Part 6
Accident and Health Insurance

31A-22-600 Scope of Part 6.

(1) Except where a provision's application is otherwise specifically limited, this part applies to all:
  (a) accident and health insurance contracts, including credit accident and health;
  (b) franchise;
  (c) group contracts; and
  (d) life insurance and annuity policies that directly or through a rider provide:
    (i) accident and health insurance benefits; or
    (ii) accelerated benefits where the receipt of benefits is contingent on morbidity requirements.
(2) Nothing in this part applies to or affects:
  (a) workers' compensation insurance;
  (b) reinsurance; or
  (c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance.
(3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy:
  (a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of:
    (i) terminal illness;
    (ii) medical conditions requiring extraordinary medical intervention; or
    (iii) permanent institutional confinement; and
  (b) that provides the option of a lump-sum payment for those benefits.

Amended by Chapter 252, 2021 General Session

31A-22-601 Applicability of life insurance provisions.

Sections 31A-22-412 through 31A-22-417 apply to death benefits in accident and health insurance policies.

Amended by Chapter 116, 2001 General Session

31A-22-602 Premium rates.

(1) Except as provided in Subsection 31A-22-701(4), this section does not apply to group accident and health insurance.
(2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.
(3) The commissioner shall prohibit the use of an accident and health insurance form or rates if the form or rates do not satisfy Subsection (2).

Amended by Chapter 198, 2022 General Session

31A-22-603 Persons insured under an individual accident and health policy.

A policy of individual accident and health insurance may insure only one person, except that originally or by subsequent amendment, upon the application of an adult policyholder, a policy may

insure any two or more eligible members of the policyholder's family, including spouse, dependent children, and any other person dependent upon the policyholder.

Amended by Chapter 138, 2016 General Session

31A-22-604 Reimbursement by insurers of Medicaid benefits.

(1) As used in this section, "Medicaid" means the program under Title XIX of the federal Social Security Act.

(2) Any accident and health insurer, including a group accident and health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.

(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.

(4) Title 26B, Chapter 3, Part 10, Medical Benefits Recovery, applies to reimbursement of insurers of Medicaid benefits.

Amended by Chapter 327, 2023 General Session

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) This section applies to all individual and franchise accident and health policies.

(3) The commissioner shall adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, 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 (5);
(d) the method of identification of policies and contracts based upon coverages provided; and
(e) rating practices.
(4) Nothing in Subsection (3)(b) precludes the issuance of policies that combine categories of coverage in Subsection (3)(b) provided that any combination of categories meets the standards of a component category of coverage.
(5) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, 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 insurance; and
(ii) applying the requirements of Subsection (5)(b)(i) 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.
(6) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (3), 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 (3);
(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.
(7) 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.
(8)
(a) 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.
(b) This Subsection (8) does not apply to a policy issued to an employer group.

Amended by Chapter 120, 2024 General Session

31A-22-605.1 Preexisting condition limitations.
(1) Any provision dealing with preexisting conditions shall be consistent with this section, Section 31A-22-609, and rules adopted by the commissioner.
(2) Except as provided in this section, an insurer that elects to use an application form without questions concerning the insured's health or medical treatment history shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of coverage due to a preexisting condition which is not specifically excluded from coverage.
(3)
(a) An insurer that issues a specified disease policy may not deny a claim for loss due to a preexisting condition that occurs more than six months after the effective date of coverage.
(b) A specified disease policy may impose a preexisting condition exclusion only if the exclusion relates to a preexisting condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.
(4)
(a) Except as otherwise provided in this section, a health benefit plan may impose a preexisting condition exclusion only if:
(i) the exclusion relates to a preexisting condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date from an individual licensed or similarly authorized to provide those services under state law and operating within the scope of practice authorized by state law;
(ii) the exclusion period ends no later than 12 months after the enrollment date, or in the case of a late enrollee, 18 months after the enrollment date; and
(iii) the exclusion period is reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection (4)(b).
(b)
(i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is determined by counting all the days on which the individual has one or more types of creditable coverage.
(ii) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(A) Days in a waiting period or affiliation period are not taken into account in determining whether a significant break in coverage has occurred.
(B) For an individual who elects federal COBRA continuation coverage during the second election period provided under the federal Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.
(c) A group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy.
(d)
(i) An insurer imposing a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion as part of any written application materials.
(ii) The general notice under this subsection shall include:
(A) a description of the existence and terms of any preexisting condition exclusion under the plan, including the six-month period ending on the enrollment date, the maximum preexisting condition exclusion period, and how the insurer will reduce the maximum preexisting condition exclusion period by creditable coverage;
(B) a description of the rights of individuals:
(I) to demonstrate creditable coverage, including any applicable waiting periods, through a certificate of creditable coverage or through other means; and
(II) to request a certificate of creditable coverage from a prior plan;
(C) a statement that the current plan will assist in obtaining a certificate of creditable coverage from any prior plan or issuer if necessary; and
(D) a person to contact, and an address and telephone number for the person, for obtaining additional information or assistance regarding the preexisting condition exclusion.
(e) An insurer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.
(f) This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under the plan.
(5)
(a) If a short-term limited duration health insurance policy provides for an extension or renewal of the policy, the insurer may not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the original effective date of the coverage, unless the insurer specifically and expressly excludes the preexisting condition in the terms of the policy or certificate.
(b)
(i) An insurer that includes a preexisting condition exclusion in a short-term limited duration health insurance policy in accordance with this subsection shall provide a written general notice of the preexisting condition exclusion as part of any written application materials.
(ii) A written general notice described in this subsection shall:
(A) 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 original effective date of the coverage.

Amended by Chapter 193, 2019 General Session

31A-22-605.5 Application.

(1) For purposes of this section "insurance mandate":
(a) means a mandatory obligation with respect to coverage, benefits, or the number or types of providers imposed on policies of accident and health insurance; and
(b) does not mean:
(i) an administrative rule imposing a mandatory obligation with respect to coverage, benefits, or providers unless that mandatory obligation was specifically imposed on policies of accident and health insurance by statute; or
(ii) an insurance mandate in an essential health benefits package imposed pursuant to the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and federal rules related to their implementation.
(2)
(a) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), the following shall apply to health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a):
(i) any law enacted under this title that becomes effective after January 1, 2002, which provides for an insurance mandate for policies of accident and health insurance; and
(ii) in accordance with Section 31A-22-613.5, disclosure requirements for coverage limitations.
(b) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), a health insurance mandate enacted under this title after January 1, 2012, shall apply to:
(i) health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a); and
(ii) health coverage offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b).
(c) If health coverage offered to the state employees' risk pool under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) offers coverage in the same manner and to the same extent as the coverage required by an insurance mandate enacted under this title or coverage that is greater than the insurance mandate enacted under this title, the coverage offered to state employees under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) will be considered in compliance with the insurance mandate.
(d) The programs regulated under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) shall report to the Retirement and Independent Entities Committee created under Section 63E-1-201 by November 30 of each year in which a mandate is enacted under the provisions of this section. The report shall include the costs and benefits of the particular mandatory obligation.
(3)
(a) An insurance mandate for policies of accident and health insurance enacted under this title after January 1, 2012, shall apply to a health plan offered by a public school district, a charter school, or a state funded institution of higher education that is not insured through the Public Employees' Benefit and Insurance Program.
(b) If an insurance mandate for policies of accident and health insurance is enacted under this title after January 1, 2012, the state shall determine whether each entity described in Subsections (2) and (3)(a) offers coverage in the same manner and to the same extent, or greater than the insurance coverage required in the mandate enacted after January 1, 2012.
(c) Before enacting an insurance mandate, the state shall, for each entity that does not offer coverage in accordance with Subsection (3)(b):
(i) determine the cost to the entity of implementing the insurance mandate; and
(ii) appropriate money necessary to fund the full cost to the entity of implementing the insurance mandate.

Amended by Chapter 127, 2012 General Session

31A-22-606 Policy examination period.

(1)

(a) Except as provided in Subsection (2), all accident and health policies shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder has the right to return the policy for any reason within 10 days after its delivery.

(b) "Return" means delivery to the insurer or its agent or mailing of the policy to either, properly addressed and stamped for first class handling, with a written statement on the policy or an accompanying communication that it is being returned for termination of coverage. A policy returned under this Subsection (1) is void from the beginning and a policyholder returning his policy is entitled to a refund of any premium paid.

(2) This section does not apply to:

(a) group policies;

(b) policies issued to persons entitled to a 30-day examination period under Subsection 31A-22-605(9);

(c) single premium nonrenewable policies issued for terms not longer than 60 days;

(d) policies covering accidents only or accidental bodily injury only; and

(e) other classes of policies which the commissioner by rule specifies after a finding that a right to return those policies would be impracticable or unnecessary to protect the policyholder's interests.

Amended by Chapter 78, 2005 General Session

31A-22-607 Grace period.

(1)

(a) An individual or franchise accident and health insurance policy shall contain one or more clauses providing for a grace period for premium payment only of:

(i) at least 15 days for a weekly or monthly premium policy; and

(ii) 30 days for a policy that is not a weekly or monthly premium policy, for each premium after the first premium payment.

(b) An insurer may elect to include a grace period that is longer than 15 days for a weekly or monthly policy.

(c) An individual or franchise accident and health insurance policy is not in force during a grace period.

(d) If an insurer receives payment before the day on which a grace period expires, the individual or franchise accident and health insurance policy continues in force with no gap in coverage.

(e) If an insurer does not receive payment before the day on which a grace period expires, the individual or franchise accident and health insurance policy terminates as of the last date for which the premium is paid in full.

(f) A grace period is not required if the policyholder has requested that the individual or franchise accident and health insurance policy be discontinued.

(2)

(a) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance shall provide for a grace period of at least 30 days, unless the policyholder gives written notice of discontinuance before the day on which the policy discontinues, in accordance with the policy terms.

(b) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance is in force during a grace period.
(c) If an insurer does not receive payment before the day on which a grace period expires, the group insurance policy offering accident and health insurance or blanket insurance policy offering accident and health insurance terminates as of the last day on which the grace period is in effect.
(d) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance may provide for payment of a pro rata premium for the period the policy is in effect during a grace period under this Subsection (2).
(3) If an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection (4).
(4)
(a) An insurer shall send a written renewal notice to the policyholder or, if the insurer issued the policy to an employer group, the producer:
(i) no sooner than 90 days before, and no later than 14 days before, the day on which an accident and health insurance policy renews; or
(ii) if the renewal notice includes a change in premium, at least 45 days before the day on which an accident and health insurance policy renews.
(b) The renewal notice described in Subsection (4)(a) shall clearly state:
(i) the renewal amount;
(ii) how the policyholder may pay the renewal premium, including the day on which the renewal premium is due; and
(iii) that failure of the policyholder to pay the renewal premium extinguishes the policyholder's right to renew.
(5) The extinguishment of a policyholder's right to renew for nonpayment of premium is effective no sooner than 10 days after the day on which the policyholder receives written notice that the policyholder has failed to pay the premium when due.

Amended by Chapter 252, 2021 General Session

31A-22-608 Reinstatement of individual or franchise accident and health insurance policies.
(1) Every individual or franchise accident and health insurance policy shall contain a provision which reads substantially as follows:

"REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the

reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the provision described in Subsection (1) may be omitted from any policy that the insured has the right to continue in force subject to the policy's terms by the timely payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least five years from the day on which the insurer issues the policy.

Amended by Chapter 252, 2021 General Session

31A-22-609 Incontestability for accident and health insurance.

(1)

(a) A statement made by an applicant relating to the person's insurability, except fraudulent misrepresentation, may not be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.

(b) The insurer has the burden of proving fraud by clear and convincing evidence.

(2) Except as provided under Section 31A-22-605.1, a claim for loss incurred or disability commencing after two years from the date of issue of the policy may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description in a provision that was in effect on the date of loss.

(3) Except as provided in Subsection (1)(a), a specified disease policy may not include wording that provides a defense based upon a disease or physical condition that existed prior to the effective date of coverage except as allowed under Subsection 31A-22-605.1(2).

Amended by Chapter 78, 2005 General Session

31A-22-610 Dependent coverage from moment of birth or adoption.

(1) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years old as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means 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.

(2)

(a) Except as provided in Subsection (5), if an accident and health insurance policy provides coverage for any members of the policyholder's or certificate holder's family, the policy shall provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis to:

(i) a newly born child from the moment of birth; and

(ii) an adopted child:

(A) beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth; or

(B) beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

(b) The coverage described in this Subsection (2):

(i) is not subject to any preexisting conditions; and

(ii) includes any injury or sickness, including the necessary care and treatment of medically diagnosed:
(A) congenital defects;
(B) birth abnormalities; or
(C) prematurity.
(c)
(i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an adopted child may be denied until the child is enrolled.
(ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).
(d) If the payment of a specific premium is required to provide coverage for a child of a policyholder or certificate holder, for there to be coverage for the child, the policyholder or certificate holder shall enroll:
(i) a newly born child within 30 days after the date of birth of the child; or
(ii) an adopted child within 30 days after the day of placement of adoption.
(e) If the payment of a specific premium is not required to provide coverage for a child of a policyholder or certificate holder, for the child to receive coverage the policyholder or certificate holder shall enroll a newly born child or an adopted child no later than 30 days after the first notification of denial of a claim for services for that child.
(3)
(a) The coverage required by Subsection (2) as to children placed for the purpose of adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless:
(i) the placement is disrupted prior to legal adoption; and
(ii) the child is removed from placement.
(b) The coverage required by Subsection (2) ends if the child is removed from placement prior to being legally adopted.
(4) The provisions of this section apply to employee welfare benefit plans as defined in Section 26B-3-1001.
(5) If an accident and health insurance policy that is not subject to the special enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual, the insurer may choose to:
(a) provide coverage according to this section; or
(b) allow application, subject to the insurer's underwriting criteria for:
(i) a newborn;
(ii) an adopted child; or
(iii) a child placed for adoption.

Amended by Chapter 327, 2023 General Session

31A-22-610.1 Indemnity benefit for adoption or infertility treatments.
(1)
(a)
(i) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If more

than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required.

(ii) This section does not prevent an accident and health insurer from:

(A) adjusting the benefit payable under this section for cost sharing measures imposed under the policy or contract for maternity benefit coverage; or

(B) providing additional adoption indemnity benefits including:

(I) extending the period of time after birth in which a child must be placed with an insured; or

(II) providing a benefit in excess of the amount specified in Subsection (1)(c).

(b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:

(i) the postplacement evaluation disapproves the adoption placement; and

(ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.

(c)

(i) The amount of the adoption indemnity benefit provided under Subsection (1) is $4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).

(ii) An insurer may comply with the provisions of this section by providing the $4,000 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining infertility treatments rather than seeking reimbursement for an adoption in accordance with terms designated by the insurer.

(d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:

(i) has coverage for maternity benefits with a different insurer; and

(ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).

(2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:

(a) a child is placed for adoption with the insured within 90 days of the child's birth; and

(b) the adoption is finalized within one year of the child's birth.

(3) If an insured qualifies for the adoption indemnity benefit under this section and receives services from a network provider, the network provider may only collect from the insured the amount that the contracting health care provider is entitled to receive for such services under the contract, including any applicable copayment.

Amended by Chapter 292, 2017 General Session

31A-22-610.2 Maternity stay minimum limits.

(1)

(a) If an insured has coverage for maternity benefits, the policy may not be limited to a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.

(b) If an insured has coverage for maternity benefits, the policy may not be limited to a less than 96-hour benefit for both mother and newborn with a caesarean section delivery.

(2) Subsection (1) applies to an accident and health insurer who offers maternity coverage.

Amended by Chapter 116, 2001 General Session

31A-22-610.5 Dependent coverage.

(1) As used in this section, "child" means the same as that term is defined in Section 81-6-101.

(2)

(a) Any individual or group accident and health insurance policy or managed care organization contract that provides coverage for a policyholder's or certificate holder's dependent:
(i) may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday; and
(ii) shall, upon application, provide coverage for all unmarried dependents up to age 26.
(b) The cost of coverage for unmarried dependents 19 to 26 years old shall be included in the premium on the same basis as other dependent coverage.
(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.
(d) An individual or group health insurance policy or managed care organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:
(i) if premiums are paid; and
(ii) notwithstanding Sections 31A-22-618.6 and 31A-22-618.7.

(3)
(a) When a parent is required by a court or administrative order to provide health insurance coverage for a child, an accident and health insurer may not deny enrollment of a child under the accident and health insurance plan of the child's parent on the grounds the child:
(i) was born out of wedlock and is entitled to coverage under Subsection (4);
(ii) was born out of wedlock and the custodial parent seeks enrollment for the child under the custodial parent's policy;
(iii) is not claimed as a dependent on the parent's federal tax return;
(iv) does not reside with the parent; or
(v) does not reside in the insurer's service area.
(b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area.

(4) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:
(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;
(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
(c) make payments on claims submitted in accordance with Subsection (4)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.

(5) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:
(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;
(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Secs. 651 through 669, the child support enforcement program; and
(c)
(i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:

(A) the court or administrative order is no longer in effect; or
(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.

(6) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.

(7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.

(8) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:
(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;
(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;
(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:
(i) the court order is no longer in effect;
(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or
(iii) the employer has eliminated family health coverage for all of its employees; and
(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(9) An order issued under Section 26B-9-225 may be considered a "qualified medical support order" for the purpose of enrolling a child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(10) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:
(a) the parent continues to be eligible for coverage;
(b) the child shall be identified to the insurer with adequate information to comply with this section; and
(c) the premium shall be paid when due.

(11) This section applies to employee welfare benefit plans as defined in Section 26B-3-1001.

(12)
(a) A policy that provides coverage to a child of a group member may not deny eligibility for coverage to a child solely because:
(i) the child does not reside with the insured; or
(ii) the child is solely dependent on a former spouse of the insured rather than on the insured.
(b) A child who does not reside with the insured may be excluded on the same basis as a child who resides with the insured.

Amended by Chapter 366, 2024 General Session

31A-22-610.6 Special enrollment for individuals receiving premium assistance.

(1) As used in this section:
(a) "Premium assistance" means assistance under Title 26B, Chapter 3, Health Care - Administration and Assistance, in the payment of premium.
(b) "Qualified beneficiary" means an individual who is approved to receive premium assistance.
(2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:
(a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or
(b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.
(3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives initial written notification, after July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.
(4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.
(5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.
(6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.
(7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:
(a) is allowed under the Health Insurance Portability and Accountability Act; and
(b) is not longer than 12 months.

Amended by Chapter 327, 2023 General Session

31A-22-611 Coverage for children with a disability.

(1) For the purposes of this section:
(a) "Dependent with a disability" means a child who is and continues to be both:
(i) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and
(ii) chiefly dependent upon an insured for support and maintenance since the child reached the age specified in Subsection 31A-22-610.5(2).
(b) "Mental impairment" means a mental or psychological disorder such as:
(i) an intellectual disability;
(ii) organic brain syndrome;
(iii) emotional or mental illness; or
(iv) specific learning disabilities as determined by the insurer.
(c) "Physical impairment" means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems:

(i) neurological;
(ii) musculoskeletal;
(iii) special sense organs;
(iv) respiratory organs;
(v) speech organs;
(vi) cardiovascular;
(vii) reproductive;
(viii) digestive;
(ix) genito-urinary;
(x) hemic and lymphatic;
(xi) skin; or
(xii) endocrine.

(2) The insurer may require proof of the impairment and dependency be furnished by the person insured under the policy within 30 days of the effective date or the date the child attains the age specified in Subsection 31A-22-610.5(2), and at any time thereafter, except that 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.

(3) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall, upon application, provide coverage for all unmarried dependents with a disability who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age specified in Subsection 31A-22-610.5(2).

(4) Every accident and health insurance policy or contract that provides coverage of a dependent with a disability may not terminate the policy due to an age limitation.

Amended by Chapter 193, 2019 General Session

31A-22-612 Conversion privileges for insured former spouse.

(1) An accident and health insurance policy, that in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce, legal separation, or annulment between the parties.

(2) Every policy that contains the type of provision described in Subsection (1) shall provide that:

(a) upon the entry of the divorce decree the spouse is entitled to have issued an individual policy offering accident and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium; and

(b) the individual policy described in Subsection (2)(a) shall:

(i) provide the coverage that is most nearly similar to the terminated coverage; and

(ii) consider a probationary or waiting period satisfied to the extent the coverage was in force under the prior policy.

(3)

(a) When an insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid.

(b) The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided.
(c) If a spouse applies and tenders the first monthly premium to the insurer within 30 days after the day on which the spouse receives the notice provided by this Subsection (3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.
(4) This section does not apply to:
(a) a blanket insurance policy offering accident and health insurance; or
(b) a health benefit plan.

Amended by Chapter 252, 2021 General Session

31A-22-613 Permitted provisions for accident and health insurance policies.

The following provisions may be contained in an accident and health insurance policy, but if they are in that policy, they shall conform to at least the minimum requirements for the policyholder in this section.
(1) Any provision respecting change of occupation may provide only for a lower maximum benefit payment and for reduction of loss payments proportionate to the change in appropriate premium rates, if the change is to a higher rated occupation, and this provision shall provide for retroactive reduction of premium rates from the date of change of occupation or the last policy anniversary date, whichever is the more recent, if the change is to a lower rated occupation.
(2) Section 31A-22-405 applies to misstatement of age in accident and health policies, with the appropriate modifications of terminology.
(3) Any policy which contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy is not effective, and if that date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after that date, the coverage provided by the policy continues in force, subject to any right of cancellation, until the end of the period for which the premium was accepted. This Subsection (3) does not apply if the acceptance of premium would not have occurred but for a misstatement of age by the insured.
(4)
(a) If an insured is otherwise eligible for maternity benefits, a policy may not contain language which requires an insured to obtain any additional preauthorization or preapproval for customary and reasonable maternity care expenses or for the delivery of the child after an initial preauthorization or preapproval has been obtained from the insurer for prenatal care. A requirement for notice of admission for delivery is not a requirement for preauthorization or preapproval, however, the maternity benefit may not be denied or diminished for failure to provide admission notice. The policy may not require the provision of admission notice by only the insured patient.
(b) This Subsection (4) does not prohibit an insurer from:
(i) requiring a referral before maternity care can be obtained;
(ii) specifying a group of providers or a particular location from which an insured is required to obtain maternity care; or
(iii) limiting reimbursement for maternity expenses and benefits in accordance with the terms and conditions of the insurance contract so long as such terms do not conflict with Subsection (4)(a).
(5)

(a) An insurer may only represent that a policy offers a vision benefit if the policy provides reimbursement for materials or services provided under the policy.
(b) An insurer may only represent that a policy covers laser vision correction, whether photorefractive keratectomy, laser assisted in-situ keratomelusis, or related procedure, if the procedure is at least a partially covered benefit.
(6) If a policy excludes coverage for the diagnosis and treatment of autism spectrum disorders, the insurer may not deny a claim for a procedure or service that is otherwise covered in the accident and health insurance policy unless the autism spectrum disorder is the primary diagnosis or reason for the service or procedure in the particular claim.

Amended by Chapter 279, 2012 General Session

31A-22-613.5 Price and value comparisons of health insurance.
(1)
(a) This section applies to all health benefit plans.
(b) Subsection (2) applies to:
(i) all health benefit plans; and
(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).
(2) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to provide to all enrollees, before enrollment in the health benefit plan, written disclosure of:
(a) restrictions or limitations on prescription drugs and biologics, including:
(i) the use of a formulary;
(ii) co-payments and deductibles for prescription drugs; and
(iii) requirements for generic substitution;
(b) coverage limits under the plan;
(c) any limitation or exclusion of coverage, including:
(i) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and
(ii) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition;
(d)
(i)
(A) each drug, device, and covered service that is subject to a preauthorization requirement as defined in Section 31A-22-650; or
(B) if listing each device or covered service in accordance with Subsection (2)(d)(i)(A) is too numerous to list separately, all devices or covered services in a particular category where all devices or covered services have the same preauthorization requirement;
(ii) each requirement for authorization as defined in Section 31A-22-650 for:
(A) each drug, device, or covered service described in Subsection (2)(d)(i)(A); and
(B) each category of devices or covered services described in Subsection (2)(d)(i)(B); and
(iii) sufficient information to allow a network provider or enrollee to submit all of the information to the insurer necessary to meet each requirement for authorization described in Subsection (2)(d)(ii);
(e) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits; and

(f) whether the insurer provides coverage for telehealth services in accordance with Section 26B-3-123 and terms associated with that coverage.

(3) An insurer shall provide the disclosure required by Subsection (2) in writing to the commissioner:

(a) upon commencement of operations in the state; and

(b) anytime the insurer amends any of the following described in Subsection (2):

(i) treatment policies;

(ii) practice standards;

(iii) restrictions;

(iv) coverage limits of the insurer's health benefit plan or health insurance policy; or

(v) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.

(4)

(a) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a):

(i) either:

(A) in writing; or

(B) on the insurer's website; and

(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.

(b) If under Subsection (2)(a) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:

(i) the drugs included;

(ii) the patented drugs not included;

(iii) any conditions that exist as a precedent to coverage; and

(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

(c) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(c).

(5) Examples of a limitation or exclusion of coverage provided under this section or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(6) An insurer shall:

(a) post the information described in Subsection (2)(d) on the insurer's website and provider portal;

(b) if requested by an enrollee, provide the enrollee with the information required by this section by mail or email; and

(c) if requested by a network provider for a specific drug, device, or covered service, provide the network provider with the information described in Subsection (2)(d) for the drug, device, or covered service by mail or email.

Amended by Chapter 327, 2023 General Session

31A-22-614 Claims under accident and health policies.

(1) Section 31A-21-312 applies generally to claims under accident and health policies.

(2)

(a) Subject to Subsection (1), an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured, or an insured's network provider,

than one which requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given.

(b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to have a disability, unless the insured is legally incapacitated. The insured's, or the insured's network provider's, delay in giving that notice does not impair the insured's, the insured's network provider's, or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given.

(3) An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured, or the insured's network provider, than a provision requiring written proof of loss, delivered to the insurer, within the following time:

(a) for a claim where periodic payments are contingent upon continuing loss, within 120 days after the termination of the period for which the insurer is liable; or

(b) for any other claim, within 120 days after the date of the loss.

(4)

(a)

(i) Section 31A-26-301 applies generally to the payment of claims.

(ii) Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate.

(b) Reasonable facility of payment clauses, specified by the commissioner by rule or in approving the policy form, are permitted. Payment made in good faith and in accordance with those clauses discharges the insurer's obligation to pay those claims.

(c) All or a portion of any indemnities provided under an accident and health policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services.

Amended by Chapter 120, 2024 General Session

31A-22-614.5 Uniform claims processing -- Electronic exchange of health information.

(1)

(a) Except as provided in Subsection (1)(c), an insurer offering health insurance shall use a uniform claim form and uniform billing and claim codes.

(b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans, shall provide for the electronic exchange of uniform:

(i) eligibility and coverage information; and

(ii) coordination of benefits information.

(c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or certificate that provides benefits solely for:

(i) income replacement; or

(ii) long-term care.

(2)

(a) The uniform electronic standards and information required in Subsection (1) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) When adopting rules under this section the commissioner:

(i) shall:
(A) consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to develop the standards for the use and electronic exchange of uniform:
(I) claim forms;
(II) billing and claim codes;
(III) insurance eligibility and coverage information; and
(IV) coordination of benefits information; and
(B) meet federal mandatory minimum standards following the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act;
(ii) may not require an insurer or administrator to use a specific software product or vendor; and
(iii) may require an insurer who participates in the all payer database created under Section 26B-8-504 to allow data regarding demographic and insurance coverage information to be electronically shared with the state's designated secure health information master person index to be used:
(A) in compliance with data security standards established by:
(I) the federal Health Insurance Portability and Accountability Act; and
(II) the electronic commerce agreements established in a business associate agreement; and
(B) for the purpose of coordination of health benefit plans.

(3)
(a) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health and Human Services for the implementation of the standards for the electronic exchange of clinical health information under Section 26B-8-411. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health and Human Services is given the opportunity to comment on proposed rules.
(b)
(i) The commissioner may provide information to health care providers regarding resources available to a health care provider to verify whether a health care provider's practice management software system meets the uniform electronic standards for data exchange required by this section.
(ii) The commissioner may provide the information described in Subsection (3)(b)(i) by partnering with:
(A) a not-for-profit, broad based coalition of state health care insurers and health care providers who are involved in the electronic exchange of the data required by this section; or
(B) some other person that the commissioner determines is appropriate to provide the information described in Subsection (3)(b)(i).
(c) The commissioner shall regulate any fees charged by insurers to the providers for:
(i) uniform claim forms;
(ii) electronic billing; or
(iii) the electronic exchange of clinical health information permitted by Section 26B-8-411.
(4) This section does not require a person to provide information concerning an employer self-insured employee welfare benefit plan as defined in 29 U.S.C. Sec. 1002(1).

Amended by Chapter 328, 2023 General Session

31A-22-614.7 Uniform claims processing -- Electronic exchange of prescription drug pre-authorization.

The commissioner shall consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to study and review:

(1) the process of prior authorization of prescription drugs; and

(2) the standards for the use and electronic exchange of a uniform prescription drug prior authorization form that meet federal mandatory minimum standards and follow the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act.

Amended by Chapter 18, 2017 General Session

31A-22-618 Nondiscrimination among health care professionals.

(1) Except as provided under Section 31A-45-303 and Subsection (2), and except as to insurers licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which 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 and the illness, injury, or condition falls within the coverage of the contract. Upon the written request of an insured alleging an insurer has violated this section, the commissioner shall hold a hearing to determine if the violation exists. The commissioner may consolidate two or more related alleged violations into a single hearing.

(2) Coverage for licensed providers for behavioral analysis may be limited by an insurer in accordance with Section 58-61-714. Nothing in this section prohibits an insurer from electing to provide coverage for other licensed professionals whose scope of practice includes behavior analysis.

Amended by Chapter 136, 2019 General Session

31A-22-618.5 Coverage of insurance mandates imposed after January 1, 2009.

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

(B) except as provided in Subsection (2)(b)(ii), basic health care services as defined in Section 31A-8-101; or

(C) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:
(a) may offer a health benefit plan that is not subject to Section 31A-22-618 and Subsection 31A-45-303(3)(b)(iii);
(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and
(c) is not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.
(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).
(5)
(a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.
(b) Any difference in price between a health benefit plan offered under Subsection (3)(a) shall be based on actuarially sound data.
(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Amended by Chapter 292, 2017 General Session

31A-22-618.6 Discontinuance, nonrenewal, or changes to group health benefit plans.
(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:
(a) with respect to all eligible employees and dependents; and
(b) at the option of the plan sponsor.
(2) A group health benefit plan for a plan sponsor may be discontinued or nonrenewed:
(a) for noncompliance with the insurer's employer contribution requirements;
(b) if there is no longer any enrollee under the group health benefit plan who lives, resides, or works in:
(i) the service area of the insurer; or
(ii) the area for which the insurer is authorized to do business;
(c) for coverage made available in the small or large employer market only through an association, if:
(i) the employer's membership in the association ceases; and
(ii) the coverage is discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered individual; or
(d) for noncompliance with the insurer's minimum employee participation requirements, except as provided in Subsection (3).
(3) If a small employer no longer employs at least one eligible employee, a carrier may not discontinue or not renew the group health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least one eligible employee.
(4)
(a) A small employer that, after purchasing a group health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the group health benefit plan purchased in the small group market.
(b) A large employer that, after purchasing a group health benefit plan in the large group market, employs on average fewer than 51 eligible employees on each business day in a calendar

year may continue to renew the group health benefit plan purchased in the large group market.

(5) A health benefit plan for a plan sponsor may be discontinued or nonrenewed if:

(a) a condition described in Subsection (2) exists;

(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;

(c) the plan sponsor:

(i) performs an act or practice that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular group health benefit plan delivered or issued for delivery in this state;

(ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee, at least 90 days before the day on which the coverage discontinues;

(iii) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee;

(iv) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other group health benefit plans currently being offered by the insurer in the market or, in the case of a large employer, any other group health benefit plans currently being offered in that market; and

(v) in exercising the option to discontinue the group health benefit plan and in offering the option of coverage in this section, acts uniformly without regard to the claims experience of a plan sponsor, any health status-related factor relating to any covered participant or beneficiary, or any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue offering all of the insurer's group health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets;

(ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee at least 180 days before the day on which the coverage discontinues;

(iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected insured individual is known to reside and, at least 30 working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee;

(iv) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i) ; and

(v)

(A) provides a plan of orderly withdrawal as required by Section 31A-4-115; or

(B) places the plan with an affiliate of the insurer with a plan of the same or similar coverage.

(6)

(a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.
(b) An eligible employee whose coverage is discontinued under Subsection (6)(a) may reenroll:
(i) 12 months after the day on which the employee's coverage discontinues; and
(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.
(c) At the time the eligible employee's coverage discontinues under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll as described in Subsection (6)(b).
(d) An eligible employee's coverage may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.
(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:
(a) with respect to coverage provided to an employer member of the association; and
(b) if the group health benefit plan is made available by an insurer in the employer market only through:
(i) an association;
(ii) a trust; or
(iii) a discretionary group.
(8) An insurer may modify a group health benefit plan for a plan sponsor only:
(a) at the time of coverage renewal; and
(b) if the modification is effective uniformly among all plans.

Amended by Chapter 198, 2022 General Session

31A-22-618.7 Discontinuance, nonrenewal, and modification for individual health benefit plans.

(1)
(a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:
(i) with respect to all enrollees or dependents; and
(ii) at the option of the enrollee.
(b) Subsection (1)(a) applies regardless of:
(i) whether the contract is issued through:
(A) a trust;
(B) an association;
(C) a discretionary group; or
(D) other similar grouping; or
(ii) the situs of delivery of the policy or contract.
(2) An individual health benefit plan may be discontinued or nonrenewed:
(a) if:
(i) there is no longer an enrollee under the individual health benefit plan who lives, resides, or works in:
(A) the service area of the insurer; or
(B) the area for which the insurer is authorized to do business; and
(ii) coverage is discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee; or
(b) for coverage made available through an association, if:
(i) the enrollee's membership in the association ceases; and

(ii) the coverage is discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee.

(3) An individual health benefit plan may be discontinued or nonrenewed if:

(a) a condition described in Subsection (2) exists;

(b) the enrollee fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the enrollee:

(i) performs an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular individual health benefit plan delivered or issued for delivery in this state; and

(ii)

(A) provides notice of the discontinuation in writing to each enrollee provided coverage at least 90 days before the day on which the coverage discontinues;

(B) provides notice of the discontinuation in writing to the commissioner and, at least three working days before the day on which the notice is sent, to each affected enrollee;

(C) offers to each covered enrollee on a guaranteed issue basis the option to purchase all other individual health benefit plans currently being offered by the insurer for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue offering all of the insurer's individual health benefit plans in the individual market;

(ii) provides notice of the discontinuation in writing to each enrollee provided coverage at least 180 days before the day on which the coverage discontinues;

(iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected enrollee is known to reside and, at least 30 working days before the day on which the insurer sends the notice, to each affected enrollee;

(iv) discontinues and nonrenews all individual health benefit plans the insurer issues or delivers for issuance in the individual market;

(v) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage; and

(vi)

(A) provides a plan of orderly withdrawal in accordance with Section 31A-4-115; or

(B) places the plan with an affiliate of the insurer with a plan of the same or similar coverage.

(4) An insurer may modify an individual health benefit plan only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all individual health benefit plans.

Amended by Chapter 198, 2022 General Session

31A-22-618.8 Discontinuance and nonrenewal limitations for health benefit plans.

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsection 31A-22-618.6(5)(e) or 31A-22-618.7(3)(e) is prohibited from writing new business:

(a) in the market in this state for which the insurer discontinues or does not renew; and

(b) for a period of five years beginning on the day on which the last coverage that is discontinued.
(2) If an insurer is doing business in one established geographic service area of the state, Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) apply only to the insurer's operations in that service area.
(3) The commissioner may, by rule or order, define the scope of service area.

Amended by Chapter 198, 2022 General Session

31A-22-619 Coordination of benefits.
(1) The commissioner shall:
(a) adopt rules concerning the coordination of benefits between accident and health insurance policies;
(b) publish a coordination of benefits guide;
(c) post the coordination of benefits guide on the state insurance exchange; and
(d) work with the Health Data Authority, health care provider groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims to develop standardized language regarding coordination of benefits for the purpose of including the standardized language in an insurer's explanation of benefits.
(2) Rules adopted by the commissioner under Subsection (1):
(a) may not prohibit coordination of benefits with individual accident and health insurance policies;
(b) shall apply equally to all accident and health insurance policies without regard to whether the policies are group or individual policies; and
(c) shall include standardized language regarding the coordination of benefits process that shall be included in each insurer's accident and health insurance policy.

Amended by Chapter 285, 2010 General Session

31A-22-620 Medicare Supplement Insurance Minimum Standards Act.
(1) As used in this section:
(a) "Applicant" means:
(i) in the case of an individual Medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and
(ii) in the case of a group Medicare supplement insurance policy, the proposed certificate holder.
(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy.
(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.
(d) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement insurance policies or certificates.
(e) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.
(2)
(a) Except as otherwise specifically provided, this section applies to:
(i) all Medicare supplement insurance policies delivered or issued for delivery in this state on or after the effective date of this section;

(ii) all certificates issued under group Medicare supplement insurance policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and

(iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4).

(b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations.

(c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement insurance policies or benefit plans.

(3)

(a) A Medicare supplement insurance policy or certificate in force in the state may not contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than: "A condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage."

(c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement insurance policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement insurance policies and certificates. The standards may include:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage;

(iv) probationary periods;

(v) benefit limitations, exceptions, and reductions;

(vi) elimination periods;

(vii) requirements for replacement;

(viii) recurrent conditions; and

(ix) definitions of terms.

(d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement insurance policies and certificates.

(e) The commissioner may adopt rules to conform Medicare supplement insurance policies and certificates to the requirements of federal law and regulations, including:

(i) requiring refunds or credits if the policies do not meet loss ratio requirements;

(ii) establishing a uniform methodology for calculating and reporting loss ratios;

(iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;
(v) establishing a policy for holding public hearings prior to approval of premium increases;
(vi) establishing standards for Medicare select policies and certificates; and
(vii) nondiscrimination for genetic testing or genetic information.

(f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement insurance policy or certificate.

(4) Medicare supplement insurance policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement insurance policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(5)

(a) To provide for full and fair disclosure in the sale of Medicare supplement insurance, a Medicare supplement insurance policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a).

(c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:
(i) a description of the principal benefits and coverage provided in the policy;
(ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and
(iii) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are:
(i) in the public interest; and
(ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than:
(A) a Medicare supplement insurance policy; or
(B) a disability income policy.

(e) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided concurrently with delivery of the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(f) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

(6) Notwithstanding Subsection (1), Medicare supplement insurance policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to the front page, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(7) Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement insurance advertisement intended for use in this state, whether through written or broadcast medium, to the commissioner for review.

(8) The commissioner may adopt rules to conform Medicare and Medicare supplement insurance policies and certificates to the marketing requirements of federal law and regulation.

Amended by Chapter 120, 2024 General Session

31A-22-623 Coverage of inborn metabolic errors.

(1) As used in this section:

(a) "Dietary products" means medical food or a low protein modified food product that:

(i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;

(ii) is not a natural food that is naturally low in protein; and

(iii) is used under the direction of a physician.

(b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more amino acid.

(2) The commissioner shall establish, by rule, minimum standards of coverage for dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels consistent with the major medical benefit provided under an accident and health insurance policy.

Amended by Chapter 116, 2001 General Session

31A-22-624 Primary care physician or physician assistant.

An accident and health insurance policy that requires an insured to select a primary care physician to receive optimum coverage:

(1) shall permit an insured to select a participating provider who:

(a) is an:

(i) obstetrician;

(ii) gynecologist;

(iii) pediatrician; or

(iv) physician assistant who works with a physician:

(A) providing primary care; or

(B) described in Subsections (1)(a)(i), (ii), or (iii); and

(b) is qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received;

(2) shall clearly state in literature explaining the policy the option available to insureds under Subsection (1); and

(3) may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured because the insured selected a primary care physician in accordance with Subsection (1).

Amended by Chapter 349, 2019 General Session

31A-22-625 Catastrophic coverage of mental health conditions.

(1) As used in this section:

(a)

(i) "Catastrophic mental health coverage" means coverage in a health benefit plan that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reaching a maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b)

(i) "50/50 mental health coverage" means coverage in a health benefit plan that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on:

(A) episodic limits;

(B) inpatient or outpatient service limits; or

(C) maximum out-of-pocket limits.

(c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(d)

(i) "Mental health condition" means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) a marital or family problem;

(B) a social, occupational, religious, or other social maladjustment;

(C) a conduct disorder;

(D) a chronic adjustment disorder;

(E) a psychosexual disorder;

(F) a chronic organic brain syndrome;

(G) a personality disorder;

(H) a specific developmental disorder or learning disability; or

(I) an intellectual disability.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2)

(a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between:
(i)
(A) catastrophic mental health coverage; or
(B) federally qualified mental health coverage as described in Subsection (3); and
(ii) 50/50 mental health coverage.
(b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:
(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or
(ii) coverage that excludes benefits for mental health conditions.
(c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions, choose either:
(i) coverage offered under Subsection (2)(a)(i);
(ii) 50/50 mental health coverage; or
(iii) coverage offered under Subsection (2)(b).
(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section 31A-30-106.1, for a small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3)
(a) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.
(b) An insurer shall provide in an individual or small employer health benefit plan, mental health and substance use disorder benefits in compliance with Sections 2705 and 2711 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(4)
(a) An insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.
(b)
(i) Notwithstanding any other provision of this title, an insurer may:
(A) establish a closed panel of providers for catastrophic mental health coverage; and
(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:
(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and
(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.
(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.
(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be rendered:
(i) by a mental health therapist as defined in Section 58-60-102; or
(ii) in a health care facility:
(A) licensed or otherwise authorized to provide mental health services pursuant to:
(I) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or
(II) Title 26B, Chapter 2, Part 1, Human Services Programs and Facilities; and
(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.
(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.
(6) The commissioner may adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section.

Amended by Chapter 328, 2023 General Session

31A-22-626 Coverage of diabetes.
(1) As used in this section:
(a) "Diabetes" includes individuals with:
(i) complete insulin deficiency or type 1 diabetes;
(ii) insulin resistant with partial insulin deficiency or type 2 diabetes; or
(iii) elevated blood glucose levels induced by pregnancy or gestational diabetes.
(b) "High deductible health plan" means the same as that term is defined in Section 223(c)(2), Internal Revenue Code.
(c) "Lowest tier" means:
(i) the lowest cost tier of a health benefit plan;
(ii) the lowest cost-sharing level of a high deductible health plan that preserves the enrollee's ability to claim tax exempt contributions from the enrollee's health savings account under federal laws and regulations; or
(iii) a discount or other cost-savings program that has the effect of equating cost-sharing of insulin to the health plan's lowest-cost tier.
(d) "Therapy category" means a type of insulin that is distinct from other types of insulin due to a difference in onset, peak time, or duration.
(2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes for accident and health insurance policies that provide a health insurance benefit before July 1, 2000.
(3) In making rules under Subsection (2), the commissioner shall require rules:
(a) with durational limits, amount limits, deductibles, and coinsurance for the treatment of diabetes equitable or identical to coverage provided for the treatment of other illnesses or diseases; and
(b) that provide coverage for:
(i) diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by an attending physician within the plan and consistent with the health plan provisions for self-management education:
(A) recognized by the federal Centers for Medicare and Medicaid Services; or
(B) certified by the Department of Health; and

(ii) the following equipment, supplies, and appliances to treat diabetes when medically necessary:
(A) blood glucose monitors, including those for the legally blind;
(B) test strips for blood glucose monitors;
(C) visual reading urine and ketone strips;
(D) lancets and lancet devices;
(E) insulin;
(F) injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems;
(G) syringes;
(H) prescriptive oral agents for controlling blood glucose levels; and
(I) glucagon kits.

(4) If a health benefit plan entered into or renewed on or after January 1, 2021, provides coverage for insulin for diabetes, the health benefit plan shall:
(a) cap the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $30 per prescription of a 30-day supply of insulin for the treatment of diabetes; and
(b) apply the cap to an insured regardless of whether the insured has met the plan's deductible.

(5) Subsection (4) does not apply to a health benefit plan that:
(a) covers at least one insulin for the treatment of diabetes in each therapy category under the lowest tier of drugs; and
(b) does not require cost-sharing other than a co-payment of an insured before the plan will cover insulin at the lowest tier.

(6) Subsection (4) does not apply to a health benefit plan that:
(a) guarantees an insured that the insured will not pay more out-of-pocket for insulin the insured obtains through the health benefit plan than the insured would pay to obtain insulin through the discount program described in Section 49-20-421; and
(b) caps the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $100 per prescription of a 30-day supply of insulin for the treatment of diabetes.

(7) A health benefit plan that provides coverage for insulin may condition the coverage of insulin at a cost-sharing method described in Subsection (4), (5), or (6) on:
(a) the insured's participation in wellness-related activities for diabetes;
(b) purchasing the insulin at an in-network pharmacy; or
(c) choosing an insulin from the lowest tier of the health benefit plan's formulary.

(8) The department may issue a waiver from the requirements described in Subsection (4) to a health benefit plan if the health benefit plan can demonstrate to the department that the plan provides an insured with substantially similar consumer cost reductions to those that result from Subsections (4) and (5).

(9) The department shall annually adjust the caps described in Subsections (4)(a) and (6)(b) for inflation based on an index that reflects the change in the previous year in the average wholesale price of insulin sold in Utah.

(10) The department shall annually provide the price of insulin available under the discount program described in Section 49-20-421 to a health benefit plan that adopts the cost-sharing method described in Subsection (6).

(11) A health benefit plan entered into or renewed on or after January 1, 2021, that provides coverage of insulin is not required to reimburse a participant, as that term is defined in

Subsection 49-20-421(1), for insulin the participant obtains through the discount program described in Section 49-20-421.

(12) The department may request information from insurers to monitor the impact of the requirements of this section on insulin prices charged by pharmaceutical manufacturers.

(13) The department shall classify records provided in response to the request described in Subsection (12) as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

(14) The department may not publish information submitted in response to the request described in Subsection (12) in a manner that:

(a) makes a specific submission from a contracting insurer identifiable; or

(b) discloses information that is a trade secret, as defined in Section 13-24-2.

Amended by Chapter 310, 2020 General Session

31A-22-627 Coverage of emergency medical services.

(1) A health insurance policy or managed care organization contract:

(a) shall provide coverage of emergency services; and

(b) may not:

(i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized;

(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured; or

(iii) impose any cost-sharing requirement for out-of-network that exceeds the cost-sharing requirement imposed for in-network.

(2)

(a) A health insurance policy or managed care organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized.

(b) If authorization described in Subsection (2)(a) is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section:

(a) "Hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.

(b) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

(4) Nothing in this section may be construed as:

(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or

(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

(5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:

(a) work with the insurer to improve the insurer's compliance with this section; or

(b) impose the following fines:

(i) not more than $5,000; or

(ii) twice the amount of any profit gained from violations of this section.

Amended by Chapter 198, 2022 General Session

31A-22-628 Standing referral to a specialist.

(1) With respect to a health insurance policy or managed care organization contract that does not allow an insured to have direct access to a health care specialist, the insurer shall establish and implement a procedure by which an insured may obtain a standing referral to a health care specialist.

(2) The procedure established under Subsection (1):

(a) shall provide for a standing referral to a specialist if the insured's primary care provider determines, in consultation with the specialist, that the insured needs continuing care from the specialist; and

(b) may require the insurer's approval of a treatment plan designed by the specialist, in consultation with the primary care provider and the insured, which may include:

(i) a limit on the number of visits to the specialist;

(ii) a time limit on the duration of the referral; and

(iii) mandatory updates on the insured's condition.

Amended by Chapter 292, 2017 General Session

31A-22-629 Adverse benefit determination review process.

(1) As used in this section:

(a)

(i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the commissioner;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Independent review organization" means a person, subject to Subsection (6), who conducts an independent external review of adverse determinations.

(d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.
(e) "Insurer" is as defined in Section 31A-1-301 and includes:
(i) a health maintenance organization; and
(ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.
(f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.
(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.
(3)
(a) An insured may submit an adverse benefit determination to the insurer.
(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.
(c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:
(i) payment of a claim regarding medical necessity; or
(ii) denial of a claim regarding medical necessity.
(4) The commissioner shall adopt rules that establish minimum standards for:
(a) internal reviews;
(b) independent reviews to ensure independence and impartiality;
(c) the types of adverse benefit determinations that may be submitted to an independent review; and
(d) the timing of the review process, including an expedited review when medically necessary.
(5) Nothing in this section may be construed as:
(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;
(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;
(c) restricting the use of arbitration in connection with or subsequent to an independent review; or
(d) altering the legal rights of any party to seek court or other redress in connection with:
(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the insured related to the action and court costs; or
(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.
(6)
(a) An independent review organization in relation to the insurer may not be:
(i) the insurer;
(ii) the health plan;
(iii) the health plan's fiduciary;
(iv) the employer; or
(v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).
(b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:
(i) the health plan;
(ii) an officer, director, or management employee of the health plan;
(iii) the enrollee;
(iv) the enrollee's health care provider;

(v) the health care provider's medical group or independent practice association;
(vi) a health care facility where service would be provided; or
(vii) the developer or manufacturer of the service that would be provided.

Amended by Chapter 319, 2018 General Session

31A-22-630 Mastectomy coverage.

(1) If an insured has coverage that provides medical and surgical benefits with respect to a mastectomy, it shall provide coverage, with consultation of the attending physician and the patient, for:
(a) reconstruction of the breast on which the mastectomy has been performed;
(b) surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance; and
(c) prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

(2)
(a) This section does not prevent an accident and health insurer from imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing measures are not greater than those imposed on any other medical condition.
(b) For purposes of this Subsection (2), cost-sharing measures include imposing a deductible or coinsurance requirement.

(3) Written notice of the availability of the coverage described in Subsection (1) shall be delivered to the participant:
(a) upon enrollment; and
(b) annually after the enrollment.

Amended by Chapter 116, 2001 General Session

31A-22-631 Policy summary or illustration.

(1)
(a) Except as provided in Subsection (1)(b), at the time a life insurance policy is delivered, a policy summary or illustration shall be delivered for the life insurance policy if:
(i) the life insurance policy includes riders or supplemental benefits, including accelerated benefits; and
(ii) receipt of benefits under the life insurance policy is contingent upon morbidity requirements.
(b) In the case of a direct response solicitation, the insurer shall deliver the policy summary or illustration at the sooner of:
(i) the applicant's request; or
(ii) at the time of policy delivery regardless of whether the applicant requests a policy summary or illustration.

(2) In addition to complying with all applicable requirements, the policy summary or illustration shall include:
(a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with other components of the policy, including deductions from death benefits and policy values;
(b) an illustration for each covered person of:
(i) the amount of benefits;
(ii) the length of benefits; and
(iii) the guaranteed lifetime benefits, if any;

(c) a disclosure of the maximum premiums for the rider or supplemental benefit;
(d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental benefit; and
(e) if applicable to the policy type:
(i) a disclosure of the effects of exercising other rights under the policy; and
(ii) guaranteed maximum lifetime benefits.

Enacted by Chapter 116, 2001 General Session

31A-22-632 Report to policy holder.
(1) An insurer shall provide the policyholder a monthly report if an accident and health rider or supplemental benefit is:
(a) funded through a life insurance vehicle by acceleration of the death benefit; and
(b) in benefit payment status.
(2) The report required by Subsection (1) shall include:
(a) any rider or supplemental benefits paid out during the month;
(b) an explanation of any changes in the policy due to rider or supplemental benefits being paid out such as:
(i) death benefits; or
(ii) cash values; and
(c) the amount of the rider or supplemental benefits existing or remaining.

Enacted by Chapter 116, 2001 General Session

31A-22-633 Exemptions from standards.
Notwithstanding the provisions of this title, any accident and health insurer or health maintenance organization may offer a choice of coverage that is less or different than is otherwise required by applicable state law if:
(1) the Department of Health and Human Services offers a choice of coverage as part of a Medicaid waiver under Title 26B, Chapter 3, Health Care - Administration and Assistance, which includes:
(a) less or different coverage than the basic coverage;
(b) less or different coverage than is otherwise required in an insurance policy or health maintenance organization contract under applicable state law; or
(c) less or different coverage than required by Subsection 31A-22-605(4)(b); and
(2) the choice of coverage offered by the carrier:
(a) is the same or similar coverage as the coverage offered by the Department of Health and Human Services under Subsection (1);
(b) is offered to the same or similar population as the coverage offered by the Department of Health and Human Services under Subsection (1); and
(c) contains an explanation for each insured of coverage exclusions and limitations.

Amended by Chapter 328, 2023 General Session

31A-22-634 Prohibition against certain use of Social Security number -- Exceptions -- Applicability of section.
(1) As used in this section:
(a) "Insurer" means:

(i) insurers governed by this part as described in Section 31A-22-600, and includes:
(A) a health maintenance organization; and
(B) a third-party administrator that is subject to this title; and
(ii) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, dental, medical, Medicare supplement, or conversion program offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
(b) "Publicly display" or "publicly post" means to intentionally communicate or otherwise make available to the general public.
(2) An insurer or its subcontractors, including a pharmacy benefit manager, may not do any of the following:
(a) publicly display or publicly post in any manner an individual's Social Security number; or
(b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.
(3) This section does not prevent the collection, use, or release of a Social Security number as required by state or federal law, or the use of a Social Security number for internal verification or administrative purposes, or the release of a Social Security number to a health care provider for claims administration purposes, or as part of the verification, eligibility, or payment process.
(4) If a federal law takes effect requiring the United States Department of Health and Human Services to establish a national unique patient health identifier program, an insurer that complies with the federal law shall be considered in compliance with this section.
(5) An insurer shall comply with the provisions of this section by July 1, 2004.
(6)
(a) An insurer may obtain an extension for compliance with the requirements of this section in accordance with Subsections (6)(b) and (c).
(b) The request for extension:
(i) shall be submitted in writing to the department prior to July 1, 2004; and
(ii) shall provide an explanation as to why the insurer cannot comply with the requirements of this section by July 1, 2004.
(c) The commissioner shall grant a request for extension:
(i) for a period of time not to exceed March 1, 2005; and
(ii) if the commissioner finds that the explanation provided under Subsection (6)(b)(ii) is a reasonable explanation.

Amended by Chapter 297, 2011 General Session

31A-22-635 Uniform application -- Uniform waiver of coverage.
(1) For purposes of this section, "insurer":
(a) is defined in Subsection 31A-22-634(1); and
(b) includes the state employee's risk pool under Section 49-20-202.
(2)
(a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.
(b) The uniform application form:
(i) may not include questions about an applicant's health history; and
(ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.
(c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions, and is limited to:
(i) information that identifies the employee;

(ii) proof of the employee's insurance coverage; and
(iii) a statement that the employee declines coverage with a particular employer group.
(3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for insurers using electronic applications.
(4)
(a) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(b) The commissioner shall regulate the fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Amended by Chapter 292, 2017 General Session

31A-22-636 Standardized health insurance information cards.
(1) As used in this section, "insurer" means:
(a) an insurer governed by this part as described in Section 31A-22-600;
(b) a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans;
(c) a third party administrator; and
(d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
(2) In accordance with Subsection (3), an insurer shall use and issue a health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in, a health benefit plan.
(3) The health benefit plan information card shall include:
(a) the covered person's name;
(b) the name of the carrier and the carrier network name;
(c) the contact information for the carrier or health benefit plan administrator;
(d) general information regarding copayments and deductibles; and
(e) an indication of whether the health benefit plan is regulated by the state.
(4)
(a) The commissioner shall work with the Department of Health and Human Services, the Health Data Authority, health care providers groups, and with state and national organizations that develop uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records.
(b) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized electronic interchange technology.
(c) After rules are adopted under Subsection (4)(a), health care providers and their licensing boards under Title 58, Occupations and Professions, and health facilities licensed under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection, shall work together to implement the adoption of card swipe technology.

Amended by Chapter 328, 2023 General Session

31A-22-637 Health care provider payment information -- Notice of admissions.
(1) For purposes of this section, "insurer" is as defined in Section 31A-22-636.

(2)
(a) An insurer shall provide its health care providers who are under contract with the insurer access to current information necessary for the health care provider to determine:
(i) the effect of procedure codes on payment or compensation before a claim is submitted for a procedure;
(ii) the plans and carrier networks that the health care provider is subject to as part of the contract with the carrier; and
(iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms under which the provider will be paid for health care services.
(b) The information required by Subsection (2)(a) may be provided through a website, and if requested by the health care provider, notice of the updated website shall be provided by the carrier.
(3)
(a) An insurer may not require a health care provider by contract, reimbursement procedure, or otherwise to notify the insurer of a hospital in-patient emergency admission within a period of time that is less than one business day of the hospital in-patient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.
(b) Subsection (3)(a) does not prohibit the applicability or administration of other contract provisions between an insurer and a health care provider that require pre-authorization for scheduled in-patient admissions.

Amended by Chapter 297, 2011 General Session

31A-22-638 Coverage for prosthetic devices.
(1) For purposes of this section:
(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck.
(b)
(i) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.
(ii) "Prosthetic device" does not include an orthotic device.
(2)
(a) Beginning January 1, 2011, an insurer, other than an insurer described in Subsection (2)(b), that provides a health benefit plan shall offer at least one plan, in each market where the insurer offers a health benefit plan, that provides coverage for benefits for prosthetics that includes:
(i) a prosthetic device;
(ii) all services and supplies necessary for the effective use of a prosthetic device, including:
(A) formulating its design;
(B) fabrication;
(C) material and component selection;
(D) measurements and fittings;
(E) static and dynamic alignments; and
(F) instructing the patient in the use of the prosthetic device;
(iii) all materials and components necessary to use the prosthetic device; and

(iv) any repair or replacement of a prosthetic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(b) Beginning January 1, 2011, an insurer that is subject to Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall offer to a covered employer at least one plan that:

(i) provides coverage for prosthetics that complies with Subsections (2)(a)(i) through (iv); and

(ii) requires an employee who elects to purchase the coverage described in Subsection (2)(b)(i) to pay an increased premium to pay the costs of obtaining that coverage.

(c) At least one of the plans with the prosthetic benefits described in Subsections (2)(a) and (b) that is offered by an insurer described in this Subsection (2) shall have a coinsurance rate, that applies to physical injury generally and to prosthetics, of 80% to be paid by the insurer and 20% to be paid by the insured, if the prosthetic benefit is obtained from a person that the insurer contracts with or approves.

(d) For policies issued on or after July 1, 2010 until July 1, 2015, an insurer is exempt from the 30% index rating restrictions in Section 31A-30-106.1, and for the first year only that coverage under this section is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds the coverage under this section.

(3) The coverage described in this section:

(a) shall, except as otherwise provided in this section, be made subject to cost-sharing provisions, including dollar limits, deductibles, copayments, and co-insurance, that are not less favorable to the insured than the cost-sharing provisions of the health benefit plan that apply to physical illness generally; and

(b) may limit coverage for the purchase, repair, or replacement of a microprocessor component for a prosthetic device to $30,000, per limb, every three years.

(4) If the coverage described in this section is provided through a managed care plan, offered under Chapter 45, Managed Care Organizations, the insured shall have access to medically necessary prosthetic clinical care, and to prosthetic devices and technology, from one or more prosthetic providers in the managed care plan's provider network.

Amended by Chapter 193, 2019 General Session

31A-22-639 Statement of preauthorization.

(1) An insurer who requires preauthorization or preapproval for coverage under accident and health insurance shall, beginning January 1, 2011, provide an enrollee with a statement of preauthorization if:

(a) the applicable CPT codes have been submitted to the insurer to determine whether a particular procedure is covered under the terms of the accident and health insurance policy;

(b) the enrollee has met the requirements for preauthorization of the procedure or encounter; and

(c) the enrollee requests a statement of preauthorization.

(2) A statement of preauthorization under Subsection (1) may be sent:

(a) by mail; or

(b) electronically.

(3) A statement of preauthorization shall include a statement that the preauthorization is:

(a) not a guarantee of payment by an insurer; and

(b) subject to the policy and contract provisions of the accident and health insurance contract.

Enacted by Chapter 204, 2010 General Session

31A-22-641 Cancer treatment parity.

(1) For purposes of this section:

(a) "Cost sharing" means the enrollee's maximum out-of-pocket costs as defined by the health benefit plan.

(b) "Health insurer" is as defined in Subsection 31A-22-634(1).

(c) "Intravenously administered chemotherapy" means a physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician, and in a hospital, medical office, or other clinical setting.

(d) "Oral chemotherapy" means a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is taken orally in the form of a tablet or capsule, and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.

(2) This section applies to health benefit plans renewed or entered into on or after October 1, 2013.

(3) A health benefit plan that covers prescribed oral chemotherapy and intravenously administered chemotherapy shall:

(a) except as provided in Subsection (3)(b), ensure that the cost sharing applied to the covered oral chemotherapy is no more restrictive than the cost sharing applied to the covered intravenously administered chemotherapy; or

(b) if the cost sharing for oral chemotherapy is more restrictive than the cost sharing for intravenous chemotherapy, the health benefit plan may not apply cost sharing for the oral chemotherapy that exceeds $300 per filled prescription.

(4)

(a) A health insurer shall not increase the cost sharing for intravenously administered chemotherapy for the purpose of achieving compliance with this section.

(b) The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to enforce the provisions of this section.

Enacted by Chapter 164, 2013 General Session

31A-22-642 Insurance coverage for autism spectrum disorder.

(1) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism spectrum disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

(i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(ii) provided or supervised by a:

(A) board certified behavior analyst; or
(B) person licensed under Title 58, Chapter 1, Division of Professional Licensing Act, whose scope of practice includes mental health services.
(d) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests:
(i) performed by a licensed physician who is board certified in neurology, psychiatry, or pediatrics and has experience diagnosing autism spectrum disorder, or a licensed psychologist with experience diagnosing autism spectrum disorder; and
(ii) necessary to diagnose whether an individual has an autism spectrum disorder.
(e) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.
(f) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
(g) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
(h) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.
(i) "Treatment for autism spectrum disorder":
(i) means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a physician or a licensed psychologist described in Subsection (1)(d) who determines the care to be medically necessary; and
(ii) includes:
(A) behavioral health treatment, provided or supervised by a person described in Subsection (1)(c)(ii);
(B) pharmacy care;
(C) psychiatric care;
(D) psychological care; and
(E) therapeutic care.
(2)
(a) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2016, and before January 1, 2020, shall provide coverage for the diagnosis and treatment of autism spectrum disorder:
(i) for a child who is at least two years old, but younger than 10 years old; and
(ii) in accordance with the requirements of this section and rules made by the commissioner.
(b) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2020, shall provide coverage for the diagnosis and treatment of autism spectrum disorder in accordance with the requirements of this section and rules made by the commissioner.
(3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to set the minimum standards of coverage for the treatment of autism spectrum disorder.
(4) Subject to Subsection (5), the rules described in Subsection (3) shall establish durational limits, amount limits, deductibles, copayments, and coinsurance for the treatment of autism spectrum disorder that are similar to, or identical to, the coverage provided for other illnesses or diseases.
(5)

(a) Coverage for behavioral health treatment for a person with an autism spectrum disorder shall cover at least 600 hours a year.
(b) Notwithstanding Subsection (5)(a), for a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2020, coverage for behavioral health treatment for a person with an autism spectrum disorder may not have a limit on the number of hours covered.
(c) Other terms and conditions in the health benefit plan that apply to other benefits covered by the health benefit plan apply to coverage required by this section.
(d) Notwithstanding Section 31A-45-303, a health benefit plan providing treatment under Subsections (5)(a) and (b) shall include in the plan's provider network both board certified behavior analysts and mental health providers qualified under Subsection (1)(c)(ii).

(6) A health care provider shall submit a treatment plan for autism spectrum disorder to the insurer within 14 business days of starting treatment for an individual. If an individual is receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once every three months. A review of treatment under this Subsection (6) may include a review of treatment goals and progress toward the treatment goals. If an insurer makes a determination to stop treatment as a result of the review of the treatment plan under this subsection, the determination of the insurer may be reviewed under Section 31A-22-629.

Amended by Chapter 415, 2022 General Session

31A-22-643 Prescription synchronization -- Copay and dispensing fee restrictions.

(1) For purposes of this section:
(a) "Copay" means the copay normally charged for a prescription drug.
(b) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).
(c) "Network pharmacy" means a pharmacy included in a health insurance plan's network of pharmacy providers.
(d) "Prescription drug" means a prescription drug, as defined in Section 58-17b-102, that is prescribed for a chronic condition.

(2) A health insurance plan may not charge an amount in excess of the copay for the dispensing of a prescription drug in a quantity less than the prescribed amount if:
(a) the pharmacy dispenses the prescription drug in accordance with the health insurer's synchronization policy; and
(b) the prescription drug is dispensed by a network pharmacy.

(3) A health insurance plan that includes a prescription drug benefit:
(a) shall implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees; and
(b) may not base the dispensing fee for an individual prescription on the quantity of the prescription drug dispensed to fill or refill the prescription unless otherwise agreed to by the plan and the contracted pharmacy at the time the individual requests synchronization.

(4) This section applies to health benefit plans renewed or entered into on or after January 1, 2015.

Enacted by Chapter 111, 2014 General Session

31A-22-644 Denial of coverage under a health benefit plan because of life expectancy or terminal condition.

(1) As used in this section:

(a) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.
(b) "Terminal condition" means an irreversible condition:
(i) caused by disease, illness, or injury; and
(ii) if:
(A) the irreversible condition will result in imminent death within a six-month period after the date the condition is diagnosed; and
(B) the application of life-sustaining treatment only prolongs the process of dying.
(2) This section applies to a health benefit plan under:
(a) this part; or
(b) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
(3) Except as provided by law, and subject to the other provisions of this section, a health benefit plan may not deny coverage for medically necessary treatment if the medically necessary treatment is:
(a) prescribed by a physician;
(b) agreed to:
(i) by a person who is:
(A) insured under the health benefit plan; and
(B) fully informed regarding the person's life expectancy or diagnosis with a terminal condition; or
(ii) if the person described in Subsection (3)(b)(i) lacks legal capacity to consent, by another person who:
(A) has legal authority to consent on behalf of the person described in Subsection (3)(b)(i); and
(B) is fully informed regarding the life expectancy or diagnosis with a terminal condition of the person described in Subsection (3)(b)(i); and
(c) denied solely because:
(i) of the life expectancy of the person described in Subsection (3)(b)(i); or
(ii) the person has been diagnosed with a terminal condition.
(4) A denial of coverage described in Subsection (3) for medically necessary treatment is a violation of this section.
(5) Whether treatment is considered to be medically necessary treatment is determined by the defined standards and policies of the health benefit plan.
(6) This section may not be interpreted to:
(a) require an insurer to offer a particular benefit or service as part of a health benefit plan; or
(b) alter the clinical policies of a health benefit plan regarding the appropriate location for services.
(7) This section does not create a new or additional private right of action.

Enacted by Chapter 375, 2015 General Session

31A-22-645 Alcohol and drug dependency treatment.
(1) An insurer offering a health benefit plan providing coverage for alcohol or drug dependency treatment may require an inpatient facility to be licensed by:
(a)
(i) the Department of Health and Human Services, under Title 26B, Chapter 2, Part 1, Human Services Programs and Facilities; or
(ii) the Department of Health and Human Services; or

(b) for an inpatient facility located outside the state, a state agency similar to one described in Subsection (1)(a).

(2) For inpatient coverage provided pursuant to Subsection (1), an insurer may require an inpatient facility to be accredited by the following:

(a) the Joint Commission; and

(b) one other nationally recognized accrediting agency.

Amended by Chapter 328, 2023 General Session

31A-22-646 Dental insurance -- Contract provision for noncovered services.

(1) For purposes of this section:

(a) "Covered services" means dental services for which reimbursement:

(i) is available or would be reimbursable under an enrollee's dental plan but for the application of one or more of the following contractual provisions:

(A) deductibles;

(B) copayments;

(C) coinsurance;

(D) waiting periods;

(E) annual or lifetime maximums;

(F) frequency limitations; or

(G) alternative benefit payments; and

(ii) is not merely nominal, for the purpose of avoiding the requirements of this section.

(b) "Dental plan"means:

(i) a health benefit plan that includes coverage for dental services; and

(ii) a policy or certificate that provides coverage solely for dental services.

(c) "Dentist" means an individual licensed under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act.

(2)

(a) This section applies to:

(i) a dental plan that is entered into or renewed on or after January 1, 2018; and

(ii) an administrator providing third-party administration services or a provider network for a dental plan.

(b) This section does not apply to a self-insured dental plan that is regulated by federal law.

(3) A contract between a dental plan and a dentist to provide covered services may not:

(a) require, directly or indirectly, that a dentist provide dental services to a covered individual at a fee set by, or a fee subject to the approval of, the dental plan unless:

(i) the dental services are covered services under the dental plan; or

(ii)

(A) the dental services are not reimbursed by the dental plan;

(B) the dental services are discounted for individuals who are part of a discount dental rates plan; and

(C) the dentist who provided the dental services has elected to participate in the discount dental rates plan; and

(b) prohibit a dentist from offering or providing noncovered dental services to a covered individual at a fee determined by the dentist and the individual who will receive the noncovered services.

Enacted by Chapter 101, 2017 General Session

31A-22-646.1 Leasing requirements for dental plans.

(1) As used in this section:

(a) "Contracting entity" means a person that enters into a direct contract with a provider for the delivery of dental services in the ordinary course of business, including a third party administrator or a dental carrier.

(b) "Dental carrier" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide a dental plan.

(c) "Dental plan" means the same as that term is defined in Section 31A-22-646.

(d)

(i) "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.

(ii) "Dental services" does not include services that a provider delivers and bills as medical expenses under a health benefit plan.

(e)

(i) "Dental service contractor" means an individual who:

(A) accepts prepayment for dental services; or

(B) for the benefit of another individual, accepts payment for providing to the individual the opportunity to receive dental services in the future.

(ii) "Dental service contractor" does not include a provider or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom the services have been pre-diagnosed.

(f)

(i) "Provider" means a person who, acting within the scope of licensure or certification, provides dental services or supplies defined by the dental plan.

(ii) "Provider" does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

(g) "Provider network contract" means a contract between a contracting entity and a provider that:

(i) specifies the rights and responsibilities of the contracting entity; and

(ii) provides for the delivery and payment of dental services to an enrollee.

(h)

(i) "Third party" means a person that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract.

(ii) "Third party" does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

(2) A contracting entity may grant a third party access to a provider network contract regarding dental services, including a provider's dental services, or a contractual discount provided under a provider network contract for dental services if:

(a) if the contracting entity is an insurer, the insurer complies with Subsection (3);

(b) the contract between the contracting entity and a person subject to the third-party access complies with Subsection (4); and

(c) the contracting entity complies with Subsection (5).

(3) An insurer shall:

(a) at the time a contract is entered into or renewed, or when there is a material modification to a contract that is relevant to third-party access to a provider network contract, allow a provider which is part of the insurer's provider network to:
(i) choose to not participate in third-party access; or
(ii) enter into a contract directly with the third party that acquired the provider network;
(b) allow a provider to opt out of lease arrangements without canceling or ending a contractual relationship with the insurer; and
(c) when initially contracting with a provider, accept a qualified provider even if a provider rejects a network lease provision.

(4) A contracting entity described in Subsection (2) shall ensure that the contract described in Subsection (2)(b) includes the following:
(a) a provision indicating the contracting entity may enter into an agreement with a third party to allow the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity;
(b) if the contracting entity is a dental carrier, a provision indicating that the provider chose to participate in third-party access at the time the provider network contract was entered into or renewed; and
(c) if the contracting entity is an insurer, a provision indicating:
(i) that the contract grants a third party access to the provider network; and
(ii) for a contract with a dental carrier, the dentist has the right to choose not to participate in third-party access.

(5) A contracting entity shall:
(a) provide a provider, in writing or electronic form, each third party in existence as of the date the contract is entered into;
(b) maintain a list of each third party in existence on the contracting entity's website that is updated at least once every 90 days;
(c) require a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken unless the transaction is an electronic transaction mandated by the Health Insurance Portability and Accountability Act;
(d) notify a third party of the termination of a provider network contract no later than 30 days after the day on which the contract terminates with the contracting entity;
(e) at least 30 days before the day on which a third party begins leasing a network provider, notify each network provider subject to the lease;
(f) make available to a participating provider, within 30 days after the day on which the provider makes a request, a copy of the provider network contract at issue in the adjudication of a claim; and
(g) maintain a list of the contracting entity's affiliates on the contracting entity's website.

(6) A third party that gains access to a contract under this section:
(a) shall comply with each term of the contract to which the third party gains access; and
(b) loses all rights to a provider's discounted rate as of the termination date of the provider network contract.

(7) A contracting entity or third party may not require a provider to perform services under a provider network contract if a third party gains access to a contract in violation of this section.

(8) This section does not apply to:
(a) a contracting entity granting access to a provider network contract to:
(i) an entity that operates in accordance with the brand licensee program of the contracting entity; or
(ii) an entity that is an affiliate of the contracting entity; and

(b) a provider network contract for dental services provided to beneficiaries of a state sponsored health program, including Medicaid and the Children's Health Insurance Program.
(9) A contract executed or renewed on or after January 1, 2022:
(a) may not waive the provisions of this section; and
(b) is null and void if the contract contains provisions that conflict with the provisions of this section or that purports to waive a requirement of this section.

Enacted by Chapter 288, 2021 General Session

31A-22-647 Insurer shared savings program.
(1) As used in this section:
(a) "Insurer" means a person who offers health care insurance, including a health maintenance organization as that term is defined in Section 31A-8-101.
(b) "PEHP" means the Public Employees' Benefit and Insurance Program created in Section 49-20-103.
(c) "Savings reward program" means a program to reward a health insurance enrollee if the enrollee receives services:
(i) covered by the enrollee's health plan; and
(ii) from a provider whose costs for services are lower than the average costs for the services.
(2) An insurer may, in accordance with Subsection (4), establish a savings reward program for a health benefit plan that is:
(a) offered by the insurer; and
(b) entered into or renewed on or after January 1, 2019.
(3) PEHP shall, in accordance with Subsection (4), establish a savings reward program for a health plan that is:
(a) offered to state employees under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act; and
(b) entered into or renewed on or after July 1, 2019.
(4) A savings reward program described in Subsection (2) or (3) may include, in accordance with federal and state law, rewards to the enrollee through:
(a) premium discounts;
(b) rebates;
(c) reduction of out-of-pocket costs; or
(d) other rewards or incentives developed by the insurer.

Enacted by Chapter 181, 2018 General Session

31A-22-648 Vision insurance -- Contract provisions.
(1) As used in this section:
(a) "Covered individual" means an individual who has insurance coverage under a vision plan.
(b) "Covered service" means a vision service that:
(i) is reimbursable under or would be reimbursable under an enrollee's vision plan, but for the application of at least one of the following contractual provisions:
(A) a deductible;
(B) a copayment;
(C) coinsurance;
(D) a waiting period;
(E) an annual or lifetime maximum;

(F) a frequency limitation; or
(G) an alternative benefit payment; and
(ii) is not merely nominal, for the purpose of avoiding the requirements of this section.
(c) "Optometrist" means an individual licensed under Title 58, Chapter 16a, Utah Optometry Practice Act.
(d) "Vendor" means a person who provides ophthalmic goods to a vision service provider.
(e) "Vision plan" means a health insurance policy or contract that provides vision coverage.
(f) "Vision service" means:
(i) professional work performed by a vision service provider; or
(ii) an opthalmic medical device, such as lenses, opthalmic frames, contact lenses, or a prosthetic device that treats a condition of the human eye or the areas surrounding the human eye.
(g) "Vision service provider" means:
(i) an optometrist; or
(ii) an individual who provides a vision service and is licensed under:
(A) Title 58, Chapter 67, Utah Medical Practice Act; or
(B) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(2)
(a) This section applies to:
(i) a vision plan that a person enters into or renews on or after January 1, 2019; and
(ii) an administrator providing third-party administration services or a provider network for a vision plan.
(b) This section does not apply to a self-insured vision plan that is regulated by federal law.
(3) A contract between a vision plan and a vision service provider to provide a covered service may not:
(a) except as provided in Subsection (4), require that a vision service provider provide a vision service to a covered individual at a fee set by, or a fee subject to the approval of, the vision plan unless the vision service is a covered service;
(b) prohibit a vision service provider from offering or providing a vision service that is not a covered service to a covered individual at a fee determined by:
(i) the vision service provider; or
(ii) the vision service provider and the covered individual; or
(c) require a vision service provider to use one or more specific vendors to replenish the vision service provider's inventory of spectacle lenses after the vision service provider dispenses the vision service provider's inventory to eligible members of the vision plan as a covered vision service.
(4)
(a) In accordance with Subsections (4)(b) and (c), a vision service provider may, in a contract with a vision plan, agree to participate in a discount program sponsored by the vision plan.
(b) A contract between a vision service provider and a vision plan to provide a covered service may not be contingent on whether the vision service provider agrees to participate in a discount program sponsored by the vision plan.
(c) Regardless of whether a vision service provider participates in a discount program sponsored by the vision plan, a vision plan shall offer equal treatment to a vision service provider under contract with the vision plan to provide a covered service, regarding:
(i) promotional treatment;
(ii) marketing benefits;
(iii) materials; and

(iv) contract terms for providing a covered service.
(5) Notwithstanding Subsection (4)(c), a vision plan may, when providing a typically-formatted list of vision service providers that accept the vision plan, identify whether a vision service provider participates in a discount program sponsored by the vision plan.

Amended by Chapter 193, 2019 General Session

31A-22-649 Coverage of telepsychiatric consultations.
(1) As used in this section:
(a) "Telehealth services" means the same as that term is defined in Section 26B-4-704.
(b) "Telepsychiatric consultation" means a consultation between a physician and a board certified psychiatrist, both of whom are licensed to engage in the practice of medicine in the state, that utilizes:
(i) the health records of the patient, provided from the patient or the referring physician;
(ii) a written, evidence-based patient questionnaire; and
(iii) telehealth services that meet industry security and privacy standards, including compliance with the:
(A) Health Insurance Portability and Accountability Act; and
(B) Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.
(2) Beginning January 1, 2019, a health benefit plan that offers coverage for mental health services shall:
(a) provide coverage for a telepsychiatric consultation during or after an initial visit between the patient and a referring in-network physician;
(b) provide coverage for a telepsychiatric consultation from an out-of-network board certified psychiatrist if a telepsychiatric consultation is not made available to a physician within seven business days after the initial request is made by the physician to an in-network provider of telepsychiatric consultations; and
(c) reimburse for the services described in Subsections (2)(a) and (b) at the equivalent in-network or out-of-network rate set by the health benefit plan after taking into account cost-sharing that may be required under the health benefit plan.
(3) A single telepsychiatric consultation includes all contacts, services, discussion, and information review required to complete an individual request from a referring physician for a patient.
(4) An insurer may satisfy the requirement to cover a telepsychiatric consultation described in Subsection (2)(a) for a patient by:
(a) providing coverage for behavioral health treatment, as defined in Section 31A-22-642, in person or using telehealth services; and
(b) ensuring that the patient receives an appointment for the behavioral health treatment in person or using telehealth services on a date that is within seven business days after the initial request is made by the in-network referring physician.
(5) A referring physician who uses a telepsychiatric consultation for a patient shall, at the time that the questionnaire described in Subsection (1)(b)(ii) is completed, notify the patient that:
(a) the referring physician plans to request a telepsychiatric consultation; and
(b) additional charges to the patient may apply.
(6)
(a) An insurer may receive a temporary waiver from the department from the requirements in this section if the insurer demonstrates to the department that the insurer is unable to provide the benefits described in this section due to logistical reasons.

(b) An insurer that receives a waiver from the department under Subsection (6)(a) is subject to the requirements of this section beginning July 1, 2019.
(7) This section does not limit an insurer from engaging in activities that ensure payment integrity or facilitate review and investigation of improper practices by health care providers.

Amended by Chapter 328, 2023 General Session

31A-22-649.5 Insurance parity for telemedicine services -- Method of technology used.
(1) As used in this section:
(a) "Mental health condition" means a mental disorder or a substance-related disorder that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.
(b) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.
(2) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market, the small group market, or the large group market shall:
(a) provide coverage for:
(i) telemedicine services that are covered by Medicare; and
(ii) treatment of a mental health condition through telemedicine services if:
(A) the health benefit plan provides coverage for the treatment of the mental health condition through in-person services; and
(B) the health benefit plan determines treatment of the mental health condition through telemedicine services meets the appropriate standard of care; and
(b) reimburse a network provider that provides the telemedicine services described in Subsection (2)(a) at a negotiated commercially reasonable rate.
(3)
(a) Notwithstanding Section 31A-45-303, a health benefit plan providing coverage under Subsection (2)(a) may not impose originating site restrictions, geographic restrictions, or distance-based restrictions.
(b) A network provider that provides the telemedicine services described in Subsection (2)(a) may utilize any synchronous audiovisual technology for the telemedicine services that is compliant with the federal Health Insurance Portability and Accountability Act of 1996.

Amended by Chapter 328, 2023 General Session

31A-22-650 Health care preauthorization requirements.
(1) As used in this section:
(a) "Adverse preauthorization determination" means a determination by an insurer that health care does not meet the preauthorization requirement for the health care.
(b) "Authorization" means a determination by an insurer that for health care with a preauthorization requirement:
(i) the proposed drug, device, or covered service meets all requirements, restrictions, limitations, and clinical criteria for authorization established by the insurer;
(ii) the drug, device, or covered service is covered by the enrollee's insurance policy; and
(iii) the insurer will provide coverage for the drug, device, or covered service subject to the provisions of the insurance policy, including any cost sharing responsibilities of the enrollee.
(c) "Device" means a prescription device as defined in Section 58-17b-102.
(d) "Drug" means the same as that term is defined in Section 58-17b-102.
(e) "Insurer" means the same as that term is defined in Section 31A-22-634.

(f) "Preauthorization requirement" means a requirement by an insurer that an enrollee obtain authorization for a drug, device, or service covered by the insurance policy, before receiving the drug, device, or service.

(2)

(a) An insurer may not modify an existing requirement for authorization unless, at least 30 days before the day on which the modification takes effect, the insurer:

(i) posts a notice of the modification on the website described in Subsection 31A-22-613.5(6)(a); and

(ii) if requested by a network provider or the network provider's representative, provides to the network provider by mail or email a written notice of modification to a particular requirement for authorization described in the request from the network provider.

(b) Subsection (2)(a) does not apply if:

(i) complying with Subsection (2)(a) would create a danger to the enrollee's health or safety; or

(ii) the modification is for a newly covered drug or device.

(c) An insurer may not revoke an authorization for a drug, device, or covered service if:

(i) the network provider submits a request for authorization for the drug, device, or covered service to the insurer;

(ii) the insurer grants the authorization requested under Subsection (2)(c)(i);

(iii) the network provider renders the drug, device, or covered service to the enrollee in accordance with the authorization and any terms and conditions of the network provider's contract with the insurer;

(iv) on the day on which the network provider renders the drug, device, or covered service to the enrollee:

(A) the enrollee is eligible for coverage under the enrollee's insurance policy; and

(B) the enrollee's condition or circumstances related to the enrollee's care have not changed;

(v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection (2)(c)(i); and

(vi) the authorization was not based on fraudulent or materially incorrect information from the network provider.

(3)

(a) An insurer that receives a request for authorization shall treat the request as a pre-service claim as defined in 29 C.F.R. Sec. 2560.503-1 and process the request in accordance with:

(i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an individual or group health insurance policy;

(ii) Subsection 31A-4-116(2); and

(iii) Section 31A-22-629.

(b) If a network provider submits a claim to an insurer that includes an unintentional error that results in a denial of the claim, the insurer shall permit the network provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time.

(c) Except as provided in Subsection (3)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.

(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:

(i) a physician and surgeon; or

(ii) a pharmacist.

(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:

(i) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or

(ii) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination.

(f) An insurer shall specify how long an authorization is valid.

(4)

(a) An insurer that removes a drug from the insurer's formulary shall:

(i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and

(ii) have a process to review and make a decision regarding an exemption requested under Subsection (4)(a)(i).

(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.

(5) Before April 1, 2021, and before April 1 of each year thereafter, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.

(6) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.

Enacted by Chapter 439, 2019 General Session

31A-22-651 Insurance coverage for assisted outpatient treatment.

(1) As used in this section, "assisted outpatient treatment" means the same as that term is defined in Section 26B-5-301.

(2) A health insurance provider may not deny an insured the benefits of the insured's policy solely because the health care that the insured receives is provided under a court order for assisted outpatient treatment, as provided in Section 26B-5-351.

Amended by Chapter 328, 2023 General Session

31A-22-652 Coverage for mental health services in schools.

(1) As used in this section, "local education agency" means:

(a) a school district;

(b) a charter school; or

(c) the Utah Schools for the Deaf and the Blind.

(2) A health benefit plan that is entered into or renewed on or after January 1, 2020, may not deny a claim for a covered mental health service solely because the mental health service is provided:

(a) at a local education agency building or facility; or
(b) by an employee or contractor of a local education agency.
(3) Nothing in this section:
(a) prohibits a health benefit plan from denying a claim:
(i) by an individual that is not a licensed health care provider;
(ii) by a health care provider practicing outside the health care provider's scope of practice;
(iii) that is submitted by a person that is not a network provider;
(iv) for a mental health service that is not medically necessary as determined by the health benefit plan; or
(v) that does not otherwise comply with the health benefit plan's policies; or
(b) requires a health benefit plan to pay a claim for a service that is:
(i) provided under an individualized education program as defined in Section 53E-4-301; or
(ii) administrative in nature to the local education agency.

Enacted by Chapter 172, 2019 General Session

31A-22-654 Study of coverage for in vitro fertilization and genetic testing -- Reporting -- Coverage requirements.

(1) As used in this section:
(a) "Qualified condition" means the same as that term is defined in Section 49-20-420.
(b) "Qualified insurer" means an insurer that provides a health benefit plan as defined in Section 31A-1-301 to more than 25,000 enrollees in the state as of December 31 of the preceding reporting year.
(c) "Qualified enrollee" means an enrollee of a qualified insurer who:
(i) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and
(ii) intends to get pregnant with a partner who is diagnosed by a physician as having a genetic trait associated with the same qualified condition as the enrollee.
(2)
(a) A qualified insurer shall submit the information described in this Subsection (2) to the department for a plan year beginning:
(i) on or after January 1, 2022, but before December 31, 2022; and
(ii) on or after January 1, 2025, but before December 31, 2025.
(b) A qualified insurer shall study whether providing the coverage for the services described in Subsections (3)(a) and (b) for qualified enrollees will result in cost savings for the qualified insurer.
(c)
(i) If a qualified insurer determines that providing the coverage described in Subsection (3) for qualified enrollees will result in cost savings for the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b), and:
(A) describe how the qualified insurer intends to provide the coverage described in Subsection (3); or
(B) submit an explanation of why the insurer will not provide the coverage described in Subsection (3).
(ii) If a qualified insurer determines that providing the coverage described in Subsection (3) will not result in cost savings to the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b).

(d) A qualified insurer shall provide the information required under this Subsection (2) to the department no later than:
(i) January 1, 2022, for a plan year beginning on or after January 1, 2022, but before December 31, 2022; and
(ii) January 1, 2025, for a plan year beginning on or after January 1, 2025, but before December 31, 2025.
(3) A qualified insurer shall consider coverage for:
(a) in vitro fertilization services for a qualified enrollee; and
(b) genetic testing of a qualified enrollee who received in vitro fertilization services under Subsection (3)(a).
(4) The department shall report the information received under Subsection (2) to the Health and Human Services Interim Committee on or before:
(a) for information submitted under Subsection (2)(a)(i), November 1, 2022; and
(b) for information submitted under Subsection (2)(a)(ii), November 1, 2025.

Amended by Chapter 252, 2021 General Session

31A-22-655 Living organ donor coverage.
(1) For the purposes of this section, "living organ donor" means an individual who has donated all or part of an organ and is not deceased.
(2) An insurer may not:
(a) deny eligibility for coverage or limit coverage of a individual under an accident and health insurance policy or contract solely due to the status of the individual as a living organ donor;
(b) preclude an individual from donating all or part of an organ as a condition of receiving or continuing to receive coverage under an accident and health insurance policy or contract; or
(c) discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of an accident and health insurance policy or contract for an individual based upon the status of the individual as a living organ donor without any additional actuarial risk.
(3) The commissioner shall make educational materials available to insurers and the public on the access of living organ donors to insurance.
(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

Enacted by Chapter 128, 2020 General Session

31A-22-656 Coverage of epinephrine auto-injector.
A health benefit plan entered into or renewed on or after July 1, 2021, that provides coverage of an epinephrine auto-injector is not required to reimburse a participant, as that term is defined in Section 49-20-421, for an epinephrine auto-injector the participant obtains through the discount program described in Section 49-20-421.

Enacted by Chapter 255, 2021 General Session

31A-22-657 Application of health insurance mandates.
(1) As used in this section:
(a) "Cost-sharing mandate" means a statutory requirement limiting a cost-sharing requirement.

(b) "Cost-sharing requirement" means a copayment, coinsurance, or deductible required by or on behalf of an enrollee in order to receive a benefit under a qualified high-deductible health plan.
(c) "Health savings account" means the same as that term is defined in 26 U.S.C. Sec. 223(d)(1).
(d) "Qualified high-deductible health plan" means a high-deductible health plan as defined in 26 U.S.C. Sec. 223(c)(2)(A) that is used in conjunction with a health savings account.
(2)
(a) Except as provided in Subsection (2)(b), if under federal law, a cost-sharing mandate would result in an enrollee becoming ineligible for a health savings account, the cost-sharing mandate applies only to the enrollee's qualified high-deductible health plan after the enrollee satisfies the enrollee's health plan deductible.
(b) Subsection (2)(a) does not apply to an item or service that is preventive care under 26 U.S.C. Sec. 223(c)(2)(C).

Amended by Chapter 139, 2023 General Session

31A-22-658 Health care provider behavioral health treatment -- Single case agreement.
(1) As used in this section:
(a) "Mental health condition" means the same as that term is defined in Section 31A-22-649.5.
(b) "Mental health provider" means:
(i) a mental health therapist, as defined in Section 58-60-102; or
(ii) an individual practicing within the scope of practice described in Title 58, Chapter 60, Part 5, Substance Use Disorder Counselor Act.
(c) "Mental health treatment" means treatment for a mental health condition.
(2)
(a) Except as provided in Subsection (3), and subject to Subsections (4) and (5), beginning January 1, 2024, a health benefit plan that offers coverage for mental health treatment shall, upon request of a health benefit plan enrollee who is employed as a health care provider, offer a single case agreement that allows the enrollee to receive covered mental health treatment from an out-of-network mental health provider selected by the enrollee.
(b) A single case agreement described in Subsection (2)(a) shall:
(i) reimburse the out-of-network mental health provider for the covered mental health treatment at the equivalent out-of-network rate set by the health benefit plan, subject to the member cost-sharing requirements imposed by the health benefit plan;
(ii) include the same coinsurance, copayments, and deductibles that would be applied for the mental health treatment if the mental health treatment was provided by a mental health provider who is a network provider;
(iii) include the terms that a network provider is subject to under the health benefit plan; and
(iv) define the length and scope of the single case agreement.
(3)
(a) Subsection (2) does not apply if:
(i)
(A) the health benefit plan has network providers for the covered mental health treatment; and
(B) the network providers described in Subsection (3)(a)(i) do not provide the covered mental health treatment in the location where the enrollee works as a health care provider; or
(ii) the enrollee selects a mental health provider for the covered mental health treatment who the health benefit plan knows or reasonably suspects has committed a fraudulent insurance act as described in Section 31A-31-103.

(b) For purposes of this Subsection (3), the location where an enrollee works as a health care provider includes all locations or facilities of the enrollee's employer.

(4) Mental health treatment provided pursuant to a single case agreement under this section:

(a) shall be:

(i) within the out-of-network mental health provider's scope of practice; and

(ii) a service that is otherwise covered under the enrollee's health benefit plan; and

(b) may not be experimental.

(5)

(a) An enrollee shall request a single case agreement under Subsection (2) prior to receiving mental health treatment from an out-of-network mental health provider.

(b) With a request for a single case agreement under Subsection (2), an enrollee shall provide information about where the enrollee works as a health care provider sufficient for the health benefit plan to determine whether the circumstances described in Subsection (3)(a)(i) exist.

Enacted by Chapter 449, 2023 General Session

31A-22-659 Provider administered drugs.

(1) As used in this section:

(a) "Clinician-administered drug" means an outpatient prescription drug as defined in Section 58-17b-102 that:

(i) cannot reasonably be self-administered by the patient to whom the drug is prescribed or by an individual assisting the patient with self-administration;

(ii) is typically administered:

(A) by a health care provider; and

(B) in a physician's office or a health care facility as defined in Section 26B-2-201; and

(iii) is not a vaccine.

(b) "Health insurer" means a person who offers health care insurance, including a health maintenance organization as defined in Section 31A-8-101.

(2) A health insurer may not require a pharmacy to dispense a clinician-administered drug directly to an enrollee with the intention that the enrollee will transport the drug to a health care provider for administering.

Enacted by Chapter 323, 2023 General Session

31A-22-660 Definitions -- Prohibitions concerning organ harvesting -- Severability.

(1) As used in this section, "forced organ harvesting" means the removal of one or more organs from a living individual, or from an individual killed for the purpose of removal of one or more of the individual's organs, by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

(2) An issuer of accident and health insurance may not cover a human organ transplant or post-transplant care if:

(a) the human organ transplant operation is performed in the People's Republic of China or any other country known to have participated in forced organ harvesting, as designated pursuant to Subsection (3); or

(b) the human organ to be transplanted was procured by sale or donation originating in the People's Republic of China or any other country known to have participated in forced organ harvesting, as designated pursuant to Subsection (3).

(3)

(a) The deputy director of the Department of Health and Human Services described in Subsection 26B-1-203(4) may designate additional countries with governments that fund, sponsor, or otherwise facilitate forced organ harvesting.
(b) If the deputy director designates an additional country under Subsection (3)(a), the deputy director shall provide written notice to the executive director of the Department of Health and Human Services and the insurance commissioner.
(4) If any provision of this section or the application of any provision of this section to any person or circumstance is held to be invalid, the remainder of this section shall be given effect without the invalid provision or application. The provisions of Section 31A-22-661 are severable.

Enacted by Chapter 273, 2024 General Session

31A-22-661 Health benefit plan procedures related to prescription drugs.
(1) As used in this section, "long-term drug" means an enrollee's prescription drug where the prescription has been active for at least 180 days with the health benefit plan.
(2)
(a) Except as provided in Subsection (2)(b), before a health benefit plan requires an enrollee to change from a prescribed long-term drug to another drug, the health benefit plan shall:
(i) at least 30 days before the day on which the health benefit plan will require the enrollee to change from the long-term drug to another drug, provide notice that the health benefit plan will require the individual to change to another drug; and
(ii) provide a justification for the change upon request.
(b) Subsection (2)(a) does not apply if:
(i) the change requires the individual to try a generic or a biosimilar of the long-term drug; or
(ii) the long-term drug is not on the health benefit plan's formulary.
(3) A health benefit plan shall provide an enrollee a justification as to why an enrollee must try a certain drug before a health benefit plan will cover a different prescribed drug.
(4) This section does not apply to a drug that is provided under the health benefit plan's medical benefit.

Enacted by Chapter 262, 2024 General Session