State of Utah
Administrative Rule Analysis
Revised May 2024

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Repeal and Reenact		
Rule or Section Number:	**R590-126**	**Filing ID: Office Use Only**
Date of Previous Publication (Only for CPRs):	Click or tap to enter a date.	

Agency Information

1. Title catchline:	Insurance, Administration	
Building:	Taylorsville State Office Building	
Street address:	4315 S. 2700 W.	
City, state	Taylorsville, UT	
Mailing address:	PO Box 146901	
City, state and zip:	Salt Lake City, UT 84114-6901	
Contact persons:		
Name:	**Phone:**	**Email:**
Steve Gooch	801-957-9322	sgooch@utah.gov
Please address questions regarding information on this notice to the persons listed above.		

General Information

2. Rule or section catchline:

R590-126. Accident and Health Insurance Standards

3. Purpose of the new rule or reason for the change:

The rule is being changed in compliance with Executive Order 2021-12. During the review of this rule, the department discovered a number of issues that needed to be amended.

4. Summary of the new rule or change:

The majority of the changes are being done to fix style issues to bring the rule text more in line with current rulewriting standards. Other changes make the language of the rule more clear, and update the Severability section to use the department's current language. The Enforcement Date section is being removed because the rule is already in force. The changes do not add, remove, or change any regulations or requirements.

Fiscal Information

5. Provide an estimate and written explanation of the aggregate anticipated cost or savings to:

A) State budget:

There is no anticipated cost or savings to the state budget. The changes are largely clerical in nature, and will not change how the department functions.

B) Local governments:

There is no anticipated cost or savings to local governments. The changes are largely clerical in nature, and will not affect local governments.

C) Small businesses ("small business" means a business employing 1-49 persons)**:**

There is no anticipated cost or savings to small businesses. The changes are largely clerical in nature, and will not affect small businesses.

D) Non-small businesses ("non-small business" means a business employing 50 or more persons)**:**

There is no anticipated cost or savings to non-small businesses. The changes are largely clerical in nature, and will not affect non-small businesses.

E) Persons other than small businesses, non-small businesses, state, or local government entities ("person" means any individual, partnership, corporation, association, governmental entity, or public or private organization of any character other than an ***agency***)**:**

There is no anticipated cost or savings to any other persons. The changes are largely clerical in nature.

F) Compliance costs for affected persons (How much will it cost an impacted entity to adhere to this rule or its changes?)**:**

There are no compliance costs for any affected persons. The changes are largely clerical in nature.

G) Regulatory Impact Summary Table (This table only includes fiscal impacts that could be measured. If there are inestimable fiscal impacts, they will not be included in this table. Inestimable impacts will be included in narratives above.)

Regulatory Impact Table

Fiscal Cost	**FY2025**	**FY2026**	**FY2027**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Cost	**$0**	**$0**	**$0**
Fiscal Benefits	**FY2025**	**FY2026**	**FY2027**
State Government	$0	$0	$0
Local Governments	$0	$0	$0
Small Businesses	$0	$0	$0
Non-Small Businesses	$0	$0	$0
Other Persons	$0	$0	$0
Total Fiscal Benefits	**$0**	**$0**	**$0**
Net Fiscal Benefits	**$0**	**$0**	**$0**

H) Department head comments on fiscal impact and approval of regulatory impact analysis:

The Commissioner of the Insurance Department, Jonathan T. Pike, has reviewed and approved this regulatory impact analysis.

Citation Information

6. Provide citations to the statutory authority for the rule. If there is also a federal requirement for the rule, provide a citation to that requirement:

Section 31A-2-201	Section 31A-2-201.1	Section 31A-22-605
Section 31A-22-605.1	Section 31A-22-623	Section 31A-22-626

Incorporations by Reference Information

7. Incorporations by Reference (if this rule incorporates more than two items by reference, please include additional tables)**:**

A) This rule adds or updates the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	
Issue or Version	

B) This rule adds or updates the following title of materials incorporated by references (a copy of materials incorporated by reference must be submitted to the Office of Administrative Rules; *if none, leave blank*)**:**

Official Title of Materials Incorporated (from title page)	
Publisher	
Issue Date	

Issue or Version	

Public Notice Information

8. The public may submit written or oral comments to the agency identified in box 1. (The public may also request a hearing by submitting a written request to the agency. See Section 63G-3-302 and Rule R15-1 for more information.)		
A) Comments will be accepted until:		03/03/2025
B) A public hearing (optional) will be held:		
Date (mm/dd/yyyy)**:**	**Time** (hh:mm AM/PM)**:**	**Place** (physical address or URL)**:**
To the agency: If more space is needed for a physical address or URL, refer readers to Box 4 in General Information. If more than two hearings will take place, continue to add rows.		

9. This rule change MAY become effective on:	03/10/2025
NOTE: The date above is the date the agency anticipates making the rule or its changes effective. It is NOT the effective date.	

Agency Authorization Information

To the agency: Information requested on this form is required by Sections 63G-3-301, 63G-3-302, 63G-3-303, and 63G-3-402. Incomplete forms will be returned to the agency for completion, possibly delaying publication in the *Utah State Bulletin* and delaying the first possible effective date.			
Agency head or designee and title:	Steve Gooch, Public Information Officer	**Date:**	01/07/2025

R590. Insurance, Administration.
R590-126. Accident and Health Insurance Standards.
~~[R590-126-1. Authority.~~
~~This rule is issued by the insurance commissioner pursuant to the following provisions of the Utah Insurance Code:~~
~~(1) Subsection 31A-2-201(3)(a) authorizes rules to implement the Insurance Code;~~
~~(2) Sections 31A-2-202 and 31A-23a-412 authorize the commissioner to request reports, conduct examinations, and inspect records of any licensee;~~
~~(3) Subsection 31A-22-605(4) requires the commissioner to adopt rules to establish standards for disclosure in the sale of, and benefits to be provided by individual and franchise accident and health polices;~~
~~(4) Section 31A-22-623 authorizes the commissioner to establish by rule minimum standards of coverage for dietary products for inborn metabolic errors;~~
~~(5) Section 31A-22-626 authorizes the commissioner to establish by rule minimum standards of coverage for diabetes for accident and health insurance;~~
~~(6) Subsection 31A-23a-402(8) authorizes the commissioner to define by rule acts and practices that are unfair and unreasonable; and~~
~~(7) Subsection 31A-26-301(1) authorizes the commissioner to set standards for timely payment of claims.~~

~~R590-126-2. Purpose and Scope.~~
~~(1) Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.~~
~~(2) Scope.~~
~~(a) This regulation applies to:~~
~~(i) all individual accident and health insurance policies and group supplemental health policies and certificates, delivered or issued for delivery in this state on and after January 1, 2006, that are not specifically exempted from this regulation, regardless of:~~
~~(A) whether the policy is issued to an association; a trust; a discretionary group; or other similar grouping; or~~
~~(B) the situs of delivery of the policy or contract; and~~
~~(ii) all dental plans and vision plans.~~
~~(b) This rule shall not apply to:~~
~~(i) employer accident and health insurance, as defined in Section 31A-22-502;~~
~~(ii) policies issued to employees or members as additions to franchise plans in existence on the effective date of this regulation;~~
~~(iii) Medicare supplement policies subject to Section 31A-22-620;~~
~~(iv) civilian Health and Medical Program of the Uniformed Services, Chapter 55, title 10 of the United States Code, CHAMPUS supplement insurance policies; or~~
~~(v) a health benefit plan that complies with R590-277, Managed Care Health Benefit Plan Policy Standards.~~

(3) The requirements contained in this regulation shall be in addition to any other applicable regulations previously adopted.

R590-126-3. Definitions.

In addition to the definitions of Section 31A-1-301 and Subsection 31A-22-605(2), the following definitions shall apply for the purpose of this rule.

(1) "Accident," "accidental injury," and "accidental means" shall be defined to employ result language and shall not include words that establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "injury" or "injuries" means accidental bodily injury sustained by the insured person that is the direct cause of the condition for which benefits are provided, independent of disease or bodily infirmity or any other cause and that occurs while the insurance is in force.

(b) Unless otherwise prohibited by law, the definition may exclude injuries for which benefits are paid under worker's compensation, any employer's liability or similar law, or a motor vehicle no-fault plan.

(2) "Adult Day Care" shall mean a facility duly licensed and operating within the scope of such license. Adult Day Care facility may not be defined more restrictively than providing continuous care and supervision for three or more adults 18 years of age and over for at least four but less than 24 hours a day, that meets the needs of functionally impaired adults through a comprehensive program that provides a variety of health, social, recreational, and related support services in a protective setting.

(3) "Certificate of Completion" shall mean a document issued by the Utah Board of Education to a person who completes an approved course of study not leading to a diploma, or to one who passes a challenge for that same course of study, or to one whose out-of-state credentials and certificate are acceptable to the Board.

(4) "Complications of Pregnancy" shall mean diseases or conditions the diagnoses of which are distinct from pregnancy but are adversely affected or caused by pregnancy and not associated with a normal pregnancy.

(a) "Complications of Pregnancy" include acute nephritis, nephrosis, cardiac decompensation, ectopic pregnancy which is terminated, a spontaneous termination of pregnancy when a viable birth is not possible, puerperal infection, eclampsia, pre-eclampsia and toxemia.

(b) This definition does not include false labor, occasional spotting, doctor prescribed rest during the period of pregnancy, morning sickness, and conditions of comparable severity associated with management of a difficult pregnancy.

(5) "Conditionally Renewable" means renewal can be declined by class, by geographic area or for stated reasons other than deterioration of health.

(6) "Convalescent Nursing Home," "extended care facility," or "skilled nursing facility" shall mean a facility duly licensed and operating within the scope of such license.

(7) "Cosmetic Surgery" or "Reconstructive Surgery" shall mean any surgical procedure performed primarily to improve physical appearance.

(a) This definition does not include surgery, which is necessary:

(i) to correct damage caused by injury or sickness;

(ii) for reconstructive treatment following medically necessary surgery;

(iii) to provide or restore normal bodily function; or

(iv) to correct a congenital disorder that has resulted in a functional defect.

(b) This provision does not require coverage for preexisting conditions otherwise excluded.

(8) "Custodial Care" shall mean a Plan of Care, which does not provide treatment for sickness or injury, but is only for the purpose of meeting personal needs and maintaining physical condition when there is no prospect of effecting remission or restoration of the patient to a condition in which care would not be required. Such care may be provided by persons without nursing skills or qualifications. If a nursing care facility is only providing custodial or residential care, the level of care may be so characterized.

(9) "Disability Income" shall mean income replacement as defined in Section 31A-1-301.

(10) "Elimination Period" or "Waiting Period" means the length of time an insured shall wait before benefits are paid under the policy.

(11) "Enrollment Form" shall mean application as defined in Section 31A-1-301.

(12) "Experimental Treatment" is defined as medical treatment, services, supplies, medications, drugs, or other methods of therapy or medical practices, which are not accepted as a valid course of treatment by the Utah Medical Association, the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

(13) "Group Supplemental Health Insurance" means group accident and health insurance policies and certificates providing hospital confinement indemnity, accident only, specified disease, specified accident or limited benefit health coverage.

(14) "Guaranteed Renewable" means renewal cannot be declined by the insurance company for any reasons, but the insurance company can revise rates on a class basis.

(15) "Home Health Agency" shall mean a public agency or private organization, or subdivision of a health care facility, licensed and operating within the scope of such license.

(16) "Home Health Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows performance of health care and other related services under the supervision of a registered nurse from the home health agency, or performance of simple procedures as an extension of physical, speech, or occupational therapy under the supervision of licensed therapists.

(17) "Home Health Care" shall mean services provided by a home health agency.

(18) "Homemaker" shall mean a person who cares for the environment in the home through performance of duties such as

housekeeping, meal planning and preparation, laundry, shopping and errands.

(19) "Homemaker/Home Health Aide" shall mean a person who has obtained a Certificate of Completion, as required by law, which allows performance of both homemaker and home health aide services, and who provides health care and other related services under the supervision of a registered nurse from the home health agency or under the supervision of licensed therapists.

(20) "Hospice" shall mean a program of care for the terminally ill and their families which occurs in a home or in a health care facility and which provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of such license.

(21) "Hospital" means a facility that is licensed and operating within the scope of such license. This definition may not preclude the requirement of medical necessity of hospital confinement or other treatment.

(22) "Intermediate Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which confinement is required.

(23) "Medical Necessity" means:

(a) health care services or products that a prudent health care professional would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract;

(b) when a medical question of fact exists medical necessity shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(i) For interventions not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For established interventions, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(24) "Medicare" means the "Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

(25) "Medicare Supplement Policy" shall mean an individual, franchise, or group policy of accident and health insurance, other than a policy issued pursuant to a contract under section 1876 of the federal Social Security Act, 42 U.S.C. section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or primarily designed as a supplement to reimbursements under Medicare for hospital, medical, or surgical expenses of persons eligible for Medicare.

(26) "Mental or Nervous Disorders" may not be defined more restrictively than a definition including neurosis, psychoneurosis, psychosis, or any other mental or emotional disease or disorder which does not have a demonstrable organic cause.

(27) "Non-Cancelable" means renewal cannot be declined nor can rates be revised by the insurance company.

(28) "Nurse" may be defined so that the description of nurse is restricted to a type of nurse, such as registered nurse, or licensed practical nurse. If the words "nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with applicable statutes or administrative rules.

(29) "Nurse, Licensed Practical" shall mean a person who is registered and licensed to practice as a practical nurse.

(30) "Nurse, Registered" shall mean any person who is registered and licensed to practice as a registered nurse.

(31) "Nursing Care" shall mean assistance provided for the health care needs of sick or disabled individuals, by or under the direction of licensed nursing personnel.

(32) "One Period of Confinement" shall mean consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy up to a maximum of 180 days.

(33) "Optionally Renewable" means renewal is at the option of the insurance company.

(34) "Partial Disability" shall be defined in relation to the individual's inability to perform one or more, but not all, of; the major, important, or essential duties of employment or occupation; customary duties of a homemaker or dependent; or may be related to a percentage of time worked or to a specified number of hours or to compensation.

(35) "Personal Care" shall mean assistance, under a plan of care by a home health agency, provided to persons in activities of daily living.

(36) "Personal Care Aide" shall mean a person who obtains a Certificate of Completion, as required by law, which allows that person to assist in the activities of daily living and emergency first aid, and who must be supervised by a registered nurse from the home health agency.

(37) "Physician" may be defined by including words such as qualified physician or licensed physician. The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws.

(38) "Preexisting Condition."

(a) Except as provided in Section (b), a preexisting condition shall not be defined more restrictively than the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a two-year period preceding the effective date of the coverage of the insured person or a condition for which medical advice or treatment was recommended by a

physician or received from a physician within a two year period preceding the effective date of the coverage of the insured person.

(b) A specified disease insurance policy shall not define preexisting condition more restrictively than a condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(39) "Probationary Period" shall mean the period of time following the date of issuance or effective date of the policy before coverage begins for all or certain conditions.

(40) "Residential Health Care Facility" shall mean a publicly or privately operated and maintained facility providing personal care to residents who require protected living arrangements which is licensed and operating within the scope of such license.

(41) "Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the major, important, or essential duties of employment or occupation, or to the inability to perform all usual duties for as long as is usually required.

(42) "Respite Care" shall mean provision of temporary support to the primary caregiver of the aged, disabled, or handicapped individual insured, by taking over the tasks of that person for a limited period of time. The insured may receive care in the home, or other appropriate community location, or in an appropriate institutional setting.

(43)(a) "Scientific evidence" means:

(i) scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or

(ii) findings, studies or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes.

(b) Scientific evidence shall not include published peer-reviewed literature sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer or a single study without other supportable studies.

(44) "Sickness" means illness, disease, or disorder of an insured person.

(45) "Skilled Nursing Care" shall mean nursing services provided by, or under the supervision of, a registered nurse. Such care shall be for the purpose of treating the condition for which the confinement is required and not for the purpose of providing intermediate or custodial care.

(46) "Therapist" may be defined as a professionally trained or duly licensed or registered person, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

(47)(a) "Total Disability" shall mean an individual who:

(i) is not engaged in employment or occupation for which he is or becomes qualified by reason of education, training or experience; and

(ii) is unable to perform all of the substantial and material duties of his or her regular occupation or words of similar import.

(b) An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

(c) The definition may not exclude benefits based on the individual's:

(i) ability to engage in any employment or occupation for wage or profit;

(ii) inability to perform any occupation whatsoever, any occupational duty, or any and every duty of his occupation; or

(iii) inability to engage in any training or rehabilitation program.

(48)(a) "Usual and Customary" shall mean the most common charge for similar services, medicines or supplies within the area in which the charge is incurred.

(b) In determining whether a charge is usual and customary, insurers shall consider one or more of the following factors:

(i) the level of skill, extent of training, and experience required to perform the procedure or service;

(ii) the length of time required to perform the procedure or services as compared to the length of time required to perform other similar services;

(iii) the severity or nature of the illness or injury being treated;

(iv) the amount charged for the same or comparable services, medicines or supplies in the locality; the amount charged for the same or comparable services, medicines or supplies in other parts of the country;

(v) the cost to the provider of providing the service, medicine or supply; and

(vi) other factors determined by the insurer to be appropriate.

(49) "Waiting Period" shall mean "Elimination Period."

R590-126-4. Prohibited Policy Provisions.

(1) Probationary periods.

(a) A policy shall not contain provisions establishing a probationary period during which no coverage is provided under the policy, subject to the further exception that a policy may specify a probationary period not to exceed six months for specified diseases or conditions and losses resulting from disease or condition related to:

(i) adenoids;

(ii) appendix;

(iii) disorder of reproductive organs;

(iv) hernia;

(v) tonsils; and

(vi) varicose veins.

(b) The six-month period in Subsection (1)(a) may not be applicable where such specified diseases or conditions are treated on an emergency basis.

(c) Accident policies may not contain probationary or waiting periods.

(d) A probationary or waiting period for a specified disease policy shall not exceed 30 days.

(2) Preexisting conditions.

(a) Except as provided in Subsections (b) and (c), a policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the issuance of the policy or certificate where the application or enrollment form for the insurance does not seek disclosure of prior illness, disease or physical conditions or prior medical care and treatment and the preexisting condition is not specifically excluded by the terms of the policy or certificate.

(b) A specified disease policy shall not exclude coverage for a loss due to a preexisting condition for a period greater than six months following the issuance of the policy or certificate, unless the preexisting condition is specifically excluded.

(c) A hospital confinement indemnity policy shall not exclude a preexisting condition for a period greater than 12 months following the effective date of coverage of an insured person unless the preexisting condition is specifically and expressly excluded.

(3) Hospital indemnity. Policies providing hospital confinement indemnity coverage shall not contain provisions excluding coverage because of confinement in a hospital operated by the federal government.

(4) Limitations or exclusions. A policy shall not limit or exclude coverage or benefits by type of illness, accident, treatment or medical condition, except as follows:

(a) abortion;

(b) acupuncture and acupressure services;

(c) administrative charges for completing insurance forms, duplication services, interest, finance charges, or other administrative charges, unless otherwise required by law;

(d) administrative exams and services;

(e) alcoholism and drug addictions;

(f) allergy tests and treatments;

(g) aviation;

(h) axillary hyperhidrosis;

(i) benefits provided under:

(i) Medicare or other governmental program, except Medicaid;

(ii) state or federal worker's compensation; or

(iii) employer's liability or occupational disease law.

(j) cardiopulmonary fitness training, exercise equipment, and membership fees to a spa or health club;

(k) charges for appointments scheduled and not kept;

(l) chiropractic;

(m) complementary and alternative medicine;

(n) corrective lenses, and examination for the prescription or fitting thereof, but policies may not exclude required lens implants following cataract surgery;

(o) cosmetic surgery; reversal, revision, repair, complications, or treatment related to a non-covered cosmetic surgery. This exclusion does not apply to reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part; or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;

(p) custodial care;

(q) dental care or treatment, except dental plans;

(r) dietary products, except as required by R590-194;

(s) educational and nutritional training, except as required by R590-200;

(t) experimental and/or investigational services;

(u) felony, riot or insurrection, when the insured is a voluntary participant;

(v) foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, including orthotics. The exclusion of routine foot care does not apply to cutting or removal of corns, calluses, or nails when provided to a person who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, of such severity that unskilled performance of the procedure would be hazardous;

(w) gastric or intestinal bypass services including lap banding, gastric stapling, and other similar procedures to facilitate weight loss; the reversal, or revision of such procedures; or services required for the treatment of complications from such procedures;

(x) gene therapy;

(y) genetic testing;

(z) hearing aids, and examination for the prescription or fitting thereof;

(aa) illegal activities, limited to losses related directly to the insured's voluntary participation;

(bb) incarceration, with respect to disability income policies;

(cc) infertility services, except as required by R590-76;

(dd) interscholastic sports, with respect to short-term nonrenewable policies;

(ee) mental or emotional disorders;

(ff) motor vehicle no-fault law, except when the covered person is required by law to have no-fault coverage, the exclusion applies to charges up to the minimum coverage required by law whether or not such coverage is in effect;

(gg) nuclear release;
(hh) preexisting conditions or diseases as allowed under Subsection R590-126-4(2), except for coverage of congenital anomalies as required by Section 31A-22-610;
(ii) pregnancy, except for complications of pregnancy;
(jj) refractive eye surgery;
(kk) rehabilitation therapy services (physical, speech, and occupational), unless required to correct an impairment caused by a covered accident or illness;
(ll) respite care;
(mm) rest cures;
(nn) routine physical examinations;
(oo) service in the armed forces or units auxiliary to it;
(pp) services rendered by employees of hospitals, laboratories or other institutions;
(qq) services performed by a member of the covered person's immediate family;
(rr) services for which no charge is normally made in the absence of insurance;
(ss) sexual dysfunction;
(tt) shipping and handling, unless otherwise required by law;
(uu) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;
(vv) telephone/electronic consultations;
(ww) territorial limitations outside the United States;
(xx) terrorism, including acts of terrorism;
(yy) transplants;
(zz) transportation;
(aaa) treatment provided in a government hospital, except for hospital indemnity policies;
(bbb) war or act of war, whether declared or undeclared; or
(ccc) others as may be approved by the commissioner.
(5) Waivers. This rule shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.
(6) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to prohibit other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

R590-126-5. General Requirements.
(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-126-3 unless such definitions comply with the requirements of that section.
(2) Rights of spouse. The following provisions apply to policies that provide coverage to a spouse of the insured:
(a) A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.
(b) A policy shall provide that in the event of the insured's death the spouse of the insured shall become the insured.
(c) The age of the younger spouse shall be used as the basis for meeting the age and durational requirements of the noncancellation or renewal provisions of the policy. However, this requirement may not prevent termination of coverage of the older spouse upon attainment of stated age limit in the policy, so long as the policy may be continued in force as to the younger spouse to the age or for durational period as specified in said definition.
(3) Cancellation, Renewability, and Termination.
The terms "conditionally renewable," "guaranteed renewable," "noncancellable," or "optionally renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Subsection R590-126-6(2).
(a) Conditionally renewable. The term "conditionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal for reasons stated in the policy, or may make changes in premium rates by classes.
(b) Guaranteed renewable. The term "guaranteed renewable" may be used only in a policy which the insured has the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change to the detriment of the insured while the policy is in force, except that the insurer may make changes in premium rates by classes.
(c) Noncancellable. The term "noncancellable" may be used only in a policy that the insured has the right to continue in force by the timely payment of premiums until the age of 65, during which period the insurer has no right to make unilaterally any change in any provision of the policy to the detriment of the insured.
(d) Optionally renewable. The term "optionally renewable" may be used only in a policy which the insured may have the right to continue in force by the timely payment of premiums at least to age 65, during which period the insurer has no right to make any unilateral change in any provision of the policy while the policy is in force. However, the insurer, at its option, and by timely notice, may decline renewal of the policy or may make changes in premium rates by classes.
(e) Notice of nonrenewal shall be given 90 days prior to nonrenewal.

(f) A policy may not be cancelled or nonrenewed solely on the grounds of deterioration of health.

(g) Termination of the policy shall be without prejudice to a continuous loss that commenced while the policy or certificate was in force. The continuous total disability of the insured may be a condition for the extension of benefits beyond the period the policy was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.

(4) Optional insureds. When accidental death and dismemberment coverage is part of the accident and health insurance coverage offered under the contract, the insured shall have the option to include all insureds under the coverage and not just the principal insured.

(5) Military service. If a policy contains a status type military service exclusion or a provision that suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to the person on a pro rata basis.

(6) Pregnancy benefit extension. In the event the insurer cancels or refuses to renew a policy providing pregnancy benefits, the policy shall provide an extension of benefits for a pregnancy commencing while the policy is in force and for which benefits would have been payable had the policy remained in force. This requirement does not apply to a policy that is canceled for the following reasons:

(a) the insured fails to pay the required premiums in accordance with the terms of the plan; or

(b) the insured person performs an act or practice that constitutes fraud in connection with the coverage or makes an intentional misrepresentation of material fact under the terms of the coverage.

(7) Post hospital admission requirement. A policy providing convalescent or extended care benefits following hospitalization shall not condition the benefits upon admission to the convalescent or extended care facility within a period of less than 14 days after discharge from the hospital.

(8) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medical expenses of a live donor to the extent that benefits remain and are available under the recipient's policy or certificate, after benefits for the recipient's own expenses have been paid.

(9) Recurrent disability. A policy may contain a provision relating to recurrent disabilities, but a provision relating to recurrent disabilities shall not specify that a recurrent disability be separated by a period greater than 6 months.

(10) Time limit for occurrence of loss.

(a) Accidental death and dismemberment benefits shall be payable if the loss occurs within 180 days from the date of the accident, irrespective of total disability.

(b) Disability income benefits, if provided, shall not require the loss to commence less than 30 days after the date of accident, nor shall any policy that the insurer cancels or refuses to renew require that it be in force at the time disability commences if the accident occurred while the coverage was in force.

(11) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific benefit equals or exceeds the other benefits.

(12) A policy providing coverage for fractures or dislocations may not provide benefits only for "full or complete" fractures or dislocations.

(13) Specified disease, also known as critical illness, dread disease, etc., insurance sold in conjunction with another insurance product, including but not limited to life insurance or annuities, shall be in the form of a separate endorsement complying with all provisions of this rule. Specified Disease insurance shall not be incorporated into a life insurance policy or annuity contract.

(14) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.

R590-126-6. Required Provisions.

(1) Applications.

(a) Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition.

(b) Completed applications shall be made part of the policy. A copy of the completed application shall be provided to the applicant prior to or upon delivery of the policy.

(c) All applications shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides limited benefits. Review your (policy)(certificate) carefully."

(d) Application forms shall provide a statement regarding the pre-existing waiting period and the requirements to receive any applicable credit for previous coverage.

(e) An application form shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing the question may be used.

(f) All applications for dental and vision plans shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or in boldface type at least equal to the size type used for the headings or captions of sections of the application and in close conjunction with the applicant's signature block on the application as follows:

"The (policy) (certificate) provides (dental) (vision) benefits only. Review your (policy) (certificate) carefully."

(2) Renewal and nonrenewal provisions. Accident and health insurance shall include a renewal, continuation or nonrenewal provision. The language or specification of the provision shall be consistent with the type of contract to be issued. The provision

shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(3) Endorsement acceptance.

(a) Except for endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all endorsements added to a policy after date of issue or at reinstatement or renewal that reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder.

(b) After the date of policy issue, any endorsement that increases benefits or coverage with a concurrent increase in premium during the policy term, must be agreed to in writing signed by the policyholder, except if the increased benefits or coverage is required by law.

(4) Additional premium. Where a separate additional premium is charged for benefits provided in connection with endorsements, the premium charge shall be set forth in the policy or certificate.

(5) Benefit payment standard. A policy or certificate that provides for the payment of benefits based on standards described as usual and customary, reasonable and customary, or words of similar import shall include a definition of the terms and an explanation of the terms in its accompanying outline of coverage.

(6) Preexisting conditions. If a policy or certificate contains any limitations with respect to preexisting conditions, the limitations shall appear as a separate paragraph of the policy or certificate and be labeled as "Preexisting Condition Limitations."

(7) Accident Only Policies.

(a) An accident only policy or certificate shall contain a prominent statement on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size of type used for headings or captions of sections in the policy or certificate, as follows:

Notice to Buyer: This is an accident only (policy)(certificate) and it does not pay benefits for loss from sickness. Review your (policy)(certificate) carefully.

(b) Accident only policies or certificates that provide coverage for hospital or medical care shall contain the following statement in addition to the notice above:

This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(c) An accident only policy providing benefits that vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under which benefits are payable that are lesser than the maximum amount payable under the policy.

(8) Age limitation. If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy or certificate as originally issued, that fact shall be prominently set forth in the outline of coverage and schedule page.

(9) Disappearance. If a policy or certificate includes a disappearance benefit, payment must be made within the time limits provided by R590-192-9 when proof of loss, satisfactory to the company, is filed and it is reasonable to assume death occurred, but a body cannot be found.

(10) Conversion privilege. If a policy or certificate contains a conversion privilege, it shall comply, in substance, with the following: The caption of the provision shall read "Conversion Privilege" or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

(11) Specified Disease Insurance Buyers Guide. An insurer, except a direct response insurer, shall give a person applying for specified disease insurance, a buyer's guide filed with the commissioner at the time of enrollment and shall obtain recipient's written acknowledgement of the guide's delivery. A direct response insurer shall provide the buyer's guide upon request, but not later than the time that the policy or certificate is delivered.

(12) Specified disease policies or certificates shall contain on the first page or attached to it in either contrasting color or in boldface type, at least equal to the size type used for headings or captions of sections in the policy or certificate, a prominent statement as follows:

Notice to Buyer: This is a specified disease (policy) (certificate). This (policy) (certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy) (certificate) carefully with the outline of coverage and the buyer's guide.

(13) Hospital confinement indemnity and limited benefit health policies or certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (hospital confinement indemnity) (limited benefit health) (policy)(certificate). This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses.

(14) Basic hospital, basic medical-surgical, and basic hospital-medical surgical expense policies and certificates shall display prominently by type, stamp or other appropriate means on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This is a (basic hospital) (basic medical-surgical) (basic hospital/medical-surgical) expense (policy)(certificate). This (policy)(certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage.

(15) Dental and vision coverage policies and certificates shall display prominently by type or stamp on the first page of the policy or certificate, or attached to it, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of sections in the policy or certificate the following:

Notice to Buyer: This (policy) (certificate) provides (dental) (vision) coverage only.

R590-126-7. Accident and Health Standards for Benefits.

The following standards for benefits are prescribed for the categories of coverage noted in the following subsections. An accident and health insurance policy or certificate subject to this rule shall not be delivered or issued for delivery unless it meets the required standards for the specified categories. This section shall not preclude the issuance of any policy or contract combining two or more categories set forth in Subsection 31A-22-605(5).

Benefits for coverages listed in this section shall include coverage of inborn metabolic errors as required by Section 31A-22-623 and Rule R590-194, and benefits for diabetes as required by Section 31A-22-626 and Rule R590-200, if applicable.

(1) Basic Hospital Expense Coverage.

Basic hospital expense coverage is a policy of accident and health insurance that provides coverage for a period of not less than 31 days during a continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness, and shall include at least the following:

(a) daily hospital room and board in an amount not less than:

(i) 80% of the charges for semiprivate room accommodations; or

(ii) $100 per day;

(b) miscellaneous hospital services for expenses incurred for the charges made by the hospital for services and supplies that are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either:

(i) 80% of the charges incurred up to at least $3000; or

(ii) ten times the daily hospital room and board benefits; and

(c) hospital outpatient services consisting of:

(i) hospital services on the day surgery is performed;

(ii) hospital services rendered within 72 hours after injury, in an amount not less than $250 per accident; and

(iii) x-ray and laboratory tests to the extent that benefits for the services would have been provided if rendered to an in-patient of the hospital to an extent not less than $200;

(d) benefits provided under Subsections (a) and (b) may be provided subject to a combined deductible amount not in excess of $200.

(2) Basic Medical-Surgical Expense Coverage.

Basic medical-surgical expense coverage is a policy of accident and health insurance that provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness for and shall include at least the following:

(a) surgical services:

(i) in amounts not less than those provided on a current procedure terminology based relative value fee schedule, up to at least $1000 for one procedure; or

(ii) 80% of the reasonable charges.

(b) anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician, or the physician assistant, performing the surgical services:

(i) in an amount not less than 80% of the reasonable charges; or

(ii) 15% of the surgical service benefit; and

(c) in-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury other than that for which surgical care is required, in an amount not less than:

(i) 80% of the reasonable charges; or

(ii) $100 per day.

(3) Basic Hospital/Medical-Surgical Expense Coverage.

Basic hospital/medical-surgical expense coverage is a policy of accident and health which combines coverage and must meet the requirements of both Subsections R590-126-7(1) and (2).

(4) Hospital Confinement Indemnity Coverage.

(a) Hospital confinement indemnity coverage is a policy of accident and health insurance that provides daily benefits for hospital confinement on an indemnity basis.

(b) Coverage includes an indemnity amount of not less than $50 per day and not less than 31 days during each period of confinement for each person insured under the policy.

(c) Benefits shall be paid regardless of other coverage.

(5) Income Replacement Coverage.

Income replacement coverage is a policy of accident and health insurance that provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination of both that:

(a) contains an elimination period no greater than:

(i) 90 days in the case of a coverage providing a benefit of one year or less;

(ii) 180 days in the case of coverage providing a benefit of more than one year but not greater than two years; or

(iii) 365 days in all other cases during the continuance of disability resulting from sickness or injury;

(b) has a maximum period of time for which it is payable during disability of at least six months except in the case of a policy covering disability arising out of pregnancy, childbirth or miscarriage in which case the period for the disability may be one month. No reduction in benefits shall be put into effect because of an increase in Social Security or similar benefits during a benefit period;

(c) where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required;

(d) a policy which provides for residual disability benefits may require a qualification period, during which the insured shall be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability;

(e) the provisions of this subsection do not apply to policies providing business buyout coverage.

(6) Accident Only Coverage.

Accident only coverage is a policy of accident and health insurance that provides coverage, singly or in combination, for death, dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under the policy shall be at least $1,000 and a single dismemberment amount shall be at least $500.

(7) Specified Accident Coverage.

Specified accident coverage is a policy of accident and health insurance that provides coverage for a specifically identified kind of accident, or accidents, for each person insured under the policy for accidental death or accidental death and dismemberment, combined with a benefit amount not less than $1,000 for accidental death, $1,000 for double dismemberment and $500 for single dismemberment.

(8) Specified Disease Coverage.

Specified disease coverage is a policy of accident and health insurance that provides coverage for the diagnosis and treatment of a specifically named disease or diseases, and includes critical illness coverages. Any such policy shall meet these general provisions. The policy shall also meet the standards set forth in the applicable Subsections R590-126-7(8)(b), (c) or (d).

(a) General Provisions.

(i) Policy designation. Policies covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease coverage under this Subsection (8).

(ii) Medical diagnosis. Any policy issued pursuant to this section which conditions payment upon pathological diagnosis of a covered disease, shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted instead.

(iii) Related conditions. Notwithstanding any other provision of this rule, specified disease policies shall provide benefits to any covered person, not only for the specified disease, but also for any other condition or disease directly caused or aggravated by the specified disease or the treatment of the specified disease.

(iv) Renewability. Specified disease coverage shall be at least guaranteed renewable.

(v) Probationary period. No policy issued pursuant to this section may contain a probationary period greater than 30 days.

(vi) Medicaid disclaimer. Any application for specified disease coverage shall contain a statement above the signature of the applicant that no person to be covered for specified disease is also covered by any Title XIX program, designated as Medicaid or any similar name. Such statement may be combined with any other statement for which the insurer may require the applicant's signature.

(vii) Medical Care. Payments may be conditioned upon an insured person's receiving medically necessary care, given in a medically appropriate location, under a medically accepted course of diagnosis or treatment.

(viii) Other insurance. Benefits for specified disease coverage shall be paid regardless of other coverage.

(ix) Retroactive application of coverage. After the effective date of the coverage, or the conclusion of an applicable probationary period, if any, benefits shall begin with the first day of care or confinement, if such care or confinement is for a covered disease, even though the diagnosis is made at some later date.

(x) Hospice. Hospice care is an optional benefit, but if offered it shall meet the following minimum standards:

(A) eligibility for payment of benefits when the attending physician of the insured provides a written statement that the insured person has a life expectance of six months or less;

(B) fixed sum payment of at least $50 per day; and

(C) lifetime maximum benefit of at least $10,000.

(b) Expense Incurred Benefits. The following benefit standards apply to specified disease coverage on an expense-incurred basis.

(i) Policy limits. A deductible amount not to exceed $250, an aggregate benefit limit of not less than $25,000 and a benefit period of not fewer than three years.

(ii) Copayment. Covered services provided on an outpatient basis may be subject to a copayment, which may not exceed 20%.

(iii) Covered Services. Covered services shall include the following:

(A) hospital room and board and any other hospital-furnished medical services or supplies;

(B) treatment by, or under the direction of, a legally qualified physician or surgeon;

(C) private duty nursing services of a registered nurse, or licensed practical nurse;

(D) x-ray, radium, chemotherapy and other therapy procedures used in diagnosis and treatment;

(E) blood transfusions, and the administration thereof, including expense incurred for blood donors;
(F) drugs and medicines prescribed by a physician;
(G) professional ambulance for local service to or from a local hospital;
(H) the rental of any respiratory or other mechanical apparatuses;
(I) braces, crutches and wheelchairs as are deemed necessary by the attending physician for the treatment of the disease;
(J) emergency transportation if, in the opinion of the attending physician, it is necessary to transport the insured to another locality for treatment of the disease;
(K) home health care with a written prescribed plan of care;
(L) physical, speech, hearing and occupational therapy;
(M) special equipment including hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy and cleostomy appliances;
(N) prosthetic devices including wigs and artificial breasts;
(O) nursing home care for non-custodial services; and
(P) reconstructive surgery when deemed necessary by the attending physician.
(c) Per Diem Benefits. The following benefit standards apply to specified disease coverage on a per diem basis.
(i) Covered services shall include the following:
(A) hospital confinement benefit with a fixed-sum payment of at least $200 for each day of hospital confinement for at least 365 days, with no deductible amount permitted;
(B) outpatient benefit with a fixed-sum payment equal to one-half the hospital inpatient benefits for each day of hospital or non-hospital outpatient surgery, radiation therapy and chemotherapy, for at least 365 days of treatment; and
(C) blood and plasma benefit with a fixed-sum benefit of at least $50 per day for blood and plasma, which includes their administration whether received as an inpatient or outpatient for at least 365 days of treatment.
(ii) Benefits tied to confinement in a skilled nursing home or home health care are optional. If a policy offers these benefits, they must equal the following:
(A) fixed-sum payment equal to one-half the hospital inpatient benefit for each day of skilled nursing home confinement for at least 180 days; and
(B) fixed-sum payment equal to one-fourth the hospital inpatient benefit for each day of home health care for at least 180 days.
(C) Any restriction or limitation applied to the benefits may not be more restrictive than those under Medicare.
(d) Lump Sum Benefits. The following benefit standards apply to specified disease coverage on a lump sum basis.
(i) Benefits shall be payable as a fixed, one-time payment, made within 30 days of submission to the insurer, of proof of diagnosis of the specified disease. Dollar benefits shall be offered for sale only in even increments of $1,000.
(ii) Where coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, e.g., "cancer insurance," "heart disease insurance," the same dollar amounts shall be payable regardless of the particular subtype of the disease, e.g., lung or bone cancer, with one exception. In the case of clearly identifiable subtypes with significantly lower treatment costs, e.g., skin cancer, lesser amounts may be payable so long as the policy clearly differentiates that subtype and its benefits.
(9) Limited Benefit Health Coverage.
Limited benefit health coverage is a policy of accident and health insurance, other than a policy covering only a specified disease or diseases, that provides benefits that are less than the standards for benefits required under this Section. These policies or contracts may be delivered or issued for delivery with the outline of coverage required by Section R590-126-8.

R590-126-8. Outline of Coverage Requirements.
(1) Basic Hospital Expense Coverage.
An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(1). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE I

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Basic hospital expense coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided

for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.
A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order: daily hospital room and board; miscellaneous hospital services; hospital out-patient services; and other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(2) Basic Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(2). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE II

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness.
Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.
A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
surgical services;
anesthesia services;
in-hospital medical services; and
other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(3) Basic Hospital/Medical-Surgical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsections R590-126-7(3). The items included in the outline of coverage must appear in the sequence prescribed.

TABLE III

(COMPANY NAME)

BASIC HOSPITAL/MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract

and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.
A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
daily hospital room and board;
miscellaneous hospital services;
hospital outpatient services;
surgical services;
anesthesia services;
in-hospital medical services; and
other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(4) Hospital Confinement Indemnity Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(4). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IV

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
A brief specific description of the benefits in the following order:
daily benefit payable during hospital confinement; and
duration of benefit.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefit.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.
Any benefits provided in addition to the daily hospital benefit.

(5) Income Replacement Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-126-7(5). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE V

(COMPANY NAME)

INCOME REPLACEMENT COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully This outline of
coverage provides a very brief description of the important
features of your policy. This is not the insurance contract
and only the actual policy provisions will control. The policy
itself sets forth in detail the rights and obligations of both
you and your insurance company. It is, therefore, important
that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Income replacement coverage is designed to provide, to persons
insured, coverage for disabilities resulting from a covered
accident or sickness, subject to any limitations set forth in
the policy. Coverage is not provided for basic hospital, basic
medical surgical, or major medical expenses.
A brief specific description of the benefits contained in the
policy.
A description of any policy provisions that exclude, eliminate,
restrict, reduce, limit, delay or in any other manner operate to
qualify payment of the benefits.
A description of policy provisions respecting renewability or
continuation of coverage, including age restrictions or any
reservation of right to change premiums.

(6) Accident Only Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with policies meeting the standards of Subsection R590-126-7(6). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VI

(COMPANY NAME)

ACCIDENT ONLY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED
TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE
Read Your (Policy) (Certificate) Carefully This outline
of coverage provides a very brief description of the important
features of the coverage. This is not the insurance contract
and only the actual policy provisions will control. The policy
itself sets forth in detail the rights and obligations of both
you and your insurance company. It is, therefore, important
that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!
Accident only coverage is designed to provide, to persons
insured, coverage for certain losses resulting from a covered
accident ONLY, subject to any limitations contained in the
policy. Coverage is not provided for basic hospital, basic
medical surgical, or major medical expenses.
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate,
restrict, reduce, limit, delay, or in any other manner operate
to qualify payment of the benefits.
A description of policy provisions respecting renewability or
continuation of coverage, including age restrictions or any
reservations of right to change premiums.

(7) Specified Accident Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of R590-126-7(7). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VII

(COMPANY NAME)

SPECIFIED ACCIDENT COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED
TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Specified accident coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits, including dollar amounts.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(8) Specified Disease Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates meeting the standards of Subsection R590-126-7(8). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE VIII

(COMPANY NAME)

SPECIFIED DISEASE COVERAGE

THIS (POLICY) (CERTIFICATE) PROVIDES LIMITED BENEFITS
BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE
Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage.
Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.
Read Your (Policy) (Certificate) Carefully This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Specified disease coverages designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.
A brief specific description of the benefits, including dollar amounts.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(9) Limited Benefit Health Coverage.

Except for dental or vision plans, an outline of coverage, in the form prescribed below, shall be issued in connection with policies or certificates which do not meet the standards of Subsections R590-126-7(1) through (8). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE IX

(COMPANY NAME)

LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully This outline of

coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.
A brief specific description of the benefits, including amounts.
A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(10) Dental Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with dental plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE X

(COMPANY NAME)

DENTAL COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES
OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(11) Vision Coverage.

An outline of coverage in the form prescribed below shall be issued in connection with vision plan policies and certificates. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE XI

(COMPANY NAME)

VISION COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL VISION EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy) (Certificate) Carefully. This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
A brief specific description of the benefits.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(12) An insurer shall deliver an outline of coverage to an applicant or enrollee prior to or upon the sale of an individual accident and health insurance policy as required in this rule.

(13) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on

a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than 12 point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued.

(14) Outlines of coverage for hospital confinement indemnity, specified disease, or limited benefit policies, which are to be delivered to persons eligible for Medicare by reason of age shall contain the following language, which shall be printed on or attached to the first page of the outline of coverage:

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

(15) Where the prescribed outline of coverage is inappropriate for the coverage provided by the policy or certificate, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(16) Advertisements may fulfill the requirements for outlines of coverage if they satisfy the standards specified for outlines of coverage in this rule.

R590-126-9. Replacement of Accident and Health Insurance Requirements.

(1) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its producer, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection (2). The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection (3). In no event, however, will the notices be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

(2) The notice required by Subsection (1) for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

TABLE XII

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.
Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.
The above "Notice to Applicant" was delivered to me on:
.....
(Date)
.....
(Applicant's Signature)

(3) The notice required by Subsection (1) for a direct response insurer shall be as follows:

TABLE XIII

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy.

~~For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.~~
~~You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.~~
~~(To be included only if the application is attached to the policy). If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.~~
~~COMPANY NAME~~

~~R590-126-10. Enforcement Date.~~

~~The commissioner will begin enforcing the revised provision of this rule January 1, 2006.~~

~~R590-126-11. Severability.~~

~~If any provision of this rule or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of the rule and the application of the provision to other persons or circumstances shall not be affected thereby.~~]

R590-126-1. Authority.

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-2-201.1, 31A-22-605, 31A-22-605.1, 31A-22-623, and 31A-22-626.

R590-126-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) standardize and simplify the terms and coverage of an accident and health insurance contract;

(b) facilitate public understanding and comparison of coverage;

(c) prohibit use of a provision that is misleading or confusing in connection with the purchase of coverage or the settlement of a claim;

(d) set minimum coverage requirements; and

(e) provide for full disclosure in the sale of insurance.

(2) This rule applies to an accident and health insurance contract that is not specifically exempted from this rule, regardless of:

(a) whether the contract is issued to an association, a trust, a discretionary group, or another similar group; or

(b) the situs of delivery of the contract.

(3) This rule does not apply to:

(a) an accident and health insurance contract issued to an employee group under Section 31A-22-502;

(b) a contract issued to an employee or member as an addition to a franchise plan in existence on January 1, 2006;

(c) a Medicare supplement contract subject to Section 31A-22-620;

(d) a TRICARE policy, formerly known as a Civilian Health and Medical Program of the Uniformed Services, 10 U.S.C. 55, CHAMPUS settlement insurance policy;

(e) a health benefit plan subject to Title 31A, Chapter 45, Managed Care Organizations;

(f) a short-term limited duration health insurance contract subject to Rule R590-286;

(g) a long-term care insurance contract subject to Title 31A, Chapter 22, Part 14, Long-Term Care Insurance Standards; or

(h) a limited long-term care insurance contract subject to Title 31A, Chapter 22, Part 20, Limited Long-Term Care Insurance Act.

R590-126-3. Definitions.

Terms used in this rule are defined in Sections 31A-1-301, 31A-22-605, 31A-22-620, and 31A-22-625. Additional terms are defined as follows:

(1) "Assisted living facility," "continued care retirement community," "convalescent nursing home," "extended care facility," "hospital," "residential health care facility," or "skilled nursing facility" means a facility licensed and operating within the scope of that license.

(2) "Buyer's guide" means the NAIC's Shopper's Guide to Cancer Insurance.

(3) "Certificate of completion" means a document issued by the Utah State Board of Education, or similar organization in another state, to an individual:

(a) who completes an approved course of study not leading to a diploma;

(b) who passes a challenge for the course of study in Subsection (3)(a); or

(c) whose out-of-state credentials or certificates are acceptable to the Utah State Board of Education.

(4) "Complication of pregnancy" means a disease or condition that is distinct from pregnancy but is adversely affected or caused by pregnancy and is not associated with a normal pregnancy.

(a) "Complication of pregnancy" includes:

(i) acute nephritis;

(ii) nephrosis;

(iii) cardiac decompensation;

(iv) terminated ectopic pregnancy;

(v) spontaneous termination of pregnancy when a viable birth is not possible;

(vi) puerperal infection;

(vii) eclampsia;

(viii) pre-eclampsia; or

(ix) toxemia.

(b) "Complication of pregnancy" does not include:

(i) false labor;

(ii) occasional spotting;

(iii) doctor prescribed rest during pregnancy;

(iv) morning sickness; or

(v) a condition of comparable severity associated with management of a difficult pregnancy.

(5) "Contract" means a policy or certificate.

(6)(a) "Cosmetic surgery" or "reconstructive surgery" means a surgical procedure performed primarily to improve physical appearance.

(b) "Cosmetic surgery" or "reconstructive surgery" does not include surgery that is necessary:

(i) to correct damage caused by injury or sickness;

(ii) for reconstructive treatment following medically necessary surgery;

(iii) to provide or restore normal bodily function; or

(iv) to correct a congenital disorder that has resulted in a functional defect.

(7)(a) "Custodial care" means a plan of care that does not provide treatment for sickness or injury, but is for meeting personal needs and maintaining physical condition when there is no prospect of remission or restoration of the patient to a condition when care would not be required, and that may be provided by a person without nursing skills or qualifications.

(8) "Elimination period" or "waiting period" means the length of time an insured shall wait before benefits are paid under the contract.

(9) "Enrollment form" means an application as defined in Section 31A-1-301.

(10) Experimental treatment" means a medical treatment, service, supply, medication, drug, or other method of therapy or medical practice that is not accepted as a valid course of treatment by the U.S. Food and Drug Administration, the American Medical Association, or the Surgeon General.

(11) "Home health agency" means a public agency, a private organization, or a subdivision of a health care facility that is licensed and operating within the scope of that license.

(12) "Home health aide" means an individual who obtains a certificate of completion, as required by law, that allows performance of:

(a) health care and other related services under the supervision of a registered nurse from the home health agency; or

(b) a simple procedure as an extension of physical, speech, or occupational therapy under the supervision of a licensed therapist.

(13) "Home health care" means a service provided by a home health agency.

(14) "Homemaker" means an individual who cares for the home through duties such as housekeeping, meal planning and preparation, laundry, shopping, and errands.

(15) "Hospice" means a program of care for the terminally ill and their families that occurs in a home or health care facility and provides medical, palliative, psychological, spiritual, or supportive care and treatment and is licensed and operating within the scope of that license.

(16)(a) "Injury" means a bodily injury resulting from an accident, independent of disease, that occurs while the coverage is in force.

(b) "Injury" is not limited to an injury with external, violent, visible wound or similar description.

(17) "Immediate family" means an insured's parent, spouse, sibling, or child, including a step or in-law relationship.

(18) "Intermediate nursing care" means a nursing service provided by, or under the supervision of, a nurse to treat a condition when confinement is required.

(19) "Licensed practical nurse" means a licensed practical nurse who provides services within the scope of their license.

(20)(a) "Medical necessity" means a health care service or product that a prudent health care provider would provide to a patient to prevent, diagnose, or treat an illness, injury, disease, or its symptoms in a manner that is:

(i) in accordance with generally accepted standards of medical practice in the United States;

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration;

(iii) not primarily for the convenience of the patient, physician, or other health care provider; and

(iv) covered under the contract.

(b) If a medical question-of-fact exists, "medical necessity" shall include the most appropriate available supply or level of service for the individual in question, considering potential benefits and harms to the individual, and known to be effective.

(c)(i) For an intervention not yet in widespread use, the effectiveness shall be based on scientific evidence.

(ii) For an established intervention, the effectiveness shall be based on:

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

(21)(a) "Nurse" means a type of licensed nurse, such as an advanced practice nurse, a registered nurse, or a licensed practical nurse.

(b) If the word "nurse" is used without specific instruction, then the use of this term requires the insurer to recognize the services of any individual who qualifies under this terminology under applicable laws.

(22) "Nursing care" means assistance provided for the health care needs of a sick or disabled individual, by or under the direction of a nurse.

(23) "One period of confinement" means consecutive days of in-hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital occurs within a period of not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the contract up to a maximum of 180 days.

(24) "Partial disability" means an individual's inability to:

(a) perform some, but not all, of the major, important, or essential duties of the individual's employment or existing occupation;

(b) work a specified:

(i) percentage of time; or

(ii) number of hours; or

(c) earn a specified amount of compensation.

(25) "Personal care" means assistance in the activities of daily living provided to an individual under a plan of care by a home health agency.

(26) "Personal care aide" means an individual who obtains a certificate of completion, as required by law, that allows that individual to assist in the activities of daily living and emergency first aid, and who must be supervised by a registered nurse from a home health agency.

(27) "Physician," "qualified physician," or "licensed physician" means a physician who provides services within the scope of their license.

(28)(a) "Preexisting condition" means:

(i) the existence of a symptom or condition that would cause an ordinarily prudent person to seek diagnosis, care, or treatment within the 24-month period before the effective date of coverage; or

(ii) a condition for which medical advice or treatment was recommended or received from a health care provider within the 24-month period before the effective date of the coverage of the insured.

(b) This definition does not apply to a specified disease insurance contract.

(29) "Probationary period" means the length of time following the date of issuance or effective date of the contract before a benefit is paid under the contract.

(30) "Registered nurse" means a registered nurse who provides services within the scope of their license.

(31) "Residual disability" means an individual's relative reduction in earnings and may be related to the inability to perform either:

(a) some part of the major, important, or essential duties of the individual's employment or existing occupation; or

(b) the individual's usual work duties for as long as is usually required.

(32) "Respite care" means providing temporary support to the primary caregiver of an aged or disabled insured by taking over the tasks of that insured for a limited time period, whether in the home, an appropriate community location, or an appropriate institutional setting.

(33)(a) "Scientific evidence" means:

(i) a scientific study published or accepted by a medical journal that meets nationally recognized standards for scientific manuscripts and that submits its published articles for review by experts who are not part of the editorial staff; or

(ii) a finding, study, or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute.

(b) "Scientific evidence" does not include:

(i) published peer-reviewed literature sponsored by:

(A) a pharmaceutical manufacturing company; or

(B) a medical device manufacturer; or

(ii) a single study without other supportable studies.

(34) "Sickness" means illness, disease, or disorder of an insured.

(35) "Skilled nursing care" means nursing services provided by, or under the supervision of, a registered nurse to treat the condition for which the confinement is required and for not providing intermediate nursing care or custodial care.

(36) "Therapist" means a professionally trained or licensed individual, such as a physical therapist, occupational therapist, or speech therapist, who is skilled in applying treatment techniques and procedures under the general direction of a physician.

(37) "Total disability" means an individual who:
(a) is not engaged in employment or occupation for which the individual is or becomes qualified, by reason of education, training, or experience; and
(b) is unable to perform each substantial and material duty of the individual's regular occupation.
(38) "Usual and customary" means the most common charge for a similar service, medicine, or supply within the geographical area in which a charge is incurred, considering one or more of the following factors:
(a) the level of skill, extent of training, and experience required to perform the procedure or service;
(b) the length of time required to perform the procedure or service as compared to the length of time required to perform a similar service;
(c) the severity or nature of the illness or injury being treated;
(d) the amount charged for the same or comparable service, medicine, or supply in the geographical area or in other parts of the country;
(e) the cost to the provider of providing the service, medicine, or supply; or
(f) another factor determined by the insurer to be appropriate.

R590-126-4. Prohibited Contract Provisions.
(1)(a) A contract may not establish a probationary period when coverage is not provided, except under Subsection (1)(b), (1)(c), or (1)(d).
(b) A contract may specify a probationary period not to exceed six months for a loss resulting from:
(i) adenoids;
(ii) appendix;
(iii) disorder of a reproductive organ;
(iv) hernia;
(v) tonsils; or
(vi) varicose veins.
(c) Coverage shall be provided for a disease, condition, or procedure in Subsection (1)(b) if the disease, condition, or procedure is treated on an emergency basis.
(d) A probationary period for a specified disease insurance contract may not exceed 30 days.
(e) An accident insurance contract may not include a probationary period.
(2) Unless otherwise required by law, a contract may not limit or exclude coverage or benefits by type of illness, accident, injury, treatment, or medical condition, except:
(a) abortion;
(b) acupuncture or acupressure;
(c) administrative charge for completing an insurance form, duplication service, interest, finance charge, or other administrative charge, unless otherwise required by law;
(d) administrative exam or service;
(e) allergy test or treatment;
(f) aviation, to a non-fare-paying passenger;
(g) axillary hyperhidrosis;
(h) benefits paid for under:
(i) employer's liability or occupational disease law;
(ii) Medicare or another governmental program, except Medicaid; or
(iii) state or federal workers' compensation;
(i) charge for a missed appointment;
(j) chiropractic care;
(k) complementary or alternative medicine;
(l) corrective lens, including an examination for the prescription or fitting, except lens implant following cataract surgery;
(m) cosmetic surgery, including reversal, revision, repair, complication, or treatment related to a non-covered cosmetic surgery, except reconstructive surgery:
(i) when the service is incidental to or follows surgery resulting from trauma, infection, or other disease of the involved part; or
(ii) due to a congenital disease or anomaly of a covered dependent child that resulted in a functional defect;
(n) custodial care;
(o) dental care or treatment, except a dental contract;
(p) dietary products;
(q) educational or nutritional training, except as required under Rule R590-200;
(r) experimental or investigational service;
(s) felony, riot, or insurrection, when it is determined the insured was a voluntary participant;
(t) fitness training, exercise equipment, or a membership to a spa or health club;
(u)(i) foot care for a corn, a callus, a flat foot, a fallen arch, a weak foot, chronic foot strain, or symptomatic complaints of a foot, including an orthotic; and
(ii) the cutting or removal of a corn, a callus, or a nail may not be excluded when provided to an insured who has a systemic

disease, such as diabetes with peripheral neuropathy or circulatory insufficiency if unskilled performance of the procedure would be hazardous;

(v)(i) gastric or intestinal bypass service, including lap banding, gastric stapling, or a similar procedure to facilitate weight loss;

(ii) the reversal or revision of a procedure in Subsection (2)(v)(i); or

(iii) a service required for the treatment of a complication from a procedure in Subsection (2)(v)(i);

(w) gender reassignment;

(x) gene therapy;

(y) genetic testing;

(z) hearing aid, including examination for the prescription or fitting;

(aa) incarceration, limited to income replacement insurance;

(bb) infertility service;

(cc) injury as a result of a motor vehicle, to the extent the insured is required to have no-fault coverage, up to the minimum coverage required by law, whether or not such coverage is in effect;

(dd) mental health condition or substance use disorder services;

(ee) nuclear release;

(ff) preexisting condition, except as required under Section 31A-22-605.1 and Subsection 31A-22-610(2);

(gg) pregnancy, except for a complication of pregnancy;

(hh) refractive eye surgery;

(ii) rehabilitation therapy service, such as physical, speech, and occupational, unless required to correct an impairment caused by a covered accident, injury, or illness;

(jj) respite care;

(kk) rest cure;

(ll) routine physical examination;

(mm) services performed by an insured's parent, spouse, sibling, or child, including a step or in-law relationship;

(nn) services performed by an employee of a hospital, laboratory, or other institution;

(oo) services for which no charge is normally made in the absence of insurance;

(pp) services while in the armed forces or an auxiliary unit;

(qq) sexual dysfunction procedure, equipment, or drug;

(rr) shipping or handling;

(ss) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;

(tt) telephone or electronic consultation;

(uu) territorial limitation outside the United States, except as required under Section 31A-22-627;

(vv) terrorism, including an act of terrorism;

(ww) transplant;

(xx) transportation;

(yy) treatment provided in a government hospital, except for fixed indemnity insurance;

(zz) war or act of war, whether declared or undeclared;

(aaa) except under Subsection (2)(bbb), a loss directly related to the insured's voluntary participation in an activity when the insured:

(i) is found guilty of an illegal activity in a criminal proceeding, including a plea of guilty, a no contest plea, and a plea in abeyance; or

(ii) is found liable for the activity in a civil proceeding;

(bbb) a loss established under Subsection (3) that is directly related to the insured violating:

(i) Section 41-6a-502, if the loss occurred in Utah; or

(ii) a law in a state other than Utah that prohibits operating a motor vehicle while exceeding the legal limit of concentration of alcohol, drugs, or a combination of both, in the blood, if the loss occurred in the other state; or

(ccc) any other exclusion that, in the opinion of the commissioner, is not inequitable, misleading, deceptive, obscure, unjust, unfair, or unfairly discriminatory to an insured.

(3)(a) A violation under Subsection (2)(bbb) shall be established:

(i) in a criminal proceeding in which the insured is found guilty, enters a no contest plea, a plea in abeyance, or enters into a diversion agreement; or

(ii) by a request for an independent review when the findings support a decision to deny coverage based on the exclusion.

(b)(i) For purposes of Subsection (3)(a)(ii), an independent review means a process that:

(A) is conducted by an independent entity designated by the insurer;

(B) renders an independent and impartial decision on a decision to deny coverage based on the exclusion; and

(C) is paid for by the insurer.

(ii) The independent review entity may not have a material professional, familial, or financial conflict with:

(A) the insurer;

(B) an officer, director, or management employee of the insurer;

(C) the insured;

(D) the insured's health care provider;

(E) the health care provider's medical group or independent practice association; or
(F) a health care facility where services were provided.
(c) The exclusion in Subsection (2)(bbb) does not apply to an insured who is under age 18.
(4)(a) An insurer may use a waiver to exclude, limit, or reduce coverage or benefits for a specifically named or described preexisting condition, physical condition, or extra hazardous activity.
(b) A signed acceptance by the insured is required if a waiver is required as a condition of issuance, renewal, or reinstatement.
(5) A contract provision precluded in this section may not be construed as a limitation on the commissioner's authority to prohibit a contract provision that, in the opinion of the commissioner, is unjust, unfair, or unfairly discriminatory to an insured.

R590-126-5. General Requirements.
(1) A contract may not include a definition regarding a matter defined in Section R590-126-3 unless the definition complies with that section.
(2)(a) A contract that provides coverage to a spouse of the contract holder:
(i) may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the contract holder, other than for nonpayment of premium;
(ii) shall provide that in the event of the contract holder's death, the spouse shall become the contract holder; and
(iii) shall use the age of the younger spouse as the basis for meeting the age and durational requirements of a noncancellation or renewal provision of a contract.
(b) The requirement in Subsection (2)(a)(iii) may not prevent termination of coverage of the older spouse upon attainment of the stated age limit in the contract, so long as the contract may be continued for the younger spouse to the age or durational period as specified in the renewal provision.
(3)(a) The term "conditionally renewable," "guaranteed renewable," "noncancellable," or "optionally renewable" may not be used without further explanatory language under the disclosure requirements of Subsection R590-126-6(2).
(b) The term "conditionally renewable" may be used only in a contract for which the insured has the right to continue coverage by the timely payment of premiums at least to age 65, during which period the insurer:
(i) may not make a unilateral change to a provision of the contract to the detriment of the insured; and
(ii) may, by timely notice:
(A) decline renewal by class, geographic area, or for a reason stated in the contract; and
(B) make changes in premium rates by class.
(c) The term "guaranteed renewable" may be used only in a contract for which the insured has the right to continue coverage by the timely payment of premiums at least to age 65, and during which period the insurer:
(i) may not:
(A) decline renewal; or
(B) make a unilateral change to a provision of the contract to the detriment of the insured while the contract is in force; and
(ii) may, by timely notice, make changes in premium rates by class.
(d) The term "noncancellable" may be used only in a contract for which the insured has the right to continue coverage by the timely payment of premiums at least to age 65, and during which period the insurer may not:
(i) decline renewal;
(ii) make a unilateral change to a provision of the contract to the detriment of the insured; or
(iii) make changes in premium rates by class.
(e) The term "optionally renewable" may be used only in a contract for which the insured has the right to continue coverage by the timely payment of premiums at least to age 65, and during which period the insurer:
(i) may not make a unilateral change to a provision of the contract to the detriment of the insured while the contract is in force; and
(ii) may, by timely notice:
(A) decline renewal; or
(B) make changes in premium rates by class.
(f) Notice of nonrenewal shall be given no less than 90 days before nonrenewal.
(g) A contract may not be canceled or nonrenewed solely on the grounds of deterioration of health.
(h) Termination of a contract shall be without prejudice to any continuous loss that commenced while the contract was in force.
(i) The continuous total disability of the insured may be a condition for an extension of benefits beyond the period the contract was in force, limited to the duration of the benefit period, if any, or payment of the maximum benefits.
(4) When accidental death and dismemberment coverage is offered under a contract, the contract holder shall have the option to include each insured under the coverage.
(5) If a contract includes a status-type military service exclusion or a provision that suspends coverage during military service, the contract shall, upon receipt of a written request, provide for a refund of premiums, as applicable, to the insured on a pro-rata basis.
(6)(a) If an insurer cancels or refuses to renew a contract providing pregnancy benefits, the contract shall provide an extension of benefits for the pregnancy benefits, if:
(i) the pregnancy commenced while the contract was in force; and

(ii) a benefit would have been payable had the contract remained in force.

(b) Subsection (6)(a) does not apply to a contract that is canceled due to the insured:

(i) failing to pay the required premium in accordance with the contract terms;

(ii) performing an act or practice that constitutes fraud in connection with the coverage; or

(iii) making an intentional misrepresentation of material fact under the terms of the contract.

(7) A contract providing convalescent care or extended care benefits following hospitalization may not condition the benefits upon admission to a convalescent nursing home or extended care facility within a period of less than 14 days after discharge from the hospital.

(8) A contract providing coverage for the recipient in a transplant operation shall also provide reimbursement of medically necessary transplant expenses of a live donor, to the extent benefits remain and are available under the recipient's contract and after benefits for the recipient's expenses have been paid.

(9)(a) A contract including a provision for total disability may not exclude or reduce benefits based on the insured's:

(i) ability to engage in any employment or occupation for wage or profit;

(ii) inability to perform any occupation, any occupational duty, or any and every duty of the insured's occupation; or

(iii) inability to engage in any training or rehabilitation program.

(b) A contract including a provision for total disability may require care by a physician other than the insured or a member of the insured's immediate family.

(10) A contract may include a provision relating to a recurrent disability, but the provision may not specify that a recurrent disability be separated by a period greater than six months.

(11) An accidental death and dismemberment benefit shall be payable if the loss occurs within 180 days from the date of the accident, regardless of total disability.

(12) A contract with an income replacement benefit may not require:

(a) the loss to begin less than 30 days after the date of accident; or

(b) the contract be in force at the time a disability commences if the accident occurred while the coverage was in force.

(13) A contract with a specific dismemberment benefit may not be in lieu of another benefit unless the specific benefit is equal to or exceeds the other benefit.

(14) A contract providing a fracture or dislocation benefit may not limit benefits based on a full or complete fracture or dislocation.

(15)(a) Specified disease insurance, also known as critical illness, dread disease, or similar language, sold in conjunction with other insurance, including a life insurance policy or an annuity contract, shall be in the form of a separate endorsement complying with each applicable provision of this rule.

(b) Specified disease insurance may not be incorporated into a life insurance or annuity contract.

(16) A premium change notice shall be given no less than 45 days before the renewal date.

R590-126-6. Required Provisions.

(1)(a) An enrollment form question regarding a health condition may not be vague and shall reference a reasonable time frame in relation to the health condition.

(b)(i) A completed application shall be made part of the policy.

(ii) A copy of the completed enrollment form shall be provided to the applicant or insured before or at delivery of the contract.

(c) Except under Subsection (1)(f), an enrollment form shall include the following prominent disclosure statement, in either contrasting color or boldface type at least equal to the font size used for the headings or captions of sections of the enrollment form and in close conjunction with the signature block on the enrollment form, stating, "This (policy)(certificate) provides limited benefits. Review your (policy)(certificate) carefully."

(d) An enrollment form shall provide a statement regarding a preexisting waiting period and the requirement to receive any applicable credit for previous coverage.

(e)(i) An enrollment form shall include a question regarding whether the insurance to be issued is intended to replace any other accident and health insurance currently in force.

(ii) A supplementary enrollment form or other form signed by the applicant containing the question may be used.

(f) An enrollment form for dental or vision insurance shall include the following prominent disclosure statement, in either contrasting color or boldface type at least equal to the font size used for the headings or captions of sections of the enrollment form and in close conjunction with the signature block on the enrollment form, stating, "This (policy)(certificate) provides (dental)(vision) benefits only. Review your (policy)(certificate) carefully."

(2)(a) A contract shall include a renewal, continuation, and nonrenewal provision.

(b) Each provision shall:

(i) appear on the first page of the contract;

(ii) be appropriately captioned; and

(iii) clearly state the duration, if limited, and the renewability of the coverage.

(3)(a) Except for an endorsement by which the insurer effectuates a written request by the policyholder or exercises a specifically reserved right under the contract, signed acceptance by the policyholder is required for an endorsement that reduces or eliminates a benefit or coverage and is added to a contract after the date of issue, at reinstatement, or at renewal.

(b) After the contract issue date, an endorsement that increases a benefit or coverage with a concurrent increase in premium

during the contract term shall be agreed to in writing and signed by the policyholder, except if the increased benefit or coverage is required by law.

(4) If a separate additional premium is charged for a benefit provided in connection with an endorsement, the premium charge shall be set forth in the contract.

(5) A contract that provides for the payment of a benefit based on a standard described as usual and customary, reasonable and customary, or similar words, shall include a definition and explanation of the term in the accompanying outline of coverage or benefit summary.

(6)(a) If a contract includes a limitation regarding a preexisting condition, the limitation shall appear as a separate paragraph in the contract and be labeled as "Preexisting Condition Limitation."

(b) The limitation shall include a description of the existence and term of the preexisting condition exclusion, including the maximum preexisting exclusion period.

(7)(a) An accident only insurance contract shall include the following prominent disclosure statement on the first page of the contract, in either contrasting color or boldface type at least equal to the font size used for headings or captions of sections in the contract, stating, "Notice to Buyer: This is an accident only (policy)(certificate) and it does not pay benefits for loss from sickness. Review your (policy)(certificate) carefully."

(b) An accident only insurance contract that provides coverage for hospital or medical care shall include the following statement in addition to the notice in Subsection (7)(a), "This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(c) An accident only insurance contract providing benefits that vary according to the type of accidental cause shall prominently state in the outline of coverage the circumstances when benefits are payable that are less than the maximum amount payable under the policy.

(8) If age is used as a determining factor for reducing the maximum aggregate benefit available in the contract as originally issued, that fact shall be prominently set forth in the contract and outline of coverage.

(9) If a contract includes a disappearance benefit, payment shall be made within the time limits under Sections 31A-26-301 and R590-192-9 when proper proof of loss, satisfactory to the insurer, is filed and it is reasonable to assume death occurred, but a body cannot be found.

(10)(a) If a contract includes a conversion privilege, it shall caption the provision as "Conversion Privilege" or similar language.

(b) The provision shall indicate each individual eligible for conversion, the circumstance applicable to the conversion privilege, including any limitation on the conversion, and how an individual may exercise a conversion privilege.

(c) The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be provided through a contract offered by the insurer for that purpose.

(11)(a) An insurer, except for a direct response insurer, shall give an applicant for a specified disease insurance contract a buyer's guide at the time of application and shall obtain the recipient's written acknowledgment of the guide's delivery.

(b) A direct response insurer shall provide a specified disease insurance buyer's guide upon request, but before or at the delivery of the contract.

(c) A specified disease insurance contract shall include the following prominent disclosure statement on the first page or attached to it, in either contrasting color or boldface type at least equal to the font size used for headings or captions of sections in the contract, stating, "Notice to Buyer: This is a specified disease (policy)(certificate). This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your (policy)(certificate) carefully with the outline of coverage and the buyer's guide."

(12) A fixed indemnity insurance or limited benefit health insurance contract shall include the following prominent disclosure statement on the first page of the contract, or attached to it, in either contrasting color or boldface type at least equal to the font size used for headings or captions of sections in the contract, "Notice to Buyer: This is a (fixed indemnity)(limited benefit health) (policy)(certificate). This (policy)(certificate) provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses."

(13) A basic hospital expense, a basic medical-surgical expense, or a basic hospital medical-surgical expense insurance contract shall include the following prominent disclosure statement on the first page of the contract, or attached to it, in either contrasting color or boldface type at least equal to the font size used for headings or captions of sections in the contract, "Notice to Buyer: This is a (basic hospital)(basic medical-surgical)(basic hospital/medical-surgical) expense (policy)(certificate). This (policy)(certificate) provides limited benefits and should not be considered a substitute for comprehensive health insurance coverage."

(14) A dental or vision contract shall include the following prominent disclosure statement on the first page of the contract, or attached to it, in either contrasting color or boldface type at least equal to the font size used for headings or captions of sections in the contract, "Notice to Buyer: This (policy)(certificate) provides (dental)(vision) coverage only."

(15)(a) A contract providing an accident benefit shall define accident, accidental injury, or accidental means to employ result language.

(b) A contract may not define accident, accidental injury, or accidental means to include words that establish an accidental means test or use words such as external, violent, visible wounds, or similar words.

R590-126-7. Accident and Health Benefit Standards.

(1)(a) An accident and health insurance contract subject to this rule may not be delivered or issued for delivery unless it meets the required standard for the specified category in this section.

(b) This section does not preclude the issuance of a contract combining two or more categories set forth in Subsection 31A-22-605(5).

(c) Insurance coverage listed in this section shall include coverage for diabetes as required by Section 31A-22-626 and Rule R590-200, if applicable.

(2)(a) Basic hospital expense insurance provides coverage for a period of not less than 31 days during a continuous hospital confinement for an expense incurred for treatment or service rendered as a result of an accident or sickness, and shall include at a minimum:

(i) daily hospital room and board in an amount not less than:

(A) 80% of the charge for a semiprivate room accommodation; or

(B) $100 per day;

(ii) miscellaneous hospital services and supplies, that are customarily rendered by the hospital and provided for use during a single period of confinement, in an amount not less than:

(A) 80% of the charge incurred up to at least $3,000; or

(B) ten times the daily hospital room and board benefit; and

(iii) hospital outpatient services on the day of surgery of an amount not less than:

(A) $250 for hospital services rendered within 72 hours after an injury; and

(B) $200 for x-ray and laboratory tests to the extent that a benefit for the service would have been provided if rendered to an inpatient of the hospital.

(b) Benefits may be subject to a combined deductible amount of not more than $200.

(3) Basic medical-surgical expense insurance provides coverage for expenses incurred for services rendered by a physician for treatment of an injury or sickness and shall include:

(a) surgical services in an amount not less than:

(i) what is provided on a current procedure terminology based relative value fee schedule, up to a maximum of at least $1,000 for one procedure; or

(ii) 80% of the reasonable charges;

(b) anesthesia services, consisting of the administration of medically necessary general anesthesia and related procedures in connection with a covered surgical service rendered by a physician, other than the physician or the physician assistant, performing the surgical service:

(i) in an amount not less than 80% of the reasonable charge; or

(ii) 15% of the surgical service benefit; and

(c) hospital medical services, consisting of physician services rendered to a person who is an inpatient at a hospital for treatment of sickness or injury, other than when surgical care is required, in an amount not less than:

(i) 80% of the reasonable charges; or

(ii) $100 per day.

(4) Basic hospital and medical-surgical expense insurance shall meet the requirements of Subsections (1) and (2).

(5)(a) Hospital fixed indemnity insurance provides a daily benefit for hospital confinement on an indemnity basis and shall include:

(i) an indemnity amount of not less than $50 per day; and

(ii) coverage for at least 31 days during each one period of confinement for each insured.

(b) Benefits shall be paid regardless of other insurance.

(6)(a) Income replacement insurance provides for periodic payments, weekly or monthly, for a specified period during the continuance of a disability resulting from either sickness or injury, or a combination of both, that:

(i) if it includes an elimination period, it is no greater than:

(A) 90 days, in the case of coverage providing a benefit of one year or less;

(B) 180 days, in the case of coverage providing a benefit of more than one year but less than two years; or

(C) 365 days in any other case; and

(ii)(A) has a maximum period that is payable during a disability of at least six months, except in the case of a contract covering a disability arising out of pregnancy, childbirth, or miscarriage when the period for the disability may be one month; and

(B) may not be reduced because of an increase in Social Security or similar benefits during a benefit period.

(b) A contract that provides total disability or partial disability benefits may not require more than one elimination period.

(c)(i) A contract that provides for a residual disability benefit may require a qualification period, when the insured shall be totally disabled before the residual disability benefit is payable.

(ii) The qualification period for residual benefits may be longer than the elimination period for total disability.

(d) This Subsection (6) does not apply to a contract providing business buyout coverage.

(7) Accident only insurance provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by accident and shall include a benefit amount for:

(a) death, no less than $1,000;

(b) double dismemberment, no less than $1,000; and

(c) single dismemberment, no less than $500.

(8) Specified accident insurance provides coverage, singly or in combination, for death, dismemberment, disability, or hospital and medical care caused by a specific accident and shall include a benefit amount for:

(a) death, no less than $1,000;

(b) double dismemberment, no less than $1,000; and

(c) single dismemberment, no less than $500.

(9) Specified disease insurance, or critical illness insurance, provides coverage for the diagnosis and treatment of at least one specifically named disease.

(a) A contract covering a single specified disease or combination of specified diseases may not be sold or offered for sale other than as specified disease insurance.

(b) A contract that conditions payment upon pathological diagnosis of a covered disease shall also provide that if a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted.

(c) A specified disease insurance contract shall provide benefits to an insured, not only for the specified disease, but also for any other condition or disease directly caused or aggravated by the specified disease or treatment of the specified disease.

(d) A specified disease insurance contract may not be more restrictive than guaranteed renewable.

(e)(i) An enrollment form for specified disease insurance shall include a statement above the signature of the applicant that an individual is not eligible for specified disease insurance if covered by a Title XIX program, designated as Medicaid or any similar name.

(ii) The disclaimer may be combined with any other statement for which the insurer may require the applicant's signature.

(f) Payments may be conditioned upon an insured receiving medically necessary care, given in a medically appropriate location, and under a medically accepted course of diagnosis or treatment.

(g) Specified disease insurance benefits shall be paid regardless of other coverage.

(h) After the effective date of the contract, or the conclusion of an applicable probationary period, benefits shall begin with the first day of care or confinement, if such care or confinement is for a covered disease, even though the diagnosis is made at a later date.

(i) Hospice care is an optional benefit that, if offered, shall meet the following standards:

(i) benefits are payable when the attending physician provides a written statement that the insured has a life expectancy of six months or less;

(ii) a fixed-sum payment of at least $50 per day; and

(iii) a lifetime maximum benefit of at least $10,000.

(j) The following standards apply to specified disease insurance issued on an expense-incurred basis:

(i) a deductible amount may not exceed $250;

(ii) an aggregate benefit limit may not be less than $25,000;

(iii) a benefit period may not be less than three years;

(iv) services provided on an outpatient basis may be subject to a copayment that may not exceed 20% of covered services;

(v) covered services shall include:

(A) hospital room and board and any other hospital-furnished medical service or supply;

(B) treatment by, or treatment under the direction of, a physician or surgeon;

(C) private duty nursing services of a registered nurse or licensed practical nurse;

(D) x-ray, radium, chemotherapy, and other therapy procedures used in diagnosis and treatment;

(E) blood transfusions, including the administration and expense incurred for blood donors;

(F) drugs and medicines prescribed by a physician;

(G) professional ambulance for local service to or from a local hospital;

(H) the rental of any respiratory or other mechanical apparatus;

(I) braces, crutches, and wheelchairs as ordered by the physician for the treatment of the disease;

(J) emergency transportation if, in the opinion of the physician, it is necessary to transport the insured to another locality for treatment of the disease;

(K) home health care with a written prescribed plan of care;

(L) physical, speech, hearing, and occupational therapy;

(M) special equipment including a hospital bed, toilette, pulleys, wheelchairs, aspirator, chux, oxygen, surgical dressings, rubber shields, colostomy, and ileostomy appliances;

(N) prosthetic devices including wigs and artificial breasts;

(O) nursing home care for non-custodial services; and

(P) reconstructive surgery when deemed necessary by the physician.

(k) Specified disease insurance offered on a per diem basis shall include covered services for:

(i) hospital confinement benefit with a fixed-sum payment of at least $200 for each day of hospital confinement, for at least 365 days, with no deductible amount permitted;

(ii) outpatient benefit with a fixed-sum payment equal to one-half of the hospital inpatient benefit for each day of hospital or non-hospital outpatient surgery, radiation therapy, and chemotherapy, for at least 365 days of treatment;

(iii) blood and plasma benefit with a fixed-sum benefit of at least $50 per day, that includes their administration whether received as an inpatient or outpatient, for at least 365 days of treatment; and

(iv) benefits tied to confinement in a skilled nursing home or home health care, if offered:

(A) shall include a fixed-sum payment equal to:

(I) one-half of the hospital inpatient benefit for each day of skilled nursing home confinement for at least 180 days; and

(II) a fixed-sum payment equal to one-fourth of the hospital inpatient benefit for each day of home health care for at least 180 days; and

(B) may not include a restriction or limitation applied to the benefits that are more restrictive than those under Medicare.

(l) The following standards apply to specified disease insurance on a lump sum basis:

(i) benefits shall be payable as a fixed, one-time payment made within 30 days of submission to the insurer of proof of diagnosis of the specified disease, and shall be offered for sale only in even increments of $1,000; and

(ii) if coverage is advertised or otherwise represented to offer generic coverage of a disease or diseases, for example "cancer insurance" or "heart disease insurance," the minimum benefit shall be:

(A) the same dollar amount regardless of the subtype of the disease, for example lung or bone cancer; or

(B) a lesser amount for a subtype with significantly lower treatment costs, for example skin cancer, if clearly identifiable and the contract clearly differentiates each subtype and its benefits.

(10) Limited benefit health insurance coverage provides benefits less than the standards required under Subsections R590-126-7(1) through R590-126-7(9).

R590-126-8. Outline of Coverage Requirements.

(1) The outline of coverage in Table 1 shall be issued with a basic hospital expense insurance contract.

TABLE 1
Basic Hospital Expense Insurance Outline of Coverage

(COMPANY NAME)

BASIC HOSPITAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Basic hospital expense coverage is designed to provide, to persons insured, coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services and hospital outpatient services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for physician or surgeon fees or unlimited hospital expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order: daily hospital room and board; miscellaneous hospital services; hospital outpatient services; and other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change

premiums.

(2) The outline of coverage in Table 2 shall be issued with a basic medical-surgical expense insurance contract.

TABLE 2
Basic Medical-Surgical Expense Insurance Outline of Coverage

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Basic medical-surgical expense coverage is designed to provide, to persons insured, coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayments set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical-surgical expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order: surgical services; anesthesia services; in-hospital medical services; and other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(3) The outline of coverage in Table 3 shall be issued with a basic hospital and medical-surgical expense insurance contract.

TABLE 3
Basic Hospital and Medical-Surgical Expense Insurance Outline of Coverage

(COMPANY NAME)

BASIC HOSPITAL/MEDICAL-SURGICAL

EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS AND SHOULD NOT BE CONSIDERED A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE COVERAGE

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Basic hospital/medical-surgical expense coverage is designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital outpatient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and copayment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical surgical expenses.

A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:
daily hospital room and board; miscellaneous hospital services; hospital outpatient services; surgical services; anesthesia services; in-hospital medical services; and other benefits, if any.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(4) The outline of coverage in Table 4 shall be issued with a hospital fixed indemnity insurance contract.

TABLE 4
Hospital Fixed Indemnity Insurance Outline of Coverage

(COMPANY NAME)

HOSPITAL CONFINEMENT INDEMNITY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Hospital indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

A brief specific description of the benefits in the following order: daily benefit payable during hospital confinement; and duration of benefit

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefit.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

Any benefits provided in addition to the daily hospital benefit.

(5) The outline of coverage in Table 5 shall be issued with an income replacement insurance contact.

TABLE 5
Income Replacement Insurance Outline of Coverage

(COMPANY NAME)

INCOME REPLACEMENT INSURANCE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance

company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Income replacement insurance coverage is designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

A brief specific description of the benefits contained in the policy.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

(6) The outline of coverage in Table 6 shall be issued with an accident only insurance contract.

TABLE 6
Accident Only Insurance Outline of Coverage

(COMPANY NAME)

ACCIDENT ONLY COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of the coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Accident only coverage is designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

A brief specific description of the benefits.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting

renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(7) The outline of coverage in Table 7 shall be issued with a specified accident insurance contract.

TABLE 7
Specified Accident Insurance Outline of Coverage

(COMPANY NAME)

SPECIFIED ACCIDENT COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Specified accident coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified accidents. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

A brief specific description of the benefits, including dollar amounts.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(8) The outline of coverage in Table 8 shall be issued with a specified disease insurance contract.

TABLE 8
Specified Disease Insurance Outline of Coverage

(COMPANY NAME)

SPECIFIED DISEASE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Specified disease coverage is designed only as a supplement to a comprehensive health insurance policy and should not be purchased unless you have this underlying coverage. Persons covered under Medicaid should not purchase it. Read the Buyer's Guide to Specified Disease Insurance to review the possible limits on benefits in this type of coverage.

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of coverage. This is not the insurance contract and only the actual policy provisions will control.

The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Specified disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of specified diseases. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

A brief specific description of the benefits, including dollar amounts.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(9) The outline of coverage in Table 9 shall be issued with a limited benefit health insurance contract.

TABLE 9
Limited Benefit Health Insurance Outline of Coverage

(COMPANY NAME)

LIMITED BENEFIT HEALTH COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

Limited benefit health coverage is designed to provide, to persons insured, limited or supplemental coverage.

A brief specific description of the benefits, including amounts.

A description of any provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(10) The outline of coverage in Table 10 shall be issued with a dental insurance contract.

TABLE 10
Dental Insurance Outline of Coverage

(COMPANY NAME)

DENTAL COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL DENTAL EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY!

A brief specific description of the benefits.

A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.

A description of policy provisions respecting renewability or continuation of coverage including age restrictions or any reservations of right to change premiums.

(11) The outline of coverage in Table 11 shall be issued with a vision insurance contract.

TABLE 11
Vision Insurance Outline of Coverage

(COMPANY NAME)

VISION COVERAGE

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL VISION EXPENSES

OUTLINE OF COVERAGE

Read Your (Policy)(Certificate) Carefully - This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY)(CERTIFICATE) CAREFULLY! A brief specific description of the benefits. A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits. A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservations of right to change premiums.

(12) An insurer shall deliver an outline of coverage to an applicant or insured before or upon the sale of an accident and health insurance contract.

(13) If an outline of coverage was delivered at the time of application or enrollment and the contract is issued on a basis that requires a revision of the outline of coverage, a substitute outline of coverage describing the contract shall accompany the contract when it is delivered and shall include the following statement in no less than 12-point font, immediately above the company name, "NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application, and the coverage originally applied for has not been issued."

(14) An outline of coverage for fixed indemnity insurance, specified disease insurance, or limited benefit health insurance delivered to a person eligible for Medicare by reason of age shall include the following language, that shall be printed on or attached to the first page of the outline of coverage, "THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company."

(15) If the outline of coverage is inappropriate for the coverage provided by the contract, an alternate outline of coverage shall be submitted to the commissioner for prior approval.

(16) An advertisement may fulfill the requirement for an outline of coverage if the advertisement satisfies the specified standards.

R590-126-9. Replacement of Accident and Health Insurance Requirements.

(1)(a) Upon determining that a sale will involve replacement, an insurer or its producer, other than a direct response insurer or its producer, shall furnish to the applicant, before issuance or delivery of the contract, the notice in Table 12.

(b) The insurer shall retain a copy of the notice.

(2) A direct response insurer shall deliver to the applicant, upon issuance of the contract, the notice in Table 13, except that a notice is not required in the solicitation of an accident only insurance contract or single-premium nonrenewable contract.

TABLE 12 Notice to Applicant Regarding Replacement of Accident and Health Insurance
NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE According to (your application)(information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully

covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

Date:	
Applicant's Signature:	

TABLE 13
Direct Response Notice to Applicant Regarding Replacement of Accident and Health Insurance

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE

According to (your application)(information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.

COMPANY NAME

R590-126-10. Severability.

If any provision of this rule, Rule R590-126, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule that can be given effect without the invalid provision or application. The remainder of this rule shall be given effect without the invalid provision or application.

KEY: health insurance
Date of Last Change: 2025[~~May 1, 2019~~]
Notice of Continuation: December 8, 2021
Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-202; 31A-21-201; 31A-22-605; 31A-22-623; 31A-22-626; 31A-23a-402; 31A-26-301

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