State of Utah
Administrative Rule Analysis
Revised May 2024

NOTICE OF SUBSTANTIVE CHANGE		
TYPE OF FILING: Repeal and Reenact		
Rule or Section Number:	**R590-286**	**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:

R590-286. Minimum Standards for Short-Term Limited Duration Health Insurance

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 Effective 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-22-605
Section 31A-22-605.1		

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

R590-286. Insurance, Administration.
R590-286. Minimum Standards for Short-Term Limited Duration Health Insurance.
[~~R590-286-1. Authority.~~
~~This rule is promulgated by the commissioner pursuant to Sections 31A-2-202 and 31A-45-103, and Subsections 31A-2-201(3)(a), 31A-22-605(4), 31A-22-605(6), and 31A-22-605.1(1).~~

~~R590-286-2. Purpose and Scope.~~
~~(1) The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of a short-term limited duration health insurance policy or certificate to:~~
~~(a) facilitate public understanding and comparison;~~
~~(b) eliminate provisions that may be misleading or confusing in connection either with the purchase of such coverage or with the settlement of a claim;~~
~~(c) comply with certain minimum requirements;~~
~~(d) set forth requirements on insurance producers that offer short-term limited duration health insurance policies; and~~
~~(e) provide for full disclosure and notice to consumers.~~
~~(2)(a) Except as provided in Subsections R590-286-2(2)(b) and R590-286-2(3), this rule applies to a short-term limited duration health insurance policy or certificate.~~
~~(b) This rule shall not apply to:~~
~~(i) Medicare supplement policies subject to Section 31A-22-620;~~
~~(ii) long-term care insurance policies subject to Title 31A, Chapter 22, Part 14 and Rule R590-148;~~
~~(iii) limited long-term care insurance policies subject to Title 31A, Chapter 22, Part 20 and Rule R590-285; or~~
~~(iv) TRICARE formerly known as the Civilian Health and Medical Program of the Uniformed Services, CHAMPUS, supplement insurance policies.~~
~~(3) A short-term limited duration health insurance policy or certificate may not be offered:~~
~~(a) to an employer group as directed by:~~
~~(i) Part A of Title XXVII of the Public Health Services Act;~~
~~(ii) Part 7 of ERISA; or~~
~~(iii) Chapter 100 of the Internal Revenue Code; and~~
~~(b) as a blanket insurance policy.~~

~~R590-286-3. Definitions.~~
~~(1) The definitions in Sections 31A-1-301 and 31A-22-625, and Rules R590-126, R590-192, and R590-203, shall apply for the purpose of this rule.~~

~~R590-286-4. Prohibited Policy Provisions.~~
~~(1) Preexisting conditions.~~
~~(a) A preexisting condition shall not be defined more restrictively than the existence of a symptom or a condition that would cause an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment within 24 months preceding the effective date, or a condition for which medical advice~~

or treatment was recommended by a health care provider within a 12-month period preceding the effective date of the policy or certificate of the insured person.

(b) A short-term limited duration health insurance policy for the entire term of the contract, including any renewals or re-issuance, may not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the first issuance of the policy or certificate.

(2) Limitations or exclusions. Unless otherwise required by law, a short-term limited duration health insurance policy or certificate 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, unless otherwise required by law;

(d) administrative exams and services;

(e) applied behavioral analysis therapy;

(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) charges for appointments scheduled and not kept;

(j) chiropractic care;

(k) complementary and alternative medicine;

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

(m) cosmetic surgery; reversal, revision, repair, complications, or treatment related to a non-covered cosmetic surgery, except that 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;

(n) custodial care;

(o) dental care or treatment;

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

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

(r) experimental or investigational services;

(s) expenses before coverage begins or after coverage ends;

(t) felony, riot, or insurrection, when it has been determined the covered person was a voluntary participant;

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

(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 PPACA;

(y) gene therapy;

(z) genetic testing;

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

(bb) except as provided in Subsection R590-286-4(2)(cc), a loss directly related to the insured's voluntary participation in an activity where the insured:

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

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

(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 R590-286-4(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 request for an independent review where the findings support a decision to deny coverage based on the exclusions of Subsection R590-286-4(2)(cc)(i);

(iii) for purposes of Subsection R590-286-4(2)(cc):

(A) an independent review means a process that:

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

(II) renders an independent and impartial decision on a decision to deny coverage based on the exclusion in Subsection R590-286-4(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 insurer;

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

(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; and

~~(C) 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;~~
~~(ff) injury as a result of a motor vehicle, to the extent the covered person is required by law to have no-fault coverage, limited to the minimum coverage required by law, whether or not such coverage is in effect;~~
~~(gg) nuclear release;~~
~~(hh) preexisting conditions or diseases:~~
~~(i) to the extent allowed under Subsections 31A-22-605.1(5) and R590-286-4(1); and~~
~~(ii) except for coverage of congenital anomalies as required by Subsection 31A-22-610(2)(b);~~
~~(ii) pregnancy, except for complications of pregnancy;~~
~~(jj) refractive eye surgery;~~
~~(kk) 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;~~
~~(ll) respite care;~~
~~(mm) rest cures;~~
~~(nn) service in the armed forces or units auxiliary to it;~~
~~(oo) services that are not medically necessary;~~
~~(pp) services performed by the covered person's parent, spouse, sibling, or child, including a step or in-law relationship;~~
~~(qq) services for which no charge is normally made in the absence of insurance;~~
~~(rr) sexual dysfunction procedures, equipment, and drugs;~~
~~(ss) shipping and handling;~~
~~(tt) telephone or electronic consultations;~~
~~(uu) territorial limitations outside the United States;~~
~~(vv) terrorism, including acts of terrorism;~~
~~(ww) transplants;~~
~~(xx) transportation, except medically necessary ambulance services;~~
~~(yy) war or act of war, whether declared or undeclared; or~~
~~(zz) others that in the opinion of the commissioner are not inequitable, misleading, deceptive, obscure, unjust, unfair, or unfairly discriminatory to the to the policyholder, beneficiary, or covered person under the policy.~~

~~R590-286-5. Required Provisions and General Requirements.~~
~~(1) Policy expiration.~~
~~(a) A policy and certificate shall include:~~
~~(i) an expiration provision that specifies the conditions for renewal or extension; and~~
~~(ii) the total number of months or days for the full term of contract, pursuant to Subsection R590-286-5(1)(c).~~
~~(b) The provision shall be appropriately captioned and appear on the first page of the policy and certificate.~~
~~(c) Considering any renewal or extension, a short-term limited duration health insurance policy or certificate is limited to 36 months.~~
~~(2) Rights of spouse. The following provisions apply to policies that provide coverage to a spouse of the insured:~~
~~(a) A policy or certificate 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 or certificate shall provide that in the event of the insured's death the spouse of the insured shall become the insured.~~
~~(3) 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) 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.~~
~~(c) Each application shall contain a prominent statement by type, stamp or other appropriate means in either contrasting color or 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, "Short-Term Limited Duration Health Insurance provides limited benefits. The (policy)(certificate), either by itself or bundled with other limited benefit products, is not meant to replace comprehensive health care insurance. It does not include benefits required by the PPACA. Review your (policy)(certificate) carefully."~~
~~(d) A statement regarding any preexisting waiting period as required by Subsection 31A-22-605.1(5)(b).~~
~~(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.~~
~~(4) Endorsement acceptance.~~
~~(a) Except for an endorsement by which the insurer effectuates a request made in writing by the policyholder, an endorsement added to a policy after date of issue 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.~~
~~(5) 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 and certificate.~~
~~(6) Benefit payment standard. A policy 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.~~
~~(7) 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 and certificate and be labeled as "Preexisting Condition Limitation."~~
~~(a) The limitation shall include a description of the existence and terms of any preexisting condition exclusion under the policy, including the maximum preexisting exclusion period; and~~

(b) state that the exclusion period ends no later than 12 months after the first issuance of the policy or certificate.
(8) Notice to Buyer.
Any short-term limited duration health insurance policy or certificate shall display prominently on the first page of the policy or certificate, in either contrasting color or in boldface type at least equal to the size type used for headings or captions of section in the policy or certificate, the following:
"Notice to Buyer: This coverage is not required to comply with certain federal market requirements for comprehensive health insurance, principally those contained in the Affordable Care Act. Be sure to read your (policy)(certificate) carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits, such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services. Your (policy)(certificate) might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."
(9) Termination of the policy shall be without prejudice to a continuous loss or deterioration of health that commenced while the policy or certificate was in force, limited to the duration of the benefit period or payment of the maximum benefits.

R590-286-6. Minimum Policy Standards.
(1) The duration of a short-term limited duration health insurance policy shall specify that the contract is less than 12 months after the first issuance of the policy or certificate.
(a) The maximum duration, considering any extensions, has an expiration date which is not more than 36 months after the first issuance of the policy or certificate.
(b) Subject to Subsection R590-286-6(1)(a), a short-term limited duration health insurance policy cannot be renewed.
(2) Short-term limited duration health insurance provides medical coverage that includes, at a minimum, the following benefits:
(a) hospital, surgical, and medical expense coverage, to an aggregate maximum of not less than:
(i) $1,000,000; and
(ii) copayment or coinsurance not to exceed 50% of covered charges;
(b) hospital services, including:
(i) inpatient services; and
(ii) other miscellaneous services associated with admission to a hospital for diagnosis and treatment of a covered condition, including medically necessary services delivered in a hospital setting, including:
(A) professional services;
(B) anesthesia;
(C) facility fees;
(D) supplies;
(E) imaging;
(F) laboratory;
(G) pharmacy services and prescription drugs;
(H) treatments;
(I) therapy; and
(J) other services delivered on an inpatient basis;
(c) outpatient services, including medically necessary services ordered by the insured's attending health care practitioner and rendered on an ambulatory basis for diagnosis and treatment of a covered condition, including:
(i) office and clinic visits;
(ii) diagnostic imaging;
(iii) laboratory services;
(iv) radiation therapy;
(v) physical therapy;
(vi) speech therapy;
(vii) occupational therapy; and
(viii) hemodialysis;
(d) surgical services for diagnosis and treatment of a covered condition must include:
(i) inpatient and outpatient surgical services at a hospital, ambulatory surgical facility, surgical suite, or provider's office; and
(ii) medically necessary services delivered in a hospital, ambulatory surgical facility, surgical suite, or provider's office related to provision of a surgical service, including:
(A) professional services;
(B) anesthesiology;
(C) facility fees;
(D) supplies;
(E) laboratory; and
(F) pharmacy services and prescription drugs related to, or required as a result of, the surgical procedure; and
(e) medical services for diagnosis and treatment of a covered condition including;
(i) office visits;
(ii) benefits for inborn metabolic errors as required by Section 31A-22-623 and Rule R590-194;
(iii) benefits for diabetes as required by Section 31A-22-626 and Rule R590-220; and
(iv) telehealth services and telemedicine services as appropriate.

R590-286-7. Outline of Coverage and Disclosure Requirements.
(1) An insurer shall deliver to an applicant the Short-Term Limited Duration Health Insurance Disclosure at application.
(2)(a) Outline of Coverage. The items included in the outline of coverage must appear in the sequence prescribed:

TABLE

(INSERT COMPANY NAME)

SHORT-TERM LIMITED DURATION HEALTH INSURANCE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS.

BENEFITS 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!

Short-term limited duration health insurance coverage is designed to provide, to persons insured, limited or supplemental coverage.

A brief specific description of the benefits, including dollar 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.

(b) an insurer shall deliver an outline of coverage to an applicant prior to or upon the sale of a short-term limited duration health insurance policy as required by this rule; and

(c) a policy 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."

(3) Every application for short-term limited duration health insurance shall contain a statement by the applicant attesting and acknowledging the following:

(a) the insured has received the Short-Term Limited Duration Health Insurance Disclosure;

(b) coverage does not meet minimum essential coverage;

(c) benefits do not comply with the Patient Protection and Affordable Care Act;

(d) exclusions or limitations, including preexisting exclusions or limitations, may apply;

(e) lifetime dollar limits may apply on health benefits; and

(f) annual dollar limits may apply on health benefits.

(4) An insurer shall, upon specific request from the commissioner, file for use a copy of any short-term limited duration health insurance advertisement intended for use in this state whether through written, radio, electronic, or television medium.

R590-286-8. Minimum Loss Ratios and Rating.

The provisions of Rule R590-85 apply to a short-term limited duration health insurance policy.

R590-286-9. Effective Date.

The commissioner will begin enforcing the provisions of this rule for new policies issued on or after April 1, 2021.

R590-286-10. Penalties.

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

R590-286-11. Severability.

If any provision of this rule, R590-286, or its application to any person or situation is held invalid, such invalidity does not affect any other provision or application of this rule which 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.]

R590-286-1. Authority.

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

R590-286-2. Purpose and Scope.

(1) The purpose of this rule is to:

(a) standardize and simplify the terms of coverage of a short-term limited duration 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;

(e) establish requirements for a producer that offers a short-term limited duration health insurance policy; and

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

(2) This rule applies to a short-term limited duration health insurance contract.

R590-286-3. Definitions.

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

(1) "Certificate" means a short-term limited duration health insurance certificate.

(2) "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) ectopic pregnancy;

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

(vi) puerperal infection;

(vii) eclampsia;

(viii) pre-eclampsia; and

(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.

(3) "Contract" means a short-term limited duration health insurance policy or certificate.

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

(a) "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 a normal bodily function; or

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

(b) "Cosmetic surgery" or "reconstructive surgery" does not require coverage for a preexisting condition that is otherwise excluded.

(5) "Custodial care" means a plan of care that does not provide treatment for sickness or injury, 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.

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

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

(8) "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.

(9) "Hospital" means a facility that is licensed and operating within the scope of that license.

(10)(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 wounds, or similar words of characterization or description.

(11)(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.

(12) "Policy" means a short-term limited duration health insurance policy.

(13) "Preexisting condition" means:

(a) the existence of a symptom or a 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 of the insured; or

(b) a condition for which medical advice or treatment was recommended or received from a health care provider within a 12-month period before the effective date of the coverage of the insured person.

(14)(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.

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

(16) "Usual and customary" means the most common charge for a similar service, medicine, or supply within the 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.
(17) "Waiting period" means "elimination period."

R590-286-4. Prohibited Provisions.
(1) For the entire term of the contract, including any renewal or re-issuance, coverage may not exclude a loss due to a preexisting condition for a period greater than 12 months following the initial issuance of the contract.
(2) Unless otherwise required by law, a contract may not limit or exclude coverage or benefits by type of illness, injury, treatment, or medical condition, except:
(a) abortion;
(b) acupuncture and acupressure;
(c) administrative charges 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) applied behavioral analysis therapy;
(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 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;
(p) dietary products, except as required under Rule R590-194;
(q) educational and nutritional training, except as required under Rule R590-200;
(r) experimental or investigational service;
(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, 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 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 in Subsection (2)(w)(i); or
(iii) a service required for the treatment of a complication from a procedure in Subsection (2)(w)(i);
(x) gene therapy;
(y) genetic testing;
(z) hearing aid, including examination for the prescription or fitting;
(aa) infertility services;
(bb) injury as a result of a motor vehicle, to the extent the covered person is required to have no-fault coverage, up to the minimum coverage required by law whether or not coverage is in effect;
(cc) mental health condition or substance use disorder services;
(dd) nuclear release;
(ee) preexisting condition, except:
(i) as required under Sections 31A-22-605.1 and R590-286-5, and Subsection 31A-22-610(2); and
(ii) for coverage of a congenital anomaly as required under Section 31A-22-610;
(ff) pregnancy, except for a complication of pregnancy;
(gg) refractive eye surgery;
(hh) rehabilitation or habilitative therapy services, such as physical, speech, and occupational, except as required to correct an impairment caused by a covered injury or illness;
(ii) respite care;
(jj) rest cure;
(kk) services while in the armed forces or an auxiliary unit;
(ll) services performed by an enrollee's parent, spouse, sibling, or child, including a step or in-law relationship;

(mm) services performed by an employee of a hospital, laboratory, or other institution;
(nn) services that are not medically necessary;
(oo) services for which no charge is normally made in the absence of insurance;
(pp) sexual dysfunction procedure, equipment, or drug;
(qq) shipping or handling, except as required by law;
(rr) telephone or electronic consultation;
(ss) territorial limitation outside the United States, except as required under Section 31A-22-627;
(tt) terrorism, including an act of terrorism;
(uu) transplant;
(vv) transportation, except medically necessary ambulance services;
(ww) war or act of war, whether declared or undeclared;
(xx) except as provided in Subsection (2)(yy), a loss directly related to an 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;
(yy) a loss established under Subsection (3)(a) 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
(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 of Subsection R590-286-4(2)(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 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 of interest with:
(A) the insurer;
(B) an officer, director, or management employee of the insurer;
(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 R592-286-4(2)(yy) does not apply to an enrollee who is under 18 years of age.
(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 the commissioner finds is unjust, unfair, or unfairly discriminatory to an enrollee.

R590-286-5. General Requirements and Required Provisions.
(1) A contract may not include a definition regarding a matter defined in Section R590-286-3 unless the definition complies with that section.
(2)(a) A contract shall include:
(i) an expiration provision that specifies the condition for renewal or extension; and
(ii) the total number of months or days for the full term of the contract under Subsection (1)(c).
(b) The provision shall be appropriately captioned and appear on the first page of the contract.
(c) Considering any renewal, extension, or continuation of premium payments, a contract is limited to 36 months.
(3) A contract that provides coverage to a spouse of the contract holder:
(a) 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; and
(b) shall provide that in the event of the contract holder's death, the spouse shall become the contract holder.
(4)(a) An application or 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 enrollment form shall be made part of the policy.
(ii) A copy of the completed application or enrollment form shall be provided to the applicant or enrollee before or upon delivery of the contract.
(c) An application or enrollment form shall include:
(i) 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, the following prominent disclosure statement, "Short-Term Limited Duration Health Insurance provides limited benefits. The (policy)(certificate), either by itself or bundled with other limited benefit products, is not meant to replace comprehensive health care insurance. It does not include benefits required by PPACA. Review your (policy)(certificate) carefully.";
(ii) a statement regarding any preexisting waiting period as required by Subsection 31A-22-605.1(5)(b); and
(iii) a question regarding whether the contract to be issued is intended to replace any other accident and health insurance presently in force.
(d) A supplementary application or other form signed by the applicant containing the question in Subsection (4)(c)(iii) may be used.
(5)(a) Except for an endorsement by which the insurer effectuates a written request by the policyholder, signed acceptance by the policyholder is required for an endorsement that reduces or eliminates a benefit or coverage and is added to a policy after the date of issue.
(b) After the date of policy issue, an endorsement that increases a benefit or coverage with a concurrent increase in premium during the policy term shall be agreed to in writing and signed by the policyholder, except if the increased benefit or coverage is required by law.
(6) When a separate additional premium is charged for a benefit provided in connection with an endorsement, the premium charge shall be set forth in the policy and certificate.

(7) 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 its accompanying outline of coverage or certificate.

(8)(a) If a policy or certificate includes a limitation regarding preexisting conditions, the limitation shall appear as a separate paragraph 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.

(9) A short-term limited duration health insurance policy or certificate shall include, on the first page of the policy or certificate, 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 policy or certificate, the following prominent disclosure statement, "Notice to Buyer: This coverage is not required to comply with certain federal market requirements for comprehensive health insurance, principally those contained in the Affordable Care Act. Be sure to read your (policy)(certificate) carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits, such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services. Your (policy)(certificate) might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage."

(10) Termination of a policy shall be without prejudice to any continuous loss or deterioration of health that commenced while the policy or certificate was in force, limited to the duration of the benefit period or payment of the maximum benefits.

(11) A contract may not be offered:

(a) to an employer group as directed by:

(i) Part A of Title XXVII of the Public Health Services Act;

(ii) Part 7 of ERISA; or

(iii) Chapter 100 of the Internal Revenue Code; or

(b) as a blanket insurance policy.

R590-286-6. Minimum Benefit Standards.

(1)(a) A short-term limited duration health insurance contract shall specify that the initial term is less than 12 months.

(b) The maximum duration, including any extensions, has an expiration date that is not more than 36 months after the first issuance of the policy or certificate.

(c) Subject to Subsection R590-286-6(1)(b), a policy may not be renewed.

(2) A contract shall provide medical coverage that includes, at a minimum, the following benefits:

(a) hospital, surgical, and medical expense coverage, to an aggregate maximum of not less than:

(i) $1,000,000; and

(ii) copayment or coinsurance not to exceed 50% of covered charges;

(b) hospital services, including:

(i) inpatient services; and

(ii) other miscellaneous services associated with admission to a hospital for diagnosis and treatment of a covered condition, including medically necessary services delivered in a hospital setting, including:

(A) professional services;

(B) anesthesia;

(C) facility fees;

(D) supplies;

(E) imaging;

(F) laboratory;

(G) pharmacy services and prescription drugs;

(H) treatments;

(I) therapy; and

(J) other services delivered on an inpatient basis;

(c) outpatient services, including medically necessary services ordered by the enrollee's attending health care practitioner and provided on an ambulatory basis for the diagnosis and treatment of a covered condition, including:

(i) office and clinic visits;

(ii) diagnostic imaging;

(iii) laboratory services;

(iv) radiation therapy;

(v) physical therapy;

(vi) speech therapy;

(vii) occupational therapy; and

(viii) hemodialysis;

(d) surgical services for the diagnosis and treatment of a covered condition, which must include:

(i) inpatient and outpatient surgical services at a hospital, ambulatory surgical facility, surgical suite, or a provider's office; and

(ii) medically necessary services related to a surgical service delivered in a hospital, ambulatory surgical facility, surgical suite, or a provider's office, including:

(A) a professional service;

(B) anesthesiology;

(C) facility fees;

(D) a supply;

(E) laboratory; and

(F) a pharmaceutical service or prescription drug related to, or required as a result of, the surgical procedure; and

(e) a medical service for the diagnosis and treatment of a covered condition, including:

(i) an office visit;

(ii) a benefit for inborn metabolic errors as required under Section 31A-22-623 and Rule R590-194;

(iii) a benefit for diabetes as required under Section 31A-22-626 and Rule R590-220; and
(iv) telehealth services and telemedicine services as appropriate.

R590-286-7. Outline of Coverage and Disclosure Requirements.

(1) An insurer shall deliver to an applicant the Short-Term Limited Duration Health Insurance Disclosure at the time of application.
(2) The outline of coverage in Table 1 shall be issued with a contract.

TABLE 1 Short-Term Limited Duration Outline of Coverage
(COMPANY NAME) SHORT-TERM LIMITED DURATION HEALTH INSURANCE COVERAGE THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS BENEFITS ARE SUPPLEMENTAL AND ARE NOT INENDED 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! Short-term limited duration health insurance coverage is designed to provide, to persons insured, limited or supplemental coverage. A brief specific description of the benefits, including dollar 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 reservation of right to change premiums.

(3) A policy delivered to a person eligible for Medicare by reason of age shall include the following language 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."
(4) An application for short-term limited duration health insurance shall include a statement by the applicant attesting and acknowledging the following:
(a) the insured has received the Short-Term Limited Duration Health Insurance Disclosure;
(b) coverage does not meet minimum essential coverage;
(c) benefits do not comply with the Patient Protection and Affordable Care Act;
(d) exclusions or limitations, including a preexisting condition exclusion or limitation, may apply;
(e) lifetime dollar limits may apply; and
(f) annual dollar limits may apply.
(5) An insurer shall, upon request from the commissioner, file for use a copy of any short-term limited duration health insurance advertisement intended for written, radio, electronic, or television use in this state.

R590-286-8. Severability.

If any provision of this rule, Rule R590-286, 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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