This rule is promulgated by the insurance commissioner pursuant to Subsections 31A-2-201(3), 31A-2-212(5)(b) and 31A-22-605(4).

(1) The purpose of this rule is to clarify rules relating to the coverage of children in the individual and group health benefit plan markets.

(2) This rule applies to any health insurer that provides individual or group health benefit plan coverage.

In addition to the definitions in Sections 31A-1-301 and 31A-30-103, the following definitions shall apply for the purposes of this rule.

(4)(a) "Health benefit plan" means a policy, contract, certificate or agreement offered by an insurer to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(b) "Health benefit plan" includes short-term and catastrophic health insurance policies, and a policy that pays on a cost-incurred basis, except as otherwise specifically exempted in this definition.

(c) "Health benefit plan" does not include:

(i) coverage for accident, or disability income insurance, or any combination thereof;
(ii) coverage issued as a supplement to liability insurance;
(iii) liability insurance, including general liability insurance and automobile liability insurance;
(iv) workers' compensation or similar insurance;
(v) automobile medical payment insurance;
(vi) credit-only insurance;
(vii) coverage for on-site medical clinics; and
(viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(d) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(i) limited scope dental or vision benefits;
(ii) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
(iii) other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(e) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) coverage only for a specified disease or illness; or
(ii) hospital indemnity or other fixed indemnity insurance.

(f) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;
(ii) coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code, TRICARE; or
(iii) similar supplemental coverage added to coverage under a group health plan.

(g) "Health insurer" means an insurer that offers a health benefit plan.

(h) "Individual health insurance coverage" means health insurance coverage offered to individuals in the individual market, which includes a health benefit plan provided to individuals through a trust arrangement, association or other discretionary group that is not an employer plan, but does not include short-term limited duration insurance.

(1) "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

(2) "Medical care" means amounts paid for:
(a) the diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any
structure or function of the body;
(b) transportation primarily for and essential to medical care referred to in R590-259-3(8)(a); and
(c) insurance covering medical care referred to in R590-259-3(8)(a) and (b).
(9) "Participant" adopts the meaning given under section 3(7) of ERISA.
(10) "Subscriber" means, in the case of individual health insurance contract, the person in whose name the contract is issued.

R590-259-4. Eligibility for Dependent Coverage to Age 26; Definition of Dependent; Uniformity of Plan Terms.
(1) A health insurer that makes available dependent coverage of children shall make that coverage available for children until attainment of 26 years of age.
(2) With respect to a child who has not attained 26 years of age, a health insurer shall not define dependent for purposes of eligibility for dependent coverage of children other than the terms of a relationship between a child and the plan participant, and, in the individual market, primary subscriber.
(3) A health insurer shall not deny or restrict coverage for a child who has not attained 26 years of age:
   (a) based on the presence or absence of the child's financial dependency upon the participant, primary subscriber or any other person, residency with the participant and in the individual market the primary subscriber, or with any other person, student status, employment or any combination of those factors; or
   (b) based on eligibility for other coverage, except as provided in R590-259-4(6).
(4) Nothing in this rule shall be construed to require a health insurer to make coverage available for the child of a child receiving dependent coverage, unless the grandparent becomes the adoptive parent of that grandchild.
(5) The terms of coverage in a health benefit plan offered by a health insurer providing dependent coverage of children cannot vary based on age except for children who are 26 years of age or older.
(6) For plan years beginning before January 1, 2014, a group health plan providing group health insurance coverage that is a grandfathered plan and makes available dependent coverage of children may exclude an adult child who has not attained 26 years of age from coverage only if the adult child is eligible to enroll in an eligible employer-sponsored health benefit plan, as defined in section 5000A(f)(2) of the Internal Revenue Code, other than the group health plan of a parent.

R590-259-5. Special Enrollment for Qualifying Events.
Nothing in this rule shall alter an applicant's ability to obtain health insurance during a special enrollment period, outside of the open enrollment period, resulting from a qualifying event as defined by the Health Insurance Portability and Accountability Act and PPACA.

R590-259-6. Penalties.
A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

R590-259-7. Severability.
If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

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