State of Utah
Administrative Rule Analysis
Revised May 2024

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Repeal and Reenact		
Rule or Section Number:	**R590-277**	**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:
R590-277. Managed Care Health Benefit Plan 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 minor 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, remove the Penalties section because penalties are already provided for in statute, remove the Enforcement Date section because the rule is already in force, and update the Severability section to use the department's current language. 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-22-623
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:		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.

[~~R590-277. Managed Care Health Benefit Plan Policy Standards.~~

~~R590-277-1. Authority.~~

~~This rule is promulgated by the commissioner pursuant to Subsections 31A-2-201(3)(a), 31A-2-202, 31A-23a-402(8), 31A-23a-412, and 31A-45-103.~~

~~R590-277-2. Purpose and Scope.~~

~~(1) The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of a managed care health benefit plan policy in order to:~~

~~(a) facilitate public understanding and comparison;~~

~~(b) prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims; and~~

~~(c) provide for full disclosure.~~

~~(2) This rule applies to any health benefit plan issued by a managed care organization to an individual or group, including policies issued to an association, trust, discretionary group, or other similar group.~~

~~(3) This rule does not apply to short-term limited duration health insurance that complies with both R590-85, Individual Accident and Health Insurance and Individual and Group Medicare Supplement rates, and R590-126, Accident and Health Insurance Standards.~~

~~R590-277-3. Definitions.~~

~~The definitions in Sections 31A-1-301, 31A-22-625, 31A-30-103 and 31A-45-102, and Rules R590-126, R590-192, R590-261 and R590-266, shall apply for the purposes of this rule.~~

~~R590-277-4. Prohibited Policy Provisions.~~

~~(1) A health benefit plan may not impose any preexisting condition limitation or exclusion provisions.~~

~~(2) Limitations or exclusions. Unless otherwise required by law, a policy may 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;~~

~~(d) administrative exams and services;~~

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

~~(f) aviation;~~

~~(g) axillary hyperhidrosis;~~

~~(h) 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;~~
~~(i) fitness training, exercise equipment, or membership fees to a spa or health club;~~
~~(j) charges for appointments scheduled and not kept;~~
~~(k) chiropractic care;~~
~~(l) complementary and alternative medicine;~~
~~(m) corrective lenses, and examination for the prescription or fitting thereof, except lens implant following cataract surgery and as required by Rule R590-266;~~
~~(n) 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 party; or reconstructive surgery because of congenital disease or anomaly of a covered dependent child that has resulted in a functional defect;~~
~~(o) custodial care;~~
~~(p) dental care or treatment;~~
~~(q) dietary products, except as required by Rule R590-194;~~
~~(r) educational and nutritional training, except as required by Rule R590-200;~~
~~(s) experimental or investigational services;~~
~~(t) expenses before coverage begins or after coverage ends;~~
~~(u) felony, riot or insurrection, when it has been determined the covered person was 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) gender reassignment, except as required by Section 1557 of the Patient Protection and Affordable Care Act;~~
~~(y) gene therapy;~~
~~(z) genetic testing;~~
~~(aa) hearing aids, and examination for the prescription or fitting thereof;~~
~~(bb)(i) except as provided in Subsection R590-277-4(2)(cc), a loss directly related to the insured's voluntary participation in an activity where the insured:~~
~~(A) is found guilty of an illegal activity in a criminal proceeding; or~~
~~(B) is found liable for the activity in a civil proceeding.~~
~~(ii) A guilty finding includes a plea of guilty, a no contest plea, and a plea in abeyance;~~
~~(cc)(i) a loss directly related to the insured or dependent violating:~~
~~(A) Section 41-6a-502; or~~
~~(B) a law that prohibits operating a motor vehicle, in a state other than Utah, while exceeding the legal limit of concentration of alcohol, drugs, or a combination of both in the blood;~~
~~(ii) Violations of Subsection R590-277-4(2)(cc)(i) shall be established:~~
~~(A) in a criminal proceeding in which the insured or dependent is found guilty, enters a no contest plea or a plea in abeyance, or enters into a diversion agreement; or~~
~~(B) a managed care organization's request for an independent review where the findings support a decision to deny coverage based on the exclusions of Subsection R590-277-4(2)(cc)(i);~~
~~(iii) For purposes of Subsection R590-277-4(2)(cc):~~
~~(A) An independent review means a process that:~~
~~(I) is conducted by an independent entity designated by the managed care organization;~~
~~(II) renders an independent and impartial decision on a decision to deny coverage based on the exclusion in Subsection R590-277-4(2)(cc)(i); and~~
~~(III) is paid for by the insurer.~~
~~(B) The independent review entity may not have a material professional, familial, or financial conflict of interest with:~~
~~(I) the managed care organization;~~
~~(II) an officer, director, or management employee of the managed care organization;~~
~~(III) the enrollee;~~
~~(IV) the enrollee's health care provider;~~
~~(V) the health care provider's medical group or independent practice association; or~~
~~(VI) a health care facility where services were provided;~~
~~(iv) this exclusion does not apply to an insured or dependent who is under 18 years of age;~~
~~(dd) infertility services;~~
~~(ee) mental health and substance use disorder services, except as required by Section 31A-22-625 and Rule R590-266;~~
~~(ff) injury as a result of a motor vehicle, to the extent the covered person is required by law to have no-fault coverage, up to the minimum coverage required by law, whether or not such coverage is in effect;~~

~~(gg) nuclear release;~~

~~(hh) refractive eye surgery;~~

~~(ii) rehabilitation or habilitative therapy services, such as physical, speech, and occupational, except as required to correct an impairment caused by a covered accident or illness, or as required by Rule R590-266;~~

~~(jj) respite care;~~

~~(kk) rest cures;~~

~~(ll) service in the armed forces or units auxiliary to it;~~

~~(mm) services that are not medically necessary;~~

~~(nn) services performed by the covered person's parent, spouse, sibling or child, including a step or in-law relationship;~~

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

~~(pp) 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;~~

~~(qq) sexual dysfunction procedures, equipment and drugs;~~

~~(rr) shipping and handling;~~

~~(ss) telephone/electronic consultations;~~

~~(tt) territorial limitations outside the United States;~~

~~(uu) terrorism, including acts of terrorism;~~

~~(vv) transplants, except as required by Rule R590-266;~~

~~(ww) transportation, except medically necessary ambulance services;~~

~~(xx) war or act of war, whether declared or undeclared; or~~

~~(yy) others that in the opinion of the commissioner are not inequitable, misleading, deceptive, obscure, unjust, unfair or unfairly discriminatory to the policyholder, beneficiary, or covered person under the policy.~~

~~R590-277-5. General Requirements.~~

~~(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in R590-277-3 unless such definitions comply with the requirements of that section.~~

~~(2) Rights of spouse and dependents. Except for an employer sponsored health plan, a policy;~~

~~(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 policyholder, other than for nonpayment of premium; and~~

~~(b) shall provide that in the event of the policyholder's death the spouse of the insured shall become the insured.~~

~~(3) Cancellation, renewability, and termination. A policy cancellation, renewability and termination provision shall comply with Sections 31A-22-618.6 or 31A-22-618.7.~~

~~(4) Transplant donor coverage. A policy providing coverage for the recipient in a transplant operation shall also provide reimbursement of any medically necessary transplant expenses of a live donor.~~

~~(5) Notice of premium change. A notice of change in premium shall be given no fewer than 45 days before the renewal date.~~

~~(6)(a) Except as provided in Subsection (b), a completed application 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.~~

~~(b) Subsection (6)(a) does not apply to:~~

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

~~(ii) an individual policy where application was effectuated directly through heathcare.gov.~~

~~(7) A managed care organization offering a health benefit plan to an individual or small employer:~~

~~(a) shall offer coverage to all individuals and eligible employees on a guaranteed basis without regard to health status;~~

~~(b) may modify coverage at the time of renewal to the extent that such modification is consistent with federal and state law and effective on a uniform basis among all individuals in the health benefit plan; and~~

~~(c) must renew or continue coverage at the option of the policyholder, subject to Subsections 31A-22-618.6 and 618.7.~~

~~R590-277-6. Required Provisions.~~

~~(1) A policy and certificate shall include a renewal, continuation, and nonrenewal provision. The provision shall be appropriately captioned, appear on the first page of the policy and certificate, and clearly state the duration of coverage.~~

~~(2) Endorsement acceptance.~~

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

~~(b) After the date of policy issue, an 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.~~

~~(3) Additional premium. Where a separate additional premium is charged for benefits provided in connection with an endorsement, the premium charge shall be set forth in the policy or certificate.~~

~~(4) 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 or certificate.~~

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

~~(1) The premium charged shall not be adjusted more frequently than annually, except that the premium rates may be changed:~~

~~(a) to reflect changes to the enrollment;~~

~~(b) to reflect changes to the health benefit plan; or~~

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

~~(2) Premium rates may vary only with respect to the particular coverage involved on the basis of the following:~~

~~(a) whether the plan covers an individual or family:~~

~~(i) the total family premium shall include only the premiums for all covered family members over the age of twenty-one and the three oldest children under the age of twenty one; and~~

~~(ii) any rating variation on the basis of age or tobacco use must 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, comprised of Cache and Rich counties;~~

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

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

~~(iv) Area 4, comprised of Utah county;~~

~~(v) Area 5, comprised of Iron and Washington counties; and~~

~~(vi) Area 6, comprised of 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 policy 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) R590-277-7(2) does not apply to:~~

~~(a) a large employer health benefit plan; or~~

~~(b) an individual or small employer health benefit plan issued prior to January 1, 2014 in which the policy rating complies with:~~

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

~~(ii) Rule R590-167, Individual, Small Employer, and Group Health Benefit Plan Rule.~~

~~**R590-277-8. Existing Policies.**~~

~~A policy issued prior to the effective date of this rule shall be amended to comply with this rule on the first policy anniversary following the effective date of this rule.~~

~~**R590-277-9. Penalties.**~~

~~A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.~~

~~**R590-277-10. Enforcement Date.**~~

~~The commissioner will begin enforcing the provisions of this rule for policies issued or renewed on or after January 1, 2020.~~

~~**R590-277-11. Severability.**~~

~~If any provision or clause of this rule or its application to any person or situation is held invalid, that invalidity may not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.~~]

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) sexual dysfunction procedures, equipment, or drugs;
(pp) shipping or handling;
(qq) telephone or electronic consultation, except as required under Sections 31A-22-649 and 31A-22-649.5;
(rr) territorial limitations outside the United States, except as required under Section 31A-22-627;
(ss) terrorism, including acts of terrorism;
(tt) transplants, except as required by Rule R590-266;
(uu) transportation, except medically necessary ambulance services;
(vv) war or act of war, whether declared or undeclared;
(ww) except under Subsection (2)(xx), 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) 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) 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) 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) 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.

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