

THE NONPROFIT HEALTH CARE CORPORATION REFORM ACT (EXCERPT)
Act 350 of 1980

PART 4

550.1400 Use of most favored nation clause in provider contract.

Sec. 400. (1) Notwithstanding any provision of this act to the contrary, this section applies to the use of a most favored nation clause in a provider contract on and after February 1, 2013.

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

(3) Beginning January 1, 2014, a health care corporation shall not use a most favored nation clause in any provider contract, including a provider contract in effect on January 1, 2014.

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

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

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

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

(d) Requires a provider to disclose, to the health care corporation or its designee, the provider's contractual payment or reimbursement rates with other parties.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401 Offering of health care benefits; limiting benefits; division of benefits into classes or kinds; prohibited conduct; grounds for denial of coverage; coordination of benefits, subrogation, and nonduplication of benefits; health care corporation as party in interest; limiting or denying coverage or participation status; requirements for participation and reimbursement; determination by commissioner; definitions.

Sec. 401. (1) A health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state, and may offer other health care benefits as the corporation specifies with the approval of the commissioner.

(2) A health care corporation may limit the health care benefits that it will furnish, except as provided in this act, and may divide the health care benefits that it elects to furnish into classes or kinds.

(3) A health care corporation shall not do any of the following:

(a) Refuse to issue or continue a certificate to 1 or more residents of this state, except while the individual, based on a transaction or occurrence involving a health care corporation, is serving a sentence arising out of a charge of fraud, is satisfying a civil judgment, or is making restitution pursuant to a voluntary payment agreement between the corporation and the individual.

(b) Refuse to continue in effect a certificate with 1 or more residents of this state, other than for failure to pay amounts due for a certificate, except as allowed for refusal to issue a certificate under subdivision (a).

(c) Limit the coverage available under a certificate, without the prior approval of the commissioner, unless the limitation is as a result of: an agreement with the person paying for the coverage; an agreement with the individual designated by the persons paying for or contracting for the coverage; or a collective bargaining agreement.

(d) Rate, cancel benefits on, refuse to provide benefits for, or refuse to issue or continue a certificate solely because a subscriber or applicant is or has been a victim of domestic violence. A health care corporation shall not be held civilly liable for any cause of action that may result from compliance with this subdivision. This subdivision applies to all health care corporation certificates issued or renewed on or after June 1, 1998. As

used in this subdivision, "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.

(e) Require a member or his or her dependent or an applicant for coverage or his or her dependent to do either of the following:

(i) Undergo genetic testing before issuing, renewing, or continuing a health care corporation certificate.

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

(4) Subsection (3) does not prevent a health care corporation from denying to a resident of this state coverage under a certificate for any of the following grounds:

(a) That the individual was not a member of a group that had contracted for coverage under this certificate.

(b) That the individual is not a member of a group with a size greater than a minimum size established for a certificate pursuant to sound underwriting requirements.

(c) That the individual does not meet requirements for coverage contained in a certificate.

(d) For groups of under 100 subscribers and except as otherwise provided in section 3709 of the insurance code of 1956, 1956 PA 218, MCL 500.3709, that the group that the individual is a member of has failed to enroll enough of its eligible members with the health care corporation. A denial under this subdivision shall be made only if the health care corporation determines that the cost for the portion of the group applying for coverage would be at least 50% more on a per subscriber basis than the per subscriber cost for the whole group. A denial under this subdivision shall not be based on the health status of any individual in the group or his or her dependent. A denial under this subdivision shall be based on sound actuarial principles and may be based on 1 or more of the following:

(i) That the contract holder for the group applying for coverage is also offering a self-funded health benefit plan.

(ii) That the group applying for coverage is composed entirely of the contract holder's retiree business segment.

(iii) That the average individual age of the members of the group applying for coverage is either 50% higher or 10 years higher than the average individual age for the whole group.

(5) A certificate may provide for the coordination of benefits, subrogation, and the nonduplication of benefits. Savings realized by the coordination of benefits, subrogation, and nonduplication of benefits shall be reflected in the rates for those certificates. If a group certificate issued by the corporation contains a coordination of benefits provision, the benefits shall be payable pursuant to the coordination of benefits act, 1984 PA 64, MCL 550.251 to 550.255.

(6) A health care corporation shall have the right to status as a party in interest, whether by intervention or otherwise, in any judicial, quasi-judicial, or administrative agency proceeding in this state for the purpose of enforcing any rights it may have for reimbursement of payments made or advanced for health care services on behalf of 1 or more of its subscribers or members.

(7) A health care corporation shall not directly reimburse a provider in this state who has not entered into a participating contract with the corporation.

(8) A health care corporation shall not limit or deny coverage to a subscriber or limit or deny reimbursement to a provider on the ground that services were rendered while the subscriber was in a health care facility operated by this state or a political subdivision of this state. A health care corporation shall not limit or deny participation status to a health care facility on the ground that the health care facility is operated by this state or a political subdivision of this state, if the facility meets the standards set by the corporation for all other facilities of that type, government-operated or otherwise. To qualify for participation and reimbursement, a facility shall, at a minimum, meet all of the following requirements, which shall apply to all similar facilities:

(a) Be accredited by the joint commission on accreditation of hospitals.

(b) Meet the certification standards of the medicare program and the medicaid program.

(c) Meet all statutory requirements for certificate of need.

(d) Follow generally accepted accounting principles and practices.

(e) Have a community advisory board.

(f) Have a program of utilization and peer review to assure that patient care is appropriate and at an acute level.

(g) Designate that portion of the facility that is to be used for acute care.

(9) Not later than the close of business on the seventh business day after denying coverage under subsection (4)(d), the health care corporation shall notify the commissioner of this denial and shall supply the

commissioner with the information used in determining the denial. The commissioner shall determine whether he or she will approve or disapprove the health care corporation denial not later than the close of business on the seventh business day after receipt of the notice and shall promptly notify the health care corporation of his or her determination. The commissioner shall base his or her determination under this subsection on whether the health care corporation met the standards in subsection (4)(d). The health care corporation or the denied contract holder may appeal the commissioner's decision in circuit court. The commissioner shall report to the senate and house of representatives standing committees on insurance issues by May 15, 2005 and biennially thereafter all of the following:

- (a) The number of denials made each calendar year by a health care corporation under subsection (4)(d).
- (b) The number of denials under subdivision (a) that were approved by the commissioner under this subsection and a summary of the type of group approved.
- (c) The number of denials under subdivision (a) that were disapproved by the commissioner under this subsection and a summary of the type of group disapproved.
- (d) The number of decisions by the commissioner under this subsection that have been appealed and the results of the appeals.

(10) As used in this section:

- (a) "Clinical purposes" includes all of the following:
 - (i) Predicted risk of diseases.
 - (ii) Identifying carriers for single-gene disorders.
 - (iii) Establishing prenatal and clinical diagnosis or prognosis.
 - (iv) Prenatal, newborn, and other carrier screening, as well as testing in high-risk families.
 - (v) Tests for metabolites if undertaken with high probability that an excess or deficiency of the metabolite indicates or suggests the presence of heritable mutations in single genes.
 - (vi) Other tests if their intended purpose is diagnosis of a presymptomatic genetic condition.
- (b) "Genetic information" means information about a gene, gene product, or inherited characteristic derived from a genetic test.

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

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1984, Act 66, Imd. Eff. Apr. 18, 1984;—Am. 1998, Act 135, Imd. Eff. June 24, 1998;—Am. 2000, Act 26, Imd. Eff. Mar. 15, 2000;—Am. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401a Health care service rendered by dentist; benefits or reimbursement; "dentist" defined; certificates to which section applicable.

Sec. 401a. (1) If a group or nongroup certificate of a health care corporation provides for health care 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 certificates which are issued or renewed on or after the effective date of this section, and shall apply notwithstanding any certificate provision to the contrary.

History: Add. 1982, Act 290, Imd. Eff. Oct. 7, 1982.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401b Certificate providing benefits for mental health services; requirements.

Sec. 401b. A certificate issued by a corporation which provides benefits for mental health services shall provide benefits for mental health services provided to an individual by a mental health care provider operated by or under contract with the department of mental health or a county community mental health board in those instances when appropriate mental health services cannot be delivered otherwise, or if the provider of the mental health services is designated by an order of a court; provided that the mental health

provider meets the standards set by the corporation for all other providers of the type.

History: Add. 1984, Act 230, Eff. Dec. 20, 1984.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401c Replacement group certificate with preexisting condition limitation; elimination, reduction, or limitation of benefits; “disability coverage” defined.

Sec. 401c. (1) If existing group disability coverage is replaced by a group certificate with a preexisting condition limitation and insuring 10 or more members, coverage in the replacement certificate applicable to the preexisting condition limitation for an individual who had been covered for that condition by the replaced coverage shall be not less than the lesser of the following:

(a) The coverage of the replacement certificate without application of the preexisting condition limitation.

(b) The benefits of the replaced group disability coverage until the individual's preexisting condition limitation expires under the replacement certificate.

(2) Other than as provided in subsection (1), a replacement group certificate insuring 10 or more members shall not include a limitation upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement certificate.

(3) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group certificate with a preexisting condition limitation and insuring less than 10 members, the replaced coverage shall extend benefits for the condition excluded by the replacement certificate because of the application of a preexisting condition limitation by providing benefits for that condition until the term of the preexisting condition limitation has expired or 6 months have elapsed, whichever occurs first. An individual not covered for a condition under replaced group disability coverage because the term of a preexisting condition limitation has not expired is covered for that condition under the replaced coverage pursuant to this subsection when the term of the preexisting condition limitation in the replaced coverage expires. If there is a dispute between the replacement carrier and the replaced carrier as to whether an individual's condition is included within a preexisting condition limitation, benefits shall be paid by the replacement carrier pending resolution of the dispute. This subsection applies only to the extent that benefits would have been available for the preexisting condition under the replaced coverage. This subsection applies only if the replaced master coverage has been in effect for at least 6 months.

(4) If existing group disability coverage issued or renewed on or after January 1, 1992 is replaced by a group certificate with a preexisting condition limitation and insuring less than 10 members, the replacement certificate shall not include a limitation for a period exceeding 6 months upon an individual or exclude an individual who was covered by the group disability coverage being replaced if the individual is a member of the class or classes of individuals eligible for coverage under the replacement certificate.

(5) This section does not preclude an elimination, reduction, or limitation of benefits which applies to an entire plan. This section applies to individuals who are covered under the replaced certificate at the time of replacement and does not apply to individuals who become eligible for or apply for coverage under a replacement group certificate after that replacement certificate is issued.

(6) As used in this section, "disability coverage" means expense-incurred hospital, medical, or surgical coverage.

History: Add. 1989, Act 256, Eff. Jan. 1, 1992.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401d Services performed by physician's assistant; reimbursement; conditions; applicability of section; supervision by physician; definitions.

Sec. 401d. (1) Subject to subsections (2) and (3), if a health care corporation group or nongroup certificate provides for health care benefits for services performed by a physician's assistant, those benefits or reimbursement for those benefits at the prevailing rate shall not be denied if the services were performed by a physician's assistant acting within the scope of his or her license and provided that the following are met:

(a) If the services were performed by a physician's assistant working for a physician or facility specializing in a particular area of medicine, a physician that specializes in that area of medicine was physically present on the premises when the physician's assistant performed the services.

(b) If the services were performed by a physician's assistant working for a physician or facility engaging in general family practice, a physician need not have been physically present on the premises when the

physician's assistant performed the services so long as a consulting physician is within 150 miles or 3 hours' commute to where the services are performed.

(2) This section applies to a physician's assistant who performs services in any of the following:

- (a) A county with a population of 25,000 or less.
- (b) A certified rural health clinic.
- (c) A health professional shortage area.

(3) For purposes of subsection (1), a physician supervising a physician's assistant shall do so from within Michigan or from a state bordering Michigan.

(4) As used in this section:

(a) "Health professional shortage area" means that term as defined in section 332(a)(1) of subpart II of part C of title III of the public health service act, chapter 373, 90 Stat. 2270, 42 U.S.C. 254e.

(b) "Medicaid" means the program of medical assistance established under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396u.

(c) "Medicare" means the federal medicare program established under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-2 to 1395i-4, 1395j to 1395t, 1395u to 1395w-2, 1395w-4 to 1395zz, and 1395bbb to 1395ccc.

(d) "Physician's assistant" means an individual licensed as a physician's assistant under article 15 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.16101 to 333.18838 of the Michigan Compiled Laws.

(e) "Rural health clinic" means a rural health clinic as defined under section 1861 of part C of title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395x, and certified to participate in medicaid and medicare.

History: Add. 1991, Act 102, Imd. Eff. Sept. 6, 1991;—Am. 1993, Act 258, Imd. Eff. Nov. 29, 1993.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401e Group certificate issued by health care corporation; renewal or continuation; guaranteed renewal; discontinuing plan, product, or coverage in nongroup or group market; conditions.

Sec. 401e. (1) Except as otherwise provided in this section, a health care corporation that has issued a nongroup certificate shall renew or continue in force the certificate at the option of the individual.

(2) Except as otherwise provided in this section, a health care corporation that has issued a group certificate shall renew or continue in force the certificate at the option of the sponsor of the plan.

(3) Guaranteed renewal is not required in cases of fraud, intentional misrepresentation of material fact, lack of payment, if the health care corporation no longer offers that particular type of coverage in the market, or if the individual or group moves outside the service area.

(4) A health care corporation shall not discontinue offering a particular plan or product in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner 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 health care corporation 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.

(5) A health care corporation shall not discontinue offering all coverage in the nongroup or group market unless the health care corporation does all of the following:

(a) Provides notice to the commissioner 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 health care corporation withdrew and, except as allowed under subsection (6), does not renew coverage under those plans.

(6) If a health care corporation discontinues coverage under subsection (5), the health care corporation shall not provide for the issuance of any health benefit plans in the nongroup or group market from which the

health care corporation withdrew during the 5-year period beginning on the date of the discontinuation of the last plan not renewed under that subsection.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401f Health care corporation; access to obstetrician-gynecologist.

Sec. 401f. (1) A health care corporation certificate that requires a member to designate a participating primary care provider and provides for annual well-woman examinations and routine obstetrical and gynecologic services shall permit a female member to access an obstetrician-gynecologist for annual well-woman examinations and routine obstetrical and gynecologic services.

(2) A health care corporation shall not require prior authorization or referral for access under subsection (1) to an obstetrician-gynecologist who participates with the health care corporation. A health care corporation may require prior authorization or referral for access to a nonparticipating obstetrician-gynecologist.

(3) A description of the benefit provided by this section shall be included by the health care corporation in a communication sent to the individual or group purchaser of coverage.

History: Add. 1998, Act 412, Eff. Mar. 23, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401g Health care corporation; access to pediatric care services.

Sec. 401g. (1) A health care corporation certificate that requires a member to designate a participating primary care provider and provides for dependent care coverage shall permit a dependent minor member to select and access a pediatrician for general pediatric care services.

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

History: Add. 1999, Act 178, Imd. Eff. Nov. 16, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401h Health care corporation providing prescription drug coverage; formulary restrictions.

Sec. 401h. A health care corporation that provides coverage for prescription drugs and limits those benefits to drugs included in a formulary shall do all of the following:

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

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

(c) Provide for exceptions from the formulary limitation when a nonformulary alternative is a medically necessary and appropriate alternative. This subdivision does not prevent a health care corporation from establishing prior authorization requirements or another process for consideration of coverage or higher cost-sharing for nonformulary alternatives. Notice as to whether or not an exception under this subdivision has been granted shall be given by the health care corporation within 24 hours after receiving all information necessary to determine whether the exception should be granted.

History: Add. 1999, Act 175, Imd. Eff. Nov. 16, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401i Prescription drug coverage; pilot project; provisions; interim report; determination; evaluation.

Sec. 401i. (1) Beginning January 1, 2004, a health care corporation shall establish and offer to provide or include prescription drug coverage in at least 1 nongroup certificate and at least 1 group conversion certificate as a pilot project under this section. This pilot project shall continue through December 1, 2006 and, while in pilot project status, is not subject to the guaranteed renewability provisions of section 401e.

(2) Unless an order of adjustment issued under subsection (4)(b)(ii) provides otherwise, a certificate that includes prescription drug coverage under subsection (1) shall include all of the following:

(a) At a minimum, a prescription drug benefit that includes a co-pay of no more than 50% of the health

care corporation's approved amount for the payment of prescription drugs, with a minimum co-pay of \$10.00 and a maximum co-pay of \$100.00 per prescription.

(b) An annual per person benefit maximum of no less than \$2,500.00.

(c) A provision that members will be entitled to purchase prescription drugs at a discount under the affinity program offered by the health care corporation once their annual per person prescription drug benefit maximum has been reached.

(3) Not later than July 1, 2005, the health care corporation shall issue an interim report to the commissioner regarding the claims experience of the market segment under this section and the ongoing viability of the pilot project. Not later than July 1, 2006, the health care corporation shall issue a final report to the commissioner regarding the claims experience of the market segment under this section and the ongoing viability of the pilot project.

(4) By December 1, 2006, the commissioner shall determine if the nongroup and group conversion certificates providing the prescription drug benefit under this section provide a useful benefit to its subscribers in an actuarially sound manner. Based upon this determination, the commissioner shall do 1 of the following:

(a) If the commissioner determines that a certificate does provide a useful benefit to its subscribers in an actuarially sound manner, the commissioner shall order the termination of the pilot project designation and order that the program continue indefinitely. If the pilot project is discontinued and the program is continued indefinitely beyond the date prescribed in subsection (3) or (5), then the certificate is subject to the guaranteed renewability provisions of section 401e.

(b) If the commissioner determines that a certificate does not provide a useful benefit to its subscribers in an actuarially sound manner, the commissioner shall do 1 of the following:

(i) Order the termination of the pilot project under this section and terminate the offering of prescription drug coverage in the nongroup and group conversion certificates.

(ii) Order an adjustment of the pilot project to operate in an actuarially sound manner and order that the pilot project continue for a specified time period. An order of adjustment under this subparagraph may revise the requirements of subsection (2) regarding coverage required under the certificates.

(5) If the commissioner orders an adjustment of the pilot project under subsection (4), the commissioner shall evaluate the project after 2 years of operation and make a determination in the same manner as prescribed in subsection (4).

History: Add. 2003, Act 41, Eff. July 15, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401j Prescription drug coverage; rate differentials; filing.

Sec. 401j. The rates charged to nongroup and group conversion subscribers for a certificate that includes prescription drug coverage pursuant to section 401i may include rate differentials based on age, with not more than 8 separate age bands. The health care corporation shall file its rates for the prescription drug coverage in this section in the same manner and under the same requirements as provided in section 607.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401k Telemedicine services; provisions; definition; applicability.

Sec. 401k. (1) A group or nongroup health care corporation certificate must not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine, as determined by the health care corporation. Telemedicine services must be provided by a health care professional who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the patient is located. Telemedicine services are subject to all terms and conditions of the certificate agreed upon between the certificate holder and the health care corporation, including, but not limited to, required copayments, coinsurances, deductibles, and approved amounts.

(2) As used in this section, "telemedicine" means the use of an electronic media to link patients with health care professionals in different locations. To be considered telemedicine under this section, the health care professional must be able to examine the patient via a health insurance portability and accountability act of 1996, Public Law 104-91 compliant, secure interactive audio or video, or both, telecommunications system, or through the use of store and forward online messaging.

(3) This section applies to a certificate issued or renewed after December 31, 2012.

History: Add. 2012, Act 214, Imd. Eff. June 28, 2012;—Am. 2020, Act 98, Imd. Eff. June 24, 2020.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1401m Offer of health care benefits to all residents regardless of health status.

Sec. 401m. Until January 1, 2014, a health care corporation established, maintained, or operating in this state shall offer health care benefits to all residents of this state regardless of health status.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402 Health care corporation; prohibited conduct; commission or compensation; new preexisting condition limitation waiting period; readjusting rates; participation in trade practice conference for disability insurers; provider class plan not altered or superseded; probable cause to believe provisions violated; notice; disposition of matter by agreement of parties; action for damages; hearing; issuance of cease and desist order; violation of cease and desist order; civil fine; action for actual monetary damage; attorneys' fees.

Sec. 402. (1) A health care corporation shall not do any of the following:

- (a) Misrepresent pertinent facts or certificate provisions relating to coverage.
 - (b) Fail to acknowledge promptly or to act reasonably and promptly upon communications with respect to a claim arising under a certificate.
 - (c) Fail to adopt and implement reasonable standards for the prompt investigation of a claim arising under a certificate.
 - (d) Refuse to pay claims without conducting a reasonable investigation based upon the available information.
 - (e) Fail to affirm or deny coverage of a claim within a reasonable time after a claim has been received.
 - (f) Fail to attempt in good faith to make a prompt, fair, and equitable settlement of a claim for which liability has become reasonably clear.
 - (g) Compel members to institute litigation to recover amounts due under a certificate by offering substantially less than the amounts due.
 - (h) By making reference to written or printed advertising material accompanying or made part of an application for coverage, attempt to settle a claim for less than the amount which a reasonable person would believe was due under the certificate.
 - (i) For the purpose of compelling a member to accept a settlement or compromise in a claim, make known to the member a policy of appealing from administrative hearing decisions in favor of members.
 - (j) Attempt to settle a claim on the basis of an application which was altered without notice to, or knowledge or consent of, the subscriber under whose certificate the claim is being made.
 - (k) Delay the investigation or payment of a claim by requiring a member, or the provider of health care services to the member, to submit a preliminary claim and then requiring subsequent submission of a formal claim, seeking solely the duplication of a verification.
 - (l) Fail to promptly provide a reasonable explanation of the basis for denial of a claim or for the offer of a compromise settlement.
 - (m) Fail to promptly settle a claim where liability has become reasonably clear under 1 portion of a certificate in order to influence a settlement under another portion of the certificate.
- (2) In order to induce a person to contract or to continue to contract with the health care corporation for the provision of health care benefits or administrative or other services offered by the corporation; to induce a person to lapse, forfeit, or surrender a certificate issued by the health care corporation; or to induce a person to secure or terminate coverage with another health care corporation, insurer, health maintenance organization, or other person, a health care corporation shall not, directly or indirectly:
- (a) Issue or deliver to the person money or any other valuable consideration.
 - (b) Offer to make or make an agreement relating to a certificate other than as plainly expressed in the certificate.
 - (c) Offer to give or pay, or give or pay, directly or indirectly, a rebate or part of the premium, or an advantage with respect to the furnishing of health care benefits or administrative or other services offered by the corporation except as reflected in the rate and expressly provided in the certificate.
 - (d) Make, issue, or circulate, or cause to be made, issued, or circulated, any estimate, illustration, circular, or statement misrepresenting the terms of a certificate or contract for administrative or other services, the benefits thereunder, or the true nature thereof.
 - (e) Make a misrepresentation or incomplete comparison, whether oral or written, between certificates of

the corporation or between certificates or contracts of the corporation and another health care corporation, health maintenance organization, or other person.

(3) A health care corporation shall not provide a commission or other compensation to the health care corporation's agent or employee for the sale or service of a health care benefits certificate issued to an individual eligible for medicare, unless the amount of the commission or compensation paid in the first year of the certificate is not more than the amount of the commission or compensation that the health care corporation's agent or employee receives for the certificate in each of the 2 subsequent, consecutive annual renewal periods.

(4) A health care corporation shall not issue a certificate to an individual eligible for medicare that provides for a new preexisting condition limitation waiting period if coverage is converted to or replaced by a new or other form of similar coverage with the same health care corporation or any of the health care corporation's affiliates. If the preexisting condition limitation waiting period in the original or replaced certificate has not expired, the replacing certificate may include the remaining term of the preexisting condition limitation waiting period of the replaced certificate. This subsection does not apply to an increase in benefits voluntarily selected by the individual.

(5) Nothing in subsection (2) shall prevent a health care corporation from readjusting the rates charged to a subscriber group which is experience-rated based on the previous claims of the group.

(6) The commissioner shall allow a health care corporation to participate in any trade practice conference for disability insurers convened under section 2047 of Act No. 218 of the Public Acts of 1956, being section 500.2047 of the Michigan Compiled Laws, and may bind a health care corporation to any rules promulgated as provided in that section.

(7) Nothing in this section shall alter or supersede any provider class plan established pursuant to part 5.

(8) If the commissioner has probable cause to believe that a health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or has probable cause to believe that a health care corporation is violating, or has violated subsection (2), (3), or (4), he or she shall give written notice to the corporation, pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969, being sections 24.201 to 24.328 of the Michigan Compiled Laws, setting forth the general nature of the complaint against the corporation and the proceedings contemplated under this section. Before the issuance of a notice of hearing, the staff of the bureau of insurance responsible for the matters which would be at issue in the hearing shall give the corporation an opportunity to confer and discuss the possible complaint and proceedings in person with the commissioner or a representative of the commissioner, and the matter may be disposed of summarily upon agreement of the parties. This subsection shall not be construed to diminish the right of a person to bring an action for damages under this section.

(9) A hearing held pursuant to subsection (8) shall be held in accordance with section 2030 of the insurance code of 1956, Act No. 218 of the Public Acts of 1956, as amended, being section 500.2030 of the Michigan Compiled Laws. The hearing shall be held pursuant to the administrative procedures act of 1969, Act No. 306 of the Public Acts of 1969. If, after the hearing, the commissioner determines that the health care corporation is violating, or has violated subsection (1), indicating a persistent tendency to engage in conduct prohibited by that subsection, or is violating, or has violated subsection (2), (3), or (4), the commissioner shall reduce his or her findings and decision to writing, and shall issue and cause to be served upon the corporation a copy of the findings and an order requiring the corporation to cease and desist from engaging in the prohibited activity. The commissioner may at any time, by order, and after notice and opportunity for a hearing, reopen and alter, modify, or set aside, in whole or in part, an order issued by him or her under this subsection, when in his or her opinion conditions of fact or law have so changed as to require that action, or if the public interest so requires.

(10) A health care corporation which violates a cease and desist order of the commissioner issued under subsection (9), after notice and an opportunity for a hearing, and upon order of the commissioner, may be subject to a civil fine of not more than \$10,000.00 for each violation.

(11) In addition to other remedies provided by law, an aggrieved member may bring an action for actual monetary damages sustained as a result of a violation of this section. If successful on the merits, the member shall be awarded actual monetary damages or \$200.00, whichever is greater, together with reasonable attorneys' fees. If the health care corporation shows by a preponderance of the evidence that a violation of this section resulted from a bona fide error notwithstanding the maintenance of procedures reasonably adapted to avoid the error, the amount of recovery shall be limited to actual monetary damages.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1989, Act 132, Eff. Nov. 1, 1989.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402a Terms and conditions of certificate; form; description; requested information; written request; "board certified" defined.

Sec. 402a. (1) A health care corporation shall provide a written form in plain English to subscribers upon enrollment that describes the terms and conditions of the corporation's certificate. The form shall provide a clear, complete, and accurate description of all of the following, as applicable:

(a) The service area.

(b) Covered benefits, including prescription drug coverage, with specifications regarding requirements for the use of generic drugs.

(c) Emergency health coverages and benefits.

(d) Out-of-area coverages and benefits.

(e) An explanation of member financial responsibility for copayments, deductibles, and any other out-of-pocket expenses.

(f) Provision for continuity of treatment if a provider's participation terminates during the course of a member's treatment by that provider.

(g) The telephone number to call to receive information concerning member grievance procedures.

(h) How the covered benefits apply in the evaluation and treatment of pain.

(i) A summary listing of the information available pursuant to subsection (2).

(2) A health care corporation shall provide upon request to members for services offered pursuant to section 502a a clear, complete, and accurate description of any of the following information that has been requested:

(a) The current provider network in the certificate's service area, including names and locations of 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 members.

(b) The professional credentials of participating health professionals, including, but not limited to, participating health professionals who are board certified in pain medicine and the evaluation and treatment of pain and have reported that certification to the health care corporation, 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 health professional presently has privileges for the treatment, illness, or procedure that is the subject of the request.

(c) The licensing verification telephone number for the Michigan department of consumer and industry services 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 immediately 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) Indication of the financial relationships between the health care corporation 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 health care corporation additional information concerning the items described in subdivisions (a) to (e).

(3) Upon request, any of the information provided under subsection (2) shall be provided in writing. A

health care corporation may require that a request under subsection (2) be submitted in writing.

(4) As used in this section, "board certified" means certified to practice in a particular medical or other health profession specialty by the American board of medical specialties or other national health professional organization.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 1998, Act 426, Eff. Apr. 1, 1999;—Am. 2001, Act 242, Imd. Eff. Jan. 8, 2002.

Compiler's note: Enacting section 1 of Act 242 of 2001 provides:

"Enacting section 1. The 2001 amendatory act that added section 402a(4) to the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1402a, shall not be construed as creating a new mandated benefit for any coverages issued under the nonprofit health care corporation reform act, 1980 PA 350, MCL 550.1101 to 550.1704."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402b Preexisting condition limitation or exclusion; prohibition; exception; "group" defined.

Sec. 402b. (1) For an individual covered under a nongroup certificate or under a certificate not covered under subsection (2), a health care corporation may exclude or limit coverage for a condition only if the exclusion or limitation relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months before enrollment and the exclusion or limitation does not extend for more than 6 months after the effective date of the certificate.

(2) A health care corporation shall not exclude or limit coverage for a preexisting condition for an individual covered under a group certificate.

(3) Notwithstanding subsection (1), a health care corporation shall not issue a certificate to a person eligible for nongroup coverage or eligible for a certificate not covered under subsection (2) that excludes or limits coverage for a preexisting condition or provides a waiting period if all of the following apply:

(a) The person's most recent health coverage prior to applying for coverage with the health care corporation was under a group health plan.

(b) The person was continuously covered prior to the application for coverage with the health care corporation under 1 or more health plans for an aggregate of at least 18 months with no break in coverage that exceeded 62 days.

(c) The person is no longer eligible for group coverage and is not eligible for medicare or medicaid.

(d) The person did not lose eligibility for coverage for failure to pay any required contribution or for an act to defraud a health care corporation, a health insurer, or a health maintenance organization.

(e) If the person was eligible for continuation of health coverage from that group health plan pursuant to the consolidated omnibus budget reconciliation act of 1985, Public Law 99-272, 100 Stat. 82, he or she has elected and exhausted that coverage.

(4) As used in this section, "group" means a group of 2 or more subscribers.

History: Add. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 1999, Act 7, Imd. Eff. Mar. 9, 1999.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402c Termination of participation between primary care physician and health care corporation; notice to member; effect of termination; definitions.

Sec. 402c. (1) If participation between a primary care physician and a health care corporation terminates, the physician may provide written notice of this termination within 15 days after the physician becomes aware of the termination to each member who has chosen the physician as his or her primary care physician. If a member is in an ongoing course of treatment with any other physician who is participating with the health care corporation and the participation between the physician and the health care corporation terminates, the physician may provide written notice of this termination to the member 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 (2) and (3).

(2) If participation between a member's current physician and a health care corporation terminates, the health care corporation shall permit the member to continue an ongoing course of treatment with that physician as follows:

(a) For 90 days from the date of notice to the member by the physician of the physician's termination with the health care corporation.

(b) If the member 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 member is determined to be terminally ill prior to a physician's termination or knowledge of the

termination and the physician was treating the terminal illness before the date of termination or knowledge of the termination, for the remainder of the member's life for care directly related to the treatment of the terminal illness.

(3) Subsection (2) applies only if the physician agrees to all of the following:

(a) To participate on a per claim basis and to accept as payment in full reimbursement from the health care corporation at the rates applicable prior to the termination.

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

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

(4) A health care corporation shall provide written notice to each participating physician that if participation between the physician and the health care corporation terminates, the physician may do both of the following:

(a) Notify the health care corporation's members 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 (2) and (3).

(5) This section does not create an obligation for a health care corporation to provide to a member coverage beyond the maximum coverage limits permitted by the health care corporation's certificate with the member. This section does not create an obligation for a health care corporation to expand who may be a primary care physician under a certificate.

(6) As used in this section:

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

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

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

History: Add. 1999, Act 228, Eff. July 1, 2000;—Am. 2000, Act 485, Imd. Eff. Jan. 11, 2001.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1402d Applicability of MCL 500.2212c to health care corporation.

Sec. 402d. Section 2212c of the insurance code of 1956, 1956 PA 218, MCL 500.2212c, applies to a health care corporation.

History: Add. 2013, Act 31, Eff. Mar. 14, 2014.

550.1403 Payment of benefits; interest; claim form; exception.

Sec. 403. (1) A health care corporation, on a timely basis, shall pay to a member benefits as are entitled and provided under the applicable certificate. When not paid on a timely basis, benefits payable to a member shall bear simple interest from a date 60 days after a satisfactory claim form was received by the health care corporation, at a rate of 12% interest per annum. The interest shall be paid in addition to, and at the time of payment of, the claim. Section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006, applies to a health care corporation.

(2) A health care corporation shall specify in writing the materials that constitute a satisfactory claim form not later than 30 days after receipt of a claim, unless the claim is settled within 30 days. If a claim form is not supplied as to the entire claim, the amount supported by the claim form shall be considered to be paid on a timely basis if paid within 60 days after receipt of the claim form by the corporation. This subsection does not apply to a health care corporation when paying a claim under section 2006(7) to (14) of the insurance code of 1956, 1956 PA 218, MCL 500.2006.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2002, Act 317, Eff. Oct. 1, 2002.

Compiler's note: Enacting section 1 of Act 317 of 2002 provides:

"Enacting section 1. This amendatory act takes effect on October 1, 2002 and applies to all health care claims with dates of service on and after October 1, 2002."

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403a Benefits paid by check or written instrument; escheat.

Sec. 403a. Benefits paid by a health care corporation to a subscriber or provider by way of a check or other similar written instrument for the transmission or payment of money, that is not cashed within the period prescribed in the uniform unclaimed property act, shall escheat to the state pursuant to the uniform unclaimed property act.

History: Add. 1990, Act 172, Imd. Eff. July 2, 1990;—Am. 1995, Act 49, Eff. Jan. 1, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1403b Advertising material prohibited.

Sec. 403b. A health care corporation shall not include in any bill for services or products any advertising material for any other service or product sold by a subsidiary of the corporation.

History: Add. 2003, Act 59, Eff. July 23, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1404 Violation of MCL 550.1402 or MCL 550.1403; private informal managerial-level conference; review by commissioner; internal procedures; determination by commissioner; expedited grievance procedure; procedural rules; hearing matter as contested case; authorization to act on behalf of member.

Sec. 404. (1) A person who has reason to believe that a health care corporation has violated section 402 or 403, if the violation was with respect to an action or inaction of the corporation with respect to that person, is entitled to a private informal managerial-level conference with the corporation, and to a review before the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 before an independent review organization under the patient's right to independent review act, if the conference fails to resolve the dispute.

(2) A health care corporation shall establish reasonable internal procedures to provide a person with a private informal managerial-level conference as provided in subsection (1). These procedures shall provide all of the following:

(a) That a final determination will be made in writing by the health care corporation not later than 35 calendar days after a grievance is submitted in writing by the member. The timing for the 35-calendar-day period may be tolled, however, for any period of time the member is permitted to take under the grievance procedure and for a period of time that shall not exceed 10 days if the health care corporation has not received requested information from a health provider.

(b) A method of providing the person, upon request and payment of a reasonable copying charge, with information pertinent to the denial of a certificate or to the rate charged.

(c) A method for resolving the dispute promptly and informally, while protecting the interests of both the person and the corporation.

(d) That when an adverse determination is made, a written statement in plain English containing the reasons for the adverse determination is provided to the member along with written notifications as required under the patient's right to independent review act.

(e) A method for providing summary data on the number and types of complaints and grievances filed. Beginning April 15, 2001, this summary data for the prior calendar year shall be filed annually with the commissioner on forms provided by the commissioner.

(3) If the health care corporation fails to provide a conference and proposed resolution within 30 days after a request by a person, or if the person disagrees with the proposed resolution of the corporation after completion of the conference, the person is entitled to a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act.

(4) A health care corporation shall establish, as part of its internal procedures, an expedited grievance procedure. The expedited grievance procedure shall provide that a determination will be made by the health care corporation not later than 72 hours after receipt of the grievance. Within 10 days after receipt of a determination, the member may request a determination of the matter by the commissioner or his or her designee through September 30, 2000 and beginning October 1, 2000 by an independent review organization under the patient's right to independent review act. If the determination by the health care corporation is made orally, the health care corporation shall provide a written confirmation of the determination to the member not later than 2 business days after the oral determination. An expedited grievance under this subsection applies if a grievance is submitted and a physician, orally or in writing, substantiates that the time frame for a grievance

under subsections (1) to (3) would seriously jeopardize the life or health of the member or would jeopardize the member's ability to regain maximum function. This subsection does not apply to a provider's complaint concerning claims payment, handling, or reimbursement for health care services. As used in this section, "grievance" means an oral or written statement, by a member to the health care corporation that the health care corporation has wrongfully refused or failed to respond in a timely manner to a request for benefits or payment.

(5) The commissioner shall by rule establish a procedure for determination under this section, which shall be reasonably calculated to resolve these matters informally and as rapidly as possible, while protecting the interests of both the person and the health care corporation.

(6) If either the health care corporation or a person other than a member disagrees with a determination of the commissioner or his or her designee under this section, the commissioner or his or her designee, if requested to do so by either party, shall proceed to hear the matter as a contested case under the administrative procedures act.

(7) A member 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.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1996, Act 516, Eff. Oct. 1, 1997;—Am. 2000, Act 250, Imd. Eff. June 29, 2000.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1405 Single billing form; development; explanation of total bill for services.

Sec. 405. (1) A health care corporation, in consultation with the department of social services, shall develop a single billing form to be used for the billing of each of the following: hospital services, physician services, and pharmaceutical services. If such forms are subsequently developed by the federal government, they may be used in the place of forms developed pursuant to this subsection.

(2) A health care corporation shall provide each member with a detailed and accurate explanation of his or her total bill for services rendered by a health care provider and provided under a certificate with a health care corporation, including charges for specific types of services rendered, the date of services rendered, the amounts reimbursed by the corporation, and the reasons for denial of any payments for expenses incurred.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1406 Confidentiality of records; disclosures; consent; policy regarding protection of privacy and confidentiality of personal data; violation as misdemeanor; penalty; civil action for damages; effect of section on governmental agencies; compliance with federal law and regulations; "health care operations" defined.

Sec. 406. (1) A health care corporation shall, in order to ensure the confidentiality of records containing personal data that may be associated with identifiable members, use reasonable care to secure these records from unauthorized access and to collect only personal data that are necessary for the proper review and payment of claims and for health care operations, treatment, and research. Except as is necessary to comply with section 603 or for the purpose of claims adjudication, claims verification, health care operations, treatment, research, payment, health oversight activities, or when required by law, a health care corporation shall not disclose records containing personal data that may be associated with an identifiable member, or personal information concerning a member, to a person other than the member, without the prior and specific informed consent of the member to whom the data or information pertains. The member's consent shall be in writing. Except when a disclosure is made to the commissioner or another governmental agency, a court, or any other governmental entity, a health care corporation shall make a disclosure for which prior and specific informed consent is not required upon the condition that the person to whom the disclosure is made protect and use the disclosed data or information only in the manner authorized by the corporation, pursuant to subsection (2). If a member has authorized the release of personal data to a specific person, a health care corporation shall make a disclosure to that person upon the condition that the person shall not release the data to a third person unless the member executes in writing another prior and specific informed consent authorizing the additional release. This subsection does not preclude the release of information to a member, pertaining to that member, by telephone, if the identity of the member is verified. This subsection does not preclude a representative of a subscriber group, upon request of a member of that subscriber group, or an elected official, upon request of a constituent, from assisting the individual in resolving a claim.

(2) The board of directors of a health care corporation shall establish and make public the policy of the

corporation regarding the protection of the privacy of members and the confidentiality of personal data. The policy, at a minimum, shall do all of the following:

(a) Provide for the corporation's implementation of provisions in this act and other applicable laws respecting collection, security, use, release of, and access to personal data.

(b) Identify the routine uses of personal data by the corporation; prescribe the means by which members will be notified regarding those uses; and provide for notification regarding the actual release of personal data and information that may be identified with, or that concern, a member, upon specific request by that member. As used in this subdivision, "routine use" means the ordinary use or release of personal data compatible with the purpose for which the data were collected.

(c) Assure that no person shall have access to personal data except on the basis of a need to know.

(d) Establish the contractual or other conditions under which the corporation will release personal data.

(e) Provide that enrollment applications and claim forms developed by the corporation shall contain a member's consent to the release of data and information that is limited to the data and information necessary for the proper review and payment of claims, and shall reasonably notify members of their rights pursuant to the board's policy and applicable law.

(f) Provide that applicants for new or renewed certificates shall be advised that the corporation does not require the use of the applicant's federal social security account number and that, when applicable, another authority does require use of the number.

(3) A health care corporation that violates this section is guilty of a misdemeanor, punishable by a fine of not more than \$1,000.00 for each violation.

(4) A member may bring a civil action for damages against a health care corporation for a violation of this section and may recover actual damages or \$200.00, whichever is greater, together with reasonable attorneys' fees and costs.

(5) This section shall not be construed to limit access to records or to enlarge or diminish the investigative and examination powers of governmental agencies, as provided for by law.

(6) Compliance by a corporation with the health insurance portability and accountability act of 1996, Public Law 104-191, and regulations promulgated under that act, 45 CFR parts 160 and 164, satisfies subsections (1) and (2).

(7) As used in this section, "health care operations" means that term as defined in 45 CFR 164.501.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 2006, Act 218, Imd. Eff. June 26, 2006.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1407 Complaint system; procedures; response to complaint; access to complaints and responses; record of complaints; annual report; other legal remedies.

Sec. 407. (1) A health care corporation shall establish and maintain a complaint system which affords adequate and reasonable procedures for the expeditious resolution of written complaints initiated by members concerning any matter relating to the provisions of a certificate. At a minimum, procedures shall be developed by a corporation for the resolution of claims for reimbursement; denial, cancellations, or nonrenewals of certificates; and complaints regarding the quality of the services delivered by health care providers and health care facilities which receive reimbursement from the corporation.

(2) A health care corporation, within 30 days after receipt of written complaint, shall give a reasonable written response to each written complaint which it receives. The commissioner shall have free access, as defined in section 603(2), to complaints and responses, which shall be made available to the commissioner for inspection. If the matter complained of is reasonably believed by the complainant to be a violation of section 402 or 403, the complainant shall be entitled to a private informal managerial-level conference with the health care corporation, as provided for in section 404.

(3) The health care corporation shall maintain a complete record of all of the written complaints of its members which the corporation has received since the date of the last examination. This record shall indicate the total number of complaints; and by line of business, the nature of each complaint, the disposition of each complaint, and the time taken to process each complaint.

(4) A health care corporation shall submit to the commissioner an annual report which describes the complaint system of the corporation, and includes a compilation and analysis of the written complaints filed with the corporation, their disposition and underlying causes, and measures being implemented to alleviate those causes. The report shall be compiled in a manner which protects an individual's right to privacy with respect to medical information and shall not disclose the identity of a member by name or other personal identifier without the member's consent pursuant to section 406(1). The annual report shall be a public record.

(5) This section shall not prevent a member from seeking other remedies available by law.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1408 False, dishonest, or fraudulent claim for payment as misdemeanor; penalty; civil action; prosecution.

Sec. 408. Any provider, member, or other person who knowingly makes, presents, or causes to be presented to a health care corporation any false, dishonest, or fraudulent claim for payment to or from the health care corporation, is guilty of a misdemeanor, punishable by a fine of not more than \$1,000.00 or imprisonment for not more than 3 months, or both. This section shall not preclude a civil action for recovery of money due the corporation, nor shall it preclude the prosecution of any such provider, member, or other person under the applicable provisions of Act No. 328 of the Public Acts of 1931, as amended, being sections 750.1 to 750.568 of the Michigan Compiled Laws.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1409 Civil action for negligence.

Sec. 409. A civil action for negligence based upon, or arising out of, the health care provider-patient relationship shall not be maintained against a health care corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1409a Coverage for children who are full-time or part-time students; continuing coverage if dependent student takes leave of absence due to illness or injury; eligibility; requirements.

Sec. 409a. (1) Any certificate delivered, issued for delivery, or renewed in this state that provides for coverage 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 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 health care corporation 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 health care corporation's certificate or rider if the dependent child takes a leave of absence from school due to illness or injury.

History: Add. 2006, Act 538, Eff. Jan. 1, 2007.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1410 Certificate providing coverage of dependent terminating at specified age; exceptions.

Sec. 410. Any certificate issued by a health care corporation that provides that coverage of a dependent of the subscriber terminates at a specified age shall not terminate with respect to an unmarried child who is incapable of self-sustaining employment by reason of developmental disability or physical disability, if the following conditions are met:

(a) The child became incapable before 19 years of age and is chiefly dependent upon the subscriber for support and maintenance.

(b) Before the child turns 19 years of age, or within 31 days after that, the subscriber has submitted proof of the dependent's incapacity to the corporation.

History: 1980, Act 350, Eff. Apr. 3, 1981;—Am. 1998, Act 24, Imd. Eff. Mar. 12, 1998;—Am. 2014, Act 75, Imd. Eff. Mar. 28,

2014.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1410a Provisions of group certificate; electing coverage under group conversion certificate; notice of conversion privilege; requirements of group conversion certificate; premium; issuance; compliance.

Sec. 410a. (1) A group certificate that is issued or renewed in this state after December 31, 1990 shall include provisions consistent with this section.

(2) If an individual subscriber has been continuously covered under a group certificate for at least 3 months immediately prior to termination, the individual subscriber and his or her covered spouse and dependents may elect coverage under a group conversion certificate upon termination. As used in this section, termination includes, but is not limited to, the following:

(a) Discontinuance of a group certificate in its entirety or with respect to a covered class.

(b) Loss of coverage due to voluntary or involuntary termination of employment except for termination of employment because of gross misconduct.

(c) For a surviving spouse or dependent, death of an individual subscriber covered under a group certificate.

(d) An event that causes a person, who is a spouse or dependent of an individual subscriber at the time of the event, to cease to be a qualified family member under a group certificate.

(3) Coverage under a group conversion certificate shall take effect immediately upon the termination of coverage under the group certificate.

(4) Notification of the conversion privilege shall be included in each certificate of coverage.

(5) A master certificate holder shall give written notice to an individual subscriber of the option to elect a group conversion certificate within 14 days after the occurrence of subsection (2)(a) or (b).

(6) An individual subscriber shall notify the health care corporation of his or her election to convert to a group conversion certificate not later than 30 days after termination of coverage. The first premium shall be paid to the health care corporation at the time the individual elects to convert to a group conversion certificate.

(7) A group conversion certificate under this section:

(a) Shall be issued without evidence of insurability.

(b) Shall not use conditions pertaining to health as a basis for classification.

(c) Shall not exclude a preexisting condition that is not excluded by the group certificate solely because it is a preexisting condition.

(d) May provide that benefits may be reduced by the amount of benefits paid for a specific covered service pursuant to the group certificate that has been terminated.

(8) The premium for a group conversion certificate under this section shall be determined using the aggregate experience for all such certificates issued in this state by the health care corporation and in accordance with premium rates applicable to the age, class of risk, and the type and amount of coverage provided. The experience of an individual under a group conversion certificate shall not be an acceptable basis for establishing that individual's rate for his or her group conversion certificate.

(9) A health care corporation is not required to issue a group conversion certificate under this section if any of the following circumstances apply:

(a) The individual is covered for similar benefits and to a similar extent by another expense-incurred hospital, medical, surgical, or sick-care insurance policy or certificate, hospital or medical service subscriber contract, medical practice or other prepayment plan, or other expense-incurred plan or program.

(b) The individual is covered under title XVIII of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1395 to 1395b, 1395b-2, 1395c to 1395i, 1395i-1a to 1395i-3, 1395j to 1395dd, 1395ff to 1395mm, and 1395oo to 1395ccc.

(c) If termination of an individual's coverage under a group certificate occurred because of any of the following:

(i) The individual failed to pay any required contribution.

(ii) Discontinued group coverage was replaced by group coverage.

(iii) The individual acted to defraud the health care corporation.

(10) A group conversion certificate under this section delivered outside this state for a group certificate that was issued and delivered in this state shall comply with this section.

History: Add. 1989, Act 260, Imd. Eff. Dec. 26, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1410b Premium for group conversion certificate after January 1, 2014; determination; rating factors.

Sec. 410b. Notwithstanding section 410a(8), for a certificate delivered, issued for delivery, or renewed in this state on or after January 1, 2014, the premium for a group conversion certificate under section 410a shall be determined only by using the rating factors set forth in section 3474a of the insurance code of 1956, 1956 PA 218, MCL 500.3474a.

History: Add. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1411-550.1413a Repealed. 1994, Act 40, Imd. Eff. Mar. 14, 1994.

Compiler's note: The repealed sections pertained to supplemental medicare benefits certificate without preexisting condition exclusion or limitation, medicare supplemental buyer's guide, certificate to complement federal medicare program, and condition to issuance of certificate.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414 Expired. 1980, Act 430, Eff. Jan. 1, 1982.

Compiler's note: The expired section pertained to treatment of alcoholism and drug abuse.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414a Treatment of substance abuse; contracts; qualifications of provider; coverage for intermediate and outpatient care for substance abuse required; demonstration projects; substance abuse advisory committee; report; contracts based on final report; reimbursement; group and nongroup certificates; exceptions; option to decline coverage; charges, terms, and conditions; reduction of coverage; deductibles and copayment provision; minimum coverage; adjustment; definitions; effective date of section.

Sec. 414a. (1) A health care corporation shall offer benefits for the inpatient treatment of substance abuse by a licensed allopathic physician or a licensed osteopathic physician in a health care facility operated by this state or approved by the department of public health for the hospitalization for, or treatment of, substance abuse.

(2) Subject to subsections (3), (5), and (7), a health care corporation may enter into contracts with providers for the rendering of inpatient substance abuse treatment by those providers.

(3) A contracting provider rendering inpatient substance abuse treatment for patients other than adolescent patients shall be a licensed hospital or a substance abuse service program licensed under article 6 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.6101 to 333.6523 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care facilities.

(4) A health care corporation shall provide coverage for intermediate and outpatient care for substance abuse, upon issuance or renewal, in all group and nongroup certificates other than service-specific certificates, such as certificates providing coverage solely for 1 of the following: dental care; hearing care; vision care; prescription drugs; or another type of health care benefit. Subject to subsections (5) and (7), a health care corporation may enter into contracts with providers for the rendering of intermediate care, outpatient care, or both types of care, for the treatment of substance abuse.

(5) A health care corporation shall enter into and maintain 5-year contracts with not less than 5 providers in this state, as demonstration projects pursuant to section 207(1)(b), for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients. A provider who contracts with a health care corporation for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients shall meet all of the following requirements:

(a) Is accredited by the joint commission on accreditation of hospitals, the council on accreditation for families and children, the commission on accreditation of rehabilitation facilities, or the American osteopathic association.

(b) If applicable, has obtained a certificate of need under part 221 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.22101 to 333.22181 of the Michigan Compiled Laws.

(c) Is licensed by the office of substance abuse services under article 6 of the public health code, Act No. 368 of the Public Acts of 1978.

(d) Is licensed by the department of social services as a child caring institution under Act No. 116 of the Public Acts of 1973, being sections 722.111 to 722.128 of the Michigan Compiled Laws.

(e) Agrees to follow generally accepted accounting principles and practices.

(f) Agrees to supply all data required to fulfill the objectives of the demonstration program.

(g) Agrees to work with the substance abuse advisory committee and the health care corporation in conducting the evaluation of the demonstration program.

(6) The substance abuse advisory committee is established, with the cooperation of the office of substance abuse services, under the direction of the office of health and medical affairs. The committee shall consist of 7 members to include the director of the office of health and medical affairs or his or her designee, the administrator of the office of substance abuse services or his or her designee, a representative of the department of public health, 2 designees of the chief executive officer of a health care corporation contracting for a demonstration project under subsection (5), a member of the family of an adolescent substance abuser to be appointed by the office of health and medical affairs, and a service provider of an adolescent substance abuse treatment program to be appointed by the office of health and medical affairs. The substance abuse advisory committee shall evaluate each demonstration project and shall report at the conclusion of each demonstration project to the senate and house standing committees responsible for public health issues. A final report of all the demonstration projects shall be issued by not later than December 31, 1994, and shall include evaluations of and recommendations concerning all of the following:

(a) The cost of specialized adolescent substance abuse treatment compared with the effectiveness of adolescent substance abuse treatment.

(b) The cost and effectiveness of the different levels of adolescent substance abuse treatment, including inpatient, intermediate, and outpatient care and aftercare programs.

(7) Based on the final report submitted pursuant to subsection (6), beginning December 31, 1994, a health care corporation shall continue to enter into and maintain contracts with not less than 5 providers in this state, and may enter into additional contracts for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients if the provider meets the requirements of subsection (5)(a) to (e). Contracts entered into under this subsection shall be based upon the recommendations of the final report submitted pursuant to subsection (6).

(8) A health care corporation shall reimburse providers for the rendering of inpatient, intermediate, and outpatient care to adolescent substance abuse patients at a rate that shall be commensurate with reimbursement rates for other similar providers rendering inpatient, intermediate, and outpatient care to adolescent substance abuse patients.

(9) In the case of group certificates, if the amount due for a group certificate would be increased by 3% or more because of the provision of the coverage required under subsection (4), the master policyholder shall have the option to decline the coverage required to be provided under subsection (4). In the case of nongroup certificates, if the total amount due for all nongroup certificates of the health care corporation would be increased by 3% or more because of the provision of the coverage required under subsection (4), the subscriber for each such certificate shall have the option to decline the coverage required to be provided under subsection (4).

(10) Charges, terms, and conditions for the coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall not be less favorable than the maximum prescribed for any other comparable service.

(11) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall not be reduced by terms or conditions which apply to other items of coverage in a certificate, group or nongroup. This subsection shall not be construed to prohibit certificates that provide for deductibles and copayment provisions for coverage for intermediate and outpatient care for substance abuse, as approved by the commissioner.

(12) The coverage for intermediate and outpatient care for substance abuse required to be provided under subsection (4) shall, at a minimum, provide for up to \$1,500.00 in health care benefits for intermediate and outpatient care for substance abuse per member per year. This minimum shall be adjusted by March 31, 1982 and by March 31 each year thereafter in accordance with the annual average percentage increase or decrease in the United States consumer price index for the 12-month period ending the preceding December 31.

(13) As used in this section:

(a) "Adolescent" means an individual who is less than 18 years of age, but more than 11 years of age.

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

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

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

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

(i) Chemotherapy.

(ii) Counseling.

(iii) Detoxification services.

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

(d) "Substance abuse" means that term as defined in section 6107 of the public health code, Act No. 368 of the Public Acts of 1978, being section 333.6107 of the Michigan Compiled Laws.

History: Add. 1980, Act 430, Eff. Jan. 1, 1982;—Am. 1988, Act 345, Imd. Eff. Oct. 25, 1988.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1414b Offer of wellness coverage by health care corporation.

Sec. 414b. (1) A health care corporation may offer group wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program offered by the employer. The employer shall provide evidence of demonstrative maintenance or improvement of the members' health behaviors as determined by assessments of agreed-upon health status indicators between the employer and the health care corporation. Any rebate or premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to employers all wellness coverage plans that it markets to employers in this state.

(2) A health care corporation may offer nongroup wellness coverage. Wellness coverage may provide for an appropriate rebate or reduction in premiums or for reduced copayments, coinsurance, or deductibles, or a combination of these incentives, for participation in any health behavior wellness, maintenance, or improvement program approved by the health care corporation. The member shall provide evidence of demonstrative maintenance or improvement of the individual's or family's health behaviors as determined by assessments of agreed-upon health status indicators between the member and the health care corporation. Any rebate of premium provided by the health care corporation is presumed to be appropriate unless credible data demonstrate otherwise, but shall not exceed 30% of paid premiums, unless otherwise approved by the commissioner. A health care corporation shall make available to individuals all wellness coverage plans that it markets to individuals in this state.

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

History: Add. 2006, Act 413, Eff. Mar. 30, 2007;—Am. 2013, Act 4, Imd. Eff. Mar. 18, 2013.

Compiler's note: Enacting section 2 of Act 413 of 2006 provides:

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

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1415 Benefits for prosthetic devices.

Sec. 415. (1) Not later than 12 months after the effective date of this act, a health care corporation shall offer or include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual whose covered illness or injury has required the removal of that body part. However, certificates resulting from collective bargaining agreements shall be exempted from this subsection. This coverage shall provide that reasonable charges for medical care and attendance for an individual fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability for a proposed course of rehabilitative treatment.

(2) Not later than 12 months after the effective date of this act, a health care corporation shall include coverage, in all group and nongroup certificates, to provide benefits for prosthetic devices to maintain or replace the body part of an individual who has undergone a mastectomy. This coverage shall provide that reasonable charges for medical care and attendance for an individual who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the individual's attending physician has certified the medical necessity or desirability of a proposed course of rehabilitative treatment. The cost and fitting of a prosthetic device following a mastectomy is included within the type of coverage intended by this subsection.

History: 1980, Act 350, Eff. Apr. 3, 1981.

Constitutionality: This act is unconstitutional in the following three particulars:

(1) The act's provision for an actuary panel to resolve risk factor disputes is an unconstitutional delegation of legislative authority in that it lacks adequate standards (MCL 550.1205(6)).

(2) The statutory restrictions on administrative services only (ASO) contracts violate equal protection of the laws insofar as they result in arbitrary and discriminatory treatment of health care corporations vis-a-vis commercial insurers (MCL 550.1104(3), 550.1211, 550.1414a, 550.1415, and 550.1607(1)).

(3) The commissioner's authority to issue a cease and desist order based on probable cause against a health care corporation for noncompliance with the act establishes an improper burden of proof (MCL 550.1402(7)).

The Supreme Court ruling on these three areas of this act does not affect the constitutionality of the remainder of the act. Where, as here, the unconstitutional provisions are easily severable, the remainder of the act need not be affected. Blue Cross and Blue Shield of Michigan v Governor, 422 Mich 1; 367 NW2d 1 (1985).

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416 Coverage for breast cancer diagnostic services, breast cancer outpatient services, and breast cancer rehabilitative services; coverage for breast cancer screening mammography; definitions; effective date of section.

Sec. 416. (1) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, a health care corporation shall offer or include, in each group and nongroup certificate, coverage for breast cancer diagnostic services, breast cancer outpatient treatment services, and breast cancer rehabilitative services.

(2) Subject to dollar limits, deductibles, and coinsurance provisions that are not less favorable than those for physical illness generally, a health care corporation shall offer or include, in each group and nongroup certificate, the following coverage for breast cancer screening mammography:

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

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

(3) As used in this section:

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

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

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

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

(4) This section shall take effect November 1, 1989.

History: Add. 1989, Act 57, Eff. Nov. 1, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416a Coverage for drug used in antineoplastic therapy and cost of its administration; conditions.

Sec. 416a. A health care corporation shall provide coverage in each group and nongroup certificate for a federal food and drug administration approved drug used in antineoplastic therapy and the reasonable cost of its administration. Coverage shall be provided regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug has received approval by the federal food and drug administration if all of the following conditions are met:

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

(b) The drug is approved by the federal food and drug administration for use in antineoplastic therapy.

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

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

(e) The physician has obtained informed consent from the patient for the treatment regimen which includes federal food and drug administration approved drugs for off-label indications.

History: Add. 1989, Act 57, Imd. Eff. June 16, 1989.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416b Establishment of program to prevent onset of clinical diabetes required; report; coverages; "diabetes" defined.

Sec. 416b. (1) A health care corporation shall establish and provide to members and participating providers a program to prevent the onset of clinical diabetes. This program for participating providers shall emphasize best practice guidelines to prevent the onset of clinical diabetes and to treat diabetes, including, but not limited to, diet, lifestyle, physical exercise and fitness, and early diagnosis and treatment.

(2) A health care corporation shall regularly measure the effectiveness of a program provided pursuant to subsection (1) by regularly surveying group and nongroup members covered by the certificate. Not later than 2 years after the effective date of the amendatory act that added this section, each health care corporation shall prepare a report containing the results of the survey and shall provide a copy of the report to the department of community health.

(3) A health care corporation certificate shall provide benefits in each group and nongroup certificate for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

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

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

(c) Insulin.

(d) Syringes.

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

(f) Nonexperimental medication for controlling blood sugar.

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

(4) A health care corporation certificate shall provide benefits in each group and nongroup certificate for medically necessary medications prescribed by an allopathic, osteopathic, or podiatric physician and used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with diabetes.

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

(a) Is limited to completion of a certified diabetes education program upon occurrence of either of the following:

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

(ii) If an allopathic or osteopathic physician diagnoses a significant change with long-term implications in

the patient's symptoms or conditions that necessitates changes in a patient's self-management or a significant change in medical protocol or treatment modalities.

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

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

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

- (a) Gestational diabetes.
- (b) Insulin-dependent diabetes.
- (c) Non-insulin-dependent diabetes.

History: Add. 2000, Act 424, Eff. Mar. 28, 2001.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416c Off-label use of approved drug; coverage; conditions; compliance; use of copayment, deductible, sanction, or utilization control; limitation; definitions.

Sec. 416c. (1) A health care corporation group or nongroup certificate that provides pharmaceutical coverage shall provide coverage for an off-label use of a federal food and drug administration approved drug and the reasonable cost of supplies medically necessary to administer the drug.

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

(a) The drug is approved by the federal food and drug administration.

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

(i) A life-threatening condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

(ii) A chronic and seriously debilitating condition so long as the drug is medically necessary to treat that condition and the drug is on the plan formulary or accessible through the health plan's formulary procedures.

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

(i) The American medical association drug evaluations.

(ii) The American hospital formulary service drug information.

(iii) The United States pharmacopoeia dispensing information, volume 1, "drug information for the health care professional".

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

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

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

(5) As used in this section:

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

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

(c) "Off-label" means the use of a drug for clinical indications other than those stated in the labeling approved by the federal food and drug administration.

History: Add. 2002, Act 539, Eff. Jan. 22, 2003.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1416d Coverage for obstetrical and gynecological services by physician or nurse

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midwife.

Sec. 416d. (1) As used in this section, "nurse midwife" means an individual licensed as a registered professional nurse under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, who has been issued a specialty certification in the practice of nurse midwifery by the Michigan board of nursing under section 17210 of the public health code, 1978 PA 368, MCL 333.17210.

(2) Effective March 1, 2005, a group or nongroup certificate that provides coverage for obstetrical and gynecological services shall include coverage for obstetrical and gynecological services whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification or shall do 1 or both of the following:

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

(b) Offer to provide coverage for maternity services and gynecological services rendered during pre- and post-natal care whether performed by a physician or a nurse midwife acting within the scope of his or her license or specialty certification.

History: Add. 2004, Act 374, Imd. Eff. Oct. 11, 2004.

550.1416e Diagnosis and treatment of autism spectrum disorders; coverage; prohibition; availability of other benefits; conditions; qualified health plan offered through American health benefit exchange pursuant to federal law; prescription drug plan; coordinated benefits; definitions.

Sec. 416e. (1) Except as otherwise provided in this section, a health care corporation group or nongroup certificate shall provide coverage for the diagnosis of autism spectrum disorders and treatment of autism spectrum disorders. A health care corporation shall not do any of the following:

(a) Limit the number of visits a member may use for treatment of autism spectrum disorders covered under this section.

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

(c) Except as otherwise provided in this subdivision, subject coverage under this section to dollar limits, copays, deductibles, or coinsurance provisions that do not apply to physical illness generally. Coverage under this section for treatment of autism spectrum disorders may be limited to a member through 18 years of age and may be subject to a maximum annual benefit as follows:

(i) For a covered member through 6 years of age, \$50,000.00.

(ii) For a covered member from 7 years of age through 12 years of age, \$40,000.00.

(iii) For a covered member from 13 years of age through 18 years of age, \$30,000.00.

(2) This section does not limit benefits that are otherwise available to a member under a certificate. A health care corporation shall utilize evidence-based care and managed care cost-containment practices pursuant to the health care corporation's procedures so long as that care and those practices are consistent with this section. The coverage under this section may be subject to other general exclusions and limitations of the certificate, including, but not limited to, coordination of benefits, participating provider requirements, restrictions on services provided by family or household members, utilization review of health care services including review of medical necessity, case management, and other managed care provisions.

(3) If a member is receiving treatment for an autism spectrum disorder, a health care corporation may, as a condition to providing the coverage under this section, do all of the following:

(a) Require a review of that treatment consistent with current protocols and may require a treatment plan. If requested by the health care corporation, the cost of treatment review shall be borne by the health care corporation.

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

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

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

(4) Beginning January 1, 2014, a qualified health plan offered through an American health benefit exchange established in this state pursuant to the federal act is not required to provide coverage under this section to the extent that it exceeds coverage that is included in the essential health benefits as required pursuant to the federal act. As used in this subsection, "federal act" means the federal patient protection and affordable care act, Public Law 111-148, as amended by the federal health care and education reconciliation act of 2010, Public Law 111-152, and any regulations promulgated under those acts.

(5) This section does not require the coverage of prescription drugs and related services unless the member is covered by a prescription drug plan. This section does not require a health care corporation to provide coverage for autism spectrum disorders to a member under more than 1 of its certificates. If a member has more than 1 policy, certificate, or contract that covers autism spectrum disorders, the benefits provided are subject to the limits of this section when coordinating benefits.

(6) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

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

(c) "Autism spectrum disorders" means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual:

(i) Autistic disorder.

(ii) Asperger's disorder.

(iii) Pervasive developmental disorder not otherwise specified.

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

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

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

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

(f) "Diagnostic and statistical manual" or "DSM" means the diagnostic and statistical manual of mental disorders published by the American psychiatric association or other manual that contains common language and standard criteria for the classification of mental disorders and that is approved by the commissioner, if the commissioner determines that the manual is recognized by the health care industry and the classification of mental disorders is at least as comprehensive as the manual published by the American psychiatric association on the effective date of this section.

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

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

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

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

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

(i) Behavioral health treatment.

(ii) Pharmacy care.

(iii) Psychiatric care.

(iv) Psychological care.

(v) Therapeutic care.

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

History: Add. 2012, Act 99, Imd. Eff. Apr. 18, 2012.

Compiler's note: Enacting section 1 of Act 99 of 2012 provides:

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

550.1417 Hospice care; contracts with health care corporation; description of benefit.

Sec. 417. (1) A health care corporation shall offer to include benefits for hospice care in each certificate that provides benefits for inpatient hospital care.

(2) A health care corporation may enter into contracts with health care providers for the rendering of hospice care. A contracting health care provider shall be a licensed hospice under article 17 of the public health code, Act No. 368 of the Public Acts of 1978, being sections 333.20101 to 333.22260 of the Michigan Compiled Laws, and shall meet the standards set by the corporation for contracting health care providers.

(3) If benefits for hospice care are provided, a description of the hospice benefit shall be included in communications sent to the individual or group purchaser of coverage.

History: Add. 1984, Act 369, Eff. Jan. 1, 1986;—Am. 1994, Act 235, Imd. Eff. June 30, 1994.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1418 Emergency health services; medical coverage required; "stabilization" defined.

Sec. 418. (1) A health care corporation certificate that provides coverage for emergency health services shall provide coverage for medically necessary services provided to a member for the sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the individual's health or to a pregnancy in the case of a pregnant woman, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. A health care corporation shall not require a physician to transfer a patient before the physician determines that the patient has reached the point of stabilization. A health care corporation shall not deny payment for emergency health services up to the point of stabilization provided to a member under this subsection because of either of the following:

(a) The final diagnosis.

(b) Prior authorization was not given by the health care corporation before emergency health services were provided.

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

History: Add. 1998, Act 124, Imd. Eff. June 10, 1998;—Am. 2004, Act 8, Imd. Eff. Feb. 20, 2004.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419 Certificate offering dependent coverage to child; denial of enrollment on certain grounds prohibited.

Sec. 419. A health care corporation certificate that offers dependent coverage shall not deny enrollment to a subscriber's child on any of the following grounds:

(a) The child was born out of wedlock.

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

(c) The child does not reside with the subscriber or in the health care corporation's service area.

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419a Eligibility of parent for dependent coverage; health coverage of child through noncustodial parent; court or administrative order and notice required.

Sec. 419a. (1) If a parent is eligible for dependent coverage through a health care corporation, the health care corporation shall:

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

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

(c) Not eliminate the child's coverage unless premiums have not been paid as required by the certificate or

the health care corporation is provided with satisfactory written evidence of either of the following:

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

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

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

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

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

(c) If applicable, reimburse or make payment on claims submitted by the custodial parent or medical provider for services obtained or provided under subdivision (b).

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

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1419b Individual eligible under title XIX of social security act; assignment of rights of subscriber to department of social services.

Sec. 419b. (1) A health care corporation shall not consider whether an individual is eligible for or has available medical assistance under title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396g and 1396i to 1396v, in this or another state when considering eligibility for coverage or making payments under its plan for eligible subscribers.

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

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

History: Add. 1995, Act 238, Eff. Mar. 28, 1996.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1420-550.1430 Repealed. 2006, Act 441, Imd. Eff. Oct. 19, 2006.

Compiler's note: The repealed sections pertained to individual and group long-term care coverage.

Popular name: Act 218

550.1435 "Program" defined.

Sec. 435. As used in sections 436 to 439, "program" means the Michigan caring program created in section 436.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1436 Michigan caring programs for children; creation; contribution requirements; rating methodologies; supersedure of inconsistent provisions.

Sec. 436. There may be created within each health care corporation a Michigan caring program for children. The program shall provide primary health care coverage for children as set forth in section 438 and shall be administered by the health care corporation. Each program shall be described in a certificate that sets forth the benefits provided. A certificate and the contribution to be charged shall be subject to the commissioner's approval. Contribution requirements shall be established in accordance with rating

methodologies approved by the commissioner which, over time, shall not result in either gain or loss to the corporation. The rating methodology for a program shall not include any factors otherwise includable pursuant to other sections of this act that are intended to provide for subsidies, surcharges, or administrative costs. Any other provisions of this act that would otherwise apply to a program but which are inconsistent with the provisions of this section and sections 437 to 439 are superseded.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1437 Eligibility of child for enrollment in program.

Sec. 437. A child is eligible for enrollment in the program if the child meets all of the following:

- (a) Is less than 19 years of age.
- (b) Is unmarried.
- (c) Resides in a household with income 185% or less of the federal poverty level.
- (d) Is ineligible to receive health care through title XIX of the social security act, chapter 531, 49 Stat. 620, 42 U.S.C. 1396 to 1396d, 1396f to 1396g, and 1396i to 1396s.
- (e) Is enrolled in the program with all other eligible siblings who have no other health care coverage available.
- (f) Is a resident of this state.
- (g) Has no other health care coverage available.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1438 Limitation of benefits; provision of other health care benefits.

Sec. 438. (1) Notwithstanding any other provision of this act, a health care corporation may limit the benefits it will furnish to an eligible child enrolled in the program to the following primary health care benefits:

- (a) Doctor office visits for a sick child.
- (b) Medically necessary outpatient diagnostic tests.
- (c) Emergency medical and accident care in a doctor's office or hospital's emergency room.
- (d) Medically necessary outpatient surgery and anesthesia.
- (e) Preventive care, including, but not limited to, immunizations and well-child visits to a doctor's office.
- (f) Outpatient substance abuse care.

(2) With the commissioner's approval, a health care corporation may provide other health care benefits in addition to the primary health care benefits set forth in subsection (1).

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350

550.1439 Fees prohibited; exception; funding; enrollment of children.

Sec. 439. The program shall not charge any fee to an enrolled eligible child or the child's parents or legal guardians except that if prescription drug benefits are offered a co-pay not to exceed \$3.00 may be charged. The program shall be funded by private donations and private and public grants. The health care corporation may provide free of charge administrative services to the program as approved by its board of directors and subject to the commissioner's approval. A child shall be enrolled as follows:

- (a) Dependent on funding on a first-come, first-served basis unless a named child is part of a group of 10 or more children who are fully sponsored by private donations.
- (b) Without regard to health status.

History: Add. 1991, Act 60, Imd. Eff. June 27, 1991.

Popular name: Blue Cross-Blue Shield

Popular name: Act 350