LEGISLATIVE GENERAL COUNSEL
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H.B. 41

HEALTH INSURANCE POLICY COVERAGE

1998 GENERAL SESSION

STATE OF UTAH

Sponsor: Peter C. Knudson

AN ACT RELATING TO INSURANCE; REQUIRING AN INSURANCE POLICY TO COVER DIAGNOSTIC AND SURGICAL PROCEDURES INVOLVING BONES OR JOINTS OF THE JAW AND FACIAL REGION TO THE SAME EXTENT AS IT COVERS DIAGNOSTIC AND SURGICAL PROCEDURES INVOLVING OTHER BONES OR JOINTS OF THE SKELETON.

This act affects sections of Utah Code Annotated 1953 as follows:

AMENDS:

31A-22-613, as last amended by Chapter 38, Laws of Utah 1996

Be it enacted by the Legislature of the state of Utah:

Section 1. Section **31A-22-613** is amended to read:

31A-22-613. Permitted provisions for disability insurance policies.

The following provisions may be contained in a disability insurance policy, but if they are in that policy, they shall conform to at least the following minimum requirements for the policyholder:

(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 disability 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 does not apply if the acceptance of premium would not have occurred but for a misstatement of age by the insured.

(4) Any provision dealing with preexisting conditions shall be consistent with Subsections 31A-22-605(9)(a) and 31A-22-609(2), and any applicable rule adopted by the commissioner.

(5) (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 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 (5)(a).

(6) A policy that provides coverage for diagnostic or surgical procedures involving bones or joints of the skeleton shall cover to the same extent, and subject to the same contract terms, diagnostic and surgical procedures involving bones or joints of the jaw and facial region if, under medically accepted standards, the procedure or surgery is medically necessary to treat conditions caused by congenital or developmental deformity, disease, or injury.

Legislative Review Note
as of 12-1-97 1:28 PM

A limited legal review of this bill raises no obvious constitutional or statutory concerns.

Office of Legislative Research and General Counsel