INSURANCE LAW AMENDMENTS

2013 GENERAL SESSION

STATE OF UTAH

LONG TITLE

General Description:

This bill modifies the Insurance Code.

Highlighted Provisions:

This bill:

- amends the definition provision;
- addresses rules related to title and escrow examinations;
- modifies the cap on appropriations from the Captive Insurance Restricted Account effective July 1, 2015;
- amends provisions related to company action level events;
- enacts provision regarding producer's duties related to replacement of life insurance;
- addresses death pending conversion of group life insurance policy;
- modifies preferred provider contract provisions;
- amends provisions related to health benefit plan offerings;
- modifies provisions related to alternative coverage;
- amends provisions related to inducements;
- addresses monies deposited into the Insurance Fraud Investigation Restricted Account and the Insurance Fraud Victim Restitution Account;
- amends lifetime maximum for covered benefits from the Comprehensive Health Insurance Pool;
- creates the Insurance Fraud Victim Restitution Account; and
- makes technical and conforming amendments.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill has an effective date.

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Laws of Utah 2012, Chapters 151 and 253

31A-2-404, as last amended by Laws of Utah 2012, Chapter 253

31A-3-304 (Effective 07/01/13), as last amended by Laws of Utah 2011, Chapter 284

31A-8-301, as last amended by Laws of Utah 2005, Chapter 123

31A-17-603, as last amended by Laws of Utah 2001, Chapter 116

31A-22-519, as enacted by Laws of Utah 1985, Chapter 242

31A-22-617, as last amended by Laws of Utah 2009, Chapter 12

31A-22-618.5, as last amended by Laws of Utah 2011, Chapters 284 and 297

31A-22-724, as last amended by Laws of Utah 2011, Chapter 400

31A-23a-204, as last amended by Laws of Utah 2011, Chapters 284 and 342

31A-23a-402.5, as last amended by Laws of Utah 2012, Chapters 253 and 279

31A-29-113, as last amended by Laws of Utah 2007, Chapter 40

31A-31-108, as last amended by Laws of Utah 2012, Chapter 253

ENACTS:

31A-22-429, Utah Code Annotated 1953

31A-31-108.5, Utah Code Annotated 1953

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

Section 1. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

(1) (a) "Accident and health insurance" means insurance to provide protection against economic losses resulting from:

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

(c) "Accident and health insurance" does not include workers' compensation insurance.

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection [~~(162)~~] (163).

(4) "Adult" means an individual who has attained the age of at least 18 years.

(5) "Affiliate" means a person who controls, is controlled by, or is under common control with, another person. A corporation is an affiliate of another corporation, regardless of ownership, if substantially the same group of individuals manage the corporations.

(6) "Agency" means:

(a) a person other than an individual, including a sole proprietorship by which an individual does business under an assumed name; and

(b) an insurance organization licensed or required to be licensed under Section 31A-23a-301, 31A-25-207, or 31A-26-209.

(7) "Alien insurer" means an insurer domiciled outside the United States.

(8) "Amendment" means an endorsement to an insurance policy or certificate.

(9) "Annuity" means an agreement to make periodical payments for a period certain or over the lifetime of one or more individuals if the making or continuance of all or some of the series of the payments, or the amount of the payment, is dependent upon the continuance of

human life.

(10) "Application" means a document:

(a) (i) completed by an applicant to provide information about the risk to be insured; and

(ii) that contains information that is used by the insurer to evaluate risk and decide whether to:

(A) insure the risk under:

(I) the coverage as originally offered; or

(II) a modification of the coverage as originally offered; or

(B) decline to insure the risk; or

(b) used by the insurer to gather information from the applicant before issuance of an annuity contract.

(11) "Articles" or "articles of incorporation" means:

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

(h) another constitutive document for a trust or other entity that is not a corporation; and

(i) an amendment to an item listed in Subsections (11)(a) through (h).

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, up to and including surrender of the person in execution of a sentence imposed under Subsection 77-20-7(1), as a condition to the release of that person from confinement.

(13) "Binder" is defined in Section 31A-21-102.

(14) "Blanket insurance policy" means a group policy covering a defined class of persons:

(a) without individual underwriting or application; and

(b) that is determined by definition without designating each person covered.

(15) "Board," "board of trustees," or "board of directors" means the group of persons with responsibility over, or management of, a corporation, however designated.

(16) "Bona fide office" means a physical office in this state:

(a) that is open to the public;

(b) that is staffed during regular business hours on regular business days; and

(c) at which the public may appear in person to obtain services.

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" is defined in Subsection (88).

(19) "Business plan" means the information required to be supplied to the commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when these subsections apply by reference under:

(a) Section 31A-7-201;

(b) Section 31A-8-205; or

(c) Subsection 31A-9-205(2).

(20) (a) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated.

(b) "Bylaws" includes comparable rules for a trust or other entity that is not a corporation.

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by another organization; and

(ii) whose exclusive purpose is to insure risks of the parent organization and an affiliated company; or

(b) in the case of a group or association, an insurer:

(i) owned by the insureds; and

(ii) whose exclusive purpose is to insure risks of:

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

(23) "Certificate" means evidence of insurance given to:

(a) an insured under a group insurance policy; or

(b) a third party.

(24) "Certificate of authority" is included within the term "license."

(25) "Claim," unless the context otherwise requires, means a request or demand on an insurer for payment of a benefit according to the terms of an insurance policy.

(26) "Claims-made coverage" means an insurance contract or provision limiting coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force.

(27) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance commissioner.

(b) When appropriate, the terms listed in Subsection (27)(a) apply to the equivalent supervisory official of another jurisdiction.

(28) (a) "Continuing care insurance" means insurance that:

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

(iii) provides the coverage described in this Subsection (28)(a) under an agreement effective:

(A) for the life of the insured; or

(B) for a period in excess of one year.

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as a service described in Subsection (28)(a)(ii).

(29) (a) "Control," "controlling," "controlled," or "under common control" means the direct or indirect possession of the power to direct or cause the direction of the management and policies of a person. This control may be:

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (29)(a)(i) through (iii).

(b) There is no presumption that an individual holding an official position with another person controls that person solely by reason of the position.

(c) A person having a contract or arrangement giving control is considered to have control despite the illegality or invalidity of the contract or arrangement.

(d) There is a rebuttable presumption of control in a person who directly or indirectly owns, controls, holds with the power to vote, or holds proxies to vote 10% or more of the voting securities of another person.

(30) "Controlled insurer" means a licensed insurer that is either directly or indirectly controlled by a producer.

(31) "Controlling person" means a person that directly or indirectly has the power to direct or cause to be directed, the management, control, or activities of a reinsurance intermediary.

(32) "Controlling producer" means a producer who directly or indirectly controls an insurer.

(33) (a) "Corporation" means an insurance corporation, except when referring to:

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

(I) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

(ii) a noninsurer that is part of a holding company system under Chapter 16, Insurance Holding Companies.

(b) "Stock corporation" means a stock insurance corporation.

(c) "Mutual" or "mutual corporation" means a mutual insurance corporation.

(34) (a) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

(b) "Creditable coverage" includes coverage that is offered through a public health plan such as:

(i) the Primary Care Network Program under a Medicaid primary care network demonstration waiver obtained subject to Section 26-18-3;

(ii) the Children's Health Insurance Program under Section 26-40-106; or

(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. 109-415.

(35) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor has a disability.

(36) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

(37) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

(38) "Credit property insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that protects the property until the debt is paid.

(39) "Credit unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(40) "Creditor" means a person, including an insured, having a claim, whether:

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(41) (a) "Crop insurance" means insurance providing protection against damage to crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils that is:

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

(b) "Crop insurance" includes multiperil crop insurance.

(42) (a) "Customer service representative" means a person that provides an insurance service and insurance product information:

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

(ii) to the customer service representative's employer's:

(A) customer;

(B) client; or

(C) organization.

(b) A customer service representative may only operate within the scope of authority of the customer service representative's producer, surplus lines producer, or consultant employer.

(43) "Deadline" means a final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

(b) by which a required filing or payment must be received by the department.

(44) "Deemer clause" means a provision under this title under which upon the occurrence of a condition precedent, the commissioner is considered to have taken a specific action. If the statute so provides, a condition precedent may be the commissioner's failure to take a specific action.

(45) "Degree of relationship" means the number of steps between two persons determined by counting the generations separating one person from a common ancestor and then counting the generations to the other person.

(46) "Department" means the Insurance Department.

(47) "Director" means a member of the board of directors of a corporation.

(48) "Disability" means a physiological or psychological condition that partially or totally limits an individual's ability to:

(a) perform the duties of:

(i) that individual's occupation; or

(ii) any occupation for which the individual is reasonably suited by education, training, or experience; or

(b) perform two or more of the following basic activities of daily living:

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(49) "Disability income insurance" is defined in Subsection (79).

(50) "Domestic insurer" means an insurer organized under the laws of this state.

(51) "Domiciliary state" means the state in which an insurer:

(a) is incorporated;

(b) is organized; or

(c) in the case of an alien insurer, enters into the United States.

(52) (a) "Eligible employee" means:

(i) an employee who:

(A) works on a full-time basis; and

(B) has a normal work week of 30 or more hours; or

(ii) a person described in Subsection (52)(b).

(b) "Eligible employee" includes, if the individual is included under a health benefit plan of a small employer:

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (52)(b):

(i) an individual who works on a temporary or substitute basis for a small employer;

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(53) "Employee" means an individual employed by an employer.

(54) "Employee benefits" means one or more benefits or services provided to:

(a) an employee; or

(b) a dependent of an employee.

(55) (a) "Employee welfare fund" means a fund:

(i) established or maintained, whether directly or through a trustee, by:

(A) one or more employers;

(B) one or more labor organizations; or

(C) a combination of employers and labor organizations; and

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund:

(A) by or on behalf of an employer doing business in this state; or

(B) for the benefit of a person employed in this state.

(b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax revenues.

(56) "Endorsement" means a written agreement attached to a policy or certificate to modify the policy or certificate coverage.

(57) "Enrollment date," with respect to a health benefit plan, means:

(a) the first day of coverage; or

(b) if there is a waiting period, the first day of the waiting period.

(58) (a) "Escrow" means:

(i) a real estate settlement or real estate closing conducted by a third party pursuant to the requirements of a written agreement between the parties in a real estate transaction; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" includes the act of conducting a:

(i) real estate settlement; or

(ii) real estate closing.

(59) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

(b) a person defined as an escrow agent in Section 7-22-101.

(60) (a) "Excludes" is not exhaustive and does not mean that another thing is not also excluded.

(b) The items listed in a list using the term "excludes" are representative examples for use in interpretation of this title.

(61) "Exclusion" means for the purposes of accident and health insurance that an insurer does not provide insurance coverage, for whatever reason, for one of the following:

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

(d) a specific prescription drug or class of prescription drugs.

(62) "Expense reimbursement insurance" means insurance:

(a) written to provide a payment for an expense relating to hospital confinement resulting from illness or injury; and

(b) written:

(i) as a daily limit for a specific number of days in a hospital; and

(ii) to have a one or two day waiting period following a hospitalization.

(63) "Fidelity insurance" means insurance guaranteeing the fidelity of a person holding a position of public or private trust.

(64) (a) "Filed" means that a filing is:

(i) submitted to the department as required by and in accordance with applicable statute, rule, or filing order;

(ii) received by the department within the time period provided in applicable statute, rule, or filing order; and

(iii) accompanied by the appropriate fee in accordance with:

(A) Section 31A-3-103; or

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (64)(a).

(65) "Filing," when used as a noun, means an item required to be filed with the

department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement; or

(o) an outline of coverage.

(66) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay a claim submitted to it by the insured for the insured's losses.

(67) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

(68) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

(b) "Form" does not include a document specially prepared for use in an individual case.

(69) "Franchise insurance" means an individual insurance policy provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

(70) "General lines of authority" include:

(a) the general lines of insurance in Subsection (71);

(b) title insurance under one of the following sublines of authority:

(i) search, including authority to act as a title marketing representative;

(ii) escrow, including authority to act as a title marketing representative; and

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

(e) any other line of insurance that the commissioner considers necessary to recognize in the public interest.

(71) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

(f) variable contracts, including variable life and annuity.

(72) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

(73) (a) "Group insurance policy" means a policy covering a group of persons that is issued:

(i) to a policyholder on behalf of the group; and

(ii) for the benefit of a member of the group who is selected under a procedure defined in:

(A) the policy; or

(B) an agreement that is collateral to the policy.

(b) A group insurance policy may include a member of the policyholder's family or a dependent.

(74) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

(75) (a) Except as provided in Subsection (75)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

(iii) is offered as a substitute for hospital or medical expense insurance, such as:

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

(b) "Health benefit plan" does not include a policy or certificate that:

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

(ii) is offered and marketed as supplemental health insurance.

(76) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

(77) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

(b) "Health care insurance" or "health insurance" does not include accident and health insurance providing a benefit for:

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

(x) a type of accident and health insurance coverage that is a part of or attached to another type of policy.

(78) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended.

(79) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

(80) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

(81) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of an insurer.

(82) "Independently procured insurance" means insurance procured under Section 31A-15-104.

(83) "Individual" means a natural person.

(84) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

(b) property in transit over water by means other than boat or ship;

(c) bailee liability;

(d) fixed transportation property such as bridges, electric transmission systems, radio and television transmission towers and tunnels; and

(e) personal and commercial property floaters.

(85) "Insolvency" means that:

(a) an insurer is unable to pay its debts or meet its obligations as the debts and obligations mature;

(b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC under Subsection 31A-17-601(8)(c); or

(c) an insurer is determined to be hazardous under this title.

(86) (a) "Insurance" means:

(i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more persons to one or more other persons; or

(ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group of persons that includes the person seeking to distribute that person's risk.

(b) "Insurance" includes:

(i) a risk distributing arrangement providing for compensation or replacement for damages or loss through the provision of a service or a benefit in kind;

(ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a business and not as merely incidental to a business transaction; and

(iii) a plan in which the risk does not rest upon the person who makes an arrangement, but with a class of persons who have agreed to share the risk.

(87) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(88) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance by an organization that is or is required to be licensed under this title;

(b) providing a benefit to an employee in the event of a contingency not within the control of the employee, in which the employee is entitled to the benefit as a right, which benefit may be provided either:

(i) by a single employer or by multiple employer groups; or

(ii) through one or more trusts, associations, or other entities;

(c) providing an annuity:

(i) including an annuity issued in return for a gift; and

(ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of a motor club as outlined in Subsection (116);

(e) providing another person with insurance;

(f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or surety, a contract or policy of title insurance;

(g) transacting or proposing to transact any phase of title insurance, including:

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

(v) transacting matters subsequent to the execution of the contract and arising out of the contract, including reinsurance;

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections (88)(a) through (h) in a manner designed to evade this title.

(89) "Insurance consultant" or "consultant" means a person who:

(a) advises another person about insurance needs and coverages;

(b) is compensated by the person advised on a basis not directly related to the insurance placed; and

(c) except as provided in Section 31A-23a-501, is not compensated directly or indirectly by an insurer or producer for advice given.

(90) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

(91) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) (i) "Producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating an insurance product of that insurer.

(ii) "Producer for the insurer" may be referred to as an "agent."

(c) (i) "Producer for the insured" means a producer who:

(A) is compensated directly and only by an insurance customer or an insured; and

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting, or negotiating an insurance product of that insurer to an insurance customer or insured.

(ii) "Producer for the insured" may be referred to as a "broker."

(92) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (92)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in an insurance policy or certificate.

(93) (a) "Insurer" means a person doing an insurance business as a principal including:

(i) a fraternal benefit society;

(ii) an issuer of a gift annuity other than an annuity specified in Subsections 31A-22-1305(2) and (3);

(iii) a motor club;

(iv) an employee welfare plan; and

(v) a person purporting or intending to do an insurance business as a principal on that person's own account.

(b) "Insurer" does not include a governmental entity to the extent the governmental entity is engaged in an activity described in Section 31A-12-107.

(94) "Interinsurance exchange" is defined in Subsection [~~(145)~~] (146).

(95) "Involuntary unemployment insurance" means insurance:

(a) offered in connection with an extension of credit; and

(b) that provides indemnity if the debtor is involuntarily unemployed for payments coming due on a:

(i) specific loan; or

(ii) credit transaction.

(96) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

(97) "Late enrollee," with respect to an employer health benefit plan, means an individual whose enrollment is a late enrollment.

(98) "Late enrollment," with respect to an employer health benefit plan, means enrollment of an individual other than:

(a) on the earliest date on which coverage can become effective for the individual under the terms of the plan; or

(b) through special enrollment.

(99) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for a specified legal expense.

(b) "Legal expense insurance" includes an arrangement that creates a reasonable expectation of an enforceable right.

(c) "Legal expense insurance" does not include the provision of, or reimbursement for, legal services incidental to other insurance coverage.

(100) (a) "Liability insurance" means insurance against liability:

(i) for death, injury, or disability of a human being, or for damage to property, exclusive of the coverages under:

(A) Subsection (110) for medical malpractice insurance;

(B) Subsection [~~(137)~~] (138) for professional liability insurance; and

(C) Subsection [~~(171)~~] (172) for workers' compensation insurance;

(ii) for a medical, hospital, surgical, and funeral benefit to a person other than the insured who is injured, irrespective of legal liability of the insured, when issued with or supplemental to insurance against legal liability for the death, injury, or disability of a human being, exclusive of the coverages under:

(A) Subsection (110) for medical malpractice insurance;

(B) Subsection [~~(137)~~] (138) for professional liability insurance; and

(C) Subsection [~~(171)~~] (172) for workers' compensation insurance;

(iii) for loss or damage to property resulting from an accident to or explosion of a boiler, pipe, pressure container, machinery, or apparatus;

(iv) for loss or damage to property caused by:

(A) the breakage or leakage of a sprinkler, water pipe, or water container; or

(B) water entering through a leak or opening in a building; or

(v) for other loss or damage properly the subject of insurance not within another kind of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

(iii) making inspection of, and issuing a certificate of inspection upon, an elevator, boiler, machinery, or apparatus of any kind when done in connection with insurance on the elevator, boiler, machinery, or apparatus.

(101) (a) "License" means authorization issued by the commissioner to engage in an activity that is part of or related to the insurance business.

(b) "License" includes a certificate of authority issued to an insurer.

(102) (a) "Life insurance" means:

(i) insurance on a human life; and

(ii) insurance pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

(iv) granting an additional benefit in the event of death by accident;

(v) granting an additional benefit to safeguard the policy against lapse; and

(vi) providing an optional method of settlement of proceeds.

(103) "Limited license" means a license that:

(a) is issued for a specific product of insurance; and

(b) limits an individual or agency to transact only for that product or insurance.

(104) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

(j) another form of insurance offered in connection with an extension of credit that:

(i) is limited to partially or wholly extinguishing the credit obligation; and

(ii) the commissioner determines by rule should be designated as a form of limited line credit insurance.

(105) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to an individual through a master, corporate, group, or individual policy.

(106) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

(k) another form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

(107) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection (106); and

(b) a customer service representative.

(108) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

(109) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

(i) in a setting other than an acute care unit of a hospital;

(ii) for not less than 12 consecutive months for a covered person on the basis of:

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

(iii) for one or more necessary or medically necessary services that are:

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

(C) (I) a nonprofit health hospital; and

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (109)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

(b) "Long-term care insurance" includes:

(i) any of the following that provide directly or supplement long-term care insurance:

(A) a group or individual annuity or rider; or

(B) a life insurance policy or rider;

(ii) a policy or rider that provides for payment of benefits on the basis of:

(A) cognitive impairment; or

(B) functional capacity; or

(iii) a qualified long-term care insurance contract.

(c) "Long-term care insurance" does not include:

(i) a policy that is offered primarily to provide basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

(vi) income replacement or related asset-protection coverage;

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

(x) a life insurance policy that accelerates the death benefit to provide the option of a lump sum payment:

(A) if the following are not conditioned on the receipt of long-term care:

(I) benefits; or

(II) eligibility; and

(B) the coverage is for one or more the following qualifying events:

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(110) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of a medical service other than the practice and provision of a dental service.

(111) "Member" means a person having membership rights in an insurance corporation.

(112) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

(113) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor has a disability.

(114) "Mortgage guaranty insurance" means surety insurance under which a mortgagee or other creditor is indemnified against losses caused by the default of a debtor.

(115) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

(116) "Motor club" means a person:

(a) licensed under:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

(b) that promises for an advance consideration to provide for a stated period of time one or more:

(i) legal services under Subsection 31A-11-102(1)(b);

(ii) bail services under Subsection 31A-11-102(1)(c); or

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections (116)(b)(iii)(A) through (D); or

(F) other services given in Subsections 31A-11-102(1)(b) through (f).

(117) "Mutual" means a mutual insurance corporation.

(118) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

(b) under which the financing and delivery of medical care is provided, in whole or in part, through a defined set of providers under contract with the insurer, including the financing and delivery of an item paid for as medical care.

(119) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive a dividend representing a share of the surplus of the insurer.

(120) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

(b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money, securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests, or other cargoes in or awaiting transit over the oceans or inland waterways;

(c) earnings such as freight, passage money, commissions, or profits derived from transporting goods or people upon or across the oceans or inland waterways; or

(d) a vessel owner or operator as a result of liability to employees, passengers, bailors, owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in connection with maritime activity.

(121) "Order" means an order of the commissioner.

(122) "Outline of coverage" means a summary that explains an accident and health insurance policy.

(123) "Participating" means a plan of insurance under which the insured is entitled to receive a dividend representing a share of the surplus of the insurer.

(124) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee:

(a) has other group health care insurance coverage; or

(b) receives:

(i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965; or

(ii) another government health benefit.

(125) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

(j) another similar entity or combination of entities acting in concert.

(126) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) an individual; or

(b) a family.

(127) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

(128) "Plan year" means:

(a) the year that is designated as the plan year in:

(i) the plan document of a group health plan; or

(ii) a summary plan description of a group health plan;

(b) if the plan document or summary plan description does not designate a plan year or there is no plan document or summary plan description:

(i) the year used to determine deductibles or limits;

(ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis; or

(iii) the employer's taxable year if:

(A) the plan does not impose deductibles or limits on a yearly basis; and

(B) (I) the plan is not insured; or

(II) the insurance policy is not renewed on an annual basis; or

(c) in a case not described in Subsection (128)(a) or (b), the calendar year.

(129) (a) "Policy" means a document, including an attached endorsement or application that:

(i) purports to be an enforceable contract; and

(ii) memorializes in writing some or all of the terms of an insurance contract.

(b) "Policy" includes a service contract issued by:

(i) a motor club under Chapter 11, Motor Clubs;

(ii) a service contract provided under Chapter 6a, Service Contracts; and

(iii) a corporation licensed under:

(A) Chapter 7, Nonprofit Health Service Insurance Corporations; or

(B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.

(c) "Policy" does not include:

(i) a certificate under a group insurance contract; or

(ii) a document that does not purport to have legal effect.

(130) "Policyholder" means a person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

(131) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

(132) "Policy summary" means a synopsis describing the elements of a life insurance policy.

(133) "PPACA" means 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 related federal regulations and guidance.

[~~(133)~~] (134) "Preexisting condition," with respect to a health benefit plan:

(a) means a condition that was present before the effective date of coverage, whether or not medical advice, diagnosis, care, or treatment was recommended or received before that day; and

(b) does not include a condition indicated by genetic information unless an actual diagnosis of the condition by a physician has been made.

[~~(134)~~] (135) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

(c) (i) "Premium" does not include consideration paid to a third party administrator for the third party administrator's services.

(ii) "Premium" includes an amount paid by a third party administrator to an insurer for insurance on the risks administered by the third party administrator.

[~~(135)~~] (136) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(136)~~] (137) "Proceeding" includes an action or special statutory proceeding.

[~~(137)~~] (138) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

[~~(138)~~] (139) (a) Except as provided in Subsection [~~(138)~~] (139)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

(ii) against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages.

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

[~~(139)~~] (140) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

(a) an individual or group insurance contract that meets the requirements of Section 7702B(b), Internal Revenue Code; or

(b) the portion of a life insurance contract that provides long-term care insurance:

(i) (A) by rider; or

(B) as a part of the contract; and

(ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue Code.

[~~(140)~~] (141) "Qualified United States financial institution" means an institution that:

(a) is:

(i) organized under the laws of the United States or any state; or

(ii) in the case of a United States office of a foreign banking organization, licensed under the laws of the United States or any state;

(b) is regulated, supervised, and examined by a United States federal or state authority having regulatory authority over a bank or trust company; and

(c) meets the standards of financial condition and standing that are considered necessary and appropriate to regulate the quality of a financial institution whose letters of credit will be acceptable to the commissioner as determined by:

(i) the commissioner by rule; or

(ii) the Securities Valuation Office of the National Association of Insurance Commissioners.

[~~(141)~~] (142) (a) "Rate" means:

(i) the cost of a given unit of insurance; or

(ii) for property or casualty insurance, that cost of insurance per exposure unit either expressed as:

(A) a single number; or

(B) a pure premium rate, adjusted before the application of individual risk variations based on loss or expense considerations to account for the treatment of:

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

(b) "Rate" does not include a minimum premium.

[~~(142)~~] (143) (a) Except as provided in Subsection [~~(142)~~] (143)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

(i) collecting, compiling, and furnishing loss or expense statistics;

(ii) recommending, making, or filing rates or supplementary rate information; or

(iii) advising about rate questions, except as an attorney giving legal advice.

(b) "Rate service organization" does not mean:

(i) an employee of an insurer;

(ii) a single insurer or group of insurers under common control;

(iii) a joint underwriting group; or

(iv) an individual serving as an actuarial or legal consultant.

[~~(143)~~] (144) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

(d) a rating formula that describes steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(144)~~] (145) "Received by the department" means:

(a) the date delivered to and stamped received by the department, if delivered in person;

(b) the post mark date, if delivered by mail;

(c) the delivery service's post mark or pickup date, if delivered by a delivery service;

(d) the received date recorded on an item delivered, if delivered by:

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

[~~(145)~~] (146) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

(a) operating through an attorney-in-fact common to all of the persons; and

(b) exchanging insurance contracts with one another that provide insurance coverage on each other.

[~~(146)~~] (147) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

(a) the insurer transferring the risk as the "ceding insurer"; and

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(147)~~] (148) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(148)~~] (149) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(149)~~] (150) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

(b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a liability assumed under a reinsurance contract.

[~~(150)~~] (151) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(151)~~] (152) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

(vi) certificate of interest or participation in a profit-sharing agreement;

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

(xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in payments out of production under such a title or lease;

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed

in Subsections [~~(151)~~] (152)(a)(i) through (xiv); or

(xvi) another interest or instrument commonly known as a security.

(b) "Security" does not include:

(i) any of the following under which an insurance company promises to pay money in a specific lump sum or periodically for life or some other specified period:

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

[~~(152)~~] (153) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

[~~(153)~~] (154) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(b) Except as provided in this Subsection [~~(153)~~] (154), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(c) "Self-insurance" includes:

(i) an arrangement by which a governmental entity undertakes to indemnify an employee for liability arising out of the employee's employment; and

(ii) an arrangement by which a person with a managed program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or employees for liability or risk that is related to the relationship or employment.

(d) "Self-insurance" does not include an arrangement with an independent contractor.

[~~(154)~~] (155) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(155)~~] (156) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.

[~~(156)~~] (157) "Significant break in coverage" means a period of 63 consecutive days

during each of which an individual does not have creditable coverage.

[~~(157)~~] (158) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

(a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and

(b) employs at least two employees on the first day of the plan year.

[~~(158)~~] (159) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

[~~(159)~~] (160) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

(b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting shares are owned by that person either alone or with its affiliates, except for the minimum number of shares the law of the subsidiary's domicile requires to be owned by directors or others.

[~~(160)~~] (161) Subject to Subsection (86)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from the failure of a principal to pay or perform the principal's obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(161)~~] (162) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of [~~a mutual~~] an insurer or organization that is designated by the insurer or organization as permanent.

(ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and [~~31A-14-209~~] 31A-14-205 require that [~~mutuals~~] insurers or organizations doing business in this state maintain specified minimum levels of permanent surplus.

(iii) Except for assessable mutuals, the minimum permanent surplus requirement is the same as the minimum required capital requirement that applies to stock insurers.

(c) "Excess surplus" means:

(i) for a life insurer, accident and health insurer, health organization, or property and

casualty insurer as defined in Section 31A-17-601, the lesser of:

(A) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 2.5; and

(II) the sum of the insurer's or health organization's minimum capital or permanent surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

(B) that amount of an insurer's or health organization's total adjusted capital that exceeds the product of:

(I) 3.0; and

(II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

(ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

(A) 1.5; and

(B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

[~~(162)~~] (163) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

(i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;

(ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or

(iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;

(c) an employer on behalf of the employer's employees or the employees of one or more of the subsidiary or affiliated corporations of the employer;

(d) an insurer licensed under the following, but only for a line of insurance for which the insurer holds a license in this state:

(i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

(ii) Chapter 7, Nonprofit Health Service Insurance Corporations;

(iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

(A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries; or

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or for which the person is exempt; or

(f) an institution, bank, or financial institution:

(i) that is:

(A) an institution whose deposits and accounts are to any extent insured by a federal deposit insurance agency, including the Federal Deposit Insurance Corporation or National Credit Union Administration; or

(B) a bank or other financial institution that is subject to supervision or examination by a federal or state banking authority; and

(ii) that does not adjust claims without a third party administrator license.

[~~(163)~~] (164) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(164)~~] (165) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

(a) the statutory accounting applicable to the annual financial statements required to be filed under Section 31A-4-113; and

(b) another item provided by the RBC instructions, as RBC instructions is defined in Section 31A-17-601.

[~~(165)~~] (166) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an

individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

[~~(166)~~] (167) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

(i) not holding a valid certificate of authority to do an insurance business in this state; or

(ii) transacting business not authorized by a valid certificate.

(b) "Admitted insurer" or "authorized insurer" means an insurer:

(i) holding a valid certificate of authority to do an insurance business in this state; and

(ii) transacting business as authorized by a valid certificate.

[~~(167)~~] (168) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(168)~~] (169) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection [~~(138)~~] (139).

[~~(169)~~] (170) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(170)~~] (171) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of the health benefit plan, can become effective.

[~~(171)~~] (172) "Workers' compensation insurance" means:

(a) insurance for indemnification of an employer against liability for compensation based on:

(i) a compensable accidental injury; and

(ii) occupational disease disability;

(b) employer's liability insurance incidental to workers' compensation insurance and written in connection with workers' compensation insurance; and

(c) insurance assuring to a person entitled to workers' compensation benefits the compensation provided by law.

Section 2. Section **31A-2-404** is amended to read:

31A-2-404. Duties of the commissioner and Title and Escrow Commission.

(1) Notwithstanding the other provisions of this chapter, to the extent provided in this part, the commissioner shall administer and enforce the provisions in this title related to:

(a) title insurance; and

(b) escrow conducted by a title licensee or title insurer.

(2) The commission shall:

(a) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and subject to Subsection [~~(3)~~] (4), make rules for the administration of the provisions in this title related to title insurance including rules related to:

(i) rating standards and rating methods for a title licensee, as provided in Section 31A-19a-209;

(ii) the licensing for a title licensee, including the licensing requirements of Section 31A-23a-204;

(iii) continuing education requirements of Section 31A-23a-202; and

[~~(iv) examination procedures, after consultation with the commissioner and the commissioner's test administrator when required by Section 31A-23a-204; and~~]

[~~(v)~~] (iv) standards of conduct for a title licensee;

(b) concur in the issuance and renewal of a license in accordance with Section 31A-23a-105 or 31A-26-203;

(c) in accordance with Section 31A-3-103, establish, with the concurrence of the commissioner, the fees imposed by this title on a title licensee;

(d) in accordance with Section 31A-23a-415 determine, after consulting with the commissioner, the assessment on a title insurer as defined in Section 31A-23a-415;

(e) conduct an administrative hearing not delegated by the commission to an administrative law judge related to the:

(i) licensing of an applicant;

(ii) conduct of a title licensee; or

(iii) approval of a continuing education program required by Section 31A-23a-202;

(f) with the concurrence of the commissioner, approve a continuing education program required by Section 31A-23a-202;

(g) with the concurrence of the commissioner, impose a penalty:

(i) under this title related to:

(A) title insurance; or

(B) escrow conducted by a title licensee;

(ii) after investigation by the commissioner in accordance with Part 3, Procedures and Enforcement; and

(iii) that is enforced by the commissioner;

(h) advise the commissioner on the administration and enforcement of any matter affecting the title insurance industry;

(i) advise the commissioner on matters affecting the commissioner's budget related to title insurance; and

(j) perform other duties as provided in this title.

(3) The commission may make rules establishing an examination for a license that will satisfy Section 31A-23a-204:

(a) after consultation with the commissioner and the commissioner's test administrator;

(b) in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(c) subject to Subsection (4).

[~~(3)~~] (4) The commission may make a rule under this title only if at the time the commission files its proposed rule and rule analysis with the Division of Administrative Rules in accordance with Section 63G-3-301, the commission provides the Real Estate Commission that same information.

[~~(4)~~] (5) (a) The commissioner shall annually report the information described in Subsection [~~(4)~~] (5)(b) in writing to:

(i) the commission; and

(ii) the Business and Labor Interim Committee.

(b) The information required to be reported under this Subsection [~~(4)~~] (5):

(i) may not identify a person; and

(ii) shall include:

(A) the number of complaints the commissioner receives with regard to transactions involving title insurance or a title licensee during the calendar year immediately proceeding the report;

(B) the type of complaints described in Subsection [~~(4)~~] (5)(b)(ii)(A); and

(C) for each complaint described in Subsection [~~(4)~~] (5)(b)(ii)(A):

(I) any action taken by the commissioner with regard to the complaint; and

(II) the time-period beginning the day on which a complaint is made and ending the day on which the commissioner determines it will take no further action with regard to the complaint.

Section 3. Section **31A-3-304 (Effective 07/01/13)** is amended to read:

31A-3-304 (Effective 07/01/13). Annual fees -- Other taxes or fees prohibited -- Captive Insurance Restricted Account.

(1) (a) A captive insurance company shall pay an annual fee imposed under this section to obtain or renew a certificate of authority.

(b) The commissioner shall:

(i) determine the annual fee pursuant to Section 31A-3-103; and

(ii) consider whether the annual fee is competitive with fees imposed by other states on captive insurance companies.

(2) A captive insurance company that fails to pay the fee required by this section is subject to the relevant sanctions of this title.

(3) (a) Except as provided in Subsection (3)(d) and notwithstanding Title 59, Chapter 9, Taxation of Admitted Insurers, the following constitute the sole taxes, fees, or charges under the laws of this state that may be levied or assessed on a captive insurance company:

(i) a fee under this section;

(ii) a fee under Chapter 37, Captive Insurance Companies Act; and

(iii) a fee under Chapter 37a, Special Purpose Financial Captive Insurance Company Act.

(b) The state or a county, city, or town within the state may not levy or collect an occupation tax or other tax, fee, or charge not described in Subsections (3)(a)(i) through (iii) against a captive insurance company.

(c) The state may not levy, assess, or collect a withdrawal fee under Section 31A-4-115 against a captive insurance company.

(d) A captive insurance company is subject to real and personal property taxes.

(4) A captive insurance company shall pay the fee imposed by this section to the commissioner by June 20 of each year.

(5) (a) Money received pursuant to a fee described in Subsection (3)(a) shall be deposited into the Captive Insurance Restricted Account.

(b) There is created in the General Fund a restricted account known as the "Captive Insurance Restricted Account."

(c) The Captive Insurance Restricted Account shall consist of the fees described in Subsection (3)(a).

(d) The commissioner shall administer the Captive Insurance Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Captive Insurance Restricted Account to:

(i) administer and enforce:

(A) Chapter 37, Captive Insurance Companies Act; and

(B) Chapter 37a, Special Purpose Financial Captive Insurance Company Act; and

(ii) promote the captive insurance industry in Utah.

(e) An appropriation from the Captive Insurance Restricted Account is nonlapsing, except that at the end of each fiscal year, money received by the commissioner in excess of [~~$950,000~~] $1,250,000 shall be treated as free revenue in the General Fund.

Section 4. Section **31A-8-301** is amended to read:

31A-8-301. Requirements for doing business in state.

(1) Only a corporation incorporated and licensed under Part 2, Domestic Organizations, may do business in this state as an organization.

(2) To do business in this state as an organization, a foreign [~~corporations~~] corporation doing a similar business in other states shall incorporate a subsidiary and license [~~if~~] it under Part 2, Domestic Organizations, for its Utah business. Except as to Chapter 16, Insurance Holding Companies, the laws applicable to a domestic [~~organizations~~] organization apply only to the domestic organization and not to its foreign parent corporation.

Section 5. Section **31A-17-603** is amended to read:

31A-17-603. Company action level event.

(1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer or health organization that indicates that:

(i) the insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC; [~~or~~]

(ii) if a life or accident and health insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 2.5; and

[~~(B) a negative trend, determined in accordance with the "trend test calculation" included in the RBC instructions;~~]

(B) triggers the trend test determined in accordance with the trend test calculation included in the life or fraternal RBC instructions; or

(iii) if a property and casualty insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a company action level event, the insurer or health organization shall prepare and submit to the commissioner an RBC plan that shall:

(i) identify the conditions that contribute to the company action level event;

(ii) contain proposals of corrective actions that the insurer or health organization intends to take and that are expected to result in the elimination of the company action level event;

(iii) provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of:

(A) statutory operating income;

(B) net income;

(C) capital;

(D) surplus; and

(E) RBC levels;

(iv) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(v) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(3) The RBC plan shall be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607, within 45 days after notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(4) (a) Within 60 days after the submission by an insurer or health organization of an RBC plan to the commissioner, the commissioner shall notify the insurer or health organization whether the RBC plan:

(i) shall be implemented; or

(ii) is unsatisfactory.

(b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination, and may propose revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer or health organization shall:

(i) prepare a revised RBC plan that incorporates any revision proposed by the commissioner; and

(ii) submit the revised RBC plan to the commissioner:

(A) within 45 days after the notification from the commissioner; or

(B) if the insurer challenges the notification from the commissioner under Section 31A-17-607, within 45 days after a notification to the insurer or health organization that after a

hearing the commissioner rejects the insurer's or health organization's challenge.

(5) In the event of a notification by the commissioner to an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event subject to the insurer's or health organization's right to a hearing under Section 31A-17-607.

(6) Every domestic insurer or health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer or health organization is authorized to do business if:

(a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and

(b) the insurance commissioner of that state notifies the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and (4).

Section 6. Section **31A-22-429** is enacted to read:

31A-22-429. Producer's duties related to replacement of life insurance or annuity.

(1) In connection with or as part of each application for life insurance or annuities, the applicant shall complete and the producer shall submit to the insurer the statements required by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act as to:

(a) whether the applicant has existing policies or contracts; and

(b) whether the proposed life insurance or annuity will replace, discontinue, or change an existing policy or contract.

(2) (a) If an applicant for life insurance or an annuity answers "yes" to the question regarding replacement, discontinuance, or change of an existing policy or contract referred to in Subsection (1), the producer shall present to the applicant, not later than at the time of taking the application, the notice regarding replacements in the form adopted by the commissioner by

rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or other substantially similar document filed with the commissioner. However, a filing is not required when an amendment to the notice is limited to the omission of a reference not applicable to the product being sold or replaced.

(b) The notice described in Subsection (2)(a) shall be signed by both the applicant and the producer attesting that the notice has been read aloud by the producer or that the applicant did not wish the notice to be read aloud, in which case the producer need not have read the notice aloud, and left with the applicant. With respect to an electronically completed application and notice, the producer is not required to leave a copy of the electronically completed notice with the applicant.

(3) (a) The notice described in Subsection (2)(a) shall:

(i) list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and

(ii) include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract.

(b) If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.

(4) In connection with a replacement transaction the producer shall leave with the applicant at the time an application for a new policy or contract is completed the original or a copy of all sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.

(5) Except as provided in rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, in connection with a replacement transaction the producer shall submit to the insurer to which an application for a policy or contract is presented:

(a) a copy of each document required by this section;

(b) a statement identifying any preprinted or electronically presented company approved sales materials used; and

(c) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Section 7. Section **31A-22-519** is amended to read:

31A-22-519. Death pending conversion.

If a person insured under a group life insurance policy, or the insured dependent of that person, dies during the period of eligibility for conversion under Section 31A-22-517 or 31A-22-518 and before the individual policy becomes effective, the amount of life insurance to which [~~he~~] the insured would have been entitled to have issued under the individual policy is payable as a claim under the group policy, whether or not application for the individual policy or the payment of the first premium has been made.

Section 8. Section **31A-22-617** is amended to read:

31A-22-617. Preferred provider contract provisions.

Health insurance policies may provide for insureds to receive services or reimbursement under the policies in accordance with preferred health care provider contracts as follows:

(1) Subject to restrictions under this section, any insurer or third party administrator may enter into contracts with health care providers as defined in Section 78B-3-403 under which the health care providers agree to supply services, at prices specified in the contracts, to persons insured by an insurer.

(a) (i) A health care provider contract may require the health care provider to accept the specified payment as payment in full, relinquishing the right to collect additional amounts from the insured person.

(ii) In any dispute involving a provider's claim for reimbursement, the same shall be determined in accordance with applicable law, the provider contract, the subscriber contract, and the insurer's written payment policies in effect at the time services were rendered.

(iii) If the parties are unable to resolve their dispute, the matter shall be subject to binding arbitration by a jointly selected arbitrator. Each party is to bear its own expense except the cost of the jointly selected arbitrator shall be equally shared. This Subsection (1)(a)(iii) does not apply to the claim of a general acute hospital to the extent it is inconsistent with the hospital's provider agreement.

(iv) An organization may not penalize a provider solely for pursuing a claims dispute or otherwise demanding payment for a sum believed owing.

(v) If an insurer permits another entity with which it does not share common ownership

or control to use or otherwise lease one or more of the organization's networks of participating providers, the organization shall ensure, at a minimum, that the entity pays participating providers in accordance with the same fee schedule and general payment policies as the organization would for that network.

(b) The insurance contract may reward the insured for selection of preferred health care providers by:

(i) reducing premium rates;

(ii) reducing deductibles;

(iii) coinsurance;

(iv) other copayments; or

(v) any other reasonable manner.

(c) If the insurer is a managed care organization, as defined in Subsection 31A-27a-403(1)(f):

(i) the insurance contract and the health care provider contract shall provide that in the event the managed care organization becomes insolvent, the rehabilitator or liquidator may:

(A) require the health care provider to continue to provide health care services under the contract until the earlier of:

(I) 90 days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or

(II) the date the term of the contract ends; and

(B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to receive from the managed care organization during the time period described in Subsection (1)(c)(i)(A);

(ii) the provider is required to:

(A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and

(B) relinquish the right to collect additional amounts from the insolvent managed care organization's enrollee, as defined in Subsection 31A-27a-403(1)(b);

(iii) if the contract between the health care provider and the managed care organization has not been reduced to writing, or the contract fails to contain the language required by Subsection (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:

(A) sums owed by the insolvent managed care organization; or

(B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);

(iv) the following may not bill or maintain any action at law against an enrollee to collect sums owed by the insolvent managed care organization or the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B):

(A) a provider;

(B) an agent;

(C) a trustee; or

(D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and

(v) notwithstanding Subsection (1)(c)(i):

(A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's regular fee set forth in the contract; and

(B) the enrollee shall continue to pay the copayments, deductibles, and other payments for services received from the provider that the enrollee was required to pay before the filing of:

(I) a petition for rehabilitation; or

(II) a petition for liquidation.

(2) (a) Subject to Subsections (2)(b) through (2)[~~(f)~~](e), an insurer using preferred health care provider contracts [~~shall pay for the services of health care providers not under the contract, unless the illnesses or injuries treated by the health care provider are not within the scope of the insurance contract. As used in this section, "class of health care providers" means all health care providers licensed or licensed and certified by the state within the same professional, trade, occupational, or facility licensure or licensure and certification category established pursuant to Titles 26, Utah Health Code and 58, Occupations and Professions~~] is subject to the reimbursement requirements in Section 31A-8-501.

[~~(b) (i) Until July 1, 2012, when the insured receives services from a health care provider not under contract, the insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for comparable services of preferred health care providers who are members of the same class of health care providers.~~]

[~~(ii) Notwithstanding Subsection (2)(b)(i), an insurer may offer a health plan that complies with the provisions of Subsection 31A-22-618.5(3).~~]

[~~(iii) The commissioner may adopt a rule dealing with the determination of what~~

~~constitutes 75% of the average amount paid by the insurer under Subsection (2)(b)(i) for comparable services of preferred health care providers who are members of the same class of health care providers.~~]

[~~(c)~~] (b) When reimbursing for services of health care providers not under contract, the insurer may make direct payment to the insured.

[~~(d) Notwithstanding Subsection (2)(b), an~~]

(c) An insurer using preferred health care provider contracts may impose a deductible on coverage of health care providers not under contract.

[~~(e)~~] (d) When selecting health care providers with whom to contract under Subsection (1), an insurer may not unfairly discriminate between classes of health care providers, but may discriminate within a class of health care providers, subject to Subsection (7).

[~~(f)~~] (e) For purposes of this section, unfair discrimination between classes of health care providers [~~shall~~] include:

(i) refusal to contract with class members in reasonable proportion to the number of insureds covered by the insurer and the expected demand for services from class members; and

(ii) refusal to cover procedures for one class of providers that are:

(A) commonly [~~utilized~~] used by members of the class of health care providers for the treatment of illnesses, injuries, or conditions;

(B) otherwise covered by the insurer; and

(C) within the scope of practice of the class of health care providers.

(3) Before the insured consents to the insurance contract, the insurer shall fully disclose to the insured that it has entered into preferred health care provider contracts. The insurer shall provide sufficient detail on the preferred health care provider contracts to permit the insured to agree to the terms of the insurance contract. The insurer shall provide at least the following information:

(a) a list of the health care providers under contract, and if requested their business locations and specialties;

(b) a description of the insured benefits, including any deductibles, coinsurance, or other copayments;

(c) a description of the quality assurance program required under Subsection (4); and

(d) a description of the adverse benefit determination procedures required under

Subsection (5).

(4) (a) An insurer using preferred health care provider contracts shall maintain a quality assurance program for assuring that the care provided by the health care providers under contract meets prevailing standards in the state.

(b) The commissioner in consultation with the executive director of the Department of Health may designate qualified persons to perform an audit of the quality assurance program. The auditors shall have full access to all records of the organization and its health care providers, including medical records of individual patients.

(c) The information contained in the medical records of individual patients shall remain confidential. All information, interviews, reports, statements, memoranda, or other data furnished for purposes of the audit and any findings or conclusions of the auditors are privileged. The information is not subject to discovery, use, or receipt in evidence in any legal proceeding except hearings before the commissioner concerning alleged violations of this section.

(5) An insurer using preferred health care provider contracts shall provide a reasonable procedure for resolving complaints and adverse benefit determinations initiated by the insureds and health care providers.

(6) An insurer may not contract with a health care provider for treatment of illness or injury unless the health care provider is licensed to perform that treatment.

(7) (a) A health care provider or insurer may not discriminate against a preferred health care provider for agreeing to a contract under Subsection (1).

(b) Any health care provider licensed to treat any illness or injury within the scope of the health care provider's practice, who is willing and able to meet the terms and conditions established by the insurer for designation as a preferred health care provider, shall be able to apply for and receive the designation as a preferred health care provider. Contract terms and conditions may include reasonable limitations on the number of designated preferred health care providers based upon substantial objective and economic grounds, or expected use of particular services based upon prior provider-patient profiles.

(8) Upon the written request of a provider excluded from a provider contract, the commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based on the criteria set forth in Subsection (7)(b).

(9) Insurers are subject to [~~the provisions of~~] Sections 31A-22-613.5, 31A-22-614.5, and 31A-22-618.

(10) Nothing in this section is to be construed as to require an insurer to offer a certain benefit or service as part of a health benefit plan.

(11) This section does not apply to catastrophic mental health coverage provided in accordance with Section 31A-22-625.

Section 9. Section **31A-22-618.5** is amended to read:

31A-22-618.5. Health benefit plan offerings.

(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) the limitation on point of service products in Subsections 31A-8-408(3) through (6);

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

(D) 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 as follows:

(A) within the organization's service area, covered services shall include health care services from non-affiliated providers when medically necessary to stabilize an emergency medical condition; and

(B) outside the organization's service area, covered services shall include medically

necessary health care services for the treatment of an emergency medical condition that are immediately required while the enrollee is outside the geographic limits of the organization's service area.

(3) An insurer that offers a health benefit plan that is not subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

[~~(a) notwithstanding Subsection 31A-22-617(2), may offer a health benefit plan that groups providers into the following reimbursement levels:~~]

[~~(i) tier one contracted providers;~~]

[~~(ii) tier two contracted providers who the insurer shall reimburse at least 75% of tier one providers; and~~]

[~~(iii) one or more tiers of non-contracted providers;~~]

[~~(b)~~] (a) notwithstanding Subsection 31A-22-617(9), may offer a health benefit plan that is not subject to Section 31A-22-618;

[~~(c) beginning July 1, 2012, may offer health benefit plans that:~~]

[~~(i) are not subject to Subsection 31A-22-617(2); and~~]

[~~(ii) are subject to the reimbursement requirements in Section 31A-8-501;~~]

[~~(d)~~] (b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627 [~~by providing coverage at a reimbursement level of at least 75% of the health benefit plan's highest contracted provider category~~]; and

[~~(e)~~] (c) are 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 [~~Subsections~~] Subsection (3)(a) [~~and (b)~~] shall be based on actuarially sound data.

(6) Nothing in this section limits the number of health benefit plans that an insurer may offer.

Section 10. Section **31A-22-724** is amended to read:

31A-22-724. Offer of alternative coverage -- Utah NetCare Plan.

(1) For purposes of this section, "alternative coverage" means:

(a) a high deductible or low deductible Utah NetCare Plan described in Subsection (2) for a conversion health benefit plan policy offered under Section 31A-22-723; and

(b) a high deductible and low deductible Utah NetCare Plans described in Subsection (2) as an alternative to COBRA and mini-COBRA health benefit plan coverage offered under Section 31A-22-722.

(2) A Utah NetCare Plan under this section is subject to Section 31A-2-212 and shall, except when prohibited by federal law, include:

(a) healthy lifestyle and wellness incentives;

(b) the benefits described in this Subsection (2) or at least the actuarial equivalent of the benefits described in this Subsection (2);

(c) a lifetime maximum benefit per person of not less than $1,000,000;

(d) an annual maximum benefit per person of not less than $250,000;

(e) the following deductibles:

(i) for a low deductible plan:

(A) $2,000 for an individual plan;

(B) $4,000 for a two party plan; and

(C) $6,000 for a family plan;

(ii) for a high deductible plan:

(A) $4,000 for an individual plan;

(B) $8,000 for a two party plan; and

(C) $12,000 for a family plan;

(f) the following out-of-pocket maximum costs, including deductibles, copayments, and coinsurance:

(i) for a low deductible plan:

(A) $5,000 for an individual plan;

(B) $10,000 for a two party plan; and

(C) $15,000 for a family plan; and

(ii) for a high deductible plan:

(A) $10,000 for an individual plan;

(B) $20,000 for a two party plan; and

(C) $30,000 for a family plan;

(g) the following benefits before applying a deductible requirement and in accordance with Section 223, Internal Revenue Code, and 42 U.S.C. Sec. 300gg-13:

(i) all well child exams and immunizations up to age five, with no annual maximum;

(ii) preventive care up to a $500 annual maximum;

(iii) primary care and specialist and urgent care not covered under Subsection (2)(g)(i) or (ii) up to a $300 annual maximum; and

(iv) supplemental accident coverage up to a $500 annual maximum;

(h) the following copayments for each exam:

(i) $15 for preventive care and well child exams;

(ii) $25 for primary care; and

(iii) $50 for urgent care and specialist care;

(i) a $200 copayment for an emergency room visit after applying the deductible;

(j) no more than a 30% coinsurance after deductible for covered plan benefits for:

(i) hospital services;

(ii) maternity;

(iii) laboratory work;

(iv) x-rays;

(v) radiology;

(vi) outpatient surgery services;

(vii) injectable medications not otherwise covered under a pharmacy benefit;

(viii) durable medical equipment;

(ix) ambulance services;

(x) in-patient mental health services; and

(xi) out-patient mental health services; and

(k) the following cost-sharing features for a prescription drug:

(i) up to a $15 copayment for a generic drug; and

(ii) up to a 50% coinsurance for a name brand drug.

(3) A Utah NetCare Plan may exclude:

(a) the benefit mandates described in Subsections 31A-22-618.5(2)(b) and (3)[~~(b)~~](a); and

(b) unless required by federal law, mandated coverage required by the following sections and related administrative rules:

(i) Section 31A-22-610.1, Adoption indemnity benefit;

(ii) Section 31A-22-623, Coverage of inborn metabolic errors;

(iii) Section 31A-22-624, Primary care physician;

(iv) Section 31A-22-626, Coverage of diabetes;

(v) Section 31A-22-628, Standing referral to a specialist; and

(vi) a mandated coverage enacted after January 1, 2009, that is not required by federal law.

(4) A Utah NetCare Plan may include a formulary or preferred drug list.

(5) (a) Except as provided in Subsection (6), a person may elect alternative coverage under this section if the person is eligible for:

(i) continuation of employer group health benefit plan coverage under federal COBRA laws;

(ii) continuation of employer group health benefit plan coverage under state mini-COBRA under Section 31A-22-722; or

(iii) a conversion to an individual health benefit plan after the exhaustion of benefits under:

(A) alternative coverage elected in place of federal COBRA; or

(B) state mini-COBRA under Section 31A-22-722.

(b) The right to extend coverage under Subsection (5)(a) applies to spouse or dependent coverages, including a surviving spouse or dependent whose coverage under the policy terminates by reason of the death of the employee or member.

(6) If a person elects federal COBRA or state mini-COBRA health benefit plan coverage under Section 31A-22-722, the person is not eligible to elect alternative coverage under this section until the person is eligible to convert coverage to an individual policy under Section 31A-22-723 and Subsection (1)(a).

(7) (a) [~~(i)~~] If alternative coverage is selected as an alternative to COBRA or mini-COBRA health benefit plan coverage under Section 31A-22-722[~~,~~]:

(i) Section 31A-22-722 applies to the alternative coverage[~~.~~];

(ii) [~~If an employee of a small employer selects alternative coverage as an alternative to COBRA or mini-COBRA health benefit plan coverage,~~] the insurer may not use a risk factor greater than the employer's most current risk factor for purposes of Subsection 31A-22-722(5)[~~.~~]; and

(iii) the insurer shall credit to the alternative coverage the current year's deductible and out of pocket amounts satisfied under the employer's plan.

(b) If alternative coverage is selected as a conversion policy under Section 31A-22-723[~~,~~]:

(i) Section 31A-22-723 applies[~~.~~]; and

(ii) the insurer shall credit to the alternative coverage the current year's deductible and out of pocket amounts satisfied under the employer's plan.

(8) The commissioner shall adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to develop a model letter for employers to use to notify an employee of the employee's options for alternative coverage.

Section 11. Section **31A-23a-204** is amended to read:

31A-23a-204. Special requirements for title insurance producers and agencies.

A title insurance producer, including an agency, shall be licensed in accordance with this chapter, with the additional requirements listed in this section.

(1) (a) A person that receives a new license under this title as a title insurance agency, shall at the time of licensure be owned or managed by at least one individual who is licensed for at least three of the five years immediately preceding the date on which the title insurance agency applies for a license with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(b) A title insurance agency subject to Subsection (1)(a) may comply with Subsection (1)(a) by having the title insurance agency owned or managed by:

(i) one or more individuals who are licensed with the search line of authority for the time period provided in Subsection (1)(a); and

(ii) one or more individuals who are licensed with the escrow line of authority for the time period provided in Subsection (1)(a).

(c) A person licensed as a title insurance agency shall at all times during the term of licensure be owned or managed by at least one individual who is licensed for at least three years within the preceding five-year period with both:

(i) a search line of authority; and

(ii) an escrow line of authority.

(d) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt an attorney with real estate experience from the experience requirements in Subsection (1)(a).

(2) (a) A title insurance agency or producer appointed by an insurer shall maintain:

(i) a fidelity bond;

(ii) a professional liability insurance policy; or

(iii) a financial protection:

(A) equivalent to that described in Subsection (2)(a)(i) or (ii); and

(B) that the commissioner considers adequate.

(b) The bond, insurance, or financial protection required by this Subsection (2):

(i) shall be supplied under a contract approved by the commissioner to provide protection against the improper performance of any service in conjunction with the issuance of a contract or policy of title insurance; and

(ii) be in a face amount no less than $50,000.

(c) The Title and Escrow Commission may by rule, subject to Section 31A-2-404, exempt title insurance producers from the requirements of this Subsection (2) upon a finding that, and only so long as, the required policy or bond is generally unavailable at reasonable rates.

(3) A title insurance agency or producer appointed by an insurer may maintain a reserve fund to the extent money was deposited before July 1, 2008, and not withdrawn to the income of the title insurance producer.

(4) An examination for licensure shall include questions regarding the search and examination of title to real property.

(5) A title insurance producer may not perform the functions of escrow unless the title insurance producer has been examined on the fiduciary duties and procedures involved in those functions.

(6) The Title and Escrow Commission [~~shall~~] may adopt rules, subject to Section 31A-2-404, after consulting with the [~~department~~] commissioner and the [~~department's~~] commissioner's test administrator, establishing an examination for a license that will satisfy this section.

(7) A license may be issued to a title insurance producer who has qualified:

(a) to perform only searches and examinations of title as specified in Subsection (4);

(b) to handle only escrow arrangements as specified in Subsection (5); or

(c) to act as a title marketing representative.

(8) (a) A person licensed to practice law in Utah is exempt from the requirements of Subsections (2) and (3) if that person issues 12 or less policies in any 12-month period.

(b) In determining the number of policies issued by a person licensed to practice law in Utah for purposes of Subsection (8)(a), if the person licensed to practice law in Utah issues a policy to more than one party to the same closing, the person is considered to have issued only one policy.

(9) A person licensed to practice law in Utah, whether exempt under Subsection (8) or not, shall maintain a trust account separate from a law firm trust account for all title and real estate escrow transactions.

Section 12. Section **31A-23a-402.5** is amended to read:

31A-23a-402.5. Inducements.

(1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee under this title, or an officer or employee of a licensee, may not induce a person to enter into, continue, or terminate an insurance contract by offering a benefit that is not:

(i) specified in the insurance contract; or

(ii) directly related to the insurance contract.

(b) An insurer may not make or knowingly allow an agreement of insurance that is not clearly expressed in the insurance contract to be issued or renewed.

(c) A licensee under this title may not absorb the tax under Section 31A-3-301.

(2) This section does not apply to a title insurer, a title producer, or an officer or employee of a title insurer or title producer.

(3) Items not prohibited by Subsection (1) include an insurer:

(a) reducing premiums because of expense savings;

(b) providing to a policyholder or insured one or more incentives, as defined by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to participate in a program or activity designed to reduce claims or claim expenses, including:

(i) a premium discount offered to a small or large employer group based on a wellness program if:

(A) the premium discount for the employer group does not exceed 20% of the group premium; and

(B) the premium discount based on the wellness program is offered uniformly by the insurer to all employer groups in the large or small group market;

(ii) a premium discount offered to employees of a small or large employer group in an amount that does not exceed federal limits on wellness program incentives; or

(iii) a combination of premium discounts offered to the employer group and the employees of an employer group, based on a wellness program, if:

(A) the premium discounts for the employer group comply with Subsection (3)(b)(i); and

(B) the premium discounts for the employees of an employer group comply with Subsection (3)(b)(ii); or

(c) receiving premiums under an installment payment plan.

(4) Items not prohibited by Subsection (1) include a producer, consultant, or other licensee, or an officer or employee of a licensee, either directly or through a third party:

(a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not conditioned on the purchase of a particular insurance product;

(b) extending credit on a premium to the insured:

(i) without interest, for no more than 90 days from the effective date of the insurance contract;

(ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid balance after the time period described in Subsection (4)(b)(i); and

(iii) except that an installment or payroll deduction payment of premiums on an insurance contract issued under an insurer's mass marketing program is not considered an extension of credit for purposes of this Subsection (4)(b);

(c) preparing or conducting a survey that:

(i) is directly related to an accident and health insurance policy purchased from the licensee; or

(ii) is used by the licensee to assess the benefit needs and preferences of insureds, employers, or employees directly related to an insurance product sold by the licensee;

(d) providing limited human resource services that are directly related to an insurance product sold by the licensee, including:

(i) answering questions directly related to:

(A) an employee benefit offering or administration, if the insurance product purchased from the licensee is accident and health insurance or health insurance; and

(B) employment practices liability, if the insurance product offered by or purchased from the licensee is property or casualty insurance; and

(ii) providing limited human resource compliance training and education directly pertaining to an insurance product purchased from the licensee;

(e) providing the following types of information or guidance:

(i) providing guidance directly related to compliance with federal and state laws for an insurance product purchased from the licensee;

(ii) providing a workshop or seminar addressing an insurance issue that is directly related to an insurance product purchased from the licensee; or

(iii) providing information regarding:

(A) employee benefit issues;

(B) directly related insurance regulatory and legislative updates; or

(C) similar education about an insurance product sold by the licensee and how the insurance product interacts with tax law;

(f) preparing or providing a form that is directly related to an insurance product purchased from, or offered by, the licensee;

(g) preparing or providing documents directly related to a premium only cafeteria plan within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but not providing ongoing administration of a flexible spending account;

(h) providing enrollment and billing assistance, including:

(i) providing benefit statements or new hire insurance benefits packages; and

(ii) providing technology services such as an electronic enrollment platform or application system;

(i) communicating coverages in writing and in consultation with the insured and employees;

(j) providing employee communication materials and notifications directly related to an insurance product purchased from a licensee;

(k) providing claims management and resolution to the extent permitted under the licensee's license;

(l) providing underwriting or actuarial analysis or services;

(m) negotiating with an insurer regarding the placement and pricing of an insurance product;

(n) recommending placement and coverage options;

(o) providing a health fair or providing assistance or advice on establishing or operating a wellness program, but not providing any payment for or direct operation of the wellness program;

(p) providing COBRA and Utah mini-COBRA administration, consultations, and other services directly related to an insurance product purchased from the licensee;

(q) assisting with a summary plan description;

(r) providing information necessary for the preparation of documents directly related to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as amended;

(s) providing information or services directly related to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services directly related to health care access, portability, and renewability when offered in connection with accident and health insurance sold by a licensee;

(t) sending proof of coverage to a third party with a legitimate interest in coverage;

(u) providing information in a form approved by the commissioner and directly related to determining whether an insurance product sold by the licensee meets the requirements of a third party contract that requires or references insurance coverage;

(v) facilitating risk management services directly related to [~~the~~] property and casualty insurance [~~product~~] products sold or offered for sale by the licensee, including:

(i) risk management;

(ii) claims and loss control services; [~~and~~]

(iii) risk assessment consulting[~~:~~], including analysis of:

(A) employer's job descriptions;

(B) employer's safety procedures or manuals; and

(iv) providing information and training on best practices;

(w) otherwise providing services that are legitimately part of servicing an insurance product purchased from a licensee; and

(x) providing other directly related services approved by the department.

(5) An inducement prohibited under Subsection (1) includes a producer, consultant, or other licensee, or an officer or employee of a licensee:

(a) (i) providing a premium or commission rebate;

(ii) paying the salary of an employee of a person who purchases an insurance product from the licensee; or

(iii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, paying the salary for an onsite staff member to perform an act prohibited under Subsection (5)(b)(xii); or

(b) engaging in one or more of the following unless a fee is paid in accordance with Subsection [~~(7)~~] (8):

(i) performing background checks of prospective employees;

(ii) providing legal services by a person licensed to practice law;

(iii) performing drug testing that is directly related to an insurance product purchased from the licensee;

(iv) preparing employer or employee handbooks, except that a licensee may:

(A) provide information for a medical benefit section of an employee handbook;

(B) provide information for the section of an employee handbook directly related to an employment practices liability insurance product purchased from the licensee; or

(C) prepare or print an employee benefit enrollment guide;

(v) providing job descriptions, postings, and applications for a person [~~that purchases an employment practices liability insurance product from the licensee~~];

(vi) providing payroll services;

(vii) providing performance reviews or performance review training;

(viii) providing union advice;

(ix) providing accounting services;

(x) providing data analysis information technology programs, except as provided in Subsection (4)(h)(ii);

(xi) providing administration of health reimbursement accounts or health savings accounts; or

(xii) if the licensee is an insurer, or a third party administrator who contracts with an insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of the following prohibited benefits:

(A) performing background checks of prospective employees;

(B) providing legal services by a person licensed to practice law;

(C) performing drug testing that is directly related to an insurance product purchased from the insurer;

(D) preparing employer or employee handbooks;

(E) providing job descriptions postings, and applications;

(F) providing payroll services;

(G) providing performance reviews or performance review training;

(H) providing union advice;

(I) providing accounting services;

(J) providing discrimination testing; or

(K) providing data analysis information technology programs.

(6) A producer, consultant, or other licensee or an officer or employee of a licensee shall itemize and bill separately from any other insurance product or service offered or provided under Subsection (5)(b)

[~~(6)~~] (7) A de minimis gift or meal not to exceed $25 for each individual receiving the gift or meal is presumed to be a social courtesy not conditioned on the quote or purchase of a particular insurance product for purposes of Subsection (4)(a).

[~~(7)~~] (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is paid a fee to provide an item listed in Subsection (5)(b), the licensee shall comply with Subsection 31A-23a-501(2) in charging the fee, except that the fee paid for the item shall equal

or exceed the fair market value of the item.

Section 13. Section **31A-29-113** is amended to read:

31A-29-113. Benefits -- Additional types of pool insurance -- Preexisting conditions -- Waiver -- Maximum benefits.

(1) (a) The pool policy shall pay for eligible medical expenses rendered or furnished for the diagnoses or treatment of illness or injury that:

(i) exceed the deductible and copayment amounts applicable under Section 31A-29-114; and

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and

operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

(b) If this Subsection (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) Covered benefits available from the pool may not exceed a [~~$1,500,000~~] $1,800,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 14. Section **31A-31-108** is amended to read:

31A-31-108. Assessment of insurers.

(1) For purposes of this section:

(a) The commissioner shall by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, define:

(i) "annuity consideration";

(ii) "membership fees";

(iii) "other fees";

(iv) "deposit-type contract funds"; and

(v) "other considerations in Utah."

(b) "Insurance fraud provisions" means:

(i) this chapter;

(ii) Section 34A-2-110; and

(iii) Section 76-6-521.

(c) "Utah consideration" means:

(i) the total premiums written for Utah risks;

(ii) annuity consideration;

(iii) membership fees collected by the insurer;

(iv) other fees collected by the insurer;

(v) deposit-type contract funds; and

(vi) other considerations in Utah.

(d) "Utah risks" means insurance coverage on the lives, health, or against the liability of persons residing in Utah, or on property located in Utah, other than property temporarily in transit through Utah.

(2) To implement insurance fraud provisions, the commissioner may assess an admitted insurer and a nonadmitted insurer transacting insurance under Chapter 15, Parts 1, Unauthorized Insurers and Surplus Lines, and 2, Risk Retention Groups Act, an annual fee as follows:

(a) $200 for an insurer for which the sum of the Utah consideration is less than or equal to $1,000,000;

(b) $450 for an insurer for which the sum of the Utah consideration is greater than $1,000,000 but is less than or equal to $2,500,000;

(c) $800 for an insurer for which the sum of the Utah consideration is greater than $2,500,000 but is less than or equal to $5,000,000;

(d) $1,600 for an insurer for which the sum of the Utah consideration is greater than $5,000,000 but less than or equal to $10,000,000;

(e) $6,100 for an insurer for which the sum of the Utah consideration is greater than $10,000,000 but less than $50,000,000; and

(f) $15,000 for an insurer for which the sum of the Utah consideration equals or exceeds $50,000,000.

(3) Money received by the state under this section shall be deposited into the Insurance Fraud Investigation Restricted Account created in Subsection (4).

(4) (a) There is created in the General Fund a restricted account known as the

"Insurance Fraud Investigation Restricted Account."

(b) The Insurance Fraud Investigation Restricted Account shall consist of the money received by the commissioner under this section and [~~Section 31A-31-109.~~] Subsections 31A-31-109(1)(a)(ii), (1)(b), (2)(b)(i), (2)(c), and (3)(a). Money ordered paid under Subsection 31A-31-109(1)(a)(i) and (2)(a) shall be deposited in the Insurance Fraud Victim Restitution Fund pursuant to Section 31A-31-108.5.

(c) The commissioner shall administer the Insurance Fraud Investigation Restricted Account. Subject to appropriations by the Legislature, the commissioner shall use the money deposited into the Insurance Fraud Investigation Restricted Account to pay for a cost or expense incurred by the commissioner in the administration, investigation, and enforcement of insurance fraud provisions.

Section 15. Section **31A-31-108.5** is enacted to read:

31A-31-108.5. Insurance Fraud Victim Restitution Fund.

(1) There is created a restricted special revenue fund known as the "Insurance Fraud Victim Restitution Fund."

(2) The Insurance Fraud Victim Restitution Fund shall consist of money ordered paid under Subsections 31A-31-109(1)(a)(i) and (2)(a).

(3) Interest on fund money shall be deposited into the General Fund.

(4) The commissioner shall administer the Insurance Fraud Victim Restitution Fund for the sole benefit of insurance fraud victims.

Section 16. **Effective date.**

This bill takes effect on May 14, 2013, except that the amendment to Section 31A-3-304 (Effective 07/01/13) takes effect on July 1, 2015.