connection with the policy or contract unless a copy of the form is filed with the department and approved by the director as conforming with the requirements of this act and not inconsistent with the law. A form is considered approved if the director fails to act within 30 days after its submittal under this section. Except for disability insurance as described in section 3400, an insurer shall plainly print the form with a type size of not less than 8-point unless the director determines that portions of the form that are printed with type less than 8-point are not deceptive or misleading.

(2) An insurer may satisfy its obligations to make form filings by becoming a member of, or a subscriber to, a rating organization licensed under section 2436 or 2630 that makes the filings that are required under this section. An insurer described in this subsection shall file with the director a copy of its authorization of the rating organization to make the filings on its behalf. Except as otherwise provided in this subsection, an insurer that is a member of or subscriber to a rating organization shall adhere to the form filings made on its behalf by the organization. An insurer may file with the director a substitute form and if a subsequent form filing by the rating organization after the filling of a substitute form affects the use of the substitute form, the insurer shall review its use and notify the director whether to withdraw its substitute form.

(3) The director shall not approve a form filed under this section that provides for or relates to an insurance policy or an annuity contract for personal, family, or household purposes if the form fails to obtain the following readability score or meet the other requirements of this subsection, as applicable:

(a) The readability score must not be less than 45, as determined by the method provided in subdivisions (b) and (c).

(b) The readability score is determined as follows:

(i) For a form containing not more than 10,000 words, the entire form must be analyzed. For a form containing more than 10,000 words, not fewer than two 200-word samples per page must be analyzed instead of the entire form. The samples must be separated by at least 20 printed lines.

(ii) Count the number of words and sentences in the form or samples and divide the total number of words by the total number of sentences. Multiply this quotient by a factor of 1.015.

(iii) Count the total number of syllables in the form or samples and divide the total number of syllables by the total number of words. Multiply this quotient by a factor of 84.6. As used in this subparagraph, "syllable" means a unit of spoken language consisting of 1 or more letters of a word as indicated by an accepted dictionary. If the dictionary shows 2 or more equally acceptable pronunciations of a word, the pronunciation containing fewer syllables may be used.

(iv) Add the figures obtained in subparagraphs (ii) and (iii) and subtract this sum from 206.835. The figure obtained equals the readability score for the form.

(c) For the purposes of subdivision (b)(ii) and (iii), the following procedures must be used:

(i) A contraction, hyphenated word, or numbers and letters when separated by spaces are counted as 1 word.

(ii) A unit of words ending with a period, semicolon, or colon, but excluding headings and captions, is counted as 1 sentence.

(d) In determining the readability score, all of the following apply to the method provided in subdivisions (b) and (c):

(i) It must be applied to an insurance policy form or an annuity contract together with a rider or indorsement form usually associated with the insurance policy form or annuity contract. It may be applied to a group of policy, contract, rider, or indorsement forms that have substantially the same language resulting in a single readability score for those forms.

(ii) It must not be applied to a word or phrase that is defined in an insurance policy form or an annuity contract or a rider, indorsement, or group certificate associated with the insurance policy form or annuity contract.

(iii) It must not be applied to language specifically agreed upon through collective bargaining or required by a collective bargaining agreement.

(iv) It must not be applied to language that is prescribed by or based on state or federal statute or any related rules, regulations, or orders.

(v) It must not be applied to medical terms that are included in the form for coverage purposes.

(e) The form must contain both of the following:

(i) Topical captions.

(ii) An identification of exclusions.

(f) Except as otherwise provided in this subdivision, an insurance policy or annuity contract that has more than 3,000 words printed on not more than 3 pages of text or that has more than 3 pages of text regardless of the number of words must contain a table of contents. This subdivision does not apply to riders or indorsements.

(g) Each rider or indorsement form that changes coverage must do all of the following:

(i) Contain a properly descriptive title.

(ii) Reproduce either the entire paragraph or the provision as changed.

(iii) At the time of filing, be accompanied by an explanation of the change.

(h) If a computer system approved by the director calculates the readability score of a form as being in compliance with this subsection, the form is considered in compliance with the readability score requirements of this subsection.

(i) A variable life product or variable annuity product approved by the United States Securities and Exchange Commission for sale in this state is considered in compliance with this section.

(4) An insurer shall submit for approval under subsection (3) a change or addition to a policy or annuity contract form for personal, family, or household purposes, whether by indorsement, rider, or otherwise, or a change or addition to a rider or indorsement form associated with the policy form or annuity contract form, if the form has not been previously approved under subsection (3).

(5) Upon written notice to the insurer, the director may, on a case-by-case review, disapprove, withdraw approval, or prohibit the issuance, advertising, or delivery of a form to any person in this state if the form violates this act, contains inconsistent, ambiguous, or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy. The director shall specify in the notice the objectionable provisions or conditions and state the reasons for the decision. If the form is legally in use by the insurer in this state, the director shall give the effective date of the disapproval in the notice, which must not be less than 30 days after the mailing or delivery of the notice to the insurer. If the form is not legally in use, the disapproval is effective immediately.

(6) If a form is disapproved or approval is withdrawn under this act, the insurer is entitled on demand to a hearing before the director or a deputy director within 30 days after the notice of disapproval or of withdrawal of approval. After the hearing, the director shall make findings of fact and law and affirm, modify, or withdraw his or her original order or decision. An insurer shall not issue the form after a final determination of disapproval or withdrawal of approval.

(7) Any issuance, use, or delivery by an insurer of a form without the prior approval of the director as required under subsection (1) or after withdrawal of approval under subsection (5) is a separate violation for which the director may order the imposition of a civil penalty of $25.00 for each offense, not to exceed a maximum penalty of $500.00 for any 1 series of offenses relating to any 1 basic policy form. The attorney general may act to recover the penalty under this subsection as provided in section 230.

(8) The filing requirements of this section do not apply to any of the following:

(a) Insurance against loss of or damage to any of the following:

(i) Imports, exports, or domestic shipments.

(ii) Bridges, tunnels, or other instrumentalities of transportation and communication.

(iii) Aircraft and attached equipment.

(iv) Vessels and watercraft that are under construction, are owned by or used in a business, or have a straight-line hull length of more than 24 feet.

(b) Insurance against loss resulting from liability, other than worker's disability compensation or employers' liability arising out of the ownership, maintenance, or use of any of the following:

(i) Imports, exports, or domestic shipments.

(ii) Aircraft and attached equipment.

(iii) Vessels and watercraft that are under construction, are owned by or used in a business, or have a straight-line hull length of more than 24 feet.

(c) Surety bonds other than fidelity bonds.

(d) Policies, riders, indorsements, or forms of unique character designed for and used with relation to insurance on a particular subject, or that relate to the manner of distribution of benefits or to the reservation of rights and benefits under life or disability insurance policies and are used at the request of the individual policyholder, contract holder, or certificate holder. By order, the director may exempt from the filing requirements of this section and sections 3401a and 4430 for as long as he or she considers proper any insurance document or form, except that portion of the document or form that establishes a relationship between group disability insurance and personal protection insurance benefits subject to exclusions or deductibles under section 3109a, as specified in the order to which this section is not practicably applied, or the filing and approval of which are considered unnecessary for the protection of the public. Insurance documents or forms providing medical payments or income replacement benefits, except that portion of the document or form that establishes a relationship between group disability

insurance and personal protection insurance benefits subject to exclusions or deductibles under section 3109a, exempt by order of the director from the filing requirements of this section and section 3401a are considered approved by the director for purposes of section 3430.

(e) An insurance policy to which both of the following apply:

(i) The insurance is sold to an exempt commercial policyholder.

(ii) The insurance policy contains a prominent disclaimer that states "This policy is exempt from the filing requirements of section 2236 of the insurance code of 1956, 1956 PA 218, MCL 500.2236." or words that are substantially similar.

(9) Notwithstanding any provision of this act to the contrary, a health insurer may satisfy a requirement for the delivery of an insurance form or notice required by this act to a subscriber, insured, enrollee, or contract holder by doing all of the following:

(a) Taking appropriate and necessary measures reasonably calculated to ensure that the system for furnishing a form or notice meets all of the following requirements:

(i) It results in the actual receipt of a delivered form or notice.

(ii) It protects the confidentiality of a subscriber's, insured's, enrollee's, or contract holder's personal information.

(b) Ensuring that an electronically delivered form or notice is prepared and furnished in a manner consistent with the style, format, and content requirements applicable to the particular form or notice.

(c) On request, delivering to the subscriber, insured, enrollee, or contract holder a paper version of an electronically delivered form or notice.

(10) Subject to the requirements of this section, an insurer may file health insurance policies, certificates, and riders quarterly. This subsection does not limit or restrict an insurer's ability to file large group health insurance policies, certificates, or riders at any time during the year.

(11) As used in this section and sections 2401 and 2601, "exempt commercial policyholder" means an insured that purchases the insurance for other than personal, family, or household purposes.

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

(13) An order made by the director under this section is subject to court review as provided in section 244.

History: 1956, Act 218, Eff. Jan. 1, 1957 ;-- Am. 1963, Act 53, Eff. Sept. 6, 1963 ;-- Am. 1970, Act 180, Imd. Eff. Aug. 3, 1970 ;-- Am. 1987, Act 52, Imd. Eff. June 22, 1987 ;-- Am. 1990, Act 137, Eff. June 29, 1990 ;-- Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990 ;-- Am. 1993, Act 200, Eff. Dec. 28, 1994 ;-- Am. 2002, Act 664, Eff. Mar. 31, 2003 ;-- Am. 2014, Act 140, Eff. Mar. 31, 2015 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016

Compiler's Notes: 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."Section 3 of Act 200 of 1993 provides as follows:"Section 3. This amendatory act shall not take effect unless the state administrative board certifies in writing to the secretary of state by December 31, 1994 that an agreement for the transfer of all or substantially all of the assets and the assumption of all or substantially all of the liabilities of the state accident fund has been consummated with a permitted transferee pursuant to the requirements of section 701a of the worker's disability compensation act of 1969, Act No. 317 of the Public Acts of 1969, being section 418.701a of the Michigan Compiled Laws."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

500.2236a Interest indexed universal life insurance; information to be maintained on file.

Sec. 2236a.

All of the following information shall be maintained on file by the insurer for all interest indexed universal life insurance policies:

(a) A description of how the interest credits are determined, including all of the following:
(i) A description of the index.
(ii) The relationship between the value of the index and the actual interest rate to be credited.
(iii) The frequency and timing that determines the interest rate.
(iv) If more than 1 rate of interest applies to different portions of the policy value, the allocation of interest credits.
(b) The insurer's investment policy, which shall include a description of all of the following:
(i) How the insurer addresses the reinvestment risks.
(ii) How the insurer plans to address the risk of capital loss on cash outflows.
(iii) How the insurer plans to address the risk that appropriate investments may not be available or not available in sufficient quantities.
(iv) How the insurer plans to address the risk that the indexed interest rate may fall below the minimum contractual interest rate guaranteed in the policy.
(v) The amount and type of assets currently held for interest indexed policies.
(vi) The amount and type of assets expected to be acquired in the future.
(c) If a policy is linked to an index for a specified period less than the maturity date of the policy, a description of the method to be used to determine interest credits upon the expiration of the period.
(d) A description of any interest guarantee in addition to or in lieu of the index.
(e) A description of any maximum premium limitations and the conditions under which they apply.

History: Add. 1993, Act 349, Eff. Oct. 1, 1994
Popular Name: Act 218

500.2237 Policy issued under chapter 34; prohibited restriction of liability.

Sec. 2237.

An insurer shall not deliver in this state an insurance policy issued under chapter 34, or issue the policy for delivery in this state, if the policy contains a provision that restricts the liability of the insurer to pay expenses because the expenses are incurred while the insured is in a hospital, institution, or other facility operated by this state or a political subdivision of this state if the insured would be legally required to pay the expenses in the absence of insurance.

History: Add. 1961, Act 133, Eff. Sept. 8, 1961 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016
Popular Name: Act 218

500.2238 Repealed. 1970, Act 180, Imd. Eff. Aug. 3, 1970.

Compiler's Notes: The repealed section pertained to basic form of policy of insurance of personal property.
Popular Name: Act 218

500.2239 Health care service rendered by dentist; benefits or reimbursement; â€œdentistâ€ defined; policies to which section applicable.

Sec. 2239.

(1) If a group or individual hospital, medical, or expense incurred policy delivered, issued for delivery, or renewed in this state provides for benefits for a health care service, those benefits or reimbursement for the provision of the service shall not be denied because the service was rendered by a dentist, provided the service was legally performed.

(2) As used in this section, "dentist" means an individual licensed under part 166 of Act No. 368 of the Public Acts of 1978, being sections 333.16601 to 333.16647 of the Michigan Compiled Laws.

(3) This section shall apply only with respect to policies issued or renewed on or after the effective date of this section, and shall apply notwithstanding any policy provision to the contrary.

History: Add. 1982, Act 291, Imd. Eff. Oct. 7, 1982
Popular Name: Act 218

500.2242 Group disability policy; filing and approval of form; grounds for disapproval; notice, hearing, and appeal requirements; withdrawal of approval; quarterly filing; applicability of section to forms filed by nonprofit dental corporation.

Sec. 2242.

(1) Except as otherwise provided in section 2236(8)(d), a group disability policy must not be issued or delivered in this state unless a copy of the form has been filed with the director and approved by him or her.

(2) The director may within 60 days after the filing of a disability insurance policy form applicable to individual or family expense coverage, disapprove the form for any of the following, subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236:

(a) The benefits provided under the policy are unreasonable in relation to the premium charged.

(b) The policy contains a provision that is unjust, unfair, inequitable, misleading, or deceptive or that encourages misrepresentation of the policy.

(c) The policy does not comply with other provisions of law.

(3) The director may at any time withdraw his or her approval of an individual or family expense policy form on any of the grounds stated in subsection (2), subject to the requirements as to notice, hearing, and appeal set forth in sections 244 and 2236. An insurer shall not issue the form after the effective date of the withdrawal of approval.

(4) Subject to the requirements of this section, an insurer may file health insurance policies, certificates, riders, and rates quarterly. This subsection does not limit or restrict an insurer's ability to file large group health insurance policies, certificates, or riders at any time during the year.

(5) After December 31, 2016, this section applies to forms filed by a nonprofit dental care corporation operating under 1963 PA 125, MCL 550.351 to 550.373.

History: 1956, Act 218, Eff. Jan. 1, 1957 ;-- Am. 1987, Act 52, Imd. Eff. June 22, 1987 ;-- Am. 1990, Act 305, Imd. Eff. Dec. 14, 1990 ;-- Am. 2013, Act 5, Imd. Eff. Mar. 18, 2013 ;-- Am. 2016, Act 276, Imd. Eff. July 1, 2016
Compiler's Notes: Section 2 of Act 52 of 1987 provides:â€œThe 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.â€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

500.2243 Group policies; optometric service; coverage.

Sec. 2243.

(1) Notwithstanding any provision of a policy or contract of group accident, group health, or group accident and health insurance, executed after July 23, 1965, if the policy or contract provides for reimbursement for any optometric service that is within the lawful scope of practice of a duly licensed optometrist, a subscriber to such group accident, group health, or group accident and group health insurance policy or contract shall be entitled to reimbursement for such service, whether the service is performed by a physician or a duly licensed optometrist. Unless the policy or contract of group accident, group health, or group accident and health insurance otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(2) If a subscriber contract provides for and offers optometric services, the subscriber shall have freedom of choice to select either a physician or an optometrist to render the services. Unless the subscriber contract otherwise provides, there shall be no reimbursement for ophthalmic materials, lenses, spectacles, eyeglasses, or appurtenances.

(3) This section does not require coverage or reimbursement for a practice of optometric service unless that service was included in the definition of practice of optometry under section 17401 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.17401 of the Michigan Compiled Laws, as of May 20, 1992.

History: Add. 1965, Act 349, Imd. Eff. July 23, 1965 ;-- Am. 1994, Act 438, Eff. Mar. 30, 1995
Popular Name: Act 218

500.2246 Insured or applicant for life insurance policy as victim of domestic violence; refusal to provide coverage prohibited; exceptions; liability; applicability to policies on or after June 1, 1998; â€œdomestic violenceâ€ defined.

Sec. 2246.

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

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

(a) An insurer from refusing to issue a life insurance policy insuring an individual who has been the victim of domestic violence if the individual who commits the domestic violence is the applicant for, prospective owner of, or beneficiary under the policy and 1 or more of the following apply:

(i) The applicant, prospective owner, or beneficiary under the policy is known on the basis of police or court records to have committed domestic violence.

(ii) The insurer knows of an arrest or conviction for a domestic violence related offense by the applicant for, prospective owner of, or beneficiary under the policy.

(iii) The insurer has reasonable grounds to believe that the applicant for, prospective owner of, or beneficiary under the policy is committing domestic violence.

(b) An insurer from inquiring about, underwriting, or charging a different premium on the basis of the individual's physical or mental condition, regardless of the cause of the condition.

(c) An insurer from refusing to issue a life insurance policy if the applicant for, prospective owner of, or beneficiary under the policy does not have an insurable interest in the life of the prospective insured individual.

(3) An insurer shall not be held civilly liable for any cause of action that may result from compliance with this section.

(4) This section applies to all life insurance policies issued or renewed on or after June 1, 1998.

(5) As used in this section, "domestic violence" means inflicting bodily injury, causing serious emotional injury or psychological trauma, 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 130, Imd. Eff. June 24, 1998
Popular Name: Act 218

500.2248 Automobile insurance; delivery of policy to insured.

Sec. 2248.

(1) A policy of insurance against fire, theft, property damage, collision, or liability in connection with automobile coverage shall not be issued unless the policy, or an exact copy of the policy, is delivered to the insured.

(2) For purposes of this section, a personal automobile insurance policy and endorsements that do not contain personally identifiable information may be delivered by mailing, delivery, or posting on the insurer's internet website. If the insurer elects to post an insurance policy and endorsements on its internet website in lieu of mailing or delivering them to the named insured, the insurer shall comply with all of the following conditions:

(a) The policy and endorsements are easily accessible and remain easily accessible for as long as the policy is in force.

(b) After the expiration of the policy, the insurer archives the policy and endorsements and makes them available on request at no charge or for a reasonable charge.

(c) The policy and endorsements are posted in a manner that enables the insured to print and save the policy and endorsements using programs or applications that are widely available on the internet and free to use.

(d) The insurer provides notice to the named insured with each declarations page of a method by which an insured may obtain, on request and without charge, a paper or electronic copy of the policy or endorsements.

(e) On each declarations page issued to an insured, the insurer clearly identifies the exact policy and endorsement forms purchased by the insured.

(f) The insurer provides notice, in the manner by which it customarily communicates with a named insured, of any of the changes to the forms or endorsements and the insured's right to obtain, on request and without charge, a paper copy of the forms or endorsements.

History: 1956, Act 218, Eff. Jan. 1, 1957 ;-- Am. 2012, Act 454, Imd. Eff. Dec. 27, 2012
Popular Name: Act 218

500.2250 Binders or other contracts for temporary insurance; applicability.

Sec. 2250.

Binders or other contracts for temporary insurance shall be considered to include all of the terms and conditions of the policy for which application is made. This section does not apply to a life insurance policy.

History: Add. 1990, Act 305, Imd. Eff. Dec. 14, 1990 ;-- Am. 1991, Act 106, Imd. Eff. Oct. 3, 1991
Popular Name: Act 218

500.2254 Action against domestic insurer by member or beneficiary; conditions.

Sec. 2254.

Suits at law may be prosecuted and maintained by any member against a domestic insurance corporation for claims which may have accrued if payments are withheld more than 60 days after such claims shall have become due. No article, bylaw, resolution or policy provision adopted by any life, disability, surety, or casualty insurance company doing business in this state prohibiting a member or beneficiary from commencing and maintaining suits at law or in equity against such company shall be valid and no such article, bylaw, provision or resolution shall hereafter be a bar to any suit in any court in this state: Provided, however, That any reasonable remedy for adjudicating claims established by such company or companies shall first be exhausted by the claimant before commencing suit: Provided further, however, That the company shall finally pass upon any claim submitted to it within a period of 6 months from and after final proofs of loss or death shall have been furnished any such company by the claimant.

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

500.2260 Life or disability insurance; acts not constituting waiver of defenses.

Sec. 2260.

The acknowledgement by any insurer of the receipt of notice given under any life or disability insurance policy or the furnishing of forms for filing proofs of loss, or the acceptance of such proofs, or the investigation of any claim thereunder shall not operate as a waiver of any of the rights of the insurer in defense of any claim arising under such policy.

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

500.2264 Termination of dependent coverage at specified age; exception.

Sec. 2264.

Any contract or insurance policy delivered on or after July 12, 1966 in this state providing for hospital care or reimbursement for the care of the policyholders and dependents that provides for termination of dependent coverage at a specified age does not apply to an unmarried child of the policyholder who is incapable of self-support due to developmental disability or physical disability, and who is dependent upon the policyholder for support and maintenance, if the policyholder submits satisfactory proof of the dependent's incapacity to the insurance carrier not later than 31 days after the attainment of the age limit by the dependent child.

History: Add. 1966, Act 274, Imd. Eff. July 12, 1966 ;-- Am. 1998, Act 26, Imd. Eff. Mar. 12, 1998 ;-- Am. 2014, Act 67, Imd. Eff. Mar. 28, 2014
Popular Name: Act 218

500.2264a Hospital or medical care coverage or reimbursement for children who are full-time or part-time students and take leave of absence.

Sec. 2264a.

(1) Any policy or certificate delivered, issued for delivery, or renewed in this state that provides for hospital or medical care coverage or reimbursement for hospital or medical care for dependent children who are full-time or part-time students shall continue coverage for that dependent student if the dependent student is covered under that policy or certificate and takes a leave of absence from school due to illness or injury. Coverage under this section shall continue for 12 months from the last day of attendance in school or until the dependent reaches the age at which coverage would otherwise terminate, whichever period is shorter.

(2) To qualify for coverage under this section, the dependent student's attending physician shall certify in writing to the dependent's insurer or health maintenance organization that it is medically necessary for the dependent student to take a leave of absence from school.

(3) Coverage under this section shall be provided at the same rate as that charged for dependent student status.

(4) A dependent child must continue to meet all other eligibility requirements for dependent coverage in the policy or certificate if the dependent child takes a leave of absence from school due to illness or injury.

History: Add. 2006, Act 537, Eff. Jan. 1, 2007
Compiler's Notes: Former MCL 500.2265a, which pertained to medicare supplemental policies, was repealed by Act 84 of 1992, Imd. Eff. June 2, 1992.
Popular Name: Act 218

500.2265-500.2290 Repealed. 1992, Act 84, Imd. Eff. June 2, 1992.

Compiler's Notes: The repealed sections pertained to medicare supplemental policies and long-term care coverage.
Popular Name: Act 218

500.2266 Electronic delivery of insurance documents; requirements; withdrawal of consent; civil liability; applicability to health insurer or health maintenance organization; definitions.

Sec. 2266.

(1) Subject to the requirements of this section, a notice to a party or any other document that is required in an insurance transaction or that is to serve as evidence of insurance coverage may be delivered, stored, and presented by electronic means if it meets the requirements of the uniform electronic transactions act, 2000 PA 305, MCL 450.831 to 450.849.

(2) Electronic delivery of a notice or document as provided in this section is equivalent to any delivery method otherwise required by law, including delivery by first-class mail, first-class mail postage prepaid, certified mail, or certificate of mailing.

(3) If an insurer has reason to believe that a party is not receiving notices or documents that the insurer attempts to deliver by electronic means, including if the insurer attempts delivery by electronic means and receives a notice that the delivery by electronic means has failed, the insurer shall deliver the notices or documents by first-class mail or by any other delivery method required for the notices or documents.

(4) An insurer may use electronic delivery of a notice or a document to a party under this section if the insurer meets the requirements of subsection (5) and if all of the following requirements are met:

(a) The party has affirmatively consented to the electronic delivery method and has not withdrawn consent.

(b) Before obtaining consent, the insurer provides the party with a clear and conspicuous statement informing the party of all of the following:

(i) The right of the party at any time to have the notice or the document provided or made available in paper form or by another nonelectronic form.

(ii) The right of the party at any time to withdraw consent to have a notice or document delivered by electronic means and any conditions or consequences imposed if consent is withdrawn.

(iii) The specific notice or document or categories of notices or documents that may be delivered by electronic means during the course of the relationship between the insurer and the party.

(iv) The means, after consent is given, by which the party may obtain a paper copy of a notice or document delivered by electronic means.

(v) The procedures for the party to follow to update information needed to contact the party electronically and to withdraw consent to have a notice or a document delivered by electronic means.

(c) Before obtaining consent, the insurer provides the party with a statement of the hardware and software requirements for access to and retention of a notice or document delivered by electronic means. The party shall provide electronic consent to the hardware and software requirements or confirm consent electronically in a manner that reasonably demonstrates that the party can access information in the electronic form that will be used for notices or documents delivered by electronic means.

(5) After the party consents as provided in subsection (4), if a change occurs in hardware or software needed to access or retain a notice or document delivered by electronic means that creates a material risk that the party will not be able to access or retain a notice or document to which consent applies, the insurer shall provide the party with a statement that includes all of the following:

(a) Information regarding the revised hardware or software requirements for access to and retention of a notice or document delivered by electronic means.

(b) A description of the right of the party to withdraw consent without the imposition of any condition or consequence that was not disclosed under subsection (4)(b)(ii).

(6) Withdrawal of consent to electronic delivery does not affect the legal effectiveness, validity, or enforceability of a notice or a document that is delivered by electronic means to a party before the withdrawal of consent is effective.

(7) Except as otherwise provided in this subsection, withdrawal of consent by a party becomes effective 30 days after the insurer receives notice of the withdrawal. Consent is automatically withdrawn if the insurer learns that the electronic delivery method currently used is no longer an effective delivery mechanism.

(8) Failure by an insurer to comply with subsection (5) may be treated, at the election of the party, as a withdrawal of consent.

(9) This section must not be construed to modify, limit, or supersede the federal electronic signatures in global national commerce act, 15 USC 7001 to 7031.

(10) An insurance producer is not subject to civil liability for any harm or injury to a party that occurs as a result of either of the following:

(a) The party's consent under subsection (4) to receive a notice or a document delivered by electronic means under this section.

(b) An insurer's failure to deliver a notice or document by electronic means unless the insurance producer causes the harm or injury.

(11) This section does not apply to a health insurer or health maintenance organization.

(12) As used in this section:

(a) "Delivered by electronic means", "delivery by electronic means", or "electronic delivery" mean delivery by either of the following methods:

(i) Delivery to an electronic mail address at which a party has consented to receive notices or documents.

(ii) Both of the following:

(A) Posting on an electronic network or site accessible by the internet through use of a mobile application, computer, mobile device, tablet, or any other electronic device.

(B) Sending separate notice of the posting described in sub-subparagraph (A) to the electronic mail address at which the party consented to receive notice of the posting or using any other delivery method to which the party has consented.

(b) "Party" means a recipient of a notice or document required as part of an insurance transaction and includes an applicant, insured, policy holder, or annuity contract holder.

History: Add. 2018, Act 205, Imd. Eff. June 20, 2018 ;-- Am. 2018, Act 429, Eff. Mar. 20, 2019
Popular Name: Act 218