

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 rehabilitative 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.

KEY: insurance, health, short-term limited duration

Date of Enactment or Last Substantive Amendment: March 11, 2021

Authorizing, and Implemented or Interpreted Law: 31A-2-201(3)(a); 31A-2-202; 31A-22-605(4); 31A-22-605(6); 31A-22-605.1(1); 31A-45-103