**R590. Insurance, Administration.**
**R590-233. Health Benefit Plan Insurance Standards.**
**R590-233-1. Authority.**

This rule is issued by the insurance commissioner pursuant to the following provisions of the Utah Insurance Code:

(1) Subsection 31A-2-201(3)(a) authorizes rules to implement the Insurance Code;

(2) Sections 31A-2-202 and 31A-23a-412 authorize the commissioner to request reports, conduct examinations, and inspect records of any licensee;

(3) Subsection 31A-22-605(4) requires the commissioner to adopt rules to establish standards for disclosure in the sale of, and benefits to be provided by individual and franchise accident and health polices;

(4) Section 31A-22-623 authorizes the commissioner to establish by rule minimum standards of coverage for dietary products for inborn metabolic errors;

(5) Section 31A-22-626 authorizes the commissioner to establish by rule minimum standards of coverage for diabetes for accident and health insurance;

(6) Subsection 31A-23a-402(8) authorizes the commissioner to define by rule acts and practices that are unfair and unreasonable; and

(7) Subsection 31A-26-301(1) authorizes the commissioner to set standards for timely payment of claims.

**R590-233-2. Purpose and Scope.**

(1) Purpose. The purpose of this rule is to provide reasonable standardization and simplification of terms and coverages of insurance policies in order to facilitate public understanding and comparison and to prohibit provisions which may be misleading or confusing in connection either with the purchase of such coverages or with the settlement of claims, and to provide for full disclosure in the sale of such insurance.

(2) Scope.

(a) Except as excluded under (b), this regulation applies to all individual and group health benefit plan policies, including policies issued to associations, trusts, discretionary groups, or other similar groupings.

(b) This rule shall not apply to employer group health benefit plans.

(c) This rule does not apply to a health benefit plan subject to R590-277, Managed Care Health Benefit Plan Policy Standards.

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

**R590-233-3. Definitions.**

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

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

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

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

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

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

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

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

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

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

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

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

(ii) for reconstructive treatment following medically necessary surgery;

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

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

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

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

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

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

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

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

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

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

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

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

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

(16) "Medical Necessity" means:

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

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

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

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

(iv) covered under the contract;

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

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

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

(A) scientific evidence;

(B) professional standards; and

(C) expert opinion.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**R590-233-4. Prohibited Policy Provisions.**

(1) Probationary periods.

(a) A policy shall not contain provisions establishing a probationary period during which no coverage is provided under the policy except as provided in R590-233-4(1)(b), (c), and (d).

(b) A policy may specify a probationary period not to exceed twelve months for losses resulting from:

(i) amenorrhea;

(ii) cataracts;

(iii) congenital deformities, unless coverage is required pursuant to Subsection 31A-22-610(2);

(iv) cystocele;

(v) dysmenorrhea;

(vi) enterocele;

(vii) infertility;

(viii) rectocele;

(ix) seasonal allergies, limited to testing and treatment;

(x) sleep disorders, including sleep studies;

(xi) surgical treatment for;

(A) adenoidectony,

(B) bunionectomy,

(C) carpal tunnel,

(D) hysterectomy, except in cases of malignancy,

(E) joint replacement,

(F) reduction mammoplasty,

(G) Morton's neuroma,

(H) myringotomy and tympanotomy, with or without tubes inserted,

(I) nasal septal repair, except for injuries after the effective date of coverage,

(J) retained hardware removal,

(K) sterilization, and

(L) tonsillectomy;

(xii) urethrocele;

(xiii) uterine prolapse; and

(xiv) varicose veins.

(c) Coverage must be provided for conditions and procedures prohibited in Subsection (1)(b) for emergency medical conditions in compliance with Section 31A-22-627.

(d) The probationary period must be reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection 31A-22-605.1(4)(b).

(2) Preexisting conditions provisions shall comply with Sections 31A-1-301, and 31A-22-605.1.

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

(a) abortion;

(b) acupuncture and acupressure services;

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

(d) administrative exams and services;

(e) alcoholism and drug addictions;

(f) allergy tests and treatments;

(g) aviation;

(h) axillary hyperhidrosis;

(i) benefits provided under:

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

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

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

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

(k) charges for appointments scheduled and not kept;

(l) chiropractic;

(m) complementary and alternative medicine;

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

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

(p) custodial care;

(q) dental care or treatment;

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

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

(t) experimental and/or investigational services;

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

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

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

(x) gene therapy;

(y) genetic testing;

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

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

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

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

(dd) mental or emotional disorders;

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

(ff) nuclear release;

(gg) preexisting conditions or diseases as allowed under Section 31A-22-605.1, except for coverage of congenital anomalies as required by Section 31A-22-610;

(hh) pregnancy, except for complications of pregnancy;

(ii) refractive eye surgery;

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

(kk) respite care;

(ll) rest cures;

(mm) routine physical examinations;
(nn) service in the armed forces or units' auxiliary to it;
(oo) services rendered by employees of hospitals, laboratories or other institutions;
(pp) services performed by a member of the covered person's immediate family;
(qq) services for which no charge is normally made in the absence of insurance;
(rr) sexual dysfunction;
(ss) shipping and handling, unless otherwise required by law;
(tt) suicide, sane or insane, attempted suicide, or intentionally self-inflicted injury;
(uu) telephone/electronic consultations;
(vv) territorial limitations outside the United States;
(ww) terrorism, including acts of terrorism;
(xx) transplants;
(yy) transportation;
(zz) treatment provided in a government hospital, except for hospital indemnity policies;
(aaa) war or act of war, whether declared or undeclared; or
(bbb) others as may be approved by the commissioner.

(4) Waivers. All waivers issued must comply with 31A-30-107.5. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required.

(5) Commissioner authority. Policy provisions precluded in this section shall not be construed as a limitation on the authority of the commissioner to prohibit other policy provisions that in the opinion of the commissioner are unjust, unfair or unfairly discriminatory to the policyholder, beneficiary or a person insured under the policy.

**R590-233-5. General Requirements.**

(1) Policy definitions. No policy subject to this rule may contain definitions respecting the matters defined in Section R590-233-3 unless such definitions comply with the requirements of that section.

(2) Rights of spouse. The following provisions apply to policies that provide coverage to a spouse of the insured:

(a) A policy may not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than for nonpayment of premium.

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

(3) Cancellation, Renewability, and Termination. Policy cancellation, renewability and termination provisions must comply with Sections 31A-8-402.3, 31A-8-402.5, 31A-8-402.7, 31A-22-721 and 31A-30-107, 107.1 and 107.3.

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

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

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

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

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

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

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

**R590-233-6. Required Provisions.**

(1) Applications.

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

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

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

(d) 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.

(2) Renewal and nonrenewal provisions. Accident and health insurance shall include a renewal, continuation or nonrenewal provision. The provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.

(3) Endorsement acceptance.

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

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

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

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

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

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

**R590-233-7. Accident and Health Standards for Benefits.**

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

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

(1) Major Medical Expense Coverage.

Major medical expense coverage is a policy of accident and health insurance that provides hospital, medical and surgical expense coverage.

(a) An aggregate maximum of not less than $1,000,000 may be applied and include any combination of the following:

(i) coinsurance percentage, paid by the covered person, not to exceed 50% of covered charges per covered person per year;

(ii) coinsurance out-of-pocket maximum after any deductibles not to exceed $20,000 per covered person per year; or

(iii) deductibles stated on per person, per family, per illness, per benefit period, or per year basis.

(b) A combination of the bases provided under Subsections(1)(a)(i), (ii), and (iii) may not exceed 5% of the aggregate maximum limit under the policy for each covered person.

(c) The following services must be provided:

(i) daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) in-hospital medical services;

(vi) out-of-hospital care, consisting of physician services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy, and hemodialysis ordered by a physician; and

(vii) at least three of the following additional benefits must also be provided:

(A) in-hospital private duty registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; or

(G) out-of-hospital prescription drugs and medications.

(d) All required benefits may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations.

(e) A major medical expense policy may also have special or internal limitations for those services covered under Subsection (1)(c).

(f) Except as authorized by this subsection through the application of special or internal limitations, a major medical expense policy must be designed to cover, after any deductibles or coinsurance provisions are met, the usual, customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(2) Basic Medical Expense Coverage.

Basic medical expense coverage is a policy of accident and health insurance that provides hospital, medical and surgical expense coverage.

(a) An aggregate maximum of not less than $500,000 may be applied, and may include any combination of the following:

(i) coinsurance percentage, paid by the covered person, not to exceed 50% of covered charges per covered person per year;

(ii) coinsurance out-of-pocket maximum after any deductibles, not to exceed $25,000 per covered person per year; or

(iii) deductibles stated on per person, per family, per illness, per benefit period, or per year basis.

(b) A combination of the bases provided in Subsections (2)(a)(i), (ii) and (iii) may not exceed 10% of the aggregate maximum limit under the policy.

(c) The following services must be covered:

(i) daily hospital room and board expenses subject only to limitations based on average daily cost of the semiprivate room rate in the area where the insured resides or such other rate agreed to between the insurer and provider for a period of not less than 31 days during continuous hospital confinement;

(ii) miscellaneous hospital services;

(iii) surgical services;

(iv) anesthesia services;

(v) in-hospital medical services;

(vi) out-of-hospital care, consisting of physicians' services rendered on an ambulatory basis where coverage is not provided elsewhere in the policy for diagnosis and treatment of sickness or injury, diagnostic x-ray, laboratory services, radiation therapy and hemodialysis ordered by a physician; and

(vii) three of the following additional benefits must also be provided:

(A) in-hospital private duty registered nurse services;

(B) convalescent nursing home care;

(C) diagnosis and treatment by a radiologist or physiotherapist;

(D) rental of special medical equipment, as defined by the insurer in the policy;

(E) artificial limbs or eyes, casts, splints, trusses or braces;

(F) treatment for functional nervous disorders, and mental and emotional disorders; or

(G) out-of-hospital prescription drugs and medications.

(d) If the policy is written to complement underlying basic hospital expense coverage and basic medical-surgical expense coverage, the deductible may be increased by the amount of the benefits provided by the underlying basic coverage.

(e) The benefits required by Subsection (2) may be subject to all applicable deductibles, coinsurance and general policy exceptions and limitations.

(f) Basic medical expense policies may also have special or internal limitations for prescription drugs, nursing facilities, intensive care facilities, mental health treatment, alcohol or substance abuse treatment, transplants, experimental treatments, mandated benefits required by law and those services covered under Subsection (2)(c) and other such special or internal limitations as are authorized or approved by the commissioner.

(g) Except as authorized by this subsection through the application of special or internal limitations, basic medical expense policies must be designed to cover, after any deductibles or coinsurance provisions are met, the usual customary and reasonable charges, as determined consistently by the carrier and as subject to approval by the commissioner, or another rate agreed to between the insurer and provider, for covered services up to the lifetime policy maximum.

(3) Catastrophic Coverage.

Catastrophic coverage is a policy of accident and health insurance that:

(a) provides benefits for medical expenses incurred by the insured to an aggregate maximum of not less than $1,000,000;

(b) contains no separate internal dollar limits;

(c) may be subject to a policy deductible which does not exceed the greater of 2% of the policy limit or the amount of other in-force accident and health insurance coverage for the same medical expenses; and

(d) contains no percentage participation or coinsurance clause for expenses which exceed the deductible.

**R590-233-8. Outline of Coverage Requirements.**

(1) Major Medical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Rule R590-233-7(1). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE I

(COMPANY NAME)

MAJOR MEDICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

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

(2) Basic Medical Expense Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-233-7(2). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE II

(COMPANY NAME)

BASIC MEDICAL EXPENSE COVERAGE

THIS (POLICY)(CERTIFICATE) PROVIDES LIMITED BENEFITS

OUTLINE OF COVERAGE

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

(3) Catastrophic Coverage.

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Subsection R590-233-7(3). The items included in the outline of coverage must appear in the sequence prescribed:

TABLE III

(COMPANY NAME)

CATASTROPHIC COVERAGE

OUTLINE OF COVERAGE
Read Your (Policy)(Certificate) Carefully-This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR (POLICY) (CERTIFICATE) CAREFULLY!
Catastrophic coverage is designed to provide benefits for medical expenses incurred by the insured. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out-of-hospital care, subject to any deductibles with no separate internal dollar limits.
A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
daily hospital room and board;
miscellaneous hospital services;
surgical services;
anesthesia services;
in-hospital medical services;
out-of-hospital care; and
other benefits, if any.
A description of any policy provisions that exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits.
A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.

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

(5) If an outline of coverage was delivered at the time of application or enrollment and the policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate must accompany the policy or certificate when it is delivered and contain the following statement in no less than 12-point type, immediately above the company name:

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

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

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

**R590-233-9. Replacement of Accident and Health Insurance Requirements.**

(1) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its producer, shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in Subsection (2). The insurer shall retain a copy of the notice. A direct response insurer shall deliver to the applicant, upon issuance of the policy, the notice described in Subsection (3).

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

TABLE IV

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (insert company name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the

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

(Applicant's Signature)

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

TABLE V

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (insert company name) Insurance Company. Your new policy provides 30 days within which you may decide without cost whether you desire to keep the policy.
For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.
Health conditions that you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
You may wish to secure the advice of your present insurer or its producer regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
(To be included only if the application is attached to the policy).
If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (insert company name and address) within ten days if any information is not correct and complete, or if any past medical history has been left out of the application.
COMPANY NAME

**R590-233-10. Existing Contracts.**

Contracts issued prior to the effective date of this rule must be amended to comply with the revised provisions on the first policy anniversary following the effective date of this rule.

**R590-233-11. Enforcement Date.**

The commissioner will begin enforcing this rule January 1, 2006.

**R590-233-12. Severability.**

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

**KEY: health insurance**
**Date of Enactment or Last Substantive Amendment: December 23, 2019**
**Notice of Continuation: December 3, 2020**
**Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-202; 31A-22-605; 31A-22-623; 31A-22-626; 31A-23a-402; 31A-23a-412; 31A-26-301**