

# 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 Annotated (U.C.A.) and those beginning with "R590" refer to department rules under Utah Administrative Code (U.A.C.). As required by U.C.A. § 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-2-309 R590-220-16	An issuer may consider some of the information filed to be privileged, proprietary, or confidential. A request shall be submitted for protection classification that complies with Section 63G-2-305 when the filing is submitted.
Filing Submission	31A-21-201 R590-220 Department Bulletin	A licensee and filer are responsible for assuring that a filing, as defined in R590-220-4(10), is in compliance with Utah laws and rules. Non-compliant filings will be rejected and not considered filed with the department.
Form Number	R590-220-7(1)(b)	Each form must be clearly identified by a unique form number, and the form number shall not be variable.
Variability	R590-220-6(4)(f) R590-220-7	All variable data must be bracketed and with an explanation, either by imbedding in the form, or by a separate form identified by its own unique form number and edition date. Changes to the variable data must be refiled prior to use. Blank spaces must be completed in John Doe fashion.

## General

Subject	Citation	Description
Age	31A-22-613	If age is used as a determining factor affecting premium or coverage it must be disclosed.
Appeal / Grievance Process	31A-22-629 R590-261	Requirements for adverse benefit determination reviews. Utah has adopted the federal claims regulations for a grievance review process. Independent review procedures are required to be disclosed to the insured.
Application	31A-21-201(3)(a)(iii) 31A-22-635 R590-247	The application must conspicuously provide the insurers exact name and domicile state. Questions and required statements must be in compliance. Use of the universal application is mandatory.
Arbitration	31A-21-313 & 314 R590-215	If included, a permissible arbitration provision shall be properly disclosed in the policy, certificate, application, and enrollment forms. It 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.
Cancellation, Renewability, and Termination	31A-22-618.6	Each policy shall include a renewal or non-renewal provision. Such provision shall be appropriately captioned, and shall appear on the first page of the policy. When discontinuing or non-renewing a plan the issuer shall include the number of policyholders, covered lives affected, and identify plan(s) currently marketed with the most similar replacement.
Certificate	31A-21-311	The certificate shall contain a summary of all the benefits, exclusions and limitations, and any rights of conversion.
Claim Settlement	31A-26-301.6 R590-192	Provide fair and rapid settlement of claims and protection of claimants from unfair claims settlement practices. Interest must be paid when claim is not paid timely.
Company Name	31A-21-201, 301 & 311	The exact name of the insurer and its state of domicile must appear conspicuously in the policy, certificate, application, and any other applicable forms. Variability is not permitted.
Definitions	31A-1-301 31A-30-103 R590-167-2	Forms must comply with these definitions, the Uniform Glossary, and any others as applicable.
Discretionary Clauses	R590-218 Bulletin 2002-7	Reservation of discretion clauses are strictly prohibited unless they are associated with an ERISA plan. If the forms contain a reservation of discretion clause, the disclosure language shall be substantially similar to that found in code.
Endorsement or Rider	31A-21-106	Grandfathered and transitional plans - A contract may not be modified unless it is in writing and requires a signed acceptance by the policyholder. If additional premiums are charged for endorsement benefits, the premium shall be disclosed on the policy or certificate.  Non-Grandfathered plans may not include an endorsement and shall be embedded within the contract.
Felony, Riot, Insurrection or Illegal Activities	31A-21-201	May exclude losses resulting from an insured's voluntary participation in a felony, riot, insurrection, or similar act.

Grace Period	31A-22-607	Policies shall provide a grace period. An in-force policy cannot be terminated prior to the end of the grace period. Group policies must provide a 30 day grace period and remain in-force.
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	Policy cannot 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	No action may be brought against an insurer until the earlier of: 60 days after proof of loss, waiver by the insurer of proof of loss, or the insurer's denial of full payment, and shall commence within three years after the inception of the loss.
Limitations or Exclusions	R590-233-4	Forms shall not limit or exclude coverage or benefits except as pre-approved by the commissioner.
Nondiscrimination Among Health Care Professionals	31A-22-618	No insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions that exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice.
Notice and Proof of Loss	31A-21-312 Bulletin 87-6	Proof of loss provision must allow the insured or claimant to file the notice and/or proof of loss as soon as reasonably possible. Failure to give any notice or file any proof of loss within the time specified neither invalidates a claim nor does it bar recovery under the policy.
Notice of Termination	31A-22-716	Every policy shall include a provision that obligates the policyholder to give 30 days prior written notice to each member.
Overpayment / Payment Recovery	31A-26-301.6(14) 31A-21-108 R590-131-8.D & F	Recovery of an amount improperly paid to a provider or insured shall be in accordance with the timeframes outlined under law and pursuant to the subrogation and right of recovery provisions.
Physical Exam	31A-21-201	If an insurer requires a physical exam, the insurer must pay for such exam.
Preauthorization	31A-22-639	Preauthorization requirements shall be disclosed.
Preferred Provider Provisions	31A-22-617(2)	An issuer using preferred health care provider contracts is subject to the reimbursement requirements in Section 31A-8-501(4) and shall reimburse a non-contracting provider or the enrollee a like dollar amount it pays to its contracting providers.
Return of Premium	31A-21-302 31A-21-315	Any excess premium must be returned and does not have to be requested.

## Dependent

Subject	Citation	Description
Administrative or Court Ordered Coverage	31A-22-610.5	Coverage must be provided without regard to the enrollment season, 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	<p>If a policy provides coverage for any member of a policy or certificate holder's family, the policy shall provide coverage for:</p> <ol style="list-style-type: none"> <li>1. A newborn child from the moment of birth; and</li> <li>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 for adoption occurs 30 days or more after the child's birth.</li> </ol> <p>Placement for adoption may not be defined more restrictively than the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.</p> <p>Notification, enrollment, and additional premium, if required, shall be completed within 30 days.</p>
Dependent Eligibility	31A-22-610.5 R590-259	<p>If dependents are covered, the following apply:</p> <ul style="list-style-type: none"> <li>- dependents must be covered up to age 26</li> <li>- all dependents must be treated equally (step, court or administrative ordered, etc)</li> <li>- cannot require student status</li> <li>- cannot require residency status</li> <li>- coverage shall continue in force through the last day of the month</li> </ul>
Disabled Dependents	31A-22-611	A policy that provides coverage for dependents shall provide coverage for disabled dependents that have been continuously covered under any accident and health insurance coverage since age 26 with no break in coverage of more than 63 days. The insurer may not require proof more often than annually after the two-year period immediately following attainment of the limiting age by the dependent with a disability.

## Specific

Subject	Citation	Description

Access to Rural Healthcare	31A-8-501 R590-237	Grandfathered plans- 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.  A notice pertaining to rural health care providers must be disclosed to enrollees and advise on the rights to access.
Adoption Indemnity Benefit / Infertility Treatment	31A-22-610.1	Coverage for maternity benefits shall include an adoption indemnity benefit. The adoption indemnity benefit may be used for the purpose of obtaining infertility treatment.
Cancer Treatment Parity	31A-22-641	A health benefit plan that covers prescribed oral chemotherapy and intravenously administered chemotherapy shall be in parity.
Clinical Treatments	Bulletin 2013-7	A health benefit plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition. The issuer shall not limit the coverage of routine patient costs for items and services provided in connection with the trial.
Coordination of Benefits	31A-22-619 R590-131	Established order of benefit coordination. Benefits may not be reduced on the basis that an insured is eligible for other coverage, Medicare, or other government programs. Benefits may be coordinated to the extent benefits are paid. *Applies to non-indemnity products only.
Diabetes Coverage	31A-22-626 R590-200 R590-233-7	Diabetes coverage including services, supplies, and self-management training.
Emergency Services	31A-22-627	Definition of "Emergency Medical Condition" and coverage requirements.
Essential Health Benefit (EHB)	31A-2-212 R590-266	Health care service categories included in non-grandfathered health benefit plans. Pediatric dental benefits may be offered in a Stand Alone Dental Plan (SADP)
Grandfather Plan Disclosure	45 CFR 147.140	To maintain grandfathered status, a statement must be included asserting grandfathered status within the meaning of section 1251 of the Patient Protection and Affordable Care Act.
Inborn Metabolic Errors	31A-22-623 R590-194	Coverage of inborn errors of amino acid or urea cycle metabolism.
Mastectomy Coverage	31A-22-630 31A-22-719	Mastectomy coverage must include coverage for reconstruction, prostheses, etc.; continued eligibility must not be prejudiced.
Maternity Minimum Stay	31A-22-610.2	If maternity is included, coverage may not be limited to less than 48 hours for normal delivery, and 96 hours for caesarean section delivery for both mother & newborn.
Mental Health / Substance abuse	31A-22-625 45 CFR 146.136 45 CFR 147.160	Plans offering mental health and / or substance abuse benefits shall comply with minimum standards and parity, where applicable.
Mini-COBRA	31A-22-722	Applicable to groups that do not have COBRA rights. Allows extension of benefits under the group policy for twelve months.
Preexisting Conditions	31A-1-301(139) 31A-22-605.1 45 CFR 147.108 45 CFR 147.140	A preexisting condition shall not be defined more restrictively than disclosed in statute and within the outlined time frames. Limitations for preexisting shall appear as a separate statement in the form. Grandfathered plans - Cannot 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) R590-76-7 Bulletin 2015-11	Non-grandfathered plans: Cover a range of routine health services including: screenings, check-ups, and patient counseling without any cost-sharing, as outlined in 45 CFR 147.130.
Prosthetic Devices	31A-22-638	Insurer shall offer at least one health benefit plan in each market that meets the minimum requirements as outlined in code.

## Rating

Subject	Citation	Description
Composite Rating	31A-30 R590-167 Bulletin 2015-4	Issuers with composite rates shall comply with the rule or the bulletin when setting composite rates.
Rate Review Justification(RRJ)	R590-167-11(2)(a)(vii)	Grandfathered and transitional plans- A Rate Summary Worksheet (preliminary justification) is required to be completed regardless of whether the rate action meets or exceeds the "subject to review" threshold of the Rate Review Regulation. The Rate Summary Worksheet is available in the HIOS system. 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	All rate filings must contain -Utah and nationwide experience -Current rates and proposed rates -Prior rate related SERFF tracking numbers -Average annual premium per policy -Other information as required in the code
Unified Rate Review (URR)	CMS Letter to Issuer	Issuers must submit the Unified Rate Review Template (URRT) to the Department and CCIIO concurrently including changes regardless of exchange participation.

## Reporting

Subject	Citation	Description
Actuarial Certification (Annual)	R590-167-11 R590-220-10(4)	Due on or before April 1. A qualified actuary must certify to the carriers rating methods, compliance, and include all required data.
Plan of Orderly Withdrawal	31A-4-115 31A-22-618.8 R590-199	Prior to withdrawing from offering a line of insurance, a carrier must provide: -a notice of discontinuance at least 180 days prior to discontinuance to affected insureds, and -a request in writing, at least 30 working days prior to the 180 day requirement, for approval by the commissioner.
Status of Carrier	R590-167-10	Prior to marketing any health benefit plan to an individual or small employer, a carrier must submit a filing that indicates it wishes to be considered a covered carrier and in which markets.