

**R590. Insurance, Administration. (Effective 2-22-2010)**

**R590-220. Submission of Accident and Health Insurance Filings.**

**R590-220-1. Authority.**

This rule is promulgated by the insurance commissioner pursuant to Section 31A-2-201.1 and Subsections 31A-2-201(3), 31A-2-202(2), 31A-22-605(4), 31A-22-620(3)(f), and 31A-30-106(1)(i) and (k).

**R590-220-2. Purpose and Scope.**

(1) The purpose of this rule is to set forth procedures for submitting:

(a) accident and health filings required by Section 31A-21-201;

(b) individual accident and health filings in accordance with Section 31A-22-605 and Rule R590-85;

(c) Medicare supplement filings in accordance with Sections 31A-22-605 and 31A-22-620, and Rules R590-85 and R590-146;

(d) long term care filings required by Section 31A-22-1404 and Rule R590-148;

(e) basic health care plan filings required by Section 31A-22-613.5 and Rule R590-175; and

(f) health benefit plan filings required by Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act, and Rule R590-167.

(2) This rule applies to:

(a) all types of accident and health insurance products; and

(b) group accident and health contracts issued to nonresident policyholders, including trusts, when Utah residents are provided coverage by certificates of insurance.

**R590-220-3. Documents Incorporated by Reference.**

(1) The department requires that the documents described in this rule shall be used for all filings.

(a) Actual copies may be used or you may adapt them to your word processing system.

(b) If adapted, the content, size, font, and format must be similar.

(2) The "NAIC Uniform Life, Accident and Health, Annuity, and Credit Coding Matrix," effective July 1, 2009, is hereby incorporated by reference and is available on the department's web site, [www.insurance.utah.gov](http://www.insurance.utah.gov)

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**R590-220-4. Definitions.**

In addition to the definitions in Sections 31A-1-301 and 31A-30-103, the following definitions shall apply for the purposes of this rule.

(1) "Certification" means a statement that the filing being submitted is in compliance with Utah laws and rules.

(2) "Discretionary group" means a group that has been specifically authorized by the commissioner under Subsection 31A-22-701(1)(b).

(3) "Electronic filing" means a

filing submitted via the Internet by using the System for Electronic Rate and Form Filings, SERFF.

(4) "Eligible group" means a group that meets the definition in Subsection 31A-22-701(1)(a).

(5) "File And Use" means a filing can be used, sold, or offered for sale after it has been filed with the department.

(6) "File Before Use" means a filing can be used, sold, or offered for sale after it has been filed with the department and a stated period of time has elapsed from the date filed.

(7) "File For Acceptance" means a filing can be used, sold, or offered for sale after it has been filed and the filer has received written confirmation that the filing was accepted.

(8) "File for Approval" means a filing can be used, sold, or offered for sale after it has been filed and the filer has received written confirmation that the filing was approved.

(9) "Filer" means a person who submits a filing.

(10) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate, rate manual, or rate methodologies;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement or rider;

(k) an actuarial memorandum, demonstration, and certification;

(l) a licensee annual statement;

(m) a licensee renewal application; or

(n) an advertisement.

(11) "Filing Objection Letter" means a letter issued by the commissioner when a review has determined the filing fails to comply with Utah law and rules. The filing objection letter, in addition to requiring correction of non-compliant items, may request clarification or additional information pertaining to the filing.

(12) "Filing status information" means a list of the states to which the filing was submitted, the date submitted, and the states' actions, including their responses.

(13) "Letter of authorization" means a letter signed by an officer of the licensee on whose behalf the filing is submitted that designates filing authority to the filer.

(14) "Market type" means the type of policy that indicates the targeted market such as individual or group.

(15) "Order to Prohibit Use" means an order issued by the commissioner that prohibits the use of a filing.

(16) "Rating methodology change" for the purpose of a health benefit plan means a:

(a) change in the number of case characteristics used by a covered licensee to determine premium rates for health benefit plans in a class of business;

(b) change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(c) change in the method of allocating expenses among health benefit plans in a class of business; or

(d) change in a rating factor, with respect to any case characteristic, if the change would produce a change in premium for any individual or small employer that exceeds 10%. A change in a rating factor shall mean the cumulative change with respect to such factor considered over a 12-month period. If a covered licensee changes rating factors with respect to more than one case characteristic in a 12-month period, the licensee shall consider the cumulative effect of all such changes in applying the 10% test.

(17) "Rejected" means a filing is:

(a) not submitted in accordance with Utah laws and rules;

(b) returned to the filer by the department with the reasons for rejection; and

(c) not considered filed with the department.

(18) "Type of insurance" means a specific accident and health product including dental, health benefit plan, long-term care, Medicare supplement, income replacement, specified disease, or vision.

(19) "Utah Filed Date" means the date provided to a filer by the Utah Insurance Department, that indicates a filing has been accepted.

#### **R590-220-5. General Filing Information.**

(1) Each filing submitted must be accurate, consistent, complete and contain all required documents in order for the filing to be processed in a timely and efficient manner. The commissioner may request any additional information deemed necessary.

(2) A licensee and filer are responsible for assuring that a filing is in compliance with Utah laws and rules. A filing not in compliance with Utah laws and rules is subject to regulatory action under Section 31A-2-308.

(3) A filing that does not comply with this rule will be rejected and returned to the filer. A rejected filing:

(a) is not considered filed with the department;

(b) must be submitted as a new filing; and

(c) will not be reopened for purposes of resubmission.

(4) A prior filing will not be researched to determine the purpose of the current filing.

(5) The department does not review or proofread every filing.

(a) A filing may be reviewed:

(i) when submitted;

(ii) as a result of a complaint;

(iii) during a regulatory examination or investigation; or

(iv) at any other time the department deems necessary.

(b) If a filing is reviewed and is not in compliance with Utah laws and rules, a Filing Objection Letter or an Order to

Prohibit Use will be issued to the filer. The commissioner may require the licensee to disclose deficiencies in forms or rating practices to affected insureds.

(6) Filing correction.

(a) Filing corrections are considered informational.

(b) Filing corrections must be submitted within 15 days of the date the original filing was submitted to the department. The filer shall include a description of the filing corrections.

(c) A new filing is required if a filing correction is made more than 15 days after the date the original filing was submitted to the department. The filer must reference the original filing in the filing description and include a description of the filing corrections.

(7) If responding to a Filing Objection Letter or an Order to Prohibit Use, refer to Section R590-220-16 for instructions.

(8) Filing withdrawal. A filer must notify the department when withdrawing a previously filed form, rate, or supplementary information.

#### **R590-220-6. Filing Submission Requirements.**

(1) All filings must be submitted as an electronic filing.

(2) A filing must be submitted by market type and type of insurance.

(3) A filing may not include more than one type of insurance, or request filing for more than one licensee.

(4)(a) Filing Description. Do not submit a cover letter. On the General Information tab, complete the Filing Description section with the following information, presented in the order shown below.

(i) Provide a description of the filing including:

(A) the intent of the filing; and

(B) the purpose of each document within the filing.

(ii) Indicate if the filing:

(A) is new;

(B) is replacing or modifying a previous submission; if so, describe the changes made, if previously rejected the reasons for rejection, and the previous filing's Utah Filed Date;

(C) includes documents for informational purposes; if so, provide the Utah Filed Date; or

(D) does not include the base policy; if so, provide the Utah Filed Date of the base policy and describe the effect on the base policy.

(iii) Identify if any of the provisions are unusual, controversial, or have been previously objected to, or prohibited, and explain why the provision is included in the filing.

(iv) Explain any change in benefits or premiums that may occur while the contract is in force.

(v) List the issue ages, which means the range of minimum and maximum ages for which a policy will be issued.

(b) Certification. The filer must certify that a filing has been properly completed AND is in compliance with Utah laws and rules. The Utah Accident and Health Insurance Filing Certification must be properly completed, signed, and attached to

the Supporting Documentation tab. A false certification may subject the licensee to administrative action.

(c) Domiciliary Approval and Filing Status Information. All filings for a foreign licensee must include on the Supporting Documentation tab:

- (i) copy of domicile approval for the exact same filing;
- (ii) filing status information which includes:
  - (A) a list of the states to which the filing was submitted;
  - (B) the date submitted; and
  - (C) summary of the states' actions and their responses; or
- (iii) if the filing is specific to Utah and only filed in Utah, then state, "UTAH SPECIFIC - NOT SUBMITTED TO ANY OTHER STATE."

(d) Group Questionnaire or Discretionary Group Authorization Letter. A group filing must attach to the Supporting Documentation tab either a:

- (i) signed and fully completed Utah Accident and Health Insurance Group Questionnaire; or

- (ii) copy of the Utah Accident and Health Insurance Discretionary Group Authorization letter.

- (e) Letter of Authorization.

- (i) When the filer is not the licensee, a letter of authorization from the licensee must be attached to the Supporting Documentation tab.

- (ii) The licensee remains responsible for the filing being in compliance with Utah laws and rules.

- (f) Variable data.

- (i) A statement of variability must be attached to the Supporting Documentation tab and certify:

- (A) the final form will not contain brackets denoting variable data;

- (B) the use of variable data will be administered in a uniform and non-discriminatory manner and will not result in unfair discrimination;

- (C) the variable data included in this statement will be used on the referenced forms;

- (D) any changes to variable data will be submitted prior to implementation.

- (ii) Variable data are denoted in brackets and are defined, either by imbedding in the form, or by a separate form identified by its own form number and edition date. Variable data submitted as a separate form must be in a manner that follows the construction of the form, by page and paragraph, or page and footnote.

- (iii) Variable data must be reasonable, appropriate and compliant.

- (iv) Use of unauthorized variable data is prohibited.

- (g) Utah Accident and Health Insurance Intake Survey.

- (i) The intake survey must be properly completed, signed and attached to the Supporting Documentation tab for filings submitted with the type of insurance of "H15G," "H15I," "H16G," "H16I," "HOrg02G," or "HOrg02I."

- (ii) If the intake survey is incomplete or not attached, the filing will be rejected.

- (h) Items being submitted for filing.
- (i) All forms must be attached to the Form-Schedule tab.
- (ii) All rating documentation, including actuarial memorandums and rate schedules, must be attached to the Rate/Rule Schedule.
- (i) Reports are exempt from the filing submission requirement listed in Subsections R590-220-6(4)(c), (d), (f) and (g).
- (5) Refer to each applicable section of this rule for additional procedures on how to submit forms, rates, and reports.

**R590-220-7. Procedures for Form Filings.**

- (1) Forms in General.
  - (a) Forms are File and Use filings.
  - (b) Each form must be identified by a unique form number. The form number may not be variable.
  - (c) A form must be in final printed form or printer's proof format. A draft may not be submitted.
  - (d)

Blank spaces within the forms must be completed in John Doe fashion to accurately represent the intended market, purpose, and use.

- (2) Application Filing.
  - (a) Each application or enrollment form may be submitted as a separate filing or may be filed with its related policy or certificate filing.
  - (b) If an application has been previously filed or is filed separately, an informational copy of the application must be included with the policy or certificate filing.

- (3) Policy Filing.
  - (a) Each type of insurance must be filed separately.
  - (b) A policy filing consists of one policy form, including its related forms, such as the application, outline of coverage, certificate, rider, endorsement, and actuarial memorandum.
  - (c) Only one policy filing for a single type of insurance may be filed, except as stated in Subsection R590-220-7(3)(d).

- (d) A Medicare supplement filing may include more than one policy filing but each filing is limited to only one of each of the Medicare supplement plans A through N.

- (4) Rider or Endorsement Only Filing.
  - (a) Up to three related riders or endorsements may be filed together.

- (b) A single rider or endorsement that affects multiple forms may be filed if the Filing Description references all affected forms.

- (c) The filing must include:
  - (i) A listing of all base policy form numbers, title and Utah Filed Dates; and
  - (ii) a description of how each filed rider or endorsement affects the base policy.

- (d) Unrelated riders or endorsements may not be filed together.

- (5) Outline of Coverage. If an outline of coverage is required to be issued with a policy, rider, or an endorsement,

the outline of coverage must be filed when the policy, rider or endorsement is filed.

**R590-220-8. Additional Procedures for Individual Accident and Health Market Filings.**

(1) A filer submitting an individual accident and health filing is advised to review:

(a) Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(b) Title 31A, Chapter 22, Part 6, Accident and Health Insurance; and

(c) Rules R590-85, R590-126, R590-131, and R590-192.

(2) This section does not apply to filings for individual health benefit plans that are subject to Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act, and Rule R590-167. Individual health benefit plan filings are discussed in Section R590-220-10.

(3) Rate and rate documentation filings.

(a) Rates and rate documentation submitted with a new form filing are a File and Use filing.

(b) A rate revision filing is a File for Acceptance filing.

(4) Every individual accident and health policy, rider, or endorsement affecting benefits shall be accompanied by a rate filing with an actuarial memorandum signed by a qualified actuary.

(a) A rate filing need not be submitted if the filing does not require a change in premiums, however the reason why there is not a change in premium must be explained in the Filing Description.

(b) Rates must be filed in accordance with the requirements of Section 31A-22-602, Rules R590-85, and R590-220.

(5) A filer submitting a long term care filing, including an endorsement or rider attached to a life insurance policy, is advised to review Title 31A, Chapter 22, Part 14, Long Term Care Insurance Standards, Rule R590-148, and Sections R590-220-12 and 13.

(6) A filer submitting a Medicare supplement filing is advised to review Section 31A-22-620, Rule R590-146, and Section R590-220-11.

**R590-220-9. Additional Procedures for Group Market Form Filings.**

(1) A filer submitting a group accident and health filing is advised to review:

(a) Title 31A, Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(b) Title 31A, Chapter 22, Parts 6 and 7;

(c) Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act; and

(d) Rules R590-76, R590-126, R590-131, R590-146, R590-148, R590-192, R590-233, and Section R590-220-10.

(2) Determine whether the group is an eligible group or a discretionary group.

(a) Eligible Group. A filing for an eligible group must include a completed Utah Accident and Health Insurance Group

Questionnaire.

(i) A questionnaire must be completed for each eligible group under Sections 31A-22-503 through 507, and Subsection 31A-22-701(2).

(ii) When a filing applies to multiple employee-employer groups under Section 31A-22-502, only one questionnaire is required to be completed.

(b) Discretionary Group. If the group is not an eligible group, then specific discretionary group authorization must be obtained prior to filing.

(i) To obtain discretionary group authorization a Utah Accident and Health Insurance Request for Discretionary Group Authorization must be submitted and include all required information.

(ii) Evidence or proof of the following items are some factors considered in determining acceptability of a discretionary group:

(A) the existence of a verifiable group;

(B) that granting permission is not contrary to public policy;

(C) the proposed group would be actuarially sound;

(D) the group would result in economies of acquisition and administration which justify a group rate; and

(E) the group would not present hazards of adverse selection.

(iii) A discretionary group filing that does not provide authorization documentation will be rejected.

(iv) A change to an authorized discretionary group, such as change of name, trustee or domicile state, must be submitted to the department within 30 days of the change.

(v) Adding additional types of insurance products to be offered, requires that the discretionary group be reauthorized. The discretionary group authorization will specify the types of products that a discretionary group may offer.

(vi) The commissioner may periodically re-evaluate the group's authorization.

(vii) A filer may not submit a rate or form filing prior to receiving discretionary group authorization. If a rate or form filing is submitted without discretionary group authorization, the filing will be rejected.

(3) A filer submitting a long-term care filing, including a long-term care endorsement or rider attached to a life insurance policy, is advised to review Title 31A, Chapter 22, Part 14, Long Term Care Insurance Standards, Rule R590-148, and Sections R590-220-12 and 13.

(4) A filer submitting a Medicare supplement filing is advised to review Section 31A-22-620, Rule R590-146, and Section R590-220-11.

#### **R590-220-10. Additional Procedures for Individual, Small Employer, and Group Health Benefit Plan Filings.**

This section contains instructions for filings subject to Title 31A, Chapter 30, Individual, Small Employer, and Group Health Insurance Act.

(1) A filer submitting health benefit plan filings that are subject to Title 31A, Chapter 30, is advised to review:

(a) Title 31A, Chapter 8, Health Maintenance Organization and Limited Health Plans;

(b) Title 31A, Chapter 22, Parts 6 and 7;

(c) Title 31A, Chapter 30; and

(d) Rules R590-76, R590-131, R590-167, R590-175, R590-176, R590-233, and R590-247.

(2)(a) Form Filing. (i) A health benefit plan form filing must include a rate manual.

(ii) If the rate manual was previously filed, provide documentation indicating the department's receipt.

(b) Rate Manual Filing.

(i) A rate manual that does not request a change in rating methodology is a File Before Use filing.

(ii) A change in rating methodology filing is a File for Approval filing.

(iii) A new and revised rate manual must:

(A) include an actuarial certification signed by a qualified actuary;

(B) be filed 30 days prior to use;

(C) list the case characteristics and rate factors to be used;

(D) be applied in the same manner for all health benefit plans in a class;

(E) contain specific area factor and industry factors applicable in Utah;

(F) include the method of calculating the risk load, including the method used to determine any experience factors;

(G) include how the overall rate is reviewed for compliance with the rate restrictions; and

(H) include detailed description of all classes of business, as provided in Section 31A-30-105.

(iv) Any case characteristic not listed in Subsection 31A-30-106(1)(h) requires prior approval of the commissioner.

(3) Health Benefit Plan Reports.

(a) Actuarial Certification.

(i) All individual and small employer licensees must file an actuarial certification as described in Section 31A-30-106 and Subsection R590-167-11(1)(a).

(ii) The report is due April 1 each year.

(b) Small Employer Index Rates Report.

All small employer licensees must file their index rates as of January 1 of the current year and preceding year, as required by Subsection 31A-29-117(2).

(i) The report must include:

(A) the actual index rates; and

(B) calculate the percentage change in these rates between the two years.

(ii) The report is due February 1 each year.

(c) Each report must be filed separately and be properly identified.

(d)(i) All health benefit plan reports must be filed with SERFF using a type of insurance of "H16I" or "H16G," and a filing

type of "Report."

(ii) A Health Maintenance Organization must use "HOrg02I" or "HOrg02G" as the type of insurance and the filing type of "Report."

**R590-220-11. Additional Procedures for Medicare Supplement Filings.**

A filer submitting Medicare supplement filings is advised to review Section 31A-22-620 and Rule R590-146. A Medicare supplement form filing that affects rates must be filed with all required rating documentation.

(1)(a) A licensee must file its Medicare Supplement Buyers Guide.

(b) If previously filed, indicate the filed date in the filing description.

(2) Rates.

(a) Rates and rate documentation submitted with a new form filing are a File and Use filing.

(b) A rate revision filing is a File for Acceptance filing.

(c) Medicare supplement rates must comply with Section 31A-22-602, and Rules R590-146 and R590-85.

(d) A licensee shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed.

(e) A rate revision request may not be used to satisfy the annual filing requirements of Subsection R590-146-14.C.

(3) Annual Medicare Supplement Reports.

(a) Medicare supplement reports are File and Use filings.

(b) Reports are due May 31 each year.

(c) Report of Multiple Policies.

(i) As required by Section R590-146-22, an issuer of Medicare supplement policies shall annually submit a report of multiple policies the licensee has issued to a single insured.

(ii) The report is required each year listing each insured with multiple policies or must state "NO MULTIPLE POLICIES WERE ISSUED."

(d) Annual Filing of Rates and Supporting Documentation.

(i) An issuer of Medicare supplement policies and certificates shall file annually its rates, rating schedule and supporting documentation, including ratios of incurred losses to earned premiums by policy duration, in accordance with Subsection R590-146-14.C.

(ii) The NAIC Medicare Supplement Insurance Model Regulations Manual details what should be included in the annual rate filing.

(iii) Annual reports submitted with a request or any type of reference to a rate revision will be rejected.

(e) Refund Calculation and Benchmark Ratio. An issuer shall file the Medicare Supplement Refund Calculation Form and Reporting Form for the Calculation of Benchmark Ratio Since Inception for Group Policies reports according to Subsection R590-146-14.B.

(f) Reports for Pre-Standardized Medicare supplement benefit plans and 1990 Standardized Medicare supplement benefit

plans must be submitted together as one filing with SERFF using a type of insurance of "MS06," and a filing type of "Report."

(g) Reports for 2010 Standardized Medicare supplement benefit plans must be submitted together as one filing with SERFF using a type of insurance of "MS09," and a filing type of "Report."

(h) If Medicare supplement reports are not submitted as one filing, the filing is considered incomplete and will be rejected.

**R590-220-12. Additional Procedures for Combination Policies or Endorsements and Riders Providing Life and Accident and Health Benefits.**

A filer submitting health and life combination policies, or health endorsements or riders, to life policies, is advised to review Rule R590-226.

(1) A combination filing is a policy, rider, or endorsement, which creates a product that provides both life and accident and health insurance benefits.

(a) The two types of acceptable combination filings are; an endorsement or rider, or an integrated policy.

(b) Combination filings take considerable time to process, and will be processed by both the Health Insurance Division, and the Life Section of the Life, Property and Casualty Insurance Division.

(2) A combination filing must be submitted separately to both the Health Insurance Division and the Life Section of the Life, Property and Casualty Insurance Division.

(3)(a) For an integrated policy, the filing must be submitted to the appropriate division based on benefits provided in the base policy.

(b) For an endorsement or rider, the filing must be submitted to the appropriate division based on benefits provided in the endorsement or rider.

(4) The Filing Description must identify the filing as having a combination of insurance types, such as:

(a) term life policy with a long-term care benefit rider;  
or

(b) major medical health policy that includes a life insurance benefit.

**R590-220-13. Additional Procedures for Long Term Care Products.**

(1) A filer submitting long-term care product filings is advised to review:

(a) Title 31A, Chapter 22, Part 14, Long Term Care Insurance Standards;

(b) Rule R590-148; and

(c) Section R590-220-12.

(2) A long-term care form filing that affects rates must be filed with all required rating documentation.

(3) Rates.

(a) Rates and rate documentation submitted with a new form filing are a File and Use filing.

(b) A rate revision filing is a File for Acceptance filing.

(c) Long-term care rates must comply with Rules R590-148

and R590-85.

(d) A licensee shall not use or change premium rates for a long-term care policy or certificate unless the rates, rating schedule and supporting documentation have been filed.

(4) Annual Long-term Care Reports.

(a) All four long-term care reports required by Section R590-148-25 must be submitted together as one filing.

(b) If all four reports are not submitted as one filing, the filing is considered incomplete and will be rejected.

(c) If there is no information to report, the reporting form must state "NONE."

(d) Reports are due June 30 each year.

(e) The four reports shown below are required by Section R590-148-25.

(i) Replacement and Lapse Reporting Form.

(ii) Claims Denial Reporting Form.

(iii) Rescission Reporting Form.

(iv) Suitability Report Form.

(f) All long term care reports must be filed with SERFF using a type of insurance of "LTC06," and a filing type of "Report."

**R590-220-14. Criteria for adding or terminating participating providers.**

(1) Criteria for adding or terminating participating providers must be submitted electronically via SERFF using a type of insurance of "H21" and a filing type of "Report."

(2) The Filing Description must state "Preferred Provider Agreement," as required by Subsection 31A-22-617.1(1)(c).

**R590-220-15. Correspondence and Status Checks.**

(1) Correspondence. When corresponding with the department, provide sufficient information to identify the original filing:

- (a) type of insurance;
- (b) date of filing;
- (c) form numbers; and
- (d) SERFF tracking number.

(2) Status Checks.

(a) A complete filing is usually processed within 45 days of receipt.

(b) A filer can request the status of its filing 60 days after the date of submission. A response will not be provided to a status request prior to 60 days.

**R590-220-16. Responses.**

(1) Response to a Filing Objection Letter. When responding to a Filing Objection Letter a filer must:

- (a) provide an explanation identifying all changes made;
- (b) include an underline and strikeout version for each revised document;
- (c) a final version of revised documents that incorporates all changes; and
- (d) attach the documents in Subsections R590-220-16(1)(b)

and (c) to the appropriate Form Schedule or Rate/Rule Schedule tabs.

(2) Response to an Order to Prohibit Use.

(a) An Order to Prohibit Use becomes final 15 days after the date of the Order.

(b) Use of the filing must be discontinued not later than the date specified in the Order.

(c) To contest an Order to Prohibit Use, the commissioner must receive a written request for a hearing not later than 15 days after the date of the Order.

(d) A new filing is required if the licensee chooses to make the requested changes addressed in the Filing Objection Letter. The new filing must reference the previously prohibited filing.

**R590-220-17. Penalties.**

A person found to be in violation of this rule shall be subject to penalties as provided under Section 31A-2-308.

**R590-220-18. Enforcement Date.**

The commissioner will begin enforcing the revised provisions of this rule 15 days from the effective date of this rule.

**R590-220-19. Severability.**

If any provision of this rule or its application to any person or situation is held to be invalid, that invalidity shall not affect any other provision or application of this rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

**KEY: health insurance filings**

**Date of Enactment or Last Substantive Amendment: 2-22-2010**

**Notice of Continuation: March 12, 2009**

**Authorizing, and Implemented or Interpreted Law: 31A-2-201; 31A-2-201.1; 31A-2-202; 31A-22-605; 31A-22-620; 31A-30-106**