Small Employer Group Health Benefit Plan

The following standard is provided to assist the insurer in submitting a filing. This is a brief synopsis and not intended to be all-inclusive or contain all requirements or exceptions. All references should be reviewed for compliance. References beginning with "31A" refer to Utah Code and those beginning with "R590" refer to department rules under Utah Admin Code. As required by § 31A-21-201(2), the insurer is responsible for assuring that all filings submitted are in compliance. Filings found to be out of compliance may be referred to our Market Conduct Division for review and possible action.

Filing

Subject	Citation	Description
Confidentiality / Classification of Documents	63G-2-305 R590-220-17	Information an insurer considers to be privileged, proprietary, or confidential must be submitted with a compliant protection request and identify the intended document(s).
Content Standards	R590-220-5(1)	A form that incorporates other accident & health insurance types must comply with the applicable content standards.
Filing Submission	31A-1-301(68) 31A-21-201 R590-220 Annual Bulletin	An insurer is responsible for assuring a filing is compliant with Utah law. A non-compliant filing will be rejected and not considered filed with the department.
Form Number	R590-220-7(1)(b)	A form must be clearly identified by a unique form number, and the form number may not be variable.
Multi-Line	R590-220-6(1) R590-220-7(3)	Utah does not allow a single filing for multiple types of insurance (TOI), aka multi-line. All filings must be submitted by TOI and market type (group or individual) according to the NAIC Product Coding Matrix.
Policy & Related Forms	31A-1-301(72) & (145) R590-220-7(3)	A policy is an enforceable contract. A policy consists of all related forms.
Variability	R590-220-6(2)(f) R590-220-7(1)	A form containing variable data must have a certification statement. Variability as a separate document must be identified by its own unique form number and edition date. Blank spaces must be completed to accurately represent the intended purpose and use.

General

Subject	Citation	Description
Age	31A-22-613	If age is used in determining a benefit, a factor affecting premium, or coverage, it must be disclosed.
Appeal / Grievance Process	31A-22-629 R590-192-8 R590-261	A form must include an adverse benefit determination, grievance, and independent review process that complies with the federal claims regulation.
Application	31A-21-201(3)(a)(iv) 31A-22-635 R590-247	Use of the universal application is mandatory. Health questions must be reasonable and include required disclosures. A policy or certificate filing must include an application or an informational copy and reference the SERFF tracking number in the Filing Description.
Arbitration	R590-215	If included, a permissible arbitration provision must be properly disclosed and may not deprive Utah courts of jurisdiction over an action against an insurer. Permissible: -Compulsory non-binding arbitration. -Voluntary binding arbitration, at the election of an insured. Not permissible: -Compulsory binding arbitration.
Beneficiary / Estate	31A-22-614(4) R590-192-12(12)	An unpaid benefit following an insured's death is to be issued to the beneficiary or estate. Imposing a dollar limit is not considered good faith.
Cancellation, Renewability, and Termination	31A-22-618.6 R590-277-6(1)	A policy may not be terminated without cause before the renewal date. A captioned renewal or non-renewal disclosure, with duration, is required on the first page of the policy.
Certificate	31A-21-311	A certificate must contain a summary of the benefits, exclusions and limitations, and any rights of conversion.
Claim Settlement	31A-26-301 & 301.6 R590-192	Claims must be settled in a fair and timely manner. Interest must be paid when a claim is not addressed promptly.
Company Name & State of Domicile	31A-21-201, 301 & 311	A form must conspicuously reference the exact name of the insurer and its state of domicile; variability is not permitted.
Definitions	31A-1-301 R590-167-2 R590-277-3	A form must comply with these definitions and others, as applicable.
Electronic Notices	31A-21-316	An electronic notification must provide consumer awareness and consent, and be filed with the department.

Endorsement or Rider	31A-21-106(2) 31A-21-302 R590-277-6(2)	Grandfathered and transitional plans: An in-force contract may not be modified unless it is in writing and requires a signed acceptance by the policyholder. If an additional premium is charged, the premium must be disclosed on the policy or certificate. Non-Grandfathered plans: Cannot include an endorsement; must be included within the contract.
Felony, Riot, Insurrection or Illegal Activities	31A-21-201(3) R590-277-4(2)	A loss must be directly related to the insured's voluntary participation.
Grace Period	31A-22-607	A policy must include a grace period. A group policy must provide a 30-day grace period and must not be terminated before the end of the grace period.
Incontestability	31A-22-609	Only a fraudulent misstatement regarding insurability is a basis for avoidance after coverage has been in effect for two years.
Incorporation by Reference	31A-21-106 Bulletin 94-1	A form may not incorporate any provision not fully disclosed unless citing a federal or state law, rule, or public directive.
Jurisdiction	31A-21-314	A form may not contain any provision requiring it to be construed according to the laws of another jurisdiction, or deny Utah courts jurisdiction.
Limitation of Actions	31A-21-313	A form may not limit an action brought against an insurer to earlier than 60 days after proof of loss, waiver of proof of loss, or denial of payment. An insurer may not limit or restrict an action to less than three years.
Limitations or Exclusions	31A-22-613.5(2) R590-277-4	A form may not limit or exclude coverage or benefits that are in the public's interest. An exception must be approved by the commissioner.
Nondiscrimination Among Health Care Professionals	31A-22-618	An insurer may not unfairly discriminate against any licensed class of health care provider when the treatment is within the scope of the provider's license.
Notice and Proof of Loss	31A-21-312 R590-192-7 Bulletin 87-6	The proof of loss provision must allow the insured or claimant to file a notice or proof of loss as soon as reasonably possible.
Notice of Termination	31A-22-716	A policy must include a provision that obligates the policyholder to give 30 days prior written notice to each member.
Overpayment / Payment Recovery	31A-21-108 31A-26-301.6(14) R590-131-8(6)	Recovery of an overpayment improperly paid must be by the timeframes outlined in statute.
Physical Exam	31A-21-201(3)(a)	If an insurer requires a physical exam, the insurer must pay for the exam.
Preauthorization	31A-22-639 31A-22-650	If preauthorization is required, it must be disclosed and comply with the requirements.
Preferred Provider Provisions	31A-45-303 31A-45-501(4)	An insurer must comply with network provider contract provisions. In a rural healthcare setting, a non-contracted provider or the insured may be required to be reimbursed a like dollar amount.
Premium Change	31A-21-106(2)(b) 31A-21-302 R590-277-5(5)	A change in premium is only allowable at renewal and in specific circumstances.
Return of Premium	31A-21-302 31A-21-315	An insurer must return any excess premium without being requested.
Usual & Customary	31A-21-201(3)(a) R590-277-6(4)	The use of a term such as usual & customary, or similar, must be defined.

Dependent

Subject	Citation	Description
Administrative or Court Ordered Coverage	31A-22-610.5	Coverage must be provided without regard to open enrollment, dependency, residency, or service area. Unless otherwise specified in a court order, coverage must remain in force as it would for any other dependent.
Coverage from the Moment of Birth or Date of Placement	31A-22-610	If providing coverage for a dependent child, coverage must also be provided for: 1. A newborn child from the moment of birth; and 2. An adopted child, from the moment of birth if placement for adoption occurs within 30 days of the child’s birth, or from the date of placement if placement occurs 30 days or more after the child’s birth. Placement for adoption may not be defined more restrictively than the assumption and retention of a legal obligation. Notification, enrollment, and additional premium, if required, must be disclosed.

Dependent Eligibility	31A-22-610.5 R590-259	If providing coverage for a dependent child, the following apply: - a dependent must be covered up to age 26; - all dependents must be treated equally (step, court or administrative ordered, etc); - may not require financial dependency; - may not require residency status; - may not require student status; and - coverage must continue in force through the last day of the month
Disabled Dependents	31A-22-611	A form that provides dependent coverage must comply with the terminology and eligibility of an impaired dependent.
Enrollment when Additional Premium not Required	31A-22-610(2)(e)	If additional premium is not required for a new dependent, an insured has 30 days from the denial of a claim to enroll the child.

Specific

Subject	Citation	Description
Adoption Indemnity Benefit / Infertility Treatment	31A-22-610.1	A plan with maternity benefits must include an adoption indemnity benefit. This benefit may be used to obtain infertility treatment.
Cancer Treatment Parity	31A-22-641	Oral chemotherapy and intravenously administered chemotherapy must be in parity.
Clinical Treatments	Bulletin 2013-7	Participation in an approved clinical trial for cancer or a life-threatening disease or condition must be covered. Coverage of routine patient costs in connection with the trial may not be limited.
Coordination of Benefits	31A-22-619 R590-131	Coordination of benefits is only allowed if the product meets the definition of a conforming plan. Benefits may not be reduced on the basis that an insured is eligible for other coverage.
Diabetes Coverage	31A-22-626 R590-200	A plan must comply with the minimum standards for services, supplies, and self-management training.
Emergency Services	31A-22-627	A plan must comply with the definition and minimum requirements of an emergency medical condition.
Essential Health Benefit (EHB)	31A-45-403 R590-266	PPACA: The required benefits that encompass Utah's benchmark plan. Pediatric dental benefits may be offered as a Stand Alone Dental Plan (SADP).
Grandfathered Plan Disclosure	31A-2-212 45 CFR 147.140	A plan must state it is a grandfathered plan and how it complies with section 1251 of PPACA.
Inborn Metabolic Errors	31A-22-623 R590-194	A plan must comply with the minimum requirements.
Mastectomy Coverage	31A-22-630 31A-22-719	A plan with mastectomy coverage must include coverage for reconstruction, prostheses, etc.
Maternity Minimum Stay	31A-22-610.2 31A-22-613(4)	A plan with maternity coverage must comply with the 48/96 hour benefit for both mother & newborn and may not require a preauthorization.
Mental Health / Substance Use Disorder	31A-22-625 45 CFR 146.136 45 CFR 147.160	A plan must comply with the applicable minimum standards and parity.
Mini-COBRA	31A-22-722	A plan is required to offer an extension of benefits and meet the minimum standards.
Preexisting Conditions	31A-1-301(147) 31A-22-605.1 R590-277-4(1) 45 CFR 147.108 45 CFR 147.140	A preexisting condition may not be defined more restrictively than outlined in statute and must appear as a separate paragraph. Grandfathered plans: May not apply preexisting conditions to individuals under the age of 19. Non-grandfathered plans: May not impose any preexisting condition exclusions.
Preventive Health	31A-2-212(5) Bulletin 2015-11 45 CFR 147.130	Non-grandfathered plan: A plan must include coverage for routine health services without cost-sharing. All: Tobacco cessation is considered preventive care and must comply with the minimum standards.
Prosthetic Devices	31A-22-638	An insurer must offer at least one health benefit plan that meets the minimum requirements as outlined in statute.
Reasonable Time Limits	31A-21-201(3)(a)(i)	A time limit exceeding a 30-day duration to receive a benefit, for a specific condition, is considered unfair and not in the public's interest.

Rural Healthcare	31A-45-501 R590-237	Grandfathered plan: Non-contracted providers must be reimbursed at the rate of 75% of the average paid contracted providers. A change may cause coverage to cease grandfathered status under PPACA. Non-grandfathered plan: A form must include a notice about rural health care providers and advise on the rights to access.
Telehealth / Telemedicine	31A-22-649.5	A plan must cover services the same as Medicare.
Transplant Donor	R590-266-4 R590-277-5(4)	A form may not limit transplant benefits for a live donor's eligible expenses. Transplant benefits are considered an EHB.

Rating

Subject	Citation	Description
Composite Rating	31A-30 R590-167 Bulletin 2015-4 Annual Bulletin	A rating structure, including composite rates, must comply with statute and bulletins.
Rate Review Justification (RRJ)	R590-167-11(2)(a)(vii)	Transitional plans: If you are submitting a rate increase that meets or exceeds the "subject to review" threshold under the Rate Review Regulation, complete the justification in the HIOS system. Non-Grandfathered plans: Refer to URR.
Requirements	31A-30 31A-45 R590-167 R590-277	A rate filing must contain: - the type of renewability; - Utah and nationwide experience; - current and proposed rates; - prior rate-related SERFF tracking number(s); - average annual premium per policy; - a list of states where a similar product has been filed; and - other information as outlined in statute.
Unified Rate Review (URR)	45 CFR 147.102 45 CFR 154.215 45 CFR 155.1020 45 CFR 156.80, 210 & 255 Annual Bulletin	An insurer must submit the Unified Rate Review Template (URRT) regardless of exchange participation. SADPs are exempt from this requirement.

Reporting

Subject	Citation	Description
Annual Report(s)	R590-167-11 R590-220-10(4)	Grandfathered plans: The actuarial certification is due on or before April 1.
Defrayal Report(s)	R590-283-4 & 6	QHP: A report regarding state defrayal is due on or before the 15th of the month after each quarter ends. The annual report regarding state defrayal is due on or before September 1.
Discontinuance	31A-21-201(1) 31A-22-618.6 R590-277-6(1)	A notice of non-renewal is required at least 90 days before renewal. When discontinuing or non-renewing a plan, the department requests the number of policyholders and covered lives affected, and identify the plan currently marketed as the most similar replacement.
Intent to Offer	R590-167-10	Before marketing a health benefit plan, an insurer must submit a filing indicating it wishes to be a covered carrier.
Plan of Orderly Withdrawal	31A-4-115 31A-22-618.8 R590-199	Before discontinuing all health benefit plans in this market, an insurer must submit: - a request in writing for approval by the commissioner, at least 30 working days before the notice of discontinuance; - a notification of intent to the appropriate divisions; - a notice of discontinuance at least 180 days before discontinuance to affected insureds; and - a copy of the above information filed in SERFF.
Withdrawal of Previous Filing(s)	R590-220-5(7)	An insurer must notify the department when they no longer offer a form, rate, or supplementary information.