

31A-22-605 Accident and health insurance standards.

- (1) The purposes of this section include:
 - (a) reasonable standardization and simplification of terms and coverages of individual and franchise accident and health insurance policies, including accident and health insurance contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to facilitate public understanding and comparison in purchasing;
 - (b) elimination of provisions contained in individual and franchise accident and health insurance contracts that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and
 - (c) full disclosure in the sale of individual and franchise accident and health insurance contracts.
- (2) As used in this section:
 - (a) "Direct response insurance policy" means an individual insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.
 - (b) "Medicare" is defined in Subsection 31A-22-620(1)(e).
 - (c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).
- (3) This section applies to all individual and franchise accident and health policies.
- (4) The commissioner shall adopt rules relating to the following matters:
 - (a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:
 - (i) terms of renewability;
 - (ii) initial and subsequent conditions of eligibility;
 - (iii) nonduplication of coverage provisions;
 - (iv) coverage of dependents;
 - (v) preexisting conditions;
 - (vi) termination of insurance;
 - (vii) probationary periods;
 - (viii) limitations;
 - (ix) exceptions;
 - (x) reductions;
 - (xi) elimination periods;
 - (xii) requirements for replacement;
 - (xiii) recurrent conditions;
 - (xiv) coverage of persons eligible for Medicare; and
 - (xv) definition of terms;
 - (b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:
 - (i) basic hospital expense coverage;
 - (ii) basic medical-surgical expense coverage;
 - (iii) hospital confinement indemnity coverage;
 - (iv) major medical expense coverage;
 - (v) income replacement coverage;
 - (vi) accident only coverage;
 - (vii) specified disease or specified accident coverage;
 - (viii) limited benefit health coverage; and
 - (ix) nursing home and long-term care coverage;

- (c) the content and format of the outline of coverage, in addition to that required under Subsection (6);
 - (d) the method of identification of policies and contracts based upon coverages provided; and
 - (e) rating practices.
- (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories of coverage in that subsection provided that any combination of categories meets the standards of a component category of coverage.
- (6) The commissioner may adopt rules relating to the following matters:
- (a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;
 - (b)
 - (i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare Supplement coverages;
 - (ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and certificates sold to persons eligible for Medicare; and
 - (c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery.
- (7) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (4), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline of coverage shall include:
- (a) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (4);
 - (b) a description of the principal benefits and coverage;
 - (c) a statement of the exceptions, reductions, and limitations contained in the policy;
 - (d) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;
 - (e) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and
 - (f) any other contents the commissioner prescribes.
- (8) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.
- (9) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

Amended by Chapter 78, 2005 General Session