State of Utah
Administrative Rule Analysis
Revised May 2024

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: CPR (Change in Proposed Rule)		
Rule or Section Number:	**R590-277**	**Filing ID: Office Use Only**
Date of Previous Publication (Only for CPRs):	**02/01/2025**	

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:

R590-277. Managed Care Health Benefit Plan Standards

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

The Department was alerted to a missing provision in the previous filing. This change in proposed rule adds that provision back into the rule.

4. Summary of the new rule or change:

This filing returns to the rule a provision related to services in connection with a prearranged surrogacy agreement. This provision was inadvertently left out of the initial repeal and reenactment filing. This filing also updates the numbering in Section R590-277-4 due to the re-added provision.

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 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 do not affect local governments because they only apply to insurer licensees of the Department.

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

There is no anticipated cost or savings to small businesses. The changes return to the rule a provision that insurer licensees of the Department already follow.

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 return to the rule a provision that insurer licensees of the Department already follow.

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 do not affect any other persons because they only apply to insurer licensees of the Department.

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 return to the rule a provision that insurer licensees of the Department already follow.

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-22-623
Section 31A-22-626	Section 31A-45-103	

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:		05/15/2025
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:	05/22/2025
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:**	03/24/2025

R590. Insurance Administration.

R590-277. Managed Care Health Benefit Plan Standards.

R590-277-1. Authority.

This rule is promulgated by the commissioner pursuant to Sections 31A-2-201, 31A-2-201.1, 31A-22-623, 31A-22-626, and 31A-45-103.

R590-277-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) standardize and simplify the terms and coverage of a managed care health benefit plan;

(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 a health benefit plan issued by a managed care organization.

(3) This rule does not apply to short-term limited duration health insurance subject to Rule R590-286.

R590-277-3. Definitions.

Terms used in this rule are defined in Sections 31A-1-301 and 31A-45-102, and Rules R590-126, R590-192, R590-233, R590-261, and R590-266.

R590-277-4. Prohibited Provisions.

(1) A contract may not impose a preexisting condition limitation or exclusion provision.

(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 services;

(c) administrative charge for completing an insurance form, duplication service, interest, finance charge, or other administrative charge;

(d) administrative exam or service;

(e) applied behavioral analysis therapy, except as required under Section 31A-22-642;

(f) aviation, to a non-fare-paying passenger;

(g) axillary hyperhidrosis;

(h) benefits paid for under:

(i) employers' 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 lenses, including examination for the prescription or fitting, except:
(i) lens implant following cataract surgery; and
(ii) as required under Rule R590-266;
(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; or
(ii) due to a congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;
(n) custodial care;
(o) dental care or treatment, except as required under Section R590-266-4;
(p) dietary products, except as required under Rule R590-194;
(q) educational or nutritional training, except as required under Rule R590-200;
(r) experimental or investigational services;
(s) expenses before coverage begins or after coverage ends;
(t) felony, riot, or insurrection, when it is determined the enrollee was a voluntary participant;
(u) fitness training, exercise equipment, or membership fee to a spa or health club;
(v)(i) foot care for a corn, a callus, flat feet, 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 enrollee who has a systemic disease, such as diabetes with peripheral neuropathy or circulatory insufficiency, if unskilled performance of the procedure would be hazardous;
(w)(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 under Subsection (2)(w)(i); or
(iii) a service required for the treatment of a complication from a procedure in Subsection (2)(w)(i);
(x) gender reassignment, except as required under Section 1557 of PPACA;
(y) gene therapy;
(z) genetic testing;
(aa) hearing aid, including examination for the prescription or fitting;
(bb) infertility services, except as required under Subsection 31A-22-610.1(1);
(cc) injury as a result of a motor vehicle, to the extent the enrollee is required to have no-fault coverage, up to the minimum coverage required by law, whether or not coverage is in effect;
(dd) mental health condition or substance use disorder services, except as required under Section 31A-22-625 and Rule R590-266;
(ee) nuclear release;
(ff) refractive eye surgery;
(gg) rehabilitation or habilitative therapy services, such as physical, speech, and occupational, unless required to correct an impairment caused by a covered accident, injury, or illness, or as required under Rule R590-266;
(hh) respite care;
(ii) rest cures;
(jj) services performed by an enrollee's parent, spouse, sibling, or child, including a step or in-law relationship;
(kk) services performed by an employee of a hospital, laboratory, or other institution;
(ll) services that are not medically necessary;
(mm) services for which no charge is normally made in the absence of insurance;
(nn) services while in the armed forces or an auxiliary unit;
(oo) services in connection with a prearranged surrogacy agreement, except for services for the baby, where the covered person relinquishes a baby and receives payment or other compensation arising out of such services;
(pp) sexual dysfunction procedures, equipment, or drugs;
[~~(pp)~~](qq) shipping or handling;
[~~(qq)~~](rr) telephone or electronic consultation, except as required under Sections 31A-22-649 and 31A-22-649.5;
[~~(rr)~~](ss) territorial limitations outside the United States, except as required under Section 31A-22-627;
[~~(ss)~~](tt) terrorism, including acts of terrorism;
[~~(tt)~~](uu) transplants, except as required by Rule R590-266;
[~~(uu)~~](vv) transportation, except medically necessary ambulance services;
[~~(vv)~~](ww) war or act of war, whether declared or undeclared;
[~~(ww)~~](xx) except under Subsection (2)[~~(xx)~~](yy), a loss directly related to the enrollee's voluntary participation in an activity when the enrollee:
(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;
[~~(xx)~~](yy) a loss established under Subsection (3) that is directly related to the enrollee 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

[~~(yy)~~](zz) any other exclusion that, in the opinion of the commissioner, is not inequitable, misleading, deceptive, obscure, unjust, unfair, or unfairly discriminatory to an enrollee.

(3)(a) A violation under Subsection (2)[~~(xx)~~](yy) shall be established:

(i) in a criminal proceeding in which the enrollee is found guilty, enters a no contest plea or 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 managed care organization;

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

(C) is paid for by the managed care organization.

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

(A) the managed care organization;

(B) an officer, director, or management employee of the managed care organization;

(C) the enrollee;

(D) the enrollee'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)[~~(xx)~~](yy) does not apply to an enrollee who is under 18 years of age.

(4) 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 enrollee.

R590-277-5. General Requirements.

(1) A contract may not include a definition regarding a matter defined in Section R590-277-3 unless the definition complies with that section.

(2) Except for an employer-sponsored health benefit plan, a contract:

(a) may not provide for termination of coverage of the spouse or a dependent solely because of the occurrence of an event specified for termination of coverage of the contract holder, other than for nonpayment of premium; and

(b) shall provide that in the event of the contract holder's death, the spouse shall become the contract holder.

(3) A contract providing coverage for the recipient in a transplant operation shall also provide reimbursement of medically necessary transplant expenses of a live donor.

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

(5)(a) Except under Subsection (5)(b), a completed application:

(i) is made part of the contract; and

(ii) shall be provided to the applicant before, or at delivery, of the contract.

(b) Subsection (5)(a) does not apply to:

(i) an employer-sponsored health benefit plan; or

(ii) an individual if the application was submitted through the health insurance exchange.

(6) A managed care organization offering an individual health benefit plan shall issue with an individual policy:

(a)(i) an outline of coverage; or

(ii) a benefit summary; and

(b) a summary of benefits and coverage.

R590-277-6. Required Provisions.

(1)(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 renewability of coverage.

(2)(a) Except for an endorsement by which the managed care organization 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.

(3) 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.

(4) 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.

R590-277-7. Restrictions Relating to Premium Rates.

(1) The premium charged may not be adjusted more frequently than annually, except the premium rate may be changed:

(a) to reflect a change in enrollment;

(b) to reflect a change to the contract; or

(c) as expressly permitted by federal or state law.

(2) Premium rates may vary based only on the following:

(a) whether the plan covers an individual or a family, as follows:

(i) the total family premium shall only include premiums for covered family members over the age of 21 and the three oldest children under the age of 21; and

(ii) a rating variation based on age or tobacco use shall be applied separately to the portion of the premium attributable to each covered family member;

(b) geographic rating area, determined by the policyholder's primary address, as follows:

(i) Area 1, Cache and Rich counties;

(ii) Area 2, Box Elder, Morgan, and Weber counties;

(iii) Area 3, Davis, Salt Lake, Summit, Tooele, and Wasatch counties;

(iv) Area 4, Utah County;

(v) Area 5, Iron and Washington counties; and

(vi) Area 6, Beaver, Carbon, Daggett, Duchesne, Emery, Garfield, Grand, Juab, Kane, Millard, Piute, San Juan, Sanpete, Sevier, Uintah, and Wayne counties;

(c) age of each enrollee, as of the date of the contract issuance or renewal, in accordance with the Utah Individual and Small Employer Health Benefit Plan Age Curve; and

(d) tobacco rate factor not greater than 1.5.

(3) Subsection (2) does not apply to:

(a) a large employer contract; or

(b) an individual or small employer contract issued before January 1, 2014, if the contract rating complies with:

(i) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and

(ii) Rule R590-167.

R590-277-8. Severability.

If any provision of this rule, Rule R590-277, 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: insurance, health insurance
Date of Last Change: April 22, 2020
Notice of Continuation: August 9, 2024
Authorizing, and Implemented or Interpreted Law: 31A-45-103; 31A-2-201(3)(a); 31A-23a-402(8); 31A-23a-412; 31A-2-202