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

500.3406bb Health insurance policy; minimum required coverage; use of in-network and out-of-network providers; use of reasonable medical management techniques; applicability to short-term or 1-time limited duration policies; effective date.

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

(a) Ambulatory patient services.

(b) Emergency services.

(c) Hospitalization.

(d) Pregnancy, maternity, and newborn care.

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

(f) Prescription drugs.

(g) Rehabilitative and habilitative services and devices.

(h) Laboratory services.

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

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

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

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

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

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

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

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

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

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

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

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

(8) This section does not apply to a short-term or 1-time limited duration policy or certificate of not more

than 6 months as described in section 2213b, or to a grandfathered plan as that term is defined in 45 CFR 147.140.

(9) Any changes to the items and services required under subsection (1)(i) must take effect for the plan year that begins on or after the date that is 1 year after the date the recommendation or guideline is issued.

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

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