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S.B. 100
2nd Sub. (Salmon)

Senator L. Steven Poulton proposes to substitute the following bill:

1 # INSURANCE LAW AMENDMENTS

2 2001 GENERAL SESSION

3 STATE OF UTAH

4 **Sponsor: L. Steven Poulton**

5 **This act modifies the Insurance Code and related provisions by addressing issues related to**
6 **the insurance business in general, health insurance, life insurance, and property insurance.**
7 **The act standardizes definition of terms and makes other technical changes. The act changes**
8 **terminology from "disability insurance" to "accident and health insurance." The act defines**
9 **the scope and applicability of certain provisions included in this act. The act imposes certain**
10 **requirements on health organizations that are imposed on insurers. The act addresses the**
11 **conditions governing the issuance and renewal of certificates of authority, including allowing**
12 **the commissioner to enter into interstate compacts. The act addresses the form of and**
13 **information required in statements filed with the department including permitting the**
14 **department to accept documents complying with National Association of Insurance**
15 **Commissioners requirements instead of statutory requirements. The act addresses the**
16 **requirements of minimum capital and permanent surplus as well as the amount of the**
17 **deposit each authorized organization shall maintain with the commissioner. The act**
18 **addresses issues related to formation, cancellation, and required provisions of insurance**
19 **contracts. The act redefines the qualified assets that may be used in determining the**
20 **financial condition of an insurer. The act changes the requirements for title insurance**
21 **reserves. The act requires that all documents and agreements that constitute a life insurance**
22 **policy shall be defined and attached to the policy. The act creates notification requirements**
23 **for termination of a group or blanket life insurance policy. The act modifies the**
24 **responsibilities of the Health Benefit Plan Committee. The act expands the commissioner's**
25 **rulemaking responsibilities for Medicare supplemental policies. The act requires a policy**

26 **summary or illustration to be delivered with a life insurance policy. The act requires, in**
27 **certain circumstances, monthly reports on an accident and health rider or supplemental**
28 **benefit. The act addresses maternity benefits required in a conversion policy. The act**
29 **changes the requirements and restrictions on long-term care insurance policies. The act**
30 **modifies the licensing, continuing education, and examination requirements for agents,**
31 **brokers, consultants, third party administrators, and independent or public adjusters. The**
32 **act also addresses the termination of licenses for agents, brokers, consultants, third party**
33 **administrators, and independent or public adjusters. The act expands the list of activities**
34 **that qualify as unfair marketing practices. The act addresses the handling of escrow funds**
35 **by title insurance agents. The act requires title insurance agents to make disclosures to loan**
36 **applicants purchasing title insurance. Ş [~~The act requires a financial institution to maintain~~**
37 **~~customer privacy by ensuring confidentiality of insurance information.~~] ĥ The act addresses**
38 **sharing commissions for referrals of potential customers. The act addresses continuance of**
39 **coverage by health maintenance organizations. ĥ The act provides a coordination clause. ĥ**
40 This act affects sections of Utah Code Annotated 1953 as follows:
41 AMENDS:
42 **7-9-5**, as last amended by Chapter 329, Laws of Utah 1999
43 **26-19-2**, as last amended by Chapters 39 and 145, Laws of Utah 1998
44 **26-40-104**, as enacted by Chapter 360, Laws of Utah 1998
45 **31A-1-103**, as last amended by Chapter 4, Laws of Utah 1993
46 **31A-1-301**, as last amended by Chapters 130 and 131, Laws of Utah 1999
47 **31A-2-214**, as last amended by Chapter 12, Laws of Utah 1987, First Special Session
48 **31A-4-103**, as enacted by Chapter 242, Laws of Utah 1985
49 **31A-4-113**, as last amended by Chapter 258, Laws of Utah 1992
50 **31A-5-211**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
51 **31A-5-418**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
52 **31A-5-703**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
53 **31A-6a-102**, as enacted by Chapter 203, Laws of Utah 1992
54 **31A-6a-110**, as enacted by Chapter 203, Laws of Utah 1992
55 **31A-8-101**, as last amended by Chapter 261, Laws of Utah 1989
56 **31A-8-103 (Effective 04/30/01)**, as last amended by Chapter 300, Laws of Utah 2000

57 **31A-8-205**, as enacted by Chapter 204, Laws of Utah 1986
58 **31A-8-209**, as enacted by Chapter 204, Laws of Utah 1986
59 **31A-8-211**, as last amended by Chapter 30, Laws of Utah 1992
60 **31A-8-213**, as enacted by Chapter 204, Laws of Utah 1986
61 **31A-8-402**, as last amended by Chapter 327, Laws of Utah 1990
62 **31A-8-407**, as enacted by Chapter 261, Laws of Utah 1989
63 **31A-8-408**, as last amended by Chapter 344, Laws of Utah 1995
64 **31A-9-212 (Effective 04/30/01)**, as last amended by Chapter 300, Laws of Utah 2000
65 **31A-11-102**, as last amended by Chapter 10, Laws of Utah 1988, Second Special Session
66 **31A-14-201**, as last amended by Chapter 204, Laws of Utah 1986
67 **31A-14-212**, as enacted by Chapter 242, Laws of Utah 1985
68 **31A-15-103**, as last amended by Chapter 55, Laws of Utah 1999
69 **31A-15-106**, as last amended by Chapter 204, Laws of Utah 1986
70 **31A-17-201**, as last amended by Chapter 131, Laws of Utah 1999
71 **31A-17-401**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
72 **31A-17-402**, as last amended by Chapter 305, Laws of Utah 1993
73 **31A-17-408**, as enacted by Chapter 242, Laws of Utah 1985
74 **31A-17-504**, as enacted by Chapter 305, Laws of Utah 1993
75 **31A-17-505**, as enacted by Chapter 305, Laws of Utah 1993
76 **31A-17-507**, as enacted by Chapter 305, Laws of Utah 1993
77 **31A-17-508**, as enacted by Chapter 305, Laws of Utah 1993
78 **31A-17-509**, as enacted by Chapter 305, Laws of Utah 1993
79 **31A-17-513**, as enacted by Chapter 305, Laws of Utah 1993
80 **31A-17-601**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
81 **31A-17-602**, as last amended by Chapter 185, Laws of Utah 1997
82 **31A-17-603**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
83 **31A-17-604**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
84 **31A-17-605**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
85 **31A-17-606**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
86 **31A-17-607**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
87 **31A-17-608**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session

88 **31A-17-609**, as last amended by Chapter 131, Laws of Utah 1999
89 **31A-17-610**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
90 **31A-17-613**, as enacted by Chapter 9, Laws of Utah 1996, Second Special Session
91 **31A-18-105**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
92 **31A-19a-101**, as renumbered and amended by Chapter 130, Laws of Utah 1999
93 **31A-21-103**, as last amended by Chapter 204, Laws of Utah 1986
94 **31A-21-104**, as last amended by Chapter 190, Laws of Utah 1996
95 **31A-21-201**, as last amended by Chapter 114, Laws of Utah 2000
96 **31A-21-301**, as last amended by Chapter 230, Laws of Utah 1992
97 **31A-21-303**, as last amended by Chapter 203, Laws of Utah 1999
98 **31A-21-307**, as last amended by Chapter 68, Laws of Utah 1989
99 **31A-21-401**, as enacted by Chapter 204, Laws of Utah 1986
100 **31A-21-402**, as enacted by Chapter 204, Laws of Utah 1986
101 **31A-21-403**, as enacted by Chapter 204, Laws of Utah 1986
102 **31A-21-404**, as enacted by Chapter 204, Laws of Utah 1986
103 **31A-21-501**, as last amended by Chapter 302, Laws of Utah 1999
104 **31A-21-502**, as enacted by Chapter 132, Laws of Utah 1997
105 **31A-21-503**, as enacted by Chapter 132, Laws of Utah 1997
106 **31A-21-505**, as enacted by Chapter 132, Laws of Utah 1997
107 **31A-22-307**, as last amended by Chapter 71, Laws of Utah 1994
108 **31A-22-403**, as enacted by Chapter 242, Laws of Utah 1985
109 **31A-22-404**, as last amended by Chapter 114, Laws of Utah 2000
110 **31A-22-415**, as last amended by Chapter 39, Laws of Utah 1998
111 **31A-22-423**, as last amended by Chapter 329, Laws of Utah 1998
112 **31A-22-510**, as last amended by Chapter 91, Laws of Utah 1987
113 **31A-22-517**, as enacted by Chapter 242, Laws of Utah 1985
114 **31A-22-518**, as enacted by Chapter 242, Laws of Utah 1985
115 **31A-22-520**, as enacted by Chapter 242, Laws of Utah 1985
116 **31A-22-600**, as enacted by Chapter 242, Laws of Utah 1985
117 **31A-22-601**, as enacted by Chapter 242, Laws of Utah 1985
118 **31A-22-602**, as enacted by Chapter 242, Laws of Utah 1985

119 **31A-22-603**, as enacted by Chapter 242, Laws of Utah 1985
120 **31A-22-604**, as last amended by Chapter 1, Laws of Utah 2000
121 **31A-22-605**, as last amended by Chapter 224, Laws of Utah 1992
122 **31A-22-606**, as last amended by Chapter 316, Laws of Utah 1994
123 **31A-22-607**, as enacted by Chapter 242, Laws of Utah 1985
124 **31A-22-608**, as last amended by Chapter 91, Laws of Utah 1987
125 **31A-22-609**, as enacted by Chapter 242, Laws of Utah 1985
126 **31A-22-610**, as last amended by Chapter 206, Laws of Utah 1996
127 **31A-22-610.2**, as enacted by Chapter 114, Laws of Utah 2000
128 **31A-22-610.5**, as last amended by Chapters 102 and 137, Laws of Utah 1995
129 **31A-22-611**, as enacted by Chapter 242, Laws of Utah 1985
130 **31A-22-612**, as last amended by Chapter 204, Laws of Utah 1986
131 **31A-22-613**, as last amended by Chapter 160, Laws of Utah 2000
132 **31A-22-613.5**, as last amended by Chapter 114, Laws of Utah 2000
133 **31A-22-614**, as enacted by Chapter 242, Laws of Utah 1985
134 **31A-22-617**, as last amended by Chapter 267, Laws of Utah 2000
135 **31A-22-619**, as last amended by Chapter 316, Laws of Utah 1994
136 **31A-22-620**, as last amended by Chapter 185, Laws of Utah 1997
137 **31A-22-623**, as enacted by Chapter 6, Laws of Utah 1998
138 **31A-22-624**, as enacted by Chapter 357, Laws of Utah 1998
139 **31A-22-626**, as enacted by Chapter 248, Laws of Utah 2000
140 **31A-22-630**, as enacted by Chapter 114, Laws of Utah 2000
141 **31A-22-701**, as last amended by Chapter 143, Laws of Utah 1996
142 **31A-22-702**, as enacted by Chapter 242, Laws of Utah 1985
143 **31A-22-703**, as last amended by Chapter 329, Laws of Utah 1998
144 **31A-22-704**, as last amended by Chapter 321, Laws of Utah 1995
145 **31A-22-705**, as last amended by Chapter 261, Laws of Utah 1989
146 **31A-22-715**, as last amended by Chapter 12, Laws of Utah 1994
147 **31A-22-716**, as enacted by Chapter 327, Laws of Utah 1990
148 **31A-22-717**, as enacted by Chapter 253, Laws of Utah 1991
149 **31A-22-720**, as enacted by Chapter 114, Laws of Utah 2000

150 **31A-22-801**, as enacted by Chapter 242, Laws of Utah 1985
151 **31A-22-802**, as enacted by Chapter 242, Laws of Utah 1985
152 **31A-22-803**, as enacted by Chapter 242, Laws of Utah 1985
153 **31A-22-804**, as enacted by Chapter 242, Laws of Utah 1985
154 **31A-22-805**, as enacted by Chapter 242, Laws of Utah 1985
155 **31A-22-806**, as last amended by Chapter 204, Laws of Utah 1986
156 **31A-22-807**, as last amended by Chapter 230, Laws of Utah 1992
157 **31A-22-808**, as enacted by Chapter 242, Laws of Utah 1985
158 **31A-22-809**, as enacted by Chapter 242, Laws of Utah 1985
159 **31A-22-1002**, as last amended by Chapter 375, Laws of Utah 1997
160 **31A-22-1101**, as enacted by Chapter 242, Laws of Utah 1985
161 **31A-22-1401**, as enacted by Chapter 243, Laws of Utah 1991
162 **31A-22-1402**, as enacted by Chapter 243, Laws of Utah 1991
163 **31A-22-1407**, as last amended by Chapter 344, Laws of Utah 1995
164 **31A-22-1409**, as enacted by Chapter 243, Laws of Utah 1991
165 **31A-22-1412**, as enacted by Chapter 344, Laws of Utah 1995
166 **31A-23-101**, as enacted by Chapter 242, Laws of Utah 1985
167 **31A-23-102**, as last amended by Chapter 1, Laws of Utah 2000
168 **31A-23-201**, as last amended by Chapter 344, Laws of Utah 1995
169 **31A-23-202**, as last amended by Chapter 232, Laws of Utah 1997
170 **31A-23-203**, as last amended by Chapter 131, Laws of Utah 1999
171 **31A-23-204**, as last amended by Chapter 131, Laws of Utah 1999
172 **31A-23-206**, as last amended by Chapter 131, Laws of Utah 1999
173 **31A-23-207**, as last amended by Chapter 316, Laws of Utah 1994
174 **31A-23-209**, as last amended by Chapter 204, Laws of Utah 1986
175 **31A-23-211.7**, as enacted by Chapter 131, Laws of Utah 1999
176 **31A-23-212**, as last amended by Chapter 131, Laws of Utah 1999
177 **31A-23-216**, as last amended by Chapter 232, Laws of Utah 1997
178 **31A-23-218**, as enacted by Chapter 242, Laws of Utah 1985
179 **31A-23-302**, as last amended by Chapter 344, Laws of Utah 1995
180 **31A-23-303**, as last amended by Chapter 204, Laws of Utah 1986

181 **31A-23-307**, as last amended by Chapter 185, Laws of Utah 1997
182 **31A-23-310**, as last amended by Chapter 344, Laws of Utah 1995
183 **31A-23-312**, as last amended by Chapter 230, Laws of Utah 1992
184 **31A-23-404**, as last amended by Chapter 293, Laws of Utah 1998
185 **31A-23-503**, as last amended by Chapter 1, Laws of Utah 2000
186 **31A-23-601**, as last amended by Chapter 1, Laws of Utah 2000
187 **31A-23-702**, as enacted by Chapter 258, Laws of Utah 1992
188 **31A-23-705**, as enacted by Chapter 258, Laws of Utah 1992
189 **31A-25-102**, as enacted by Chapter 242, Laws of Utah 1985
190 **31A-25-202**, as enacted by Chapter 242, Laws of Utah 1985
191 **31A-25-203**, as enacted by Chapter 242, Laws of Utah 1985
192 **31A-25-205**, as last amended by Chapters 1 and 114, Laws of Utah 2000
193 **31A-25-206**, as enacted by Chapter 242, Laws of Utah 1985
194 **31A-25-207**, as enacted by Chapter 242, Laws of Utah 1985
195 **31A-25-208**, as enacted by Chapter 242, Laws of Utah 1985
196 **31A-26-101**, as last amended by Chapter 30, Laws of Utah 1992
197 **31A-26-202**, as last amended by Chapter 232, Laws of Utah 1997
198 **31A-26-203**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
199 **31A-26-204**, as last amended by Chapter 131, Laws of Utah 1999
200 **31A-26-206**, as last amended by Chapter 131, Laws of Utah 1999
201 **31A-26-207**, as last amended by Chapter 204, Laws of Utah 1986
202 **31A-26-208**, as last amended by Chapter 204, Laws of Utah 1986
203 **31A-26-209**, as last amended by Chapter 204, Laws of Utah 1986
204 **31A-26-213**, as last amended by Chapter 232, Laws of Utah 1997
205 **31A-26-302**, as enacted by Chapter 242, Laws of Utah 1985
206 **31A-28-102**, as last amended by Chapter 316, Laws of Utah 1994
207 **31A-28-103**, as last amended by Chapter 316, Laws of Utah 1994
208 **31A-28-106**, as repealed and reenacted by Chapter 211, Laws of Utah 1991
209 **31A-28-108**, as last amended by Chapter 344, Laws of Utah 1995
210 **31A-28-109**, as repealed and reenacted by Chapter 211, Laws of Utah 1991
211 **31A-28-202**, as last amended by Chapter 97, Laws of Utah 1988

212 **31A-29-103**, as enacted by Chapter 232, Laws of Utah 1990
213 **31A-29-117**, as last amended by Chapter 114, Laws of Utah 2000
214 **31A-30-103**, as last amended by Chapter 265, Laws of Utah 1997
215 **31A-30-104**, as last amended by Chapter 131, Laws of Utah 1999
216 **31A-30-106**, as last amended by Chapter 267, Laws of Utah 2000
217 **31A-30-106.5**, as enacted by Chapter 321, Laws of Utah 1995
218 **31A-30-107**, as last amended by Chapters 114 and 315, Laws of Utah 2000
219 **31A-32a-102**, as enacted by Chapter 131, Laws of Utah 1999
220 **31A-33-103.5**, as last amended by Chapter 107, Laws of Utah 1998
221 **31A-33-113**, as last amended by Chapter 375, Laws of Utah 1997
222 **34A-2-103**, as last amended by Chapters 55 and 199, Laws of Utah 1999
223 **58-67-501**, as last amended by Chapter 227, Laws of Utah 1997
224 **58-68-501**, as last amended by Chapter 227, Laws of Utah 1997
225 **59-10-114**, as last amended by Chapter 257, Laws of Utah 2000
226 **62A-11-326.1**, as last amended by Chapter 145, Laws of Utah 1998
227 **62A-11-326.2**, as last amended by Chapter 145, Laws of Utah 1998
228 **63-25a-413**, as renumbered and amended by Chapter 242, Laws of Utah 1996
229 **63-55-231**, as last amended by Chapters 52 and 267, Laws of Utah 2000
230 **67-22-1**, as last amended by Chapter 117, Laws of Utah 2000
231 **67-22-2**, as last amended by Chapter 117, Laws of Utah 2000
232 **78-14-4.5**, as last amended by Chapters 30 and 240, Laws of Utah 1992
233 **78-45-7.5**, as last amended by Chapter 161, Laws of Utah 2000
234 ENACTS:
235 **31A-2-217**, Utah Code Annotated 1953
236 **31A-22-424**, Utah Code Annotated 1953
237 **31A-22-522**, Utah Code Annotated 1953
238 **31A-22-631**, Utah Code Annotated 1953
239 **31A-22-632**, Utah Code Annotated 1953
240 **31A-22-1413**, Utah Code Annotated 1953
241 **31A-22-1414**, Utah Code Annotated 1953
242 **31A-23-201.5**, Utah Code Annotated 1953

243 **31A-23-317**, Utah Code Annotated 1953
244 **31A-26-215**, Utah Code Annotated 1953
245 REPEALS AND REENACTS:
246 **31A-27-311.5**, as enacted by Chapter 170, Laws of Utah 1990
247 REPEALS:
248 **31A-8-210**, as last amended by Chapter 9, Laws of Utah 1996, Second Special Session
249 **31A-8-212**, as last amended by Chapter 327, Laws of Utah 1990
250 *Be it enacted by the Legislature of the state of Utah:*
251 Section 1. Section **7-9-5** is amended to read:
252 **7-9-5. Powers of credit unions.**
253 In addition to the powers specified elsewhere in this chapter, a credit union may:
254 (1) make contracts;
255 (2) sue and be sued;
256 (3) acquire, lease, or hold fixed assets, including real property, furniture, fixtures, and
257 equipment as the directors consider necessary or incidental to the operation and business of the
258 credit union, but the value of the real property may not exceed 7% of credit union assets, unless
259 approved by the commissioner;
260 (4) pledge, hypothecate, sell, or otherwise dispose of real or personal property, either in
261 whole or in part, necessary or incidental to its operation;
262 (5) incur and pay necessary and incidental operating expenses;
263 (6) require an entrance or membership fee;
264 (7) receive the funds of its members in payment for:
265 (a) shares;
266 (b) share certificates;
267 (c) deposits;
268 (d) deposit certificates;
269 (e) share drafts;
270 (f) NOW accounts; and
271 (g) other instruments;
272 (8) allow withdrawal of shares and deposits, as requested by a member orally to a third
273 party with prior authorization in writing, including, but not limited to, drafts drawn on the credit

274 union for payment to the member or any third party, in accordance with the procedures established
275 by the board of directors, including, but not limited to, drafts, third-party instruments, and other
276 transaction instruments, as provided in the bylaws;
277 (9) charge fees for its services;
278 (10) extend credit to its members, at rates established in accordance with the bylaws or by
279 the board of directors;
280 (11) extend credit secured by real estate;
281 (12) make loan participation arrangements with other credit unions, credit union
282 organizations, or financial organizations in accordance with written policies of the board of
283 directors, if the credit union that originates a loan for which participation arrangements are made
284 retains an interest of at least 10% of the loan;
285 (13) sell and pledge eligible obligations in accordance with written policies of the board
286 of directors;
287 (14) engage in activities and programs of the federal government or this state or any
288 agency or political subdivision of the state, when approved by the board of directors and not
289 inconsistent with this chapter;
290 (15) act as fiscal agent for and receive payments on shares and deposits from the federal
291 government, this state, or its agencies or political subdivisions not inconsistent with the laws of
292 this state;
293 (16) borrow money and issue evidence of indebtedness for a loan or loans for temporary
294 purposes in the usual course of its operations;
295 (17) discount and sell notes and obligations;
296 (18) sell all or any portion of its assets to another credit union or purchase all or any
297 portion of the assets of another credit union;
298 (19) invest funds as provided in this title and in its bylaws;
299 (20) maintain deposits in insured depository institutions as provided in this title and in its
300 bylaws;
301 (21) (a) hold membership in corporate credit unions organized under this chapter or under
302 other state or federal statutes; and
303 (b) hold membership or equity interest in associations and organizations of credit unions,
304 including credit union service organizations;

305 (22) declare and pay dividends on shares, contract for and pay interest on deposits, and pay
306 refunds of interest on loans as provided in this title and in its bylaws;
307 (23) collect, receive, and disburse funds in connection with the sale of negotiable or
308 nonnegotiable instruments and for other purposes that provide benefits or convenience to its
309 members, as provided in this title and in its bylaws;
310 (24) make donations for the members' welfare or for civic, charitable, scientific, or
311 educational purposes as authorized by the board of directors or provided in its bylaws;
312 (25) act as trustee of funds permitted by federal law to be deposited in a credit union as
313 a deferred compensation or tax deferred device, including, but not limited to, individual retirement
314 accounts as defined by Section 408, Internal Revenue Code;
315 (26) purchase reasonable [~~disability~~] <u>accident and health</u> insurance, including accidental
316 death benefits, for directors and committee members through insurance companies licensed in this
317 state as provided in its bylaws;
318 (27) provide reasonable protection through insurance or other means to protect board
319 members, committee members, and employees from liability arising out of consumer legislation
320 such as, but not limited to, truth-in-lending and equal credit laws and as provided in its bylaws;
321 (28) reimburse directors and committee members for reasonable and necessary expenses
322 incurred in the performance of their duties;
323 (29) participate in systems which allow the transfer, withdrawal, or deposit of funds of
324 credit unions or credit union members by automated or electronic means and hold membership in
325 entities established to promote and effectuate these systems, if:
326 (a) the participation is not inconsistent with the law and rules of the department; and
327 (b) any credit union participating in any system notifies the department as provided by law;
328 (30) issue credit cards and debit cards to allow members to obtain access to their shares,
329 deposits, and extensions of credit;
330 (31) provide any act necessary to obtain and maintain membership in the credit union;
331 (32) exercise incidental powers necessary to carry out the purpose for which a credit union
332 is organized;
333 (33) undertake other activities relating to its purpose as its bylaws may provide;
334 (34) engage in other activities, exercise other powers, and enjoy other rights, privileges,
335 benefits, and immunities authorized by rules of the commissioner;

336 (35) act as trustee, custodian, or administrator for Keogh plans, individual retirement
337 accounts, credit union employee pension plans, and other employee benefit programs; and
338 (36) advertise to the general public the products and services offered by the credit union
339 if the advertisement prominently discloses that to use the products or services of the credit union
340 a person is required to:
341 (a) be eligible for membership in the credit union; and
342 (b) become a member of the credit union.
343 Section 2. Section **26-19-2** is amended to read:
344 **26-19-2. Definitions.**
345 As used in this chapter:
346 (1) "Employee welfare benefit plan" means a medical insurance plan developed by an
347 employer under 29 U.S.C. Section 1001, et seq., the Employee Retirement Income Security Act
348 of 1974 as amended.
349 (2) "Estate" means, regarding a deceased recipient, all real and personal property or other
350 assets included within a decedent's estate as defined in Section 75-1-201 and a decedent's
351 augmented estate as defined in Section 75-2-203.
352 (3) "Insurer" includes:
353 (a) a group health plan as defined in Subsection 607(1) of the federal Employee Retirement
354 Income Security Act of 1974;
355 (b) a health maintenance organization; and
356 (c) any entity offering a health service benefit plan.
357 (4) "Medical assistance" means:
358 (a) all funds expended for the benefit of a recipient under Title 26, Chapter 18, Medical
359 Assistance Act, or under Titles XVIII and XIX, federal Social Security Act; and
360 (b) any other services provided for the benefit of a recipient by a prepaid health care
361 delivery system under contract with the department.
362 (5) "Provider" means a person or entity who provides services to a recipient.
363 (6) "Recipient" means:
364 (a) a person who has applied for or received medical assistance from the state;
365 (b) the guardian, conservator, or other personal representative of a person under Subsection
366 (6)(a) if the person is a minor or an incapacitated person; or

367 (c) the estate and survivors of a person under Subsection (6)(a) if the person is deceased.
368 (7) "State plan" means the state Medicaid program as enacted in accordance with Title
369 XIX, federal Social Security Act.
370 (8) "Third party" includes:
371 (a) an individual, institution, corporation, public or private agency, trust, estate, insurance
372 carrier, employee welfare benefit plan, health maintenance organization, health service
373 organization, preferred provider organization, governmental program such as Medicare,
374 CHAMPUS, and workers' compensation, which may be obligated to pay all or part of the medical
375 costs of injury, disease, or disability of a recipient, unless any of these are excluded by department
376 rule; and
377 (b) a spouse or a parent who:
378 (i) may be obligated to pay all or part of the medical costs of a recipient under law or by
379 court or administrative order; or
380 (ii) has been ordered to maintain health, dental, or [~~disability~~] accident and health
381 insurance to cover medical expenses of a spouse or dependent child by court or administrative
382 order.
383 Section 3. Section **26-40-104** is amended to read:
384 **26-40-104. Advisory Council.**
385 (1) There is created a Utah Children's Health Insurance Program Advisory Council
386 consisting of at least eight and no more than eleven members appointed by the executive director
387 of the department. The term of each appointment shall be three years. The appointments shall be
388 staggered at one-year intervals to ensure continuity of the advisory council.
389 (2) The advisory council shall meet at least quarterly.
390 (3) The membership of the advisory council shall include at least one representative from
391 each of the following groups:
392 (a) child health care providers;
393 (b) parents and guardians of children enrolled in the program;
394 (c) ethnic populations other than American Indians;
395 (d) American Indians;
396 (e) the Health Policy Commission;
397 (f) the Utah Association of Health Care Providers;

398 (g) health and [~~disability~~] accident and health insurance providers; and
399 (h) the general public.
400 (4) The advisory council shall advise the department on:
401 (a) benefits design;
402 (b) eligibility criteria;
403 (c) outreach;
404 (d) evaluation; and
405 (e) special strategies for under-served populations.
406 (5) (a) (i) Members who are not government employees may not receive compensation or
407 benefits for their services, but may receive per diem and expenses incurred in the performance of
408 the member's official duties at the rates established by the Division of Finance under Sections
409 63A-3-106 and 63A-3-107.
410 (ii) Members may decline to receive per diem and expenses for their service.
411 (b) (i) State government officer and employee members who do not receive salary, per
412 diem, or expenses from their agency for their service may receive per diem and expenses incurred
413 in the performance of their official duties from the council at the rates established by the Division
414 of Finance under Sections 63A-3-106 and 63A-3-107.
415 (ii) State government officer and employee members may decline to receive per diem and
416 expenses for their service.
417 Section 4. Section **31A-1-103** is amended to read:
418 **31A-1-103. Scope and applicability of title.**
419 (1) This title does not apply to:
420 (a) retainer contracts made by attorneys-at-law with individual clients with fees based on
421 estimates of the nature and amount of services to be provided to the specific client, and similar
422 contracts made with a group of clients involved in the same or closely related legal matters;
423 (b) arrangements for providing benefits that do not exceed a limited amount of
424 consultations, advice on simple legal matters, either alone or in combination with referral services,
425 or the promise of fee discounts for handling other legal matters;
426 (c) limited legal assistance on an informal basis involving neither an express contractual
427 obligation nor reasonable expectations, in the context of an employment, membership, educational,
428 or similar relationship; or

429 (d) legal assistance by employee organizations to their members in matters relating to
430 employment.
431 (2) (a) This title restricts otherwise legitimate business activity.
432 (b) What this title does not prohibit is permitted unless contrary to other provisions of Utah
433 law.
434 (3) Except as otherwise expressly provided, this title does not apply to:
435 (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of
436 the federal Employee Retirement Income Security Act of 1974, as amended;
437 (b) ocean marine insurance;
438 (c) death and [~~disability~~] accident and health benefits provided by an organization where
439 the principal purpose is to achieve charitable, educational, social, or religious objectives rather than
440 to provide death and [~~disability~~] accident and health benefits, if the organization does not incur a
441 legal obligation to pay a specified amount and does not create reasonable expectations of receiving
442 a specified amount on the part of an insured person;
443 (d) other business specified in rules adopted by the commissioner on a finding that the
444 transaction of such business in this state does not require regulation for the protection of the
445 interests of the residents of this state or on a finding that it would be impracticable to require
446 compliance with this title;
447 (e) (i) transactions independently procured through negotiations under Section
448 31A-15-104;
449 (ii) however, the transactions described in Subsection (3)(e)(i) are subject to taxation under
450 Section 31A-3-301;
451 (f) self-insurance;
452 (g) reinsurance;
453 (h) subject to Subsection (4), employee and labor union group or blanket insurance
454 covering risks in this state if:
455 (i) the policyholder exists primarily for purposes other than to procure insurance;
456 (ii) the policyholder is not a resident of this state or a domestic corporation or does not
457 have its principal office in this state;
458 (iii) no more than 25% of the certificate holders or insureds are residents of this state;
459 (iv) on request of the commissioner, the insurer files with the department a copy of the

460 policy and a copy of each form or certificate; and
461 (v) the insurer agrees to pay premium taxes on the Utah portion of its business, as if it were
462 authorized to do business in this state, and if the insurer provides the commissioner with the
463 security the commissioner considers necessary for the payment of premium taxes under Title 59,
464 Chapter 9, Taxation of Admitted Insurers; or
465 (i) to the extent provided in Subsection (5):
466 (A) a manufacturer's [warranties issued in the ordinary course of sale;] warranty; and
467 [(j) manufacturer's warranties or service contracts paid for with separate or additional
468 consideration; or]
469 [(k) service contracts paid for with separate or additional consideration, issued in the
470 ordinary course of sale, that are for the repair or maintenance of goods, other than motor vehicles,
471 having a purchase price of $3,000 or less]
472 (B) a manufacturer's service contract.
473 (4) (a) After a hearing, the commissioner may order an insurer of certain group or blanket
474 contracts to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h)
475 to an authorized insurer if the contracts have been written by an unauthorized insurer.
476 (b) If the commissioner finds that the conditions required for the exemption of a group or
477 blanket insurer are not satisfied or that adequate protection to residents of this state is not provided,
478 [he] the commissioner may require:
479 (i) the insurer to be authorized to do business in this state; or [require]
480 (ii) that any of the insurer's transactions be subject to this title.
481 (5) (a) As used in Subsection (3)(i) and this Subsection (5):
482 (i) "manufacturer's service contract" means a service contract:
483 (A) made available by a manufacturer of a product:
484 (I) on one specific product; or
485 (II) on products that are components of a system; and
486 (B) under which the manufacturer is liable for services to be provided under the service
487 contract including, if the manufacturer's service contract designates, providing parts and labor;
488 (ii) "manufacturer's warranty" means the guaranty of the manufacturer of a product:
489 (A) (I) on one specific product; or
490 (II) on products that are components of a system; and

491 (B) under which the manufacturer is liable for services to be provided under the warranty,
492 including, if the manufacturer's warranty designates, providing parts and labor; and
493 (iii) "service contract" is as defined in Section 31A-6a-101.
494 (b) A manufacturer's warranty may be designated as:
495 (i) a warranty;
496 (ii) a guaranty; or
497 (iii) a term similar to a term described in Subsection (5)(b)(i) or (ii).
498 (c) This title does not apply to:
499 (i) a manufacturer's warranty;
500 (ii) a manufacturer's service contract paid for with consideration that is in addition to the
501 consideration paid for the product itself; and
502 (iii) a service contract that is not a manufacturer's warranty or manufacturer's service
503 contract if:
504 (A) the service contract is paid for with consideration that is in addition to the
505 consideration paid for the product itself; and
506 (B) the service contract is for the repair or maintenance of goods;
507 (C) the cost of the product is equal to an amount determined in accordance with
508 Subsection (5)(e); and
509 (D) the product is not a motor vehicle.
510 (d) This title does not apply to a manufacturer's warranty or service contract paid for with
511 consideration that is in addition to the consideration paid for for the product itself regardless of
512 whether the manufacturer's warranty or service contract is sold:
513 (i) at the time of the purchase of the product; or
514 (ii) at a time other than the time of the purchase of the product.
515 (e) (i) For fiscal year 2001-02, the amount described in Subsection (5)(c)(iii)(C) shall be
516 equal to $3,700 or less.
517 (ii) For each fiscal year after fiscal year 2001-02, the commissioner shall annually
518 determine whether the amount described in Subsection (5)(c)(iii)(C) should be adjusted in
519 accordance with changes in the Consumer Price Index published by the United States Bureau of
520 Labor Statistics selected by the commissioner by rule, between:
521 (A) the Consumer Price Index for the February immediately preceding the adjustment; and

522 (B) the Consumer Price Index for February 2001.

523 (iii) If under Subsection (5)(e)(ii) the commissioner determines that an adjustment should

524 be made, the commission shall make the adjustment by rule.

525 Section 5. Section **31A-1-301** is amended to read:

526 **31A-1-301. Definitions.**

527 As used in this title, unless otherwise specified:

528 (1) (a) "Accident and health insurance" means insurance to provide protection against

529 economic losses resulting from:

530 (i) a medical condition including:

531 (A) medical care expenses; or

532 (B) the risk of disability;

533 (ii) accident; or

534 (iii) sickness.

535 (b) "Accident and health insurance":

536 (i) includes a contract with disability contingencies including:

537 (A) an income replacement contract;

538 (B) a health care contract;

539 (C) an expense reimbursement contract;

540 (D) a credit accident and health contract;

541 (E) a continuing care contract; and

542 (F) long-term care contracts; and

543 (ii) may provide:

544 (A) hospital coverage;

545 (B) surgical coverage;

546 (C) medical coverage; or

547 (D) loss of income coverage.

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

549 [~~(1)~~] (2) "Administrator" is defined in Subsection [~~(90)~~] (111).

550 [~~(2)~~] (3) "Adult" means a natural person who has attained the age of at least 18 years.

551 [~~(3)~~] (4) "Affiliate" means any person who controls, is controlled by, or is under common

552 control with, another person. A corporation is an affiliate of another corporation, regardless of

553 ownership, if substantially the same group of natural persons manages the corporations.
554 [~~(4)~~] (5) "Alien insurer" means an insurer domiciled outside the United States.
555 (6) "Amendment" means an endorsement to an insurance policy or certificate.
556 [~~(5)~~] (7) "Annuity" means an agreement to make periodical payments for a period certain
557 or over the lifetime of one or more natural persons if the making or continuance of all or some of
558 the series of the payments, or the amount of the payment, is dependent upon the continuance of
559 human life.
560 (8) "Application" means a document:
561 (a) completed by an applicant to provide information about the risk to be insured; and
562 (b) that contains information that is used by the insurer to:
563 (i) evaluate risk; and
564 (ii) decide whether to:
565 (A) insure the risk under:
566 (I) the coverages as originally offered; or
567 (II) a modification of the coverage as originally offered; or
568 (B) decline to insure the risk.
569 [~~(6)~~] (9) "Articles" or "articles of incorporation" means the original articles, special laws,
570 charters, amendments, restated articles, articles of merger or consolidation, trust instruments, and
571 other constitutive documents for trusts and other entities that are not corporations, and
572 amendments to any of these.
573 [~~(7)~~] (10) "Bail bond insurance" means a guarantee that a person will attend court when
574 required, or will obey the orders or judgment of the court, as a condition to the release of that
575 person from confinement.
576 [~~(8)~~] (11) "Binder" is defined in Section 31A-21-102.
577 [~~(9)~~] (12) "Board," "board of trustees," or "board of directors" means the group of persons
578 with responsibility over, or management of, a corporation, however designated.
579 [~~(10)~~] (13) "Business of insurance" is defined in Subsection [~~(53)~~] (64).
580 [~~(11)~~] (14) "Business plan" means the information required to be supplied to the
581 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required when
582 these subsections are applicable by reference under:
583 (a) Section 31A-7-201;

584 (b) Section 31A-8-205; or
585 (c) Subsection 31A-9-205(2).
586 [(12)] (15) "Bylaws" means the rules adopted for the regulation or management of a
587 corporation's affairs, however designated and includes comparable rules for trusts and other entities
588 that are not corporations.
589 [(13)] (16) "Casualty insurance" means liability insurance as defined in Subsection [(59)]
590 (70).
591 [(14)] (17) "Certificate" means [the] evidence of insurance given to:
592 (a) an insured under a group insurance policy; or
593 (b) a third party.
594 [(15)] (18) "Certificate of authority" is included within the term "license."
595 [(16)] (19) "Claim," unless the context otherwise requires, means a request or demand on
596 an insurer for payment of benefits according to the terms of an insurance policy.
597 [(17)] (20) "Claims-made coverage" means an insurance contract or provision limiting
598 coverage under a policy insuring against legal liability to claims that are first made against the
599 insured while the policy is in force.
600 [(18)] (21) (a) "Commissioner" or "commissioner of insurance" means Utah's insurance
601 commissioner.
602 (b) When appropriate, the terms listed in Subsection [(18)] (21)(a) apply to the equivalent
603 supervisory official of another jurisdiction.
604 (22) (a) "Continuing care insurance" means insurance that:
605 (i) provides board and lodging;
606 (ii) provides one or more of the following services:
607 (A) personal services;
608 (B) nursing services;
609 (C) medical services; or
610 (D) other health-related services; and
611 (iii) provides the coverage described in Subsection (22)(a)(i) under an agreement effective:
612 (A) for the life of the insured; or
613 (B) for a period in excess of one year.
614 (b) Insurance is continuing care insurance regardless of whether or not the board and

615 lodging are provided at the same location as the services described in Subsection (22)(a)(ii).

616 [~~(19)~~] (23) (a) "Control," "controlling," "controlled," or "under common control" means
617 the direct or indirect possession of the power to direct or cause the direction of the management
618 and policies of a person. This control may be:

619 (i) by contract;

620 (ii) by common management;

621 (iii) through the ownership of voting securities; or

622 (iv) by a means other than those described in Subsections [~~(19)~~] (23)(a)(i) through (iii).

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

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

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

630 [~~(20)~~] (24) (a) "Corporation" means insurance corporation, except when referring to:

631 (i) a corporation doing business as an insurance broker, consultant, or adjuster under:

632 (A) Chapter 23, Insurance Marketing - Licensing Agents, Brokers, Consultants, and
633 Reinsurance Intermediaries; and

634 (B) Chapter 26, Insurance Adjusters; or

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

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

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

639 [~~(21)~~] (25) "Credit [~~disability~~] accident and health insurance" means insurance on a debtor
640 to provide indemnity for payments coming due on a specific loan or other credit transaction while
641 the debtor is disabled.

642 [~~(22)~~] (26) "Credit insurance" means surety insurance under which mortgagees and other
643 creditors are indemnified against losses caused by the default of debtors.

644 [~~(23)~~] (27) "Credit life insurance" means insurance on the life of a debtor in connection
645 with a loan or other credit transaction.

646 [~~(24)~~] (28) "Creditor" means a person, including an insured, having any claim, whether:
647 (a) matured;
648 (b) unmatured;
649 (c) liquidated;
650 (d) unliquidated;
651 (e) secured;
652 (f) unsecured;
653 (g) absolute;
654 (h) fixed; or
655 (i) contingent.
656 [~~(25)~~] (29) (a) "Customer service representative" means a person that provides insurance
657 services and insurance product information:
658 (i) for its agent, broker, or consultant employer; and
659 (ii) to its employer's customer, client, or organization.
660 (b) A customer service representative may only operate within the scope of authority of
661 its agent, broker, or consultant employer.
662 (30) "Deadline" means the final date or time:
663 (a) imposed by:
664 (i) statute;
665 (ii) rule; or
666 (iii) order; and
667 (b) by which a required filing or payment must be received by the department.
668 [~~(26)~~] (31) "Deemer clause" means a provision under this title under which upon the
669 occurrence of a condition precedent, the commissioner is deemed to have taken a specific action.
670 If the statute so provides, the condition precedent may be the commissioner's failure to take a
671 specific action.
672 [~~(27)~~] (32) "Degree of relationship" means the number of steps between two persons
673 determined by counting the generations separating one person from a common ancestor and then
674 counting the generations to the other person.
675 [~~(28)~~] (33) "Department" means the Insurance Department.
676 [~~(29)~~] (34) "Director" means a member of the board of directors of a corporation.

677 [(30) "Disability insurance" means insurance written to:]
678 [(a) indemnify for losses and expenses resulting from accident or sickness;]
679 [(b) provide payments to replace income lost from accident or sickness; and]
680 [(c) pay for services resulting directly from accident or sickness, including medical,
681 surgical, hospital, and other ancillary expenses.]
682 (35) "Disability" means a physiological or psychological condition that partially or totally
683 limits an individual's ability to:
684 (a) perform the duties of:
685 (i) that individual's occupation; or
686 (ii) any occupation for which the individual is reasonably suited by education, training, or
687 experience; or
688 (b) perform two or more of the following basic activities of daily living:
689 (i) eating;
690 (ii) toileting;
691 (iii) transferring;
692 (iv) bathing; or
693 (v) dressing.
694 [(31)] (36) "Domestic insurer" means an insurer organized under the laws of this state.
695 [(32)] (37) "Domiciliary state" means the state in which an insurer:
696 (a) is incorporated;
697 (b) is organized; or
698 (c) in the case of an alien insurer, enters into the United States.
699 [(33)] (38) "Employee benefits" means one or more benefits or services provided
700 employees or their dependents.
701 [(34)] (39) (a) "Employee welfare fund" means a fund:
702 (i) established or maintained, whether directly or through trustees, by:
703 (A) one or more employers;
704 (B) one or more labor organizations; or
705 (C) a combination of employers and labor organizations; and
706 (ii) that provides employee benefits paid or contracted to be paid, other than income from
707 investments of the fund, by or on behalf of an employer doing business in this state or for the

708 benefit of any person employed in this state.
709 (b) "Employee welfare fund" includes a plan funded or subsidized by user fees or tax
710 revenues.
711 (40) "Endorsement" means a written agreement attached to a policy or certificate to modify
712 one or more of the provisions of the policy or certificate.
713 [~~(35)~~] (41) "Excludes" is not exhaustive and does not mean that other things are not also
714 excluded. The items listed are representative examples for use in interpretation of this title.
715 (42) "Expense reimbursement insurance" means insurance:
716 (a) written to provide payments for expenses relating to hospital confinements resulting
717 from illness or injury; and
718 (b) written:
719 (i) as a daily limit for a specific number of days in a hospital; and
720 (ii) to have a one or two day waiting period following a hospitalization.
721 [~~(36)~~] (43) "Fidelity insurance" means insurance guaranteeing the fidelity of persons
722 holding positions of public or private trust.
723 (44) (a) "Filed" means that a filing is:
724 (i) submitted to the department in accordance with any applicable statute, rule, or filing
725 order;
726 (ii) received by the department within the time period provided in the applicable statute,
727 rule, or filing order; and
728 (iii) accompanied with the applicable one or more filing fees required by:
729 (A) Section 31A-3-103; or
730 (B) rule.
731 (b) "Filed" does not include a filing that is rejected by the department because it is not
732 submitted in accordance with Subsection (44)(a).
733 (45) "Filing," when used as a noun, means an item required to be filed with the department
734 including:
735 (a) a policy;
736 (b) a rate;
737 (c) a form;
738 (d) a document;

739 (e) a plan;
740 (f) a manual;
741 (g) an application;
742 (h) a report;
743 (i) a certificate;
744 (j) an endorsement;
745 (k) an actuarial certification;
746 (l) a licensee annual statement;
747 (m) a licensee renewal application; or
748 (n) an advertisement.
749 [(37)] (46) "First party insurance" means an insurance policy or contract in which the
750 insurer agrees to pay claims submitted to it by the insured for the insured's losses.
751 [(38)] (47) "Foreign insurer" means an insurer domiciled outside of this state, including
752 an alien insurer.
753 [(39)] (48) (a) "Form" means a policy, certificate, or application prepared for general use.
754 (b) "Form" does not include a document specially prepared for use in an individual case.
755 [(40)] (49) "Franchise insurance" means individual insurance policies provided through
756 a mass marketing arrangement involving a defined class of persons related in some way other than
757 through the purchase of insurance.
758 (50) "Health care" means any of the following intended for use in the diagnosis, treatment,
759 mitigation, or prevention of a human ailment or impairment:
760 (a) professional services;
761 (b) personal services;
762 (c) facilities;
763 (d) equipment;
764 (e) devices;
765 (f) supplies; or
766 (g) medicine.
767 [(41)] (51) (a) "Health care insurance" or "health insurance" means [disability] insurance
768 providing [benefits solely of medical, surgical, hospital, or other ancillary services or payment of
769 medical, surgical, hospital, or other ancillary expenses incurred.]:

770 (i) health care benefits; or
771 (ii) payment of incurred health care expenses.
772 (b) "Health care insurance" or "health insurance" does not include [~~disability~~] accident and
773 health insurance providing benefits for:
774 (i) replacement of income;
775 (ii) short-term accident;
776 (iii) fixed indemnity;
777 (iv) credit [~~disability~~] accident and health;
778 (v) supplements to liability;
779 (vi) workers' compensation;
780 (vii) automobile medical payment;
781 (viii) no-fault automobile;
782 (ix) equivalent self-insurance; or
783 (x) any type of [~~disability~~] accident and health insurance coverage that is a part of or
784 attached to another type of policy.
785 (52) "Income replacement insurance" or "disability income insurance" means insurance
786 written to provide payments to replace income lost from accident or sickness.
787 [~~(42)~~] (53) "Indemnity" means the payment of an amount to offset all or part of an insured
788 loss.
789 [~~(43)~~] (54) "Independent adjuster" means an insurance adjuster required to be licensed
790 under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.
791 [~~(44)~~] (55) "Independently procured insurance" means insurance procured under Section
792 31A-15-104.
793 [~~(45)~~] (56) "Individual" means a natural person.
794 [~~(46)~~] (57) "Inland marine insurance" includes insurance covering:
795 (a) property in transit on or over land;
796 (b) property in transit over water by means other than boat or ship;
797 (c) bailee liability;
798 (d) fixed transportation property such as bridges, electric transmission systems, radio and
799 television transmission towers and tunnels; and
800 (e) personal and commercial property floaters.

801 [~~(47)~~] (58) "Insolvency" means that:
802 (a) an insurer is unable to pay its debts or meet its obligations as they mature;
803 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level RBC
804 under Subsection 31A-17-601[~~(7)~~](8)(c); or
805 (c) an insurer is determined to be hazardous under this title.
806 [~~(48)~~] (59) (a) "Insurance" means:
807 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more
808 persons to one or more other persons; or
809 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a group
810 of persons that includes the person seeking to distribute that person's risk.
811 (b) "Insurance" includes:
812 (i) risk distributing arrangements providing for compensation or replacement for damages
813 or loss through the provision of services or benefits in kind;
814 (ii) contracts of guaranty or suretyship entered into by the guarantor or surety as a business
815 and not as merely incidental to a business transaction; and
816 (iii) plans in which the risk does not rest upon the person who makes the arrangements,
817 but with a class of persons who have agreed to share it.
818 [~~(49)~~] (60) "Insurance adjuster" means a person who directs the investigation, negotiation,
819 or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf
820 of an insurer, policyholder, or a claimant under an insurance policy.
821 [~~(50)~~] (61) "Interinsurance exchange" is defined in Subsection [~~(81)~~] (100).
822 [~~(51)~~] (62) Except as provided in Subsection [~~31A-23-102(2)~~] 31A-23-201.5(1),
823 "insurance agent" or "agent" means a person who represents insurers in soliciting, negotiating, or
824 placing insurance.
825 [~~(52)~~] (63) Except as provided in Subsection [~~31A-23-102(2)~~] 31A-23-201.5(1),
826 "insurance broker" or "broker" means a person who:
827 (a) acts in procuring insurance on behalf of an applicant for insurance or an insured; and
828 (b) does not act on behalf of the insurer except by collecting premiums or performing other
829 ministerial acts.
830 [~~(53)~~] (64) "Insurance business" or "business of insurance" includes:
831 (a) providing health care insurance, as defined in Subsection [~~(41)~~] (51), by organizations

832 that are or should be licensed under this title;
833 (b) providing benefits to employees in the event of contingencies not within the control
834 of the employees, in which the employees are entitled to the benefits as a right, which benefits may
835 be provided either:
836 (i) by single employers or by multiple employer groups; or
837 (ii) through trusts, associations, or other entities;
838 (c) providing annuities, including those issued in return for gifts, except those provided
839 by persons specified in Subsections 31A-22-1305(2) and (3);
840 (d) providing the characteristic services of motor clubs as outlined in Subsection [~~(65)~~]
841 (77);
842 (e) providing other persons with insurance as defined in Subsection [~~(48)~~] (59);
843 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor, or
844 surety, any contract or policy of title insurance;
845 (g) transacting or proposing to transact any phase of title insurance, including solicitation,
846 negotiation preliminary to execution, execution of a contract of title insurance, insuring, and
847 transacting matters subsequent to the execution of the contract and arising out of it, including
848 reinsurance; and
849 (h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(53)~~]
850 (64)(a) through (g) in a manner designed to evade the provisions of this title.
851 [~~(54)~~] (65) Except as provided in Subsection [~~31A-23-102(2)~~] 31A-23-201.5(1),
852 "insurance consultant" or "consultant" means a person who:
853 (a) advises other persons about insurance needs and coverages;
854 (b) is compensated by the person advised on a basis not directly related to the insurance
855 placed; and
856 (c) is not compensated directly or indirectly by an insurer, agent, or broker for advice
857 given.
858 [~~(55)~~] (66) "Insurance holding company system" means a group of two or more affiliated
859 persons, at least one of whom is an insurer.
860 [~~(56)~~] (67) (a) "Insured" means a person to whom or for whose benefit an insurer makes
861 a promise in an insurance policy and includes:
862 (i) policyholders;

863 (ii) subscribers;
864 (iii) members; and
865 (iv) beneficiaries.
866 (b) The definition in Subsection [~~(56)~~] (67)(a) applies only to this title and does not define
867 the meaning of this word as used in insurance policies or certificates.
868 [~~(57)~~] (68) (a) (i) "Insurer" means any person doing an insurance business as a principal
869 including:
870 (A) fraternal benefit societies;
871 (B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and
872 (3);
873 (C) motor clubs;
874 (D) employee welfare plans; and
875 (E) any person purporting or intending to do an insurance business as a principal on that
876 person's own account.
877 (ii) "Insurer" does not include a governmental entity, as defined in Section 63-30-2, to the
878 extent it is engaged in the activities described in Section 31A-12-107.
879 (b) "Admitted insurer" is defined in Subsection [~~(94)~~] (115)(b).
880 (c) "Alien insurer" is defined in Subsection [~~(4)~~] (5).
881 (d) "Authorized insurer" is defined in Subsection [~~(94)~~] (115)(b).
882 (e) "Domestic insurer" is defined in Subsection [~~(31)~~] (36).
883 (f) "Foreign insurer" is defined in Subsection [~~(38)~~] (47).
884 (g) "Nonadmitted insurer" is defined in Subsection [~~(94)~~] (115)(a).
885 (h) "Unauthorized insurer" is defined in Subsection [~~(94)~~] (115)(a).
886 [~~(58)~~] (69) (a) Except as provided in Section 31A-1-103, "legal expense insurance" means
887 insurance written to indemnify or pay for specified legal expenses.
888 (b) "Legal expense insurance" includes arrangements that create reasonable expectations
889 of enforceable rights, but it does not include the provision of, or reimbursement for, legal services
890 incidental to other insurance coverages.
891 [~~(59)~~] (70) (a) "Liability insurance" means insurance against liability:
892 (i) for death, injury, or disability of any human being, or for damage to property, exclusive
893 of the coverages under:

894 (A) Subsection [~~(62)~~] (74) for medical malpractice insurance;
895 (B) Subsection [~~(77)~~] (92) for professional liability insurance; and
896 (C) Subsection [~~(97)~~] (119) for workers' compensation insurance;
897 (ii) for medical, hospital, surgical, and funeral benefits to persons other than the insured
898 who are injured, irrespective of legal liability of the insured, when issued with or supplemental to
899 insurance against legal liability for the death, injury, or disability of human beings, exclusive of
900 the coverages under:
901 (A) Subsection [~~(62)~~] (74) for medical malpractice insurance;
902 (B) Subsection [~~(77)~~] (92) for professional liability insurance; and
903 (C) Subsection [~~(97)~~] (118) for workers' compensation insurance;
904 (iii) for loss or damage to property resulting from accidents to or explosions of boilers,
905 pipes, pressure containers, machinery, or apparatus;
906 (iv) for loss or damage to any property caused by the breakage or leakage of sprinklers,
907 water pipes and containers, or by water entering through leaks or openings in buildings; or
908 (v) for other loss or damage properly the subject of insurance not within any other kind
909 or kinds of insurance as defined in this chapter, if such insurance is not contrary to law or public
910 policy.
911 (b) "Liability insurance" includes:
912 (i) vehicle liability insurance as defined in Subsection [~~(95)~~] (116);
913 (ii) residential dwelling liability insurance as defined in Subsection [~~(83)~~] (102); and
914 (iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers,
915 machinery, and apparatus of any kind when done in connection with insurance on them.
916 [~~(60)~~] (71) "License" means the authorization issued by the insurance commissioner under
917 this title to engage in some activity that is part of or related to the insurance business. It includes
918 certificates of authority issued to insurers.
919 [~~(61)~~] (72) (a) "Life insurance" means insurance on human lives and insurances pertaining
920 to or connected with human life.
921 (b) The business of life insurance includes:
922 (i) granting death benefits;
923 [~~(i)~~] (ii) granting annuity benefits;
924 [~~(ii)~~] (iii) granting endowment benefits;

925 [~~(iii)~~] (iv) granting additional benefits in the event of death by accident [~~or accidental~~
926 ~~means~~];
927 [~~(iv)~~] (v) granting additional benefits to safeguard the policy against lapse in the event of
928 [~~the total and permanent~~] disability [~~of the insured~~]; and
929 [~~(v)~~] (vi) providing optional methods of settlement of proceeds.
930 (73) (a) "Long-term care insurance" means an insurance policy or rider advertised,
931 marketed, offered, or designated to provide coverage:
932 (i) in a setting other than an acute care unit of a hospital;
933 (ii) for not less than 12 consecutive months for each covered person on the basis of:
934 (A) expenses incurred;
935 (B) indemnity;
936 (C) prepayment; or
937 (D) another method;
938 (iii) for one or more necessary or medically necessary services that are:
939 (A) diagnostic;
940 (B) preventative;
941 (C) therapeutic;
942 (D) rehabilitative;
943 (E) maintenance; or
944 (F) personal care; and
945 (iv) that may be issued by:
946 (A) an insurer;
947 (B) a fraternal benefit society;
948 (C) (I) a nonprofit health hospital; and
949 (II) a medical service corporation;
950 (D) a prepaid health plan;
951 (E) a health maintenance organization; or
952 (F) an entity similar to the entities described in Subsections (73)(a)(iv)(A) through (E) to
953 the extent that the entity is otherwise authorized to issue life or health care insurance.
954 (b) "Long-term care insurance" includes:
955 (i) any of the following that provide directly or supplement long-term care insurance:

956 (A) a group or individual annuity or rider; or
957 (B) a life insurance policy or rider;
958 (ii) a policy or rider that provides for payment of benefits based on:
959 (A) cognitive impairment; or
960 (B) functional capacity; or
961 (iii) a qualified long-term care insurance contract.
962 (c) "Long-term care insurance" does not include:
963 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
964 (ii) basic hospital expense coverage;
965 (iii) basic medical/surgical expense coverage;
966 (iv) hospital confinement indemnity coverage;
967 (v) major medical expense coverage;
968 (vi) income replacement or related asset-protection coverage;
969 (vii) accident only coverage;
970 (viii) coverage for a specified:
971 (A) disease; or
972 (B) accident;
973 (ix) limited benefit health coverage; or
974 (x) a life insurance policy that accelerates the death benefit to provide the option of a lump
975 sum payment:
976 (A) if neither the benefits nor eligibility is conditioned on the receipt of long-term care;
977 and
978 (B) the coverage is for one or more the following qualifying events:
979 (I) terminal illness;
980 (II) medical conditions requiring extraordinary medical intervention; or
981 (III) permanent institutional confinement.
982 [~~(62)~~] (74) "Medical malpractice insurance" means insurance against legal liability
983 incident to the practice and provision of medical services other than the practice and provision of
984 dental services.
985 [~~(63)~~] (75) "Member" means a person having membership rights in an insurance
986 corporation.

987 [~~(64)~~] (76) "Minimum capital" or "minimum required capital" means the capital that must
988 be constantly maintained by a stock insurance corporation as required by statute.
989 [~~(65)~~] (77) "Motor club" means a person:
990 (a) licensed under:
991 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
992 (ii) Chapter 11, Motor Clubs; or
993 (iii) Chapter 14, Foreign Insurers; and
994 (b) that promises for an advance consideration to provide for a stated period of time:
995 (i) legal services under Subsection 31A-11-102(1)(b);
996 (ii) bail services under Subsection 31A-11-102(1)(c); or
997 (iii) trip reimbursement, towing services, emergency road services, stolen automobile
998 services, a combination of these services, or any other services given in Subsections
999 31A-11-102(1)(b) through (f).
1000 [~~(66)~~] (78) "Mutual" means mutual insurance corporation.
1001 [~~(67)~~] (79) "Nonparticipating" means a plan of insurance under which the insured is not
1002 entitled to receive dividends representing shares of the surplus of the insurer.
1003 [~~(68)~~] (80) "Ocean marine insurance" means insurance against loss of or damage to:
1004 (a) ships or hulls of ships;
1005 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, moneys,
1006 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia interests,
1007 or other cargoes in or awaiting transit over the oceans or inland waterways;
1008 (c) earnings such as freight, passage money, commissions, or profits derived from
1009 transporting goods or people upon or across the oceans or inland waterways; or
1010 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
1011 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons in
1012 connection with maritime activity.
1013 [~~(69)~~] (81) "Order" means an order of the commissioner.
1014 (82) "Outline of coverage" means a summary that explains an accident and health
1015 insurance policy.
1016 [~~(70)~~] (83) "Participating" means a plan of insurance under which the insured is entitled
1017 to receive dividends representing shares of the surplus of the insurer.

1018 [(71)] (84) "Person" includes an individual, partnership, corporation, incorporated or
1019 unincorporated association, joint stock company, trust, reciprocal, syndicate, or any similar entity
1020 or combination of entities acting in concert.
1021 [(72)] (85) (a) (i) "Policy" means any document, including attached endorsements and
1022 riders, purporting to be an enforceable contract, which memorializes in writing some or all of the
1023 terms of an insurance contract.
1024 (ii) "Policy" includes a service contract issued by:
1025 (A) a motor club under Chapter 11, Motor Clubs; [and]
1026 (B) a service contract provided under Chapter 6a, Service Contracts; and
1027 [(B)] (C) a corporation licensed under:
1028 (I) Chapter 7, Nonprofit Health Service Insurance Corporations; or
1029 (II) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
1030 (iii) "Policy" does not include:
1031 (A) a certificate under a group insurance contract; or
1032 (B) a document that does not purport to have legal effect.
1033 (b) "Group insurance policy" means a policy covering a group of persons that is issued to
1034 a policyholder on behalf of the group, for the benefit of group members who are selected under
1035 procedures defined in the policy or in agreements which are collateral to the policy. This type of
1036 policy may include members of the policyholder's family or dependents.
1037 (c) "Blanket insurance policy" means a group policy covering classes of persons without
1038 individual underwriting, where the persons insured are determined by definition of the class with
1039 or without designating the persons covered.
1040 [(73)] (86) "Policyholder" means the person who controls a policy, binder, or oral contract
1041 by ownership, premium payment, or otherwise.
1042 (87) "Policy illustration" means a presentation or depiction that includes nonguaranteed
1043 elements of a policy of life insurance over a period of years.
1044 (88) "Policy summary" means a synopsis describing the elements of a life insurance policy.
1045 [(74)] (89) (a) "Premium" means the monetary consideration for an insurance policy, and
1046 includes assessments, membership fees, required contributions, or monetary consideration,
1047 however designated.
1048 (b) Consideration paid to third party administrators for their services is not "premium,"

1049 though amounts paid by third party administrators to insurers for insurance on the risks
1050 administered by the third party administrators are "premium."
1051 [~~(75)~~] (90) "Principal officers" of a corporation means the officers designated under
1052 Subsection 31A-5-203(3).
1053 [~~(76)~~] (91) "Proceedings" includes actions and special statutory proceedings.
1054 [~~(77)~~] (92) "Professional liability insurance" means insurance against legal liability
1055 incident to the practice of a profession and provision of any professional services.
1056 [~~(78)~~] (93) "Property insurance" means insurance against loss or damage to real or personal
1057 property of every kind and any interest in that property, from all hazards or causes, and against loss
1058 consequential upon the loss or damage including vehicle comprehensive and vehicle physical
1059 damage coverages, but excluding inland marine insurance and ocean marine insurance as defined
1060 under Subsections [~~(46)~~] (57) and [~~(68)~~] (80).
1061 [~~(79)~~] (94) (a) "Public agency insurance mutual" means any entity formed by joint venture
1062 or interlocal cooperation agreement by two or more political subdivisions or public agencies of the
1063 state for the purpose of providing insurance coverage for the political subdivisions or public
1064 agencies.
1065 (b) Any public agency insurance mutual created under this title and Title 11, Chapter 13,
1066 Interlocal Cooperation Act, is considered to be a governmental entity and political subdivision of
1067 the state with all of the rights, privileges, and immunities of a governmental entity or political
1068 subdivision of the state.
1069 (95) "Qualified long-term care insurance contract" or "federally tax qualified long-term
1070 care insurance contract" means:
1071 (a) an individual or group insurance contract that meets the requirements of Section
1072 7702B(b), Internal Revenue Code; or
1073 (b) the portion of a life insurance contract that provides long-term care insurance:
1074 (i) (A) by rider; or
1075 (B) as a part of the contract; and
1076 (ii) that satisfies the requirements of Section 7702B(b) and (e), Internal Revenue Code.
1077 (96) (a) "Rate" means:
1078 (i) the cost of a given unit of insurance; or
1079 (ii) for property-casualty insurance, that cost of insurance per exposure unit either

1080 expressed as:
1081 (A) a single number; or
1082 (B) a pure premium rate, adjusted before any application of individual risk variations based
1083 on loss or expense considerations to account for the treatment of:
1084 (I) expenses;
1085 (II) profit; and
1086 (III) individual insurer variation in loss experience.
1087 (b) "Rate" does not include a minimum premium.
1088 [(80)] (97) (a) Except as provided in Subsection [(80)] (97)(b), "rate service organization"
1089 means any person who assists insurers in rate making or filing by:
1090 (i) collecting, compiling, and furnishing loss or expense statistics;
1091 (ii) recommending, making, or filing rates or supplementary rate information; or
1092 (iii) advising about rate questions, except as an attorney giving legal advice.
1093 (b) "Rate service organization" does not mean:
1094 (i) an employee of an insurer;
1095 (ii) a single insurer or group of insurers under common control;
1096 (iii) a joint underwriting group; or
1097 (iv) a natural person serving as an actuarial or legal consultant.
1098 (98) "Rating manual" means any of the following used to determine initial and renewal
1099 policy premiums:
1100 (a) a manual of rates;
1101 (b) classifications;
1102 (c) rate-related underwriting rules; and
1103 (d) rating formulas that describe steps, policies, and procedures for determining initial and
1104 renewal policy premiums.
1105 (99) "Received by the department" means:
1106 (a) except as provided in Subsection (99)(b), the date delivered to and stamped received
1107 by the department, whether delivered:
1108 (i) in person;
1109 (ii) by a delivery service; or
1110 (iii) electronically; and

1111 (b) if an item with a department imposed deadline is delivered to the department by a
1112 delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:
1113 (i) statute;
1114 (ii) rule; or
1115 (iii) a specific filing order.
1116 [(81)] (100) "Reciprocal" or "interinsurance exchange" means any unincorporated
1117 association of persons:
1118 (a) operating through an attorney-in-fact common to all of them; and
1119 (b) exchanging insurance contracts with one another that provide insurance coverage on
1120 each other.
1121 [(82)] (101) "Reinsurance" means an insurance transaction where an insurer, for
1122 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to
1123 reinsurance transactions, this title sometimes refers to:
1124 (a) the insurer transferring the risk as the "ceding insurer"; and
1125 (b) the insurer assuming the risk as the:
1126 (i) "assuming insurer"; or
1127 (ii) "assuming reinsurer."
1128 [(83)] (102) "Residential dwelling liability insurance" means insurance against liability
1129 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is
1130 a detached single family residence or multifamily residence up to four units.
1131 [(84)] (103) "Retrocession" means reinsurance with another insurer of a liability assumed
1132 under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part
1133 of a liability assumed under a reinsurance contract.
1134 (104) "Rider" means an endorsement to:
1135 (a) an insurance policy; or
1136 (b) an insurance certificate.
1137 [(85)] (105) (a) "Security" means any:
1138 (i) note;
1139 (ii) stock;
1140 (iii) bond;
1141 (iv) debenture;

1142 (v) evidence of indebtedness;
1143 (vi) certificate of interest or participation in any profit-sharing agreement;
1144 (vii) collateral-trust certificate;
1145 (viii) preorganization certificate or subscription;
1146 (ix) transferable share;
1147 (x) investment contract;
1148 (xi) voting trust certificate;
1149 (xii) certificate of deposit for a security;
1150 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
1151 payments out of production under such a title or lease;
1152 (xiv) commodity contract or commodity option;
1153 (xv) any certificate of interest or participation in, temporary or interim certificate for,
1154 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in
1155 Subsections [~~(85)~~] (105)(a)(i) through (xiv); or
1156 (xvi) any other interest or instrument commonly known as a security.
1157 (b) "Security" does not include:
1158 (i) any insurance or endowment policy or annuity contract under which an insurance
1159 company promises to pay money in a specific lump sum or periodically for life or some other
1160 specified period; or
1161 (ii) a burial certificate or burial contract.
1162 [~~(86)~~] (106) "Self-insurance" means any arrangement under which a person provides for
1163 spreading its own risks by a systematic plan.
1164 (a) Except as provided in this Subsection [~~(86)~~] (106), self-insurance does not include an
1165 arrangement under which a number of persons spread their risks among themselves.
1166 (b) Self-insurance does include an arrangement by which a governmental entity, as defined
1167 in Section 63-30-2, undertakes to indemnify its employees for liability arising out of the
1168 employees' employment.
1169 (c) Self-insurance does include an arrangement by which a person with a managed
1170 program of self-insurance and risk management undertakes to indemnify its affiliates, subsidiaries,
1171 directors, officers, or employees for liability or risk which is related to the relationship or
1172 employment.

1173 (d) Self-insurance does not include any arrangement with independent contractors.
1174 (107) "Short-term care insurance" means any insurance policy or rider advertised,
1175 marketed, offered, or designed to provide coverage that is similar to long-term care insurance but
1176 that provides coverage for less than 12 consecutive months for each covered person.
1177 [~~(87)~~] (108) (a) "Subsidiary" of a person means an affiliate controlled by that person either
1178 directly or indirectly through one or more affiliates or intermediaries.
1179 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting shares
1180 are owned by that person either alone or with its affiliates, except for the minimum number of
1181 shares the law of the subsidiary's domicile requires to be owned by directors or others.
1182 [~~(88)~~] (109) Subject to Subsection [~~(48)~~] (59)(b), "surety insurance" includes:
1183 (a) a guarantee against loss or damage resulting from failure of principals to pay or
1184 perform their obligations to a creditor or other obligee;
1185 (b) bail bond insurance; and
1186 (c) fidelity insurance.
1187 [~~(89)~~] (110) (a) "Surplus" means the excess of assets over the sum of paid-in capital and
1188 liabilities.
1189 (b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated
1190 by the insurer as permanent.
1191 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-209 require that
1192 mutuals doing business in this state maintain specified minimum levels of permanent surplus.
1193 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is
1194 essentially the same as the minimum required capital requirement that applies to stock insurers.
1195 (c) "Excess surplus" means:
1196 (i) for life or [~~disability insurers, as defined in Subsection 31A-17-601(3),~~] accident and
1197 health insurers, health organizations, and property and casualty insurers[~~,~~] as defined in
1198 [~~Subsection~~] Section 31A-17-601[~~(4)~~], the lesser of:
1199 (A) that amount of an insurer's or health organization's total adjusted capital, as defined
1200 in Subsection [~~(92)~~] (113), that exceeds the product of:
1201 (I) 2.5; and
1202 (II) the sum of the insurer's or health organization's minimum capital or permanent surplus
1203 required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1204 (B) that amount of an insurer's or health organization's total adjusted capital, as defined
1205 in Subsection [~~(92)~~] 113, that exceeds the product of:
1206 (I) 3.0; and
1207 (II) the authorized control level RBC as defined in Subsection 31A-17-601[~~(7)~~](8)(a); and
1208 (ii) for monoline mortgage guaranty insurers, financial guaranty insurers, and title insurers,
1209 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:
1210 (A) 1.5; and
1211 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).
1212 [~~(90)~~] (111) "Third party administrator" or "administrator" means any person who collects
1213 charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the
1214 state in connection with insurance coverage, annuities, or service insurance coverage, except:
1215 (a) a union on behalf of its members;
1216 (b) a person [~~exempt as a trust under Section 514 of~~] administering any:
1217 (i) pension plan subject to the federal Employee Retirement Income Security Act of 1974;
1218 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
1219 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
1220 (c) an employer on behalf of the employer's employees or the employees of one or more
1221 of the subsidiary or affiliated corporations of the employer;
1222 (d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only [~~with respect to insurance~~
1223 ~~issued by the insurer~~] for a line of insurance for which the insurer holds a license in this state; or
1224 (e) a person licensed or exempt from licensing under Chapter 23 or 26 whose activities are
1225 limited to those authorized under the license the person holds or for which the person is exempt.
1226 [~~(91)~~] (112) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners
1227 of real or personal property or the holders of liens or encumbrances on that property, or others
1228 interested in the property against loss or damage suffered by reason of liens or encumbrances upon,
1229 defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any
1230 liens or encumbrances on the property.
1231 [~~(92)~~] (113) "Total adjusted capital" means the sum of an insurer's or health organization's
1232 statutory capital and surplus as determined in accordance with:
1233 (a) the statutory accounting applicable to the annual financial statements required to be
1234 filed under Section 31A-4-113; and

1235 (b) any other items provided by the RBC instructions, as RBC instructions is defined in
1236 [~~Subsection~~] Section 31A-17-601[~~(6)~~].
1237 [~~(93)~~] (114) (a) "Trustee" means "director" when referring to the board of directors of a
1238 corporation.
1239 (b) "Trustee," when used in reference to an employee welfare fund, means an individual,
1240 firm, association, organization, joint stock company, or corporation, whether acting individually
1241 or jointly and whether designated by that name or any other, that is charged with or has the overall
1242 management of an employee welfare fund.
1243 [~~(94)~~] (115) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer"
1244 means an insurer:
1245 (i) not holding a valid certificate of authority to do an insurance business in this state; or
1246 (ii) transacting business not authorized by a valid certificate.
1247 (b) "Admitted insurer" or "authorized insurer" means an insurer:
1248 (i) holding a valid certificate of authority to do an insurance business in this state; and
1249 (ii) transacting business as authorized by a valid certificate.
1250 [~~(95)~~] (116) "Vehicle liability insurance" means insurance against liability resulting from
1251 or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle
1252 comprehensive and vehicle physical damage coverages under Subsection [~~(78)~~] (93).
1253 [~~(96)~~] (117) "Voting security" means a security with voting rights, and includes any
1254 security convertible into a security with a voting right associated with it.
1255 [~~(97)~~] (118) "Workers' compensation insurance" means:
1256 (a) insurance for indemnification of employers against liability for compensation based
1257 on:
1258 (i) compensable accidental injuries; and
1259 (ii) occupational disease disability;
1260 (b) employer's liability insurance incidental to workers compensation insurance and written
1261 in connection with it; and
1262 (c) insurance assuring to the persons entitled to workers compensation benefits the
1263 compensation provided by law.
1264 Section 6. Section **31A-2-214** is amended to read:
1265 **31A-2-214. Market assistance programs -- Joint underwriting associations.**

1266 (1) (a) If the commissioner finds that in any part of this state a line of insurance is not
1267 generally available in the marketplace or that it is priced in such a manner as to severely limit its
1268 availability, and that the public interest requires it, [~~he~~] the commissioner may by rule implement
1269 a market assistance program whereby all licensed insurers and agents may pool their information
1270 as to the available markets.
1271 (b) Insurers doing business in this state may, at their own instance or at the request of the
1272 commissioner, prepare and submit to the commissioner, for [~~his~~] the commissioner's approval and
1273 adoption, voluntary plans providing any line of insurance coverage for all or any part of this state
1274 in which this insurance is not generally available in the voluntary market or is priced in such a
1275 manner as to severely limit its availability and in which the public interest requires the availability
1276 of this coverage.
1277 (2) (a) If the commissioner finds after notice and hearing that a market assistance program
1278 formed under Subsection (1)(a) or (b) has not met the needs it was intended to address, [~~he~~] the
1279 commissioner may by rule form a joint underwriting association to make available the insurance
1280 to applicants who are in good faith entitled to but unable to procure this insurance through ordinary
1281 methods.
1282 (b) The commissioner shall allow any market assistance program formed under Subsection
1283 (1)(a) or (b) a minimum of 30 days operation before [~~he~~] the commissioner forms a joint
1284 underwriting association. The commissioner may not adopt a rule forming a joint underwriting
1285 association unless [~~he~~] the commissioner finds as a result of the hearing that:
1286 (i) a certain coverage is not available or that the price for that coverage is no longer
1287 commensurate with the risk in this state; and
1288 (ii) the coverage is:
1289 (A) vital to the economic health of this state[~~, is~~];
1290 (B) vital to the quality of life in this state[~~, is~~];
1291 (C) vital in maintaining competition in insurance in this state[~~;~~]; or
1292 (D) the number of people affected is significant enough to justify its creation.
1293 [~~(b)~~] (c) The commissioner may not adopt a rule forming a joint underwriting association
1294 under Subsection (2)(a) on the basis that applicants for particular lines of insurance are unable to
1295 pay a premium that is commensurate with the risk involved or that the number of applicants or
1296 people affected is too small to justify its creation.

1297 [(c)] (d) Each joint underwriting association formed under Subsection (2)(a) shall require
1298 participation by all insurers licensed and engaged in writing that line of insurance or any
1299 component of that line of insurance within this state.
1300 [(d)] (e) Each association formed under Subsection (2)(a) shall:
1301 (i) give consideration to:
1302 (A) the need for adequate and readily accessible coverage;
1303 (B) alternative methods of improving the market affected;
1304 (C) the preference of the insurers and agents;
1305 (D) the inherent limitations of the insurance mechanism;
1306 (E) the need for reasonable underwriting standards; and
1307 (F) the requirement of reasonable loss prevention measures;
1308 (ii) establish procedures that will create minimum interference with the voluntary market;
1309 (iii) allocate the burden imposed by the association equitably and efficiently among the
1310 insurers doing business in this state;
1311 (iv) establish procedures for applicants and participants to have grievances reviewed by
1312 an impartial body;
1313 (v) provide for the method of classifying risks and making and filing applicable rates; and
1314 (vi) specify:
1315 (A) the basis of participation of insurers and agents in the association;
1316 (B) the conditions under which risks must be accepted; and
1317 (C) the commission rates to be paid for insurance business placed with the association.
1318 [(e)] (f) Any deficit in an association in any year shall be recouped by rate increases for
1319 the association, applicable prospectively. Any surplus in excess of the loss reserves of the
1320 association in any year shall be distributed either by rate decreases or by distribution to the
1321 members of the association on a pro-rata basis.
1322 (3) Notwithstanding [the provisions of] Subsection (2), the commissioner may not create
1323 a joint underwriting association under [that subsection] Subsection (2) for:
1324 (a) life insurance[,];
1325 (b) annuities[, disability];
1326 (c) accident and health insurance[,];
1327 (d) ocean marine insurance[,];

1328 (e) medical malpractice insurance[,];
1329 (f) earthquake insurance[,];
1330 (g) workers' compensation insurance[,];
1331 (h) public agency insurance mutuals[,]; or
1332 (i) private passenger automobile liability insurance.
1333 (4) Every insurer and agent participating in a joint underwriting association adopted by the
1334 commissioner under Subsection (2) shall provide the services prescribed by the association to any
1335 person seeking coverage of the kind available in the plan, including full information about the
1336 requirements and procedures for obtaining coverage with the association.
1337 (5) If the commissioner finds that the lack of cooperating insurers or agents in an area
1338 makes the functioning of the association difficult, [he] the commissioner may order the association
1339 to:
1340 (a) establish branch service offices[,];
1341 (b) make special contracts for provision of the service[,]; or
1342 (c) take other appropriate steps to ensure that service is available.
1343 (6) The association may issue policies for a period of one year. If, at the end of any one
1344 year period, the commissioner determines that the market conditions justify the continued
1345 existence of the association, [he] the commissioner may reauthorize its existence. In reauthorizing
1346 the association, the commissioner shall follow the procedure set forth in Subsection (2).
1347 Section 7. Section **31A-2-217** is enacted to read:
1348 **31A-2-217. Coordination with other states.**
1349 (1) (a) Subject to Subsection (1)(b), the commissioner, by rule, may adopt one or more
1350 agreements with another governmental regulatory agency, within and outside of this state, or with
1351 the National Association of Insurance Commissioners to address:
1352 (i) licensing of insurance companies;
1353 (ii) licensing of agents;
1354 (iii) regulation of premium rates and policy forms; and
1355 (iv) regulation of insurer insolvency and insurance receiverships.
1356 (b) An agreement described in Subsection (1)(a), may authorize the commissioner to
1357 modify a requirement of this title if the commissioner determines that the requirements under the
1358 agreement provide protections similar to or greater than the requirements under this title.

1359 (2) (a) The commissioner may negotiate an interstate compact that addresses issuing
1360 certificates of authority, if the commissioner determines that:
1361 (i) each state participating in the compact has requirements for issuing certificates of
1362 authority that provide protections similar to or greater than the requirements of this title; or
1363 (ii) the interstate compact contains requirements for issuing certificates of authority that
1364 provide protections similar to or greater than the requirements of this title.
1365 (b) If an interstate compact described in Subsection (2)(a) is adopted by the Legislature,
1366 the commissioner may issue certificates of authority to insurers in accordance with the terms of
1367 the interstate compact.
1368 (3) If any provision of this title conflicts with a provision of the annual statement
1369 instructions or the National Association of Insurance Commissioners Accounting Practices and
1370 Procedures Manual, the commissioner may, by rule, resolve the conflict in favor of the annual
1371 statement instructions or the National Association of Insurance Commissioners Accounting
1372 Practices and Procedures Manual.
1373 (4) The commissioner may, by rule, accept the information prescribed by the National
1374 Association of Insurance Commissioners instead of the documents required to be filed with an
1375 application for a certificate of authority under:
1376 (a) Section 31A-4-103, 31A-5-204, 31A-8-205, or 31A-14-201; or
1377 (b) rules made by the commissioner.
1378 (5) Before November 30, 2001, the commissioner shall report to the Business, Labor, and
1379 Economic Development Interim Committee regarding the status of:
1380 (a) any agreements entered into under Subsection (1);
1381 (b) any interstate compact entered into under Subsection (2); and
1382 (c) any rule made under Subsections (3) and (4).
1383 (6) This section shall be repealed in accordance with Section 63-55-231.
1384 Section 8. Section **31A-4-103** is amended to read:
1385 **31A-4-103. Certificate of authority.**
1386 (1) Each certificate of authority issued by the commissioner shall specify:
1387 (a) the name of the insurer[;];
1388 (b) the kinds of insurance it is authorized to transact in Utah[;]; and
1389 (c) any other information the commissioner requires.

1390 (2) A certificate of authority issued under this chapter remains in force until, under
1391 Subsection (3), the certificate of authority is:
1392 (a) revoked;
1393 (b) suspended; or
1394 (c) limited.
1395 (3) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative
1396 Procedures Act, the commissioner may revoke, suspend, or limit in whole or in part the certificate
1397 of authority of any insurer if:
1398 (i) the insurer is found to have:
1399 (A) failed to pay when due any fee due under Section 31A-3-103;
1400 (B) violated or failed to comply with:
1401 (I) this title;
1402 (II) a rule made under Subsection 31A-2-201(3); or
1403 (III) an order issued under Subsection 31A-2-201(4); or
1404 (ii) the insurer's methods and practices in the conduct of business endanger the legitimate
1405 interests of customers and the public.
1406 (b) An order suspending or limiting a certificate of authority issued under this chapter shall
1407 specify:
1408 (i) the period of the suspension or limitation, which in no event may be in excess of 12
1409 months;
1410 (ii) the conditions and limitations imposed on the insurer during the suspension or
1411 limitation; and
1412 (iii) the conditions and procedures for reinstatement from suspension or limitation.
1413 (4) Subject to the requirements of this section and in accordance with Title 63, Chapter
1414 46a, Utah Administrative Rulemaking Act, the commissioner shall by rule prescribe procedures
1415 to renew or reinstate a certificate of authority.
1416 (5) An insurer under this chapter whose certificate of authority is suspended or revoked,
1417 but that continues to act as an authorized insurer, is subject to the penalties for acting as an insurer
1418 without a certificate of authority.
1419 (6) Any insurer holding a certificate of authority in this state shall immediately report to
1420 the commissioner a suspension or revocation of that insurer's certificate of authority in any:

1421 (a) state;
1422 (b) the District of Columbia; or
1423 (c) a territory of the United States.
1424 (7) (a) An order revoking a certificate of authority under Subsection (3) may specify a time
1425 within which the former authorized insurer may not apply for a new certificate of authority, except
1426 that the time may not exceed five years from the date the certificate of authority is revoked.
1427 (b) If no time is specified in an order revoking a certificate of authority under Subsection
1428 (3), the former authorized insurer may not apply for a new certificate of authority for five years
1429 from the date the certificate of authority is revoked without express approval by the commissioner.
1430 (8) (a) Subject to Subsection (8)(b), the insurer shall pay all fees under Section 31A-3-103
1431 that would have been payable if the certificate of authority had not been suspended or revoked,
1432 unless the commissioner, in accordance with rule, waives the payment of the fees by no later than
1433 the day of:
1434 (i) a suspension under Subsection (3) of an insurer's certificate of authority ends; or
1435 (ii) a new certificate of authority is issued to an insurer whose certificate of authority is
1436 revoked under Subsection (3).
1437 (b) If a new certificate of authority is issued more than three years after the revocation of
1438 a similar certificate of authority, this Subsection (8) applies only to the fees that would have
1439 accrued during the three years immediately following the revocation.
1440 Section 9. Section **31A-4-113** is amended to read:
1441 **31A-4-113. Annual statements.**
1442 (1) (a) Each authorized insurer shall annually, on or before March 1, file with the
1443 commissioner a true statement of its financial condition, transactions, and affairs as of December
1444 31 of the preceding year. [~~This~~]
1445 (b) The statement required by Subsection (1)(a) shall be:
1446 (i) verified by the oaths of at least two of the insurer's principal officers[~~.~~]; and
1447 (ii) in the general form and provide the information as prescribed by the commissioner by
1448 rule.
1449 (c) The commissioner may, for good cause shown, extend the date for filing the statement[~~.~~
1450 ~~The~~] required by Subsection (1)(a), except that the deadline for filing fee payment may not be
1451 extended.

1452 [~~(2) The statement shall be in the general form and provide the information as prescribed~~
1453 ~~by rule of the commissioner. In the absence of a statute providing otherwise, the statement shall~~
1454 ~~be prepared in accordance with the annual statement instructions and the Accounting Practices and~~
1455 ~~Procedures Manual which is published by the National Association of Insurance Commissioners.~~]
1456 [~~(3)~~] (2) The annual statement of an alien insurer shall:
1457 (a) relate only to its transactions and affairs in the United States unless the commissioner
1458 requires otherwise[~~. The statement shall~~]; and
1459 (b) be verified by:
1460 (i) the insurer's United States manager; or [~~by its~~]
1461 (ii) the insurer's authorized officers.
1462 Section 10. Section **31A-5-211** is amended to read:
1463 **31A-5-211. Minimum capital or permanent surplus requirements.**
1464 (1) (a) Except as provided in Subsections (4) and (5), insurers being organized or operating
1465 under this chapter shall maintain minimum capital or permanent surplus for a mutual, in amounts
1466 specified in Subsection (2).
1467 (b) The certificate of authority issued under Section 31A-5-212 does not permit an insurer
1468 to transact types of insurance for which the insurer does not have the required minimum capital
1469 or permanent surplus for a mutual, in at least the amounts specified under Subsection (2).
1470 (c) The types of insurance under this section are defined in Section 31A-1-301. Minimum
1471 capital and permanent surplus requirements under this section are based upon all types of insurance
1472 transacted by the insurer in any and all areas which it operates, whether or not only a portion of
1473 those types of insurance is or is to be transacted in this state.
1474 (2) The minimum capital, or permanent surplus for a nonassessable mutual, is as follows
1475 for the indicated types of insurance:
1476 (a) life, annuity, [~~disability~~] accident and health, or any combination of these $400,000
1477 (b) subject to an aggregate maximum of $1,000,000 for more than one of the following
1478 types of coverages:
1479 (i) property insurance 200,000
1480 (ii) surety insurance 300,000
1481 (iii) bail bonds insurance only 100,000
1482 (iv) marine and transportation insurance 200,000

1483 (v) vehicle liability insurance, residential dwelling liability insurance,
1484 or both 400,000
1485 (vi) liability insurance 600,000
1486 (vii) workers' compensation insurance 300,000
1487 (c) title insurance 200,000
1488 (d) professional liability insurance, excluding medical malpractice 700,000
1489 (e) professional liability, including medical malpractice 1,000,000
1490 (f) all types of insurance, except life, annuity, or title 2,000,000
1491 (3) Prior to beginning operations, an insurer licensed under this chapter shall have total
1492 adjusted capital in excess of the company action level RBC as defined in Subsection
1493 31A-17-601[~~(7)~~](8)(b).
1494 (4) (a) Subject to Subsections (4)(b) and (4)(c), an insurer holding a valid certificate of
1495 authority to transact insurance in this state prior to July 1, 1986, continues to be authorized to
1496 transact the same kinds of insurance as permitted by that certificate of authority, if the insurer
1497 maintains not less than the amount of minimum capital or permanent surplus required for that
1498 authority under the laws of this state in force immediately prior to July 1, 1986.
1499 (b) If, after July 1, 1986, an insurer ever has minimum capital or permanent surplus that
1500 meets or exceeds the requirements of Subsections (2) and (3), then Subsection (4)(a) is
1501 inapplicable to that insurer and it shall comply with Subsections (2) and (3).
1502 (c) Any insurer satisfying the minimum capital or permanent surplus requirement through
1503 application of Subsection (4)(a) shall comply with Subsections (2) and (3) by July 1, 1990.
1504 (d) Beginning July 1, 1987, former county mutuals shall comply with the capital and
1505 surplus requirements of this section.
1506 (5) (a) An assessable mutual may be organized under this chapter, but it may not issue life
1507 insurance or annuities. An assessable mutual need not have a permanent surplus if the assessment
1508 liability of its policyholders is unlimited and all insurance policies clearly state that. If assessments
1509 are limited to a specified amount or a specified multiple of annual advance premiums, the
1510 minimum permanent surplus is the amount that would be required under Subsections (2) and (3)
1511 if the corporation were not assessable, reduced by an amount that reasonably reflects the value of
1512 the policyholders' assessment liability in satisfying the financial needs of the corporation. The
1513 liability of members in an assessable mutual is joint and several up to the limits provided by the

1514 articles of incorporation or this title.
1515 (b) (i) Except as provided in Subsections (5)(c) and (d), no certificate of authority may be
1516 issued to an assessable mutual until it has at least 400 bona fide applications for insurance from
1517 not less than 400 separate applicants, on separate risks located in this state, in each of the classes
1518 of business upon which assessments may be separately levied. A full year's premium shall be paid
1519 with each application and the aggregate premium is at least $50,000 for each class.
1520 (ii) If at any time while the corporation is an assessable mutual, the business plan is
1521 amended to include an additional class of business on which assessments may be separately levied,
1522 identical requirements of Subsection (5)(b)(i) are applicable to each additional class.
1523 (c) Five or more employers may join in the formation of an assessable mutual to write only
1524 workers' compensation insurance if, instead of the requirements of Subsection (5)(b), policies are
1525 simultaneously put into effect that cover at least 1,500 employees, with no single employer having
1526 more than 1/5 of the employees insured by the assessable mutual. A full year's premium shall be
1527 paid by each employer, aggregating at least $200,000.
1528 (d) The number and amount of required initial applications and premium payments may
1529 be reduced by substituting surplus for the applications or premium payments. The commissioner
1530 shall determine the reduction in required initial applications and premium payments that is
1531 appropriate for a given amount of surplus. The insurer shall continue to be assessable until
1532 conversion under Subsection 31A-5-508(1) to a nonassessable mutual.
1533 (6) The capital or permanent surplus requirements of Subsection (2) apply to persons
1534 seeking certificates of authority under this chapter to write reinsurance. This subsection may not
1535 be construed as requiring reinsurers to obtain a certificate of authority. However, Section
1536 31A-17-404 imposes alternate safety prerequisites to reserve credit being granted for reinsurance
1537 ceded to a reinsurer without a certificate of authority.
1538 Section 11. Section **31A-5-418** is amended to read:
1539 **31A-5-418. Dividends and other distributions.**
1540 (1) Subject to the requirements of Section 16-10a-842 and Subsection 31A-16-106(2), a
1541 stock corporation may make distributions under Section 16-10a-640 if all the following conditions
1542 are satisfied:
1543 (a) A dividend may not be paid that would reduce the insurer's total adjusted capital below
1544 the insurer's company action level RBC as defined in Subsection 31A-17-601[~~(7)~~](8)(b).

1545 (b) Except as to excess surplus, or unless the commissioner issues an order allowing
1546 otherwise, a dividend may not be paid that exceeds the insurer's net gain from operations or net
1547 income for the period ending December 31 of the preceding year.
1548 (2) Title 67, Chapter 4a, Unclaimed Property Act, applies to unclaimed dividends and
1549 distributions in insurance corporations.
1550 Section 12. Section **31A-5-703** is amended to read:
1551 **31A-5-703. Nonrenewals, cancellations, or revisions of ceded reinsurance**
1552 **agreements.**
1553 (1) (a) A nonrenewal, cancellation, or revision of ceded reinsurance agreements is not
1554 subject to the reporting requirements of Section 31A-5-701 if:
1555 (i) the nonrenewal, cancellation, or revision is not material; or
1556 (ii) with respect to a property and casualty business, the insurer's total ceded written
1557 premium [~~represents~~], on an annualized basis, is less than 10% of its total written premium for
1558 direct and assumed business; or
1559 (iii) with respect to a life, annuity, and [~~disability~~] accident and health business, the total
1560 reserve credit taken for business ceded [~~represents~~], on an annualized basis, is less than 10% of the
1561 statutory reserve requirement prior to a cession.
1562 (b) For purposes of this part, a material nonrenewal, cancellation, or revision is one that
1563 affects:
1564 (i) with respect to a property and casualty business:
1565 (A) more than 50% of the insurer's total ceded written premium; or
1566 (B) more than 50% of the insurer's total ceded indemnity and loss adjustment reserves;
1567 (ii) with respect to a life, annuity, and [~~disability~~] accident and health business, more than
1568 50% of the total reserve credit taken for business ceded, on an annualized basis, as indicated in the
1569 insurer's most recent annual statement; or
1570 (iii) with respect to either property and casualty or life, annuity, or [~~disability~~] accident and
1571 health business[~~, is either of the following events~~]:
1572 (A) an authorized reinsurer representing more than 10% of a total cession is replaced by
1573 one or more unauthorized reinsurers; or
1574 (B) previously established collateral requirements have been reduced or waived as respects
1575 one or more unauthorized reinsurers representing collectively more than 10% of a total cession.

1576 (2) (a) The following information is required to be disclosed in any report filed pursuant
1577 to Section 31A-5-701 of a material nonrenewal, cancellation, or revision of a ceded reinsurance
1578 agreement:
1579 (i) the effective date of the nonrenewal, cancellation, or revision;
1580 (ii) the description of the transaction with an identification of the initiator of the
1581 transaction;
1582 (iii) the purpose of, or reason for the transaction; and
1583 (iv) if applicable, the identity of the replacement reinsurers.
1584 (b) (i) Insurers are required to report all material nonrenewals, cancellations, or revisions
1585 of ceded reinsurance agreements on a nonconsolidated basis unless the insurer:
1586 (A) is part of a consolidated group of insurers that uses a pooling arrangement or 100%
1587 reinsurance agreement that affects the solvency and integrity of the insurer's reserves; and
1588 (B) ceded substantially all of its direct and assumed business to the pool.
1589 (ii) An insurer is considered to have ceded substantially all of its direct and assumed
1590 business to a pool if:
1591 (A) the insurer has less than $1,000,000 total direct plus assumed written premiums during
1592 a calendar year that are not subject to a pooling arrangement; and
1593 (B) the net income of the business not subject to the pooling arrangement represents less
1594 than 5% of the insurer's capital and surplus.
1595 Section 13. Section **31A-6a-102** is amended to read:
1596 **31A-6a-102. Scope and purposes.**
1597 (1) The purposes of this chapter are to:
1598 (a) create a legal framework within which service contracts may be sold in this state;
1599 (b) encourage innovation in the marketing and development of more economical and
1600 effective ways of providing services under service contracts, while placing the risk of innovation
1601 on the service contract providers rather than on consumers; and
1602 (c) permit and encourage fair and effective competition among different systems of
1603 providing and paying for these services.
1604 (2) Service contracts may not be issued, sold, or offered for sale in this state unless the
1605 provider has complied with this chapter. [~~Subsections 31A-1-103(3)(i), (j), and (k) limit the~~
1606 ~~application of this chapter to certain persons engaged in a limited manner in providing extended~~

1607 warranties or service contracts.]
1608 (3) This chapter applies only to a service contract not otherwise exempted from this title
1609 by Section 31A-1-103.
1610 Section 14. Section **31A-6a-110** is amended to read:
1611 **31A-6a-110. Rulemaking.**
1612 (1) Pursuant to Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the
1613 commissioner may make rules necessary to assist in the enforcement of this chapter.
1614 (2) The commissioner may by rule or order, after a hearing, exempt certain service contract
1615 providers or service contract providers for a specific class of service contracts that are not
1616 otherwise exempt under [Subsections] Subsection 31A-1-103(3)[(i), (j), or (k),] from any provision
1617 of this title. The commissioner may order substitute requirements on a finding that a particular
1618 provision of this title is not necessary for the protection of the public or that the substitute
1619 requirement is reasonably certain to provide equivalent protection to the public.
1620 Section 15. Section **31A-8-101** is amended to read:
1621 **31A-8-101. Definitions.**
1622 For purposes of this chapter:
1623 (1) "Basic health care services" means:
1624 (a) emergency care[;];
1625 (b) inpatient hospital and physician care[;];
1626 (c) outpatient medical services[;]; and
1627 (d) out-of-area coverage.
1628 (2) "Director of health" means the executive director of the Department of Health or his
1629 authorized representative.
1630 (3) "Enrollee" means [any] an individual:
1631 (a) who has entered into a contract with [a health maintenance] an organization for health
1632 care; or
1633 (b) in whose behalf [such] an arrangement for health care has been made.
1634 (4) "Health care" [means professional or personal services, facilities, equipment, devices,
1635 supplies, or medicine, intended for use in the diagnosis, treatment, mitigation, or prevention of any
1636 human ailment or impairment] is as defined in Section 31A-1-301.
1637 (5) "Health maintenance organization" means any person[;]:

1638 (a) other than:
1639 (i) an insurer licensed under Chapter 7; or
1640 (ii) an individual who contracts to render professional or personal services that [he] the
1641 individual directly performs [himself, which:]; and
1642 (b) that:
1643 [(a)] (i) furnishes at a minimum, either directly or through arrangements with others, basic
1644 health care services to an enrollee in return for prepaid periodic payments agreed to in amount
1645 prior to the time during which the health care may be furnished; and
1646 [(b)] (ii) is obligated to the enrollee to arrange for or to directly provide available and
1647 accessible health care.
1648 (6) (a) "Limited health plan" means, except as limited under Subsection (6)(b), any person
1649 who furnishes, either directly or through arrangements with others, [the] services:
1650 (i) of:
1651 (A) dentists[,];
1652 (B) optometrists[,];
1653 (C) physical therapists[,];
1654 (D) podiatrists[,];
1655 (E) psychologists[,];
1656 (F) physicians[,];
1657 (G) chiropractic physicians[,];
1658 (H) naturopathic physicians[,];
1659 (I) osteopathic physicians[,];
1660 (J) social workers[,];
1661 (K) family counselors[,];
1662 (L) other health care providers[,]; or
1663 (M) reasonable combinations of [these,] the services described in this Subsection (1)(a)(i);
1664 (ii) to an enrollee;
1665 (iii) in return for prepaid periodic payments agreed to in amount prior to the time during
1666 which the services may be furnished[,]; and [who is]
1667 (iv) for which the person is obligated to the enrollee to arrange for or directly provide
1668 available and accessible the services described in this Subsection (6)(a).

1669 (b) "Limited health plan" does not include:
1670 (i) a health maintenance organization;
1671 (ii) an insurer licensed under Chapter 7; or
1672 (iii) an individual who contracts to render professional or personal services that he
1673 performs himself.
1674 (7) (a) "Nonprofit organization" or "nonprofit corporation" means an organization no part
1675 of the income of which is distributable to its members, trustees, or officers, or a nonprofit
1676 cooperative association, except in a manner allowed under Section 31A-8-406.
1677 (b) "Nonprofit health maintenance organization" and "nonprofit limited health plan" are
1678 used when referring specifically to one of the types of organizations with "nonprofit" status.
1679 (8) "Organization" means health maintenance organization and limited health plan, unless
1680 used in the context of:
1681 (a) "organization permit," in which case see Sections 31A-8-204 and 31A-8-206[,]; or
1682 [unless used in the context of]
1683 (b) "organization expenses," in which case see Section 31A-8-208.
1684 (9) "Participating provider" means a provider as defined in Subsection (10) who, under [an
1685 express or implied] a contract with the health maintenance organization, has agreed to provide
1686 health care services to enrollees with an expectation of receiving payment, directly or indirectly,
1687 from the health maintenance organization, other than copayment.
1688 (10) "Provider" means any person who furnishes health care directly to the enrollee and
1689 who is licensed or otherwise authorized to furnish this care in this state.
1690 (11) "Uncovered expenditures" means the costs of health care services that are covered by
1691 an organization for which an enrollee is liable in the event of the organization's insolvency.
1692 (12) "Unusual or infrequently used health services" means those health services which are
1693 projected to involve fewer than 10% of the organization's enrollees' encounters with providers,
1694 measured on an annual basis over the organization's entire enrollment.
1695 Section 16. Section **31A-8-103 (Effective 04/30/01)** is amended to read:
1696 **31A-8-103 (Effective 04/30/01). Applicability to other provisions of law.**
1697 (1) (a) Except for exemptions specifically granted under this title, [organizations are] an
1698 organization is subject to regulation under all of the provisions of this title.
1699 (b) Notwithstanding any provision of this title, [organizations] an organization licensed

1700 under this chapter [are] is:
1701 (i) wholly exempt from [the provisions of] Chapters 7, 9, 10, 11, 12, 13, 19, and 28[. In
1702 addition, organizations are] and not subject to:
1703 [(a)] (A) Chapter 3, except for Part I;
1704 [(b)] (B) Section 31A-4-107;
1705 [(c)] (C) Chapter 5, except for provisions specifically made applicable by this chapter;
1706 [(d)] (D) Chapter 14, except for provisions specifically made applicable by this chapter;
1707 [(e) Chapters] (E) Chapter 17 [and 18], except:
1708 (I) Part VI; or
1709 (II) as made applicable by the commissioner by rule consistent with this chapter; [and]
1710 (F) Chapter 18, except as made applicable by the commissioner by rule consistent with this
1711 chapter; and
1712 [(f)] (G) Chapter 22, except for Parts VI, VII, and XII.
1713 (2) The commissioner may by rule waive other specific provisions of this title that [he] the
1714 commissioner considers inapplicable to health maintenance organizations or limited health plans,
1715 upon a finding that [such a] the waiver will not endanger the interests of:
1716 (a) enrollees[,];
1717 (b) investors[,]; or
1718 (c) the public.
1719 (3) Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, and Title 16, Chapter
1720 10a, Utah Revised Business Corporation Act, do not apply to [organizations] an organization
1721 except as specifically made applicable by:
1722 (a) this chapter;
1723 (b) a provision referenced under this chapter; or
1724 (c) a rule adopted by the commissioner to deal with corporate law issues of health
1725 maintenance organizations that are not settled under this chapter.
1726 (4) (a) Whenever in this chapter [a section, subsection, or paragraph of], Chapter 5, or
1727 Chapter 14 is made applicable to [organizations] an organization, the application is:
1728 (i) of those provisions that apply to a mutual [corporations] corporation if the organization
1729 is nonprofit; and
1730 (ii) of those that apply to a stock [corporations] corporation if the organization is for profit.

1731 [~~Whenever a provision under~~]

1732 (b) When Chapter 5 or 14 is made applicable to [~~organizations~~] an organization under this
1733 chapter, "mutual" means nonprofit organization.

1734 (5) Solicitation of enrollees by an organization is not a violation of any provision of law
1735 relating to solicitation or advertising by health professionals if that solicitation is made in
1736 accordance with [~~the provisions of~~]:

1737 (a) this chapter; and

1738 (b) Chapter 23.

1739 (6) Nothing in this title prohibits any health maintenance organization from meeting the
1740 requirements of any federal law that enables the health maintenance organization to:

1741 (a) receive federal funds; or [~~to~~]

1742 (b) obtain or maintain federal qualification status.

1743 (7) Except as provided in Section 31A-8-501, [~~organizations are~~] an organization is exempt
1744 from statutes in this title or department rules that restrict or limit [~~their~~] its freedom of choice in
1745 contracting with or selecting health care providers, including Section 31A-22-618.

1746 (8) [~~Organizations are exempt from~~] the assessment or payment of premium taxes imposed
1747 by Sections 59-9-101 through 59-9-104.

1748 Section 17. Section **31A-8-205** is amended to read:

1749 **31A-8-205. Organization permit and certificate of incorporation.**

1750 (1) Section 31A-5-204 applies to the formation of organizations, except that "Section
1751 31A-5-211" in Subsection 31A-5-204 (5) shall be read "Section 31A-8-209."

1752 (2) In addition to the requirements of Section 31A-5-204, the application for a permit shall
1753 include a description of the initial locations of facilities where health care will be available to
1754 enrollees, the hours during which various services will be provided, the types of health care
1755 personnel to be used at each location and the approximate number of each personnel type to be
1756 available at each location, the methods to be used to monitor the quality of health care furnished,
1757 the method of resolving grievances initiated by enrollees or providers, the method used to give
1758 enrollees an opportunity to participate in matters of policy, the medical records system, and the
1759 method for documentation of utilization of health care by persons insured.

1760 Section 18. Section **31A-8-209** is amended to read:

1761 **31A-8-209. Minimum capital or minimum permanent surplus.**

1762 (1) [~~Health~~] A health maintenance [~~organizations~~] organization being organized or
1763 operating under this chapter shall have and maintain a minimum capital or minimum permanent
1764 surplus of $100,000.
1765 [~~(2) Limited health plans being organized or operating under this chapter shall have and~~
1766 ~~maintain a minimum capital or permanent surplus in an amount determined under Subsection~~
1767 ~~31A-8-210 (9).~~]
1768 [~~(3) For purposes of measuring compliance with Section 31A-8-210, to the extent an~~
1769 ~~organization has capital or permanent surplus in excess of its required minimum capital, or in~~
1770 ~~excess of its required minimum permanent surplus, the excess shall be counted as surplus.~~]
1771 (2) (a) The minimum required capital or minimum permanent surplus for a limited health
1772 plan:
1773 (i) is at least $10,000; and
1774 (ii) may not exceed $100,000.
1775 (b) The initial minimum required capital or minimum permanent surplus for a limited
1776 health plan required by Subsection (2)(a) shall be set by the commissioner, after:
1777 (i) a hearing; and
1778 (ii) consideration of:
1779 (A) the services to be provided by the limited health plan;
1780 (B) the size and geographical distribution of the population the limited health plan
1781 anticipates serving;
1782 (C) the nature of the limited health plan's arrangements with providers; and
1783 (D) the arrangements, agreements, and relationships in place or reasonably anticipated with
1784 respect to:
1785 (I) insolvency insurance;
1786 (II) reinsurance;
1787 (III) lenders subordinating to the interests of enrollees and trade creditors;
1788 (IV) personal and corporate financial guarantees;
1789 (V) provider withholds and assessments;
1790 (VI) surety bonds;
1791 (VII) hold harmless agreements in provider contracts; and
1792 (VIII) other arrangements, agreements, and relationships impacting the security of

1793 enrollees.
1794 (c) Upon a material change in the scope or nature of a limited health plan's operations, the
1795 commissioner may, after a hearing, alter the limited health plan's minimum required capital or
1796 minimum permanent surplus.
1797 (3) Before beginning operations, a health maintenance organization licensed under this
1798 chapter shall have total adjusted capital in excess of the company action level RBC as defined in
1799 Subsection 31A-17-601(8)(b).
1800 (4) Each health maintenance organization authorized to do business in this state shall
1801 maintain assets in an amount equal to the total of the health maintenance organization's:
1802 (a) liabilities;
1803 (b) minimum capital or minimum permanent surplus required by Subsection (1) or (2); and
1804 (c) the company action level RBC as defined in Subsection 31A-17-601(8)(b).
1805 (5) As a prerequisite to receiving an original certificate of authority to do business in this
1806 state, a health maintenance organization shall have initial surplus at least $400,000 in excess of
1807 the capital and surplus required by Subsection (4).
1808 [~~(4)~~] (6) The commissioner may allow the minimum capital or permanent surplus account
1809 of an organization to be designated by some other name.
1810 (7) A pattern of persistent deviation from the accounting and investment standards under
1811 this section may be grounds for the commissioner to find that the one or more persons with
1812 authority to make the organization's accounting or investment decisions are incompetent for
1813 purposes of Subsection 31A-5-410(3).
1814 Section 19. Section **31A-8-211** is amended to read:
1815 **31A-8-211. Deposit.**
1816 (1) Except as provided in Subsection (2), each Ş **HEALTH MAINTENANCE** ĥ organization
1816a authorized in this state shall
1817 maintain a deposit with the commissioner under Section 31A-2-206 in an amount equal to the sum
1818 of:
1819 (a) the Ş **HEALTH MAINTENANCE** ĥ organization's minimum capital or minimum permanent
1819a surplus [~~plus~~] requirement
1820 of Subsection 31A-8-209(1) or (2); and
1821 (b) 50% of [~~compulsory surplus.~~] the greater of:
1822 (i) $900,000;
1823 (ii) 2% of the annual premium revenues as reported on the most recent annual financial

1824 statement filed with the commissioner; or

1825 (iii) an amount equal to the sum of three months uncovered health care expenditures as

1826 reported on the most recent financial statement filed with the commissioner.

1827 (2) [~~A~~] (a) After a hearing the commissioner may exempt a health maintenance

1828 organization from the deposit requirement of Subsection (1) if:

1829 (i) the commissioner determines that the enrollees' interests are adequately protected;

1830 (ii) the health maintenance organization [~~which~~] has been continuously authorized to do

1831 business in this state for at least five years[~~,~~]; and [~~which~~]

1832 (iii) the health maintenance organization has $5,000,000 surplus [~~over and above~~] in

1833 excess of its [~~compulsory surplus in an amount specified in Subsection (3), may, after a hearing,~~

1834 ~~be exempted from the deposit requirement of Subsection (1) if the commissioner determines that~~

1835 ~~the enrollees' interests are adequately protected~~] company action level RBC as defined in

1836 Subsection 31A-17-601(8)(b).

1837 (b) The commissioner may rescind [~~such~~] an exemption given under Subsection (2)(a).

1838 [~~(3) No health maintenance organization may be exempted under Subsection (2) from the~~

1839 ~~deposit requirement unless:~~]

1840 [~~(a) disregarding assets described in Subsection 31A-8-210 (8)(a), the health maintenance~~

1841 ~~organization has $1,000,000 of surplus in excess of the amount required to satisfy its compulsory~~

1842 ~~surplus requirement; or~~]

1843 [~~(b) the health maintenance organization has $5,000,000 surplus in excess of the amount~~

1844 ~~required to satisfy its compulsory surplus requirement.~~]

1844a Ş **(3)(a) Each limited health plan authorized in this state shall maintain a deposit with the**

1844b **commissioner under Section 31A-2-206 in an amount equal to the minimum capital or permanent**

1844c **surplus plus 50% of the greater of:**

1844d **(i) .5 times minimum required capital; or**

1844e **(ii)(A) during the first year of operation, 10% of the limited health plan's projected uncovered**

1844f **expenditures for the first year of operation;**

1844g **(B) during the second year of operation, 12% of the limited health plan's projected uncovered**

1844h **expenditures for the second year of operation;**

1844i **(C) during the third year of operation, 14% of the limited health plan's projected uncovered**

1844j **expenditures for the third year of operation;**

1844k **(D) during the fourth year of operation, 18% of the limited health plan's projected**

1844l **expenditures during the fourth year of operation; or**

1844m **(E) during the fifth year of operation, and during all subsequent years, 20% of the limited**

1844n **health plan's projected uncovered expenditures for the previous 12 months.**

1844o **(b) Projections of future uncovered expenditures shall be established in a manner that is**

1844p **approved by the commissioner.** ĥ

1845 Section 20. Section **31A-8-213** is amended to read:

1846 **31A-8-213. Certificate of authority.**

1847 (1) [The] An organization may apply for a certificate of authority at any time prior to the

1848 expiration of its organization permit. The application shall include:

1849 (a) a detailed statement by a principal officer about any material changes that have taken

1850 place or are likely to take place in the facts on which the issuance of the organization permit was

1851 based[,]; and

1852 (b) if any material changes are proposed in the business plan, the information about the

1853 changes that would be required if an organization permit were then being applied for.

1854 (2) The commissioner shall issue a certificate of authority, if [he] the commissioner finds

1855 that:

1856 (a) the [~~organization satisfies~~] organization's capital and surplus complies with the

1857 requirements of [~~Sections~~] Section 31A-8-209 [~~and 31A-8-210~~] as to the operations proposed

1858 under the new certificate of authority;

1859 (b) there is no basis for revoking the organization permit under Section 31A-8-207;

1860 (c) the deposit required by Section 31A-8-211 has been made;

1861 (d) the organization satisfies the requirements of Section 31A-8-104; and

1862 [~~(e) the organization satisfies the surplus requirement of Subsection 31A-8-210 (4) or (5),~~

1863 ~~whichever applies; and~~]

1864 [~~(f)~~] (e) all other applicable requirements of the law have been met.

1865 (3) The certificate of authority shall specify any limits imposed by the commissioner upon

1866 the organization's business or methods of operation, including the general types of health care

1867 services the organization is authorized to provide.

1868 (4) Upon the issuance of the certificate of authority:

1869 (a) the board shall authorize and direct the issuance of certificates for shares, bonds, or

1870 notes subscribed to under the organization permit, and of insurance policies upon qualifying

1871 applications obtained under the organization permit; and

1872 (b) the commissioner shall authorize the release to the organization of all funds held in

1873 escrow under Section 31A-5-208, as adopted by Section 31A-8-206.

1874 (5) (a) An organization may at any time apply to the commissioner for a new or amended

1875 certificate of authority altering the limits on its business or methods of operation. The application

1876 shall contain or be accompanied by that information reasonably required by the commissioner

1877 under Subsections 31A-5-204(2) and 31A-8-205(2). The commissioner shall issue the new

1878 certificate as requested if [~~he~~] the commissioner finds that the organization continues to satisfy the

1879 requirements specified under Subsection (2).

1880 (b) If the commissioner issues a summary order under Section 31A-27-201 against an

1881 organization, [~~he~~] the commissioner may also revoke the organization's certificate and issue a new

1882 one with any limitation he considers necessary.

1883 Section 21. Section **31A-8-402** is amended to read:

1884 **31A-8-402. Contract cancellation or nonrenewal.**

1885 (1) An enrollee may not be cancelled or nonrenewed except for:

1886 [~~(a) failure to pay the charge for the enrollment or coverage;~~]
1887 [~~(b)~~] (a) violation of reasonable, published policies of the organization;
1888 [~~(c)~~] (b) unreasonable refusal to comply with care or treatment prescribed by the health
1889 care personnel of the organization; or
1890 [~~(d) such other reasons as the commissioner may specify by rule.~~]
1891 (c) nonpayment of a premium or contribution;
1892 (d) a fraudulent act or an intentional misrepresentation of a material fact under the terms
1893 of the coverage committed by the plan sponsor or covered individual under the plan;
1894 (e) a violation of participation or contribution rules;
1895 (f) termination of the plan where the issuer is ceasing to offer coverage in the market
1896 according to:
1897 (i) regulations required under the Health Insurance Portability and Accountability Act of
1898 1996 42 U.S.C. 1301, et seq.; and
1899 (ii) Subsections 31A-2-201(3), 31A-4-115(8), and 31A-30-106(1)(k); or
1900 (g) the enrollee moving to outside of the service area.
1901 (2) Every organization authorized under this chapter shall provide its enrollees an
1902 opportunity, at least once each year, to:
1903 (a) enroll again with the organization; or
1904 (b) choose another source through which they may secure health care services or benefits.
1905 (3) This section does not prohibit reasonable underwriting classifications for the purpose
1906 of establishing rates nor does it prohibit experience rating.
1907 (4) (a) The requirement in [~~Part VII of~~] Chapter 22, Part VII, Group Accident and Health
1908 Insurance, that a conversion policy be available for certain persons who are no longer entitled to
1909 group coverage does not require an organization to provide a conversion policy to a person
1910 residing outside of the organization's service area.
1911 (b) The commissioner may, by rule or order, define the scope of an organization's service
1912 area.
1913 Section 22. Section **31A-8-407** is amended to read:
1914 **31A-8-407. Written contracts -- Limited liability of enrollee.**
1915 (1) (a) Every contract between [~~a health maintenance~~] an organization and a participating
1916 provider of health care services shall be in writing and shall set forth that [~~in the event the health~~

1917 maintenance] if the organization:
1918 (i) fails to pay for health care services as set forth in the contract, the enrollee [shall] may
1919 not be liable to the provider for any sums owed by the [health maintenance] organization[.]; and
1920 (ii) the organization becomes insolvent, the rehabilitator or liquidator may require the
1921 participating provider of health care services to:
1922 (A) continue to provide health care services under the contract between the participating
1923 provider and the organization until the later of:
1924 (I) 90 days from the date of the filing of a petition for rehabilitation or the petition for
1925 liquidation; or
1926 (II) the date the term of the contract ends; and
1927 (B) subject to Subsection (1)(c), reduce the fees the participating provider is otherwise
1928 entitled to receive from the organization under the contract between the participating provider and
1929 the organization during the time period described in Subsection (1)(b)(i).
1930 (b) If the conditions of Subsection (1)(a)(ii)(b) are met, the participating provider shall:
1931 (i) accept the reduced payment as payment in full; and
1932 (ii) relinquish the right to collect additional amounts from the insolvent organization's
1933 enrollee.
1934 (c) Notwithstanding Subsection (1)(a)(ii)(b):
1935 (i) the rehabilitator or liquidator may not reduce a fee to less than 75% of the regular fee
1936 set forth in the participating provider contract; and
1937 (ii) the enrollee shall continue to pay the same copayments, deductibles, and other
1938 payments for services received from the participating provider that the enrollee was required to pay
1939 before the filing of:
1940 (A) the petition for reorganization; or
1941 (B) the petition for liquidation.
1942 (2) [In the event that the participating provider contract has not been reduced to writing
1943 as required by Subsection (1) or that the contract fails to contain the required prohibition, the] A
1944 participating provider [shall] may not collect or attempt to collect from the enrollee sums owed
1945 by the [health maintenance] organization or the amount of the regular fee reduction authorized
1946 under Subsection (1)(a)(ii) if the participating provider contract:
1947 (a) is not in writing as required in Subsection (1); or

1948 (b) fails to contain the language required by Subsection (1).
1949 (3) (a) [No participating provider, or agent, trustee, or assignee thereof] A person listed
1950 in Subsection (3)(b) may not bill or maintain any action at law against an enrollee to collect:
1951 (i) sums owed by the [health maintenance] organization[.]; or
1952 (ii) the amount of the regular fee reduction authorized under Subsection (1)(a)(ii).
1953 (b) Subsection (3)(a) applies to:
1954 (i) a participating provider;
1955 (ii) an agent;
1956 (iii) a trustee; or
1957 (iv) an assignee of a person described in Subsections (3)(b)(i) through (iii).
1958 Section 23. Section **31A-8-408** is amended to read:
1959 **31A-8-408. Organizations offering point of service products.**
1960 Effective July 1, 1991, a health maintenance [organizations] organization offering products
1961 that permit members the option of obtaining covered services from a noncontracted provider,
1962 which is a point of service or [POS] point of sale product, shall comply with the [following]
1963 requirements[:] of Subsections (1) through (7).
1964 (1) The cost of an encounter with a noncontracted provider is considered an uncovered
1965 expenditure as defined in Section 31A-8-101 [for purposes of Section 31A-8-210].
1966 (2) Any organization offering to sell point of service products shall report the number of
1967 encounters with contracted and noncontracted providers to the commissioner on a monthly basis.
1968 The commissioner shall define the form, content, and due date of the report and shall require
1969 audited reports of the information on a yearly basis.
1970 (3) An organization may not offer point of service products unless it has secured contracts
1971 with participating providers located within the organization's service area for each covered service
1972 other than those unusual or infrequently used health services that are not available from the
1973 organization's health care providers.
1974 (4) An organization may not enroll members who do not work or reside in the service area
1975 as defined by rule, except this Subsection (4) does not apply to dependents of enrollees.
1976 (5) Any organization [which] that exceeds the 10% limit of unusual or infrequently used
1977 health services as defined in Section 31A-8-101 is subject to a forfeiture of up to $50 per
1978 encounter.

1979 (6) [~~Organizations~~] An organization shall disclose to employees and members the
1980 existence of the 10% limit at or prior to enrollment.
1981 (7) The commissioner shall hold hearings and adopt rules providing any additional
1982 limitations or requirements necessary to secure the public interest in conformity with this section.
1983 Section 24. Section **31A-9-212 (Effective 04/30/01)** is amended to read:
1984 **31A-9-212 (Effective 04/30/01). Separate accounts and subsidiaries.**
1985 (1) Except as provided in Subsections (2) and (3), Sections 31A-5-217 and 31A-5-218
1986 apply to separate accounts and subsidiaries of fraternals. If a fraternal issues contracts on a variable
1987 basis, Subsections 31A-22-902(2) and (6) and 31A-9-209(2) do not apply, except that Subsection
1988 31A-9-209(2) applies to any benefits contained in the variable contracts which are fixed or
1989 guaranteed dollar amounts.
1990 (2) If a fraternal engages in any insurance business other than life, [~~disability~~] accident
1991 and health, annuities, property, or liability insurance, it shall do so through a subsidiary under
1992 Section 31A-5-218.
1993 (3) (a) A local lodge may incorporate under Title 16, Chapter 6a, Utah Revised Nonprofit
1994 Corporation Act, or the corresponding law of the state where it is located, to carry out the
1995 noninsurance activities of the local lodge.
1996 (b) Corporations may be formed under Title 16, Chapter 6a, Utah Revised Nonprofit
1997 Corporation Act, to implement Subsection 31A-9-602(2).
1998 Section 25. Section **31A-11-102** is amended to read:
1999 **31A-11-102. Activities of motor clubs.**
2000 (1) Motor clubs authorized under this chapter may provide or arrange for the following
2001 services:
2002 (a) service as agent or broker in obtaining insurance coverage from authorized insurers,
2003 subject to Chapter 23;
2004 (b) provision of, or payment for, legal services and costs in the defense of traffic offenses
2005 or other legal problems connected with the ownership or use of a motor vehicle, provided the
2006 maximum amount payable for any one incident is not more than 100 times the [~~the~~] annual charge
2007 for the motor club contract;
2008 (c) guaranteed arrest bond certificates and cash bond guarantees as specified under Section
2009 31A-11-112;

2010 (d) payment of specified expenses resulting from an automobile accident, other than
2011 expenses for personal injury or for damage to an automobile, provided the maximum amount
2012 payable for any one accident is not more than 100 times the annual charge for the motor club
2013 contract;
2014 (e) towing and emergency road services and theft services; and
2015 (f) any services relating to travel not involving the transfer and distribution of risk.
2016 (2) Unless they are also insurers under Chapter 5 or 14, motor clubs may not provide any
2017 liability or physical damage insurance or insurance of life or [~~disability~~] accident and health,
2018 whether or not related to motor vehicles.
2019 (3) If a motor club is a separate division of a corporation, the activities of the other
2020 divisions of the corporation are not limited by this section, if the motor club division complies with
2021 Subsection 31A-11-106(3).
2022 Section 26. Section **31A-14-201** is amended to read:
2023 **31A-14-201. Application.**
2024 [~~Any~~] (1) (a) An incorporated person, other than a foreign health maintenance
2025 organization[~~, including the United States branch of an alien insurer~~], authorized as an insurer in
2026 another jurisdiction in the United States may apply under this section for a certificate of authority
2027 as an insurer in this state. [~~This insurer~~]
2028 (b) An alien insurer that is incorporated may apply under this section for a certificate of
2029 authority as an insurer in this state.
2030 (2) An applicant for a certificate of authority under this section shall:
2031 (a) use the forms prescribed by the commissioner[~~. The applicant shall~~]; and
2032 (b) provide the information and documents the commissioner requests, including the
2033 following[~~, unless the commissioner excludes any of them because they will not be helpful in~~
2034 ~~making the decision of whether to issue a certificate of authority~~]:
2035 [~~(1)~~] (i) a copy of the applicant's articles and bylaws;
2036 [~~(2)~~] (ii) financial statements for the most recent complete fiscal year, with an explanation
2037 of the bases of all valuations and computations, in the detail reasonably required by the
2038 commissioner;
2039 [~~(3)~~] (iii) a summary, as detailed as the commissioner reasonably requires, of the
2040 applicant's financial history for:

2041 (A) the preceding ten years[,]; or [for]
2042 (B) the entire period of the applicant's existence if less than ten years;
2043 [(4)] (iv) [the names of the] for each of the applicant's current or proposed directors and
2044 principal officers [and their addresses and occupations]:
2045 (A) the name of the director or principal officer;
2046 (B) the address of the director or principal officer; and
2047 (C) the occupation for the preceding ten years of the director or principal officer;
2048 [(5)] (v) for an alien insurer[,]:
2049 (A) the name of its United States manager, the manager's addresses and occupations for
2050 the preceding ten years; and
2051 (B) if the manager is a corporation, the names, addresses, and occupations of its directors
2052 and principal officers, and its most recent detailed financial statements;
2053 [(6)] (vi) a schedule listing:
2054 [(a)] (A) all jurisdictions in which applicant has done or has been authorized to conduct
2055 an insurance business during the preceding ten years;
2056 [(b)] (B) all jurisdictions in which the applicant has applied for authorization to conduct
2057 an insurance business during the preceding ten years, and the dates and results of those
2058 applications;
2059 [(c)] (C) all jurisdictions from which the applicant has withdrawn from conducting an
2060 insurance business during the preceding ten years, and the reasons for its withdrawals; and
2061 [(d)] (D) the name of and the circumstances surrounding any officer, director, or
2062 controlling shareholder of the corporation ever being subject to a:
2063 [(i)] (I) felony indictment or conviction; or
2064 [(ii)] (II) civil, criminal, or administrative action alleging fraud;
2065 [(7)] (vii) a summary description of the applicant's present business operations, including
2066 the coverages written and the states and countries in which it does business;
2067 [(8)] (viii) a list of any statements, reports, or other documents that have, within the last
2068 five years, been generally transmitted or distributed to or among the insurer's creditors,
2069 shareholders, members, subscribers, or policyholders;
2070 [(9)] (ix) if the applicant has been in the insurance business for less than ten years, a
2071 summary of the past and a projection of the anticipated operating results at the end of each year

2072 of the first ten years of operation, based, where known, on actual data and otherwise on reasonable
2073 assumptions of loss experience, premium and other income, operating expenses, and acquisition
2074 costs;
2075 [~~(10)~~] (x) a statement that organizational and promotional expenses have been paid, and
2076 that organizational procedures required by the insurer's domiciliary authority are complete;
2077 [~~(11)~~] (xi) a statement from the domiciliary regulatory authority and the state of entry into
2078 the United States, if any, that so far as known, the applicant is sound and there are no legitimate
2079 objections to its proposed operations in this state;
2080 [~~(12)~~] (xii) the plan for conducting an insurance business in this state, including:
2081 [~~(a)~~] (A) the geographical area where business is to be conducted;
2082 [~~(b)~~] (B) the types of insurance to be written;
2083 [~~(c)~~] (C) the proposed general marketing methods;
2084 [~~(d)~~] (D) the proposed method for establishing premium rates; and
2085 [~~(e)~~] (E) copies of the policy and application forms to be used in this state;
2086 [~~(13)~~] (xiii) any other information the commissioner reasonably requires;
2087 [~~(14)~~] (xiv) authorization to the commissioner to make inquiry of any person about the
2088 applicant, its manager under a management contract, its attorney in fact, its general agents, and any
2089 of the officers, directors, or shareholders of any of them designated by the commissioner; and
2090 [~~(15)~~] (xv) written agreement by the applicant and any other designated persons that in the
2091 absence of actual malice, no communication made in response to any inquiry under Subsection
2092 [~~(14)~~] (2)(xiv) will subject the person making it to an action for damages for defamation brought
2093 by the applicant, the designated person, or a legal representative of either.
2094 (3) No action for damages for defamation lies even in the absence of this agreement.
2095 (4) Notwithstanding Subsection (2), the commissioner may exempt an applicant for a
2096 certificate of authority from providing the information described in Subsection (2) if the
2097 commissioner finds that the information will not be helpful in making the decision of whether to
2098 issue a certificate of authority.
2099 Section 27. Section **31A-14-212** is amended to read:
2100 **31A-14-212. Changes in business plan.**
2101 (1) Within two years after the initial issuance of a certificate of authority to a foreign
2102 insurer by its domiciliary jurisdiction, the insurer may not substantially deviate from its business

2103 plan under Subsection 31A-14-201 [~~(12)~~] (2)(xii) unless notice of the proposed action is filed with
2104 the commissioner 30 days in advance of the proposed effective date.
2105 (2) If the commissioner believes that the change proposed under Subsection (1) would be
2106 contrary to Utah law or to the interests of insureds, creditors, or the public, he may prohibit the
2107 application of the change to Utah. In his prohibitory order he shall explain why he has prohibited
2108 the change.
2109 (3) If the commissioner finds after a hearing that the application of the proposed change
2110 outside Utah would endanger the interests of insureds, creditors, or the public in Utah, the
2111 commissioner may revoke the insurer's certificate of authority unless the insurer agrees not to make
2112 the change.
2113 Section 28. Section **31A-15-103** is amended to read:
2114 **31A-15-103. Surplus lines insurance -- Unauthorized insurers.**
2115 (1) Notwithstanding Section 31A-15-102, a foreign insurer that has not obtained a
2116 certificate of authority to do business in this state under Section 31A-14-202 may negotiate for and
2117 make insurance contracts with persons in this state and on risks located in this state, subject to the
2118 limitations and requirements of this section.
2119 (2) For contracts made under this section, the insurer may, in this state, inspect the risks
2120 to be insured, collect premiums and adjust losses, and do all other acts reasonably incidental to the
2121 contract, through employees or through independent contractors.
2122 (3) (a) Subsections (1) and (2) do not permit any person to solicit business in this state on
2123 behalf of an insurer that has no certificate of authority.
2124 (b) Any insurance placed with a nonadmitted insurer shall be placed with a surplus lines
2125 broker licensed under Chapter 23.
2126 (c) The commissioner may by rule prescribe how a surplus lines broker may:
2127 (i) pay or permit the payment, commission, or other remuneration on insurance placed by
2128 the surplus lines broker under authority of the surplus lines broker's license to one holding a license
2129 to act as an insurance agent; and
2130 (ii) advertise the availability of the surplus lines broker's services in procuring, on behalf
2131 of persons seeking insurance, contracts with nonadmitted insurers.
2132 (4) For contracts made under this section, nonadmitted insurers are subject to Sections
2133 31A-23-302 and 31A-26-303 and the rules adopted under those sections.

2134 (5) A nonadmitted insurer may not issue workers' compensation insurance coverage to
2135 employers located in this state, except for stop loss coverages issued to employers securing
2136 workers' compensation under Subsection 34A-2-201(3).
2137 (6) (a) The commissioner may by rule prohibit making contracts under Subsection (1) for
2138 a specified class of insurance if authorized insurers provide an established market for the class in
2139 this state that is adequate and reasonably competitive.
2140 (b) The commissioner may by rule place restrictions and limitations on and create special
2141 procedures for making contracts under Subsection (1) for a specified class of insurance if there
2142 have been abuses of placements in the class or if the policyholders in the class, because of limited
2143 financial resources, business experience, or knowledge, cannot protect their own interests
2144 adequately.
2145 (c) The commissioner may prohibit an individual insurer from making any contract under
2146 Subsection (1) and all insurance agents and brokers from dealing with the insurer if:
2147 (i) the insurer has willfully violated this section, Section 31A-4-102, 31A-23-302, or
2148 31A-26-303, or any rule adopted under any of these sections;
2149 (ii) the insurer has failed to pay the fees and taxes specified under Section 31A-3-301; or
2150 (iii) the commissioner has reason to believe that the insurer is in an unsound condition or
2151 is operated in a fraudulent, dishonest, or incompetent manner or in violation of the law of its
2152 domicile.
2153 (d) (i) The commissioner may issue lists of unauthorized foreign insurers whose solidity
2154 the commissioner doubts, or whose practices the commissioner considers objectionable.
2155 (ii) The commissioner shall issue lists of unauthorized foreign insurers the commissioner
2156 considers to be reliable and solid. [~~The~~]
2157 (iii) In addition to the lists described in Subsections (7)(d)(i) and (ii), the commissioner
2158 may [~~also~~] issue other relevant evaluations of unauthorized insurers. [~~No~~]
2159 (iv) An action [~~lies~~] may not lie against the commissioner or any employee of the
2160 department for any written or oral communication made in, or in connection with the issuance of,
2161 [~~these~~] the lists or evaluations described in this Subsection (6)(d).
2162 (e) A foreign unauthorized insurer shall be listed on the commissioner's "reliable" list only
2163 if the unauthorized insurer:
2164 (i) has delivered a request to the commissioner to be on the list;

2165 (ii) has established satisfactory evidence of good reputation and financial integrity;
2166 (iii) has delivered to the commissioner a copy of its current annual statement certified by
2167 the insurer and continues each subsequent year to file its annual statements with the commissioner
2168 within 60 days of its filing with the insurance regulatory authority where it is domiciled; [~~and~~]
2169 (iv) (A) is in substantial compliance with the solvency standards in Chapter 17, Part VI,
2170 Risk-Based Capital, or maintains capital and surplus of at least [~~$5,000,000~~] $15,000,000,
2171 whichever is greater, and maintains in the United States an irrevocable trust fund in either a
2172 national bank or a member of the Federal Reserve System, or maintains a deposit meeting the
2173 statutory deposit requirements for insurers in the state where it is made, which trust fund or
2174 deposit:
2175 (I) shall be in an amount not less than [~~$1,500,000~~] $2,500,000 for the protection of all of
2176 the insurer's policyholders in the United States;
2177 (II) may consist of cash, securities, or investments of substantially the same character and
2178 quality as those which are "qualified assets" under Section 31A-17-201; and
2179 (III) may include as part of the trust arrangement a letter of credit that qualifies as
2180 acceptable security under Subsection 31A-17-404(3)(c)(iii); or
2181 (B) in the case of any "Lloyd's" or other similar incorporated or unincorporated group of
2182 alien individual insurers, maintains a trust fund that:
2183 (I) shall be in an amount not less than $50,000,000 as security to its full amount for all
2184 policyholders and creditors in the United States of each member of the group;
2185 (II) may consist of cash, securities, or investments of substantially the same character and
2186 quality as those which are "qualified assets" under Section 31A-17-201; and
2187 (III) may include as part of this trust arrangement a letter of credit that qualifies as
2188 acceptable security under Subsection 31A-17-404(3)(c)(iii)[~~.~~]; and
2189 (v) for an alien insurer not domiciled in the United States or a territory of the United
2190 States, is listed on the Quarterly Listing of Alien Insurers maintained by the National Association
2191 of Insurance Commissions International Insurers Department.
2192 (7) A surplus lines broker may not, either knowingly or without reasonable investigation
2193 of the financial condition and general reputation of the insurer, place insurance under this section
2194 with financially unsound insurers or with insurers engaging in unfair practices, or with otherwise
2195 substandard insurers, unless the broker gives the applicant notice in writing of the known

2196 deficiencies of the insurer or the limitations on his investigation, and explains the need to place
2197 the business with that insurer. A copy of this notice shall be kept in the office of the broker for at
2198 least five years. To be financially sound, an insurer shall satisfy standards that are comparable to
2199 those applied under the laws of this state to authorized insurers. Insurers on the "doubtful or
2200 objectionable" list under Subsection (6)(d) and insurers not on the commissioner's "reliable" list
2201 under Subsection (6)[(d)](e) are presumed substandard.
2202 (8) A policy issued under this section shall include a description of the subject of the
2203 insurance and indicate the coverage, conditions, and term of the insurance, the premium charged
2204 and premium taxes to be collected from the policyholder, and the name and address of the
2205 policyholder and insurer. If the direct risk is assumed by more than one insurer, the policy shall
2206 state the names and addresses of all insurers and the portion of the entire direct risk each has
2207 assumed. All policies issued under the authority of this section shall have attached or affixed to
2208 the policy the following statement: "The insurer issuing this policy does not hold a certificate of
2209 authority to do business in this state and thus is not fully subject to regulation by the Utah
2210 insurance commissioner. This policy receives no protection from any of the guaranty associations
2211 created under Title 31A, Chapter 28."
2212 (9) Upon placing a new or renewal coverage under this section, the broker shall promptly
2213 deliver to the policyholder or his agent evidence of the insurance consisting either of the policy as
2214 issued by the insurer or, if the policy is not then available, a certificate, cover note, or other
2215 confirmation of insurance complying with Subsection (8).
2216 (10) If the commissioner finds it necessary to protect the interests of insureds and the
2217 public in this state, the commissioner may by rule subject policies issued under this section to as
2218 much of the regulation provided by this title as is required for comparable policies written by
2219 authorized foreign insurers.
2220 (11) (a) Each surplus lines transaction in this state shall be examined to determine whether
2221 it complies with:
2222 (i) the surplus lines tax levied under Chapter 3;
2223 (ii) the solicitation limitations of Subsection (3);
2224 (iii) the requirement of Subsection (3) that placement be through a surplus lines broker;
2225 (iv) placement limitations imposed under Subsections (6)(a), (b), and (c); and
2226 (v) the policy form requirements of Subsections (8) and (10).

2227 (b) The examination described in Subsection (11)(a) shall take place as soon as practicable
2228 after the transaction. The surplus lines broker shall submit to the examiner information necessary
2229 to conduct the examination within a period specified by rule.
2230 (c) The examination described in Subsection (11)(a) may be conducted by the
2231 commissioner or by an advisory organization created under Section 31A-15-111 and authorized
2232 by the commissioner to conduct these examinations. The commissioner is not required to
2233 authorize any additional advisory organizations to conduct examinations under this Subsection
2234 (11)(c). The commissioner's authorization of one or more advisory organizations to act as
2235 examiners under this subsection shall be by rule. In addition, the authorization shall be evidenced
2236 by a contract, on a form provided by the commissioner, between the authorized advisory
2237 organization and the department.
2238 (d) The person conducting the examination described in Subsection (11)(a) shall collect
2239 a stamping fee of an amount not to exceed 1% of the policy premium payable in connection with
2240 the transaction. Stamping fees collected by the commissioner shall be deposited in the General
2241 Fund. The commissioner shall establish this fee by rule. Stamping fees collected by an advisory
2242 organization are the property of the advisory organization to be used in paying the expenses of the
2243 advisory organization. Liability for paying the stamping fee is as required under Subsection
2244 31A-3-303(1) for taxes imposed under Section 31A-3-301. The commissioner shall adopt a rule
2245 dealing with the payment of stamping fees. If stamping fees are not paid when due, the
2246 commissioner or advisory organization may impose a penalty of 25% of the fee due, plus 1-1/2%
2247 per month from the time of default until full payment of the fee. Fees relative to policies covering
2248 risks located partially in this state shall be allocated in the same manner as under Subsection
2249 31A-3-303(4).
2250 (e) The commissioner, representatives of the department, advisory organizations,
2251 representatives and members of advisory organizations, authorized insurers, and surplus lines
2252 insurers are not liable for damages on account of statements, comments, or recommendations made
2253 in good faith in connection with their duties under this Subsection (11)(e) or under Section
2254 31A-15-111.
2255 (f) Examinations conducted under this Subsection (11) and the documents and materials
2256 related to the examinations are confidential.
2257 Section 29. Section **31A-15-106** is amended to read:

2258 **31A-15-106. Servicing of contracts made out of state.**
2259 (1) A foreign insurer that does not have a certificate of authority to do business in this state
2260 under Section 31A-14-202 may, in this state, collect premiums and adjust losses and do all other
2261 acts reasonably incidental to contracts made outside this state without violating this chapter. Any
2262 premiums collected under this section are subject to Section 31A-3-301.
2263 (2) Subsection (1) does not permit a renewal, extension, increase, or other substantial
2264 change in the terms of any contract under Subsection (1) unless:
2265 (a) it is permitted under Section 31A-15-103;
2266 (b) the contract is for life or [~~disability~~] accident and health insurance or annuities; or
2267 (c) a rule adopted by the commissioner permits this action when the interests of the
2268 policyholder and the public appear to be sufficiently protected.
2269 Section 30. Section **31A-17-201** is amended to read:
2270 **31A-17-201. Qualified assets.**
2271 (1) Except as provided under Subsections (3) and (4), only the qualified assets listed in
2272 Subsection (2) may be used in determining the financial condition of an insurer, except to the
2273 extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in
2274 Section 31A-1-301.
2275 (2) For purposes of Subsection (1), "qualified assets" means:
2276 [~~(a) investments, securities, properties, and loans acquired or held in accordance with~~
2277 ~~Sections 31A-18-105 and 31A-18-106, and the income due and accrued on these;~~]
2278 [~~(b) the net amount of uncollected and deferred premiums for a life insurer that carries the~~
2279 ~~full annual mean tabular reserve liability;~~]
2280 [~~(c) premiums in the course of collection, other than for life insurance, not more than 90~~
2281 ~~days past due, less commissions payable on the premiums, with the 90-day limitation being~~
2282 ~~inapplicable to premiums payable directly or indirectly by the United States government or any of~~
2283 ~~its instrumentalities;~~]
2284 [~~(d) installment premiums, other than life insurance premiums, in accordance with:~~]
2285 [~~(i) the rules adopted by the commissioner; or~~]
2286 [~~(ii) in the absence of rules adopted by the commissioner, practices formulated or adopted~~
2287 ~~by the National Association of Insurance Commissioners;~~]
2288 [~~(e) notes and similar written obligations that are:~~]

2289 [~~(i) not past due;~~]
2290 [~~(ii) taken for premiums other than life insurance premiums;~~]
2291 [~~(iii) on policies permitted to be issued on that basis; and~~]
2292 [~~(iv) to the extent of the unearned premium reserves carried on the policies;~~]
2293 [~~(f) amounts recoverable or receivable from reinsurers under a reinsurance contract that~~
2294 ~~qualifies for reserve credit under Section 31A-17-404;~~]
2295 [~~(g) electronic and mechanical machines constituting a data processing and accounting~~
2296 ~~system, the cost of which is depreciated in full over a period of five years or less;~~]
2297 [~~(h) tangible components of the health care delivery systems of insurers licensed under~~
2298 ~~Chapter 7, with the cost of these assets having a finite useful life being depreciated in full over~~
2299 ~~periods provided by rule;~~]
2300 [~~(i) cash or currency; and~~]
2301 (a) assets as determined to be admitted in the Accounting Practices and Procedures
2302 Manual, published by the National Association of Insurance Commissioners; and
2303 [~~(j)~~] (b) other assets authorized by rule.
2304 (3) (a) Subject to Subsection (5) and even if they could not otherwise be counted under this
2305 chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the
2306 purposes of Subsection (1) and Sections 31A-18-105 and 31A-18-106:
2307 (i) for five years after their acquisition if they are real property; and
2308 (ii) for one year if they are not real property.
2309 (b) (i) The commissioner may allow reasonable extensions of the periods described in
2310 Subsection (3)(a), if disposal of the assets within the periods given is not possible without
2311 substantial loss.
2312 (ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total
2313 of five years.
2314 (4) Subject to Subsection (5), and even though under this chapter the assets could not
2315 otherwise be counted, assets acquired in connection with mergers, consolidations, or bulk
2316 reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in
2317 the same manner, and for the same periods as assets acquired under Subsection (3).
2318 (5) Assets described under Subsection (3) or (4) may not be counted for the purposes of
2319 Subsection (1), except to the extent they are counted as assets in determining insurer solvency

2320 under the laws of the state of domicile of the creditor or acquired insurer.
2321 Section 31. Section **31A-17-401** is amended to read:
2322 **31A-17-401. Valuation of assets.**
2323 (1) The commissioner shall value the assets of insurers in accordance with then current
2324 insurance business practices, but not in a manner inconsistent with the provisions of this title. In
2325 valuing assets, the commissioner shall consider any method then current, formulated, or approved
2326 by the National Association of Insurance Commissioners.
2327 (2) Assets that are not qualified assets under Subsection 31A-17-201(2) are considered to
2328 have no value in evaluating an insurer's compliance with Chapter 17, Part 6, Risk-Based Capital.
2329 Those assets may be used in evaluating the insurer's financial condition only to the extent the
2330 insurer has excess surplus.
2331 (3) (a) Insurance subsidiaries are valued on the books of a parent insurer as follows:
2332 (i) Except as provided under Subsections (3)(a)(iii) [~~through (vi)~~] and (iv), common stock
2333 of the subsidiary is valued on the basis of the parent insurer's percentage of ownership of the
2334 common stock multiplied by the total of the subsidiary's capital and surplus, less amounts needed
2335 to liquidate all claims to the capital and surplus which are senior to common stock. Subsection
2336 31A-18-106(1)(k) provides applicable limitations on investments in subsidiaries.
2337 (ii) The value of securities other than common stock issued by a subsidiary is the lesser
2338 of the present value of the future income to be derived under the securities or the amount the parent
2339 insurer would receive as a result of the securities if the subsidiary were liquidated and all creditors
2340 of the subsidiary and holders of the subsidiary's securities with senior priority were paid in full.
2341 The present value of future income derived from securities is determined by rule adopted by the
2342 commissioner. A parent insurer may attribute value to a security of its subsidiary only if the parent
2343 insurer is being paid dividends or interest on the security, and only if the parent insurer can
2344 reasonably anticipate that dividends or interest will continue to be paid on the security.
2345 (iii) Except as provided under [~~Subsections (3)(a)(iv) through (vi)~~] Subsection (3)(iv), any
2346 portion of the subsidiary's value permitted under Subsection (3)(a) that is represented by assets
2347 other than assets listed under Section 31A-17-201, may only be classified as excess surplus of the
2348 parent insurer, and then only to the extent the parent insurer has established that it has excess
2349 surplus under Section 31A-17-202.
2350 (iv) For the purposes of Subsection (3)(a)(iii), assets of a newly acquired subsidiary that

2351 are the equivalent of qualified assets in the subsidiary's domiciliary state, are, for the first five years
2352 after the subsidiary's acquisition, considered to be qualified assets under Section 31A-17-201. This
2353 assumption stands even if the assets are not otherwise qualified assets under Section 31A-17-201.
2354 [~~(v) Under a plan of merger approved by the commissioner, a newly-acquired insurance~~
2355 ~~subsidiary may be valued initially at its cost to the parent insurer, or a greater or lesser value~~
2356 ~~established by the commissioner. The amount in excess of the parent insurer's proportionate share~~
2357 ~~of the subsidiary's capital and surplus shall be written off for regulatory purposes over a period~~
2358 ~~specified by the commissioner in the commissioner's order approving the plan of merger. This~~
2359 ~~period may not exceed five years. Once they are established by the commissioner, any amounts~~
2360 ~~not yet written off may be counted as assets for the purposes specified under Chapter 17, Part 6,~~
2361 ~~Risk-Based Capital.~~]
2362 [~~(vi) Subject to Subsection 31A-18-106(1)(k), an insurance subsidiary that is acquired by~~
2363 ~~another insurer, but not under an approved plan of merger, may be valued initially at the lesser of~~
2364 ~~its cost to the parent insurer, or the parent insurer's proportionate share of the subsidiary's capital~~
2365 ~~and surplus plus 10% of the parent insurer's capital and surplus. The amount in excess of the~~
2366 ~~parent insurer's proportionate share of the subsidiary's capital and surplus shall be written off for~~
2367 ~~regulatory purposes over a period specified by the commissioner in an order approving the~~
2368 ~~acquisition. This period may not exceed ten years.~~]
2369 [~~(vii) For subsidiaries valued under Subsection (3)(a)(v) or (3)(a)(vi), until the excess of~~
2370 ~~the subsidiary's cost over the parent insurer's proportionate share of the subsidiary's capital and~~
2371 ~~surplus is completely amortized, the commissioner shall semiannually review the actual~~
2372 ~~performance of the subsidiary to determine whether the amortization schedule provided by the~~
2373 ~~commissioner's order is reasonable, based on the subsidiary's actual performance. The~~
2374 ~~commissioner may adjust the amortization schedule based on the findings of this semiannual~~
2375 ~~review.~~]
2376 (b) A subsidiary formed or acquired to hold or manage investments that the parent
2377 insurance company might hold or manage directly, shall be valued as if the assets of the subsidiary
2378 were owned directly by the insurer in a percentage equal to the insurer's percentage of ownership
2379 of the subsidiary. The subsidiary investment limitation of Subsection 31A-18-106(1)(k) does not
2380 apply to these subsidiaries.
2381 (c) Subsidiaries other than those described in Subsections (3)(a) and (b) shall be valued

2382 in accordance with Subsection (1). The subsidiary investment limitation under Subsection
2383 31A-18-106(1)(k) applies to these subsidiaries in the same manner as to subsidiaries described in
2384 Subsection (3)(a).
2385 (d) In determining an insurer's financial condition, no value is given to:
2386 (i) any interest held by the insurer in its own stock, including debts due the insurer that are
2387 secured by the insurer's own stock; or
2388 (ii) any proportionate interest in the insurer's own stock, including debts that are secured
2389 by the insurer's own stock, which is held by any corporation, partnership, business unit, firm, or
2390 person owned in whole or in part by the insurer.
2391 (4) The commissioner shall adopt rules to implement the provisions of this section.
2392 Section 32. Section **31A-17-402** is amended to read:
2393 **31A-17-402. Valuation of liabilities.**
2394 The commissioner shall adopt rules specifying the liabilities required to be reported by
2395 insurers in financial statements submitted under Section 31A-2-202 and the methods of valuing
2396 them. For life insurance, those methods shall be consistent with Part 5 of this chapter, Standard
2397 Valuation Law. Title insurance reserves are provided for under Section 31A-17-408. In
2398 determining the financial condition of an insurer, liabilities include:
2399 (l) the estimated amount necessary to pay all its unpaid losses and claims incurred on or
2400 prior to the date of statement, whether reported or unreported, together with the expense of
2401 adjustment or settlement of the loss or claim;
2402 (2) for life, [~~disability~~] accident and health insurance, and annuity contracts:
2403 (a) the reserves on life insurance policies and annuity contracts in force, valued according
2404 to appropriate tables of mortality and the applicable rates of interest;
2405 (b) the reserves for [~~disability~~] accident and health benefits, for both active and disabled
2406 lives;
2407 (c) the reserves for accidental death benefits; and
2408 (d) any additional reserves which may be required by the commissioner by rule, or if no
2409 rule is applicable, then in a manner consistent with the practice formulated or approved by the
2410 National Association of Insurance Commissioners with respect to those types of insurance;
2411 (3) for insurance other than life, [~~disability~~] accident and health, and title insurance, the
2412 amount of reserves equal to the unearned portions of the gross premiums charged on policies in

2413 force, computed on a daily or monthly pro rata basis or other basis approved by the commissioner;
2414 provided that after adopting any one of the methods for computing those reserves, an insurer may
2415 not change methods without the commissioner's written consent;
2416 (4) for ocean marine and other transportation insurance, reserves equal to 50% of the
2417 amount of premiums upon risks covering not more than one trip or passage not terminated, and
2418 computed upon a pro rata basis or, with the commissioner's consent, in accordance with methods
2419 provided under Subsection (3); and
2420 (5) its other liabilities, including taxes, expenses, and other obligations due or accrued at
2421 the date of statement.
2422 Section 33. Section **31A-17-408** is amended to read:
2423 **31A-17-408. Title insurance reserves.**
2424 (1) In addition to an adequate reserve for outstanding losses, a title insurance company
2425 shall either:
2426 (a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for
2427 each $1,000 face amount of retained liability under each title insurance contract or policy on a
2428 single insurance risk issued[~~, except that during each of the 20 years following the year in which~~
2429 ~~the title insurance policy or contract was issued, the reserve applicable to the contract may be~~
2430 ~~reduced by 5% of the original amount of the reserve~~]; or
2431 (b) have the commissioner review and approve a contract of reinsurance applicable to the
2432 title insurance company's policies, which contract adequately covers the exposure or risk which
2433 the unearned premium reserve would serve.
2434 (2) The fund shall be maintained for the protection of policyholders and is not subject to
2435 the claims of stockholders or creditors other than policyholders.
2436 Section 34. Section **31A-17-504** is amended to read:
2437 **31A-17-504. Computation of minimum standard.**
2438 Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the
2439 minimum standard for the valuation of all life insurance policies and annuity and pure endowment
2440 contracts issued prior to January 1, 1994, shall be that provided by the laws in effect immediately
2441 prior to that date. Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and
2442 31A-17-513, the minimum standard for the valuation of all such policies and contracts issued on
2443 or after January 1, 1994, shall be the commissioner's reserve valuation methods defined in Sections

2444 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-513, 3.5% interest, or in the case of life
2445 insurance policies and contracts, other than annuity and pure endowment contracts, issued on or
2446 after June 1, 1973, 4% interest for such policies issued prior to April 2, 1980, 5.5% interest for
2447 single premium life insurance policies, and 4.5% interest for all other such policies issued on and
2448 after April 2, 1980, and the following tables:
2449 (1) For all ordinary policies of life insurance issued on the standard basis, excluding any
2450 [~~disability~~] accident and health and accidental death benefits in such policies: the National
2451 Association of Insurance Commissioners 1941 Standard Ordinary Mortality Table for such policies
2452 issued prior to the operative date of Subsection 31A-22-408(6)(a) (that is, the Standard
2453 Nonforfeiture Law for Life Insurance), the National Association of Insurance Commissioners 1958
2454 Standard Ordinary Mortality Table for such policies issued on or after the operative date of
2455 Subsection 31A-22-408(6)(a) and prior to the operative date of Subsection 31A-22-408(6)(d),
2456 provided that for any category of such policies issued on female risks, all modified net premiums
2457 and present values referred to in this section may be calculated according to an age not more than
2458 six years younger than the actual age of the insured; and for such policies issued on or after the
2459 operative date of Subsection 31A-22-408(6)(d):
2460 (a) the National Association of Insurance Commissioners 1980 Standard Ordinary
2461 Mortality Table;
2462 (b) at the election of the company for any one or more specified plans of life insurance,
2463 the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table
2464 with Ten-Year Select Mortality Factors; or
2465 (c) any ordinary mortality table, adopted after 1980 by the National Association of
2466 Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in
2467 determining the minimum standard of valuation for such policies.
2468 (2) For all industrial life insurance policies issued on the standard basis, excluding any
2469 [~~disability~~] accident and health and accidental death benefits in such policies: the 1941 Standard
2470 Industrial Mortality Table for such policies issued prior to the operative date of Subsection
2471 31A-22-408(6)(c), and for such policies issued on or after such operative date, the National
2472 Association of Insurance Commissioners 1961 Standard Industrial Mortality Table or any
2473 industrial mortality table, adopted after 1980 by the National Association of Insurance
2474 Commissioners, that is approved by rule promulgated by the commissioner for use in determining

2475 the minimum standard of valuation for such policies.
2476 (3) For individual annuity and pure endowment contracts, excluding any disability and
2477 accidental death benefits in such policies:
2478 (a) the 1937 Standard Annuity Mortality Table[, or];
2479 (b) at the option of the company, the Annuity Mortality Table for 1949, Ultimate[,]; or
2480 (c) any modification of either of these tables approved by the commissioner.
2481 (4) For group annuity and pure endowment contracts, excluding any [disability] accident
2482 and health and accidental death benefits in such policies:
2483 (a) the Group Annuity Mortality Table for 1951, any modification of such table approved
2484 by the commissioner[,]; or
2485 (b) at the option of the company, any of the tables or modifications of tables specified for
2486 individual annuity and pure endowment contracts.
2487 (5) For total and permanent disability benefits in or supplementary to ordinary policies or
2488 contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2
2489 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the
2490 Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and
2491 termination rates adopted after 1980 by the National Association of Insurance Commissioners, that
2492 are approved by rule promulgated by the commissioner for use in determining the minimum
2493 standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961,
2494 and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3)
2495 Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability
2496 Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted
2497 for calculating the reserves for life insurance policies.
2498 (6) For accidental death benefits in or supplementary to policies issued on or after January
2499 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted
2500 after 1980 by the National Association of Insurance Commissioners, that is approved by rule
2501 promulgated by the commissioner for use in determining the minimum standard of valuation for
2502 such policies, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either
2503 such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table;
2504 and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality
2505 Table. Either table shall be combined with a mortality table for calculating the reserves for life

2506 insurance policies.
2507 (7) For group life insurance, life insurance issued on the substandard basis and other
2508 special benefits: such tables as may be approved by the commissioner.
2509 Section 35. Section **31A-17-505** is amended to read:
2510 **31A-17-505. Computation of minimum standard for annuities.**
2511 (1) Except as provided in Section 31A-17-506, the minimum standard for the valuation
2512 of all individual annuity and pure endowment contracts issued on or after the operative date of this
2513 section, as defined in Subsection (2), and for all annuities and pure endowments purchased on or
2514 after such operative date under group annuity and pure endowment contracts, shall be the
2515 commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and
2516 the following tables and interest rates:
2517 (a) For individual annuity and pure endowment contracts issued prior to April 2, 1980,
2518 excluding any [~~disability~~] accident and health and accidental death benefits in such contracts: the
2519 1971 Individual Annuity Mortality Table, or any modification of this table approved by the
2520 commissioner, and 6% interest for single premium immediate annuity contracts, and 4% interest
2521 for all other individual annuity and pure endowment contracts.
2522 (b) For individual single premium immediate annuity contracts issued on or after April 2,
2523 1980, excluding any [~~disability~~] accident and health and accidental death benefits in such
2524 contracts: the 1971 Individual Annuity Mortality Table or any individual annuity mortality table,
2525 adopted after 1980 by the National Association of Insurance Commissioners that is approved by
2526 rule promulgated by the commissioner for use in determining the minimum standard of valuation
2527 for such contracts, or any modification of these tables approved by the commissioner, and 7.5%
2528 interest.
2529 (c) For individual annuity and pure endowment contracts issued on or after April 2, 1980,
2530 other than single premium immediate annuity contracts, excluding any [~~disability~~] accident and
2531 health and accidental death benefits in such contracts: the 1971 Individual Annuity Mortality Table
2532 or any individual annuity mortality table adopted after 1980 by the National Association of
2533 Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in
2534 determining the minimum standard of valuation for such contracts, or any modification of these
2535 tables approved by the commissioner, and 5.5% interest for single premium deferred annuity and
2536 pure endowment contracts and 4.5% interest for all other such individual annuity and pure

2537 endowment contracts.

2538 (d) For all annuities and pure endowments purchased prior to April 2, 1980, under group
2539 annuity and pure endowment contracts, excluding any [~~disability~~] <u>accident and health</u> and
2540 accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table
2541 or any modification of this table approved by the commissioner, and 6.5% interest.

2542 (e) For all annuities and pure endowments purchased on or after April 2, 1980, under
2543 group annuity and pure endowment contracts, excluding any [~~disability~~] <u>accident and health</u> and
2544 accidental death benefits purchased under such contracts: the 1971 Group Annuity Mortality Table,
2545 or any group annuity mortality table adopted after 1980 by the National Association of Insurance
2546 Commissioners, that is approved by rule and promulgated by the commissioner for use in
2547 determining the minimum standard of valuation for such annuities and pure endowments, or any
2548 modification of these tables approved by the commissioner, and 7.5% interest.

2549 (2) After June 1, 1973, any company may file with the commissioner a written notice of
2550 its election to comply with the provisions of this section after a specified date before January 1,
2551 1979, which shall be the operative date of this section for such company, provided, if a company
2552 makes no such election, the operative date of this section for such company shall be January 1,
2553 1979.

2554 Section 36. Section **31A-17-507** is amended to read:

2555 **31A-17-507. Reserve valuation method -- Life insurance and endowment benefits.**

2556 (1) Except as otherwise provided in Sections 31A-17-508, 31A-17-511, and 31A-17-513,
2557 reserves according to the commissioner's reserve valuation method, for the life insurance and
2558 endowment benefits of policies providing for a uniform amount of insurance and requiring the
2559 payment of uniform premiums shall be the excess, if any, of the present value, at the date of
2560 valuation, of such future guaranteed benefits provided for by such policies, over the then present
2561 value of any future modified net premiums therefor. The modified net premiums for any such
2562 policy shall be such uniform percentage of the respective contract premiums for such benefits that
2563 the present value, at the date of issue of the policy, of all such modified net premiums shall be
2564 equal to the sum of the then present value of such benefits provided for by the policy and the
2565 excess of <u>Subsection (1)</u>(a) over <u>Subsection (1)</u>(b), as follows:

2566 (a) A net level annual premium equal to the present value, at the date of issue, of such
2567 benefits provided for after the first policy year, divided by the present value, at the date of issue,

2568 of an annuity of one per annum payable on the first and each subsequent anniversary of such policy
2569 on which a premium falls due; provided, however, that such net level annual premium shall not
2570 exceed the net level annual premium on the 19 year premium whole life plan for insurance of the
2571 same amount at an age one year higher than the age at issue of such policy.
2572 (b) A net one year term premium for such benefits provided for in the first policy year.
2573 (2) Provided that for any life insurance policy issued on or after January 1, 1997, for which
2574 the contract premium in the first policy year exceeds that of the second year and for which no
2575 comparable additional benefit is provided in the first year for such excess and which provides an
2576 endowment benefit or a cash surrender value or a combination thereof in an amount greater than
2577 such excess premium, the reserve according to the commissioner's reserve valuation method as of
2578 any policy anniversary occurring on or before the assumed ending date defined herein as the first
2579 policy anniversary on which the sum of any endowment benefit and any cash surrender value then
2580 available is greater than such excess premium shall, except as otherwise provided in Section
2581 31A-17-511, be the greater of the reserve as of such policy anniversary calculated as described in
2582 Subsection (1) and the reserve as of such policy anniversary calculated as described in that
2583 subsection, but with:
2584 (a) the value defined in Subsection (1)(a) being reduced by 15% of the amount of such
2585 excess first year premium[~~,~~];
2586 (b) all present values of benefits and premiums being determined without reference to
2587 premiums or benefits provided for by the policy after the assumed ending date[~~,~~];
2588 (c) the policy being assumed to mature on such date as an endowment[~~,~~]; and
2589 (d) the cash surrender value provided on such date being considered as an endowment
2590 benefit. In making the above comparison the mortality and interest bases stated in Sections
2591 31A-17-504 and 31A-17-506 shall be used.
2592 (3) Reserves according to the commissioner's reserve valuation method for:
2593 (a) life insurance policies providing for a varying amount of insurance or requiring the
2594 payment of varying premiums;
2595 (b) group annuity and pure endowment contracts purchased under a retirement plan or plan
2596 of deferred compensation, established or maintained by an employer, including a partnership or
2597 sole proprietorship, or by an employee organization, or by both, other than a plan providing
2598 individual retirement accounts or individual retirement annuities under [~~26 U.S.C. Sec. 408, as~~

2599 ~~amended~~] Section 408, Internal Revenue Code;
2600 (c) [~~disability~~] accident and health and accidental death benefits in all policies and
2601 contracts; and
2602 (d) all other benefits, except life insurance and endowment benefits in life insurance
2603 policies and benefits provided by all other annuity and pure endowment contracts, shall be
2604 calculated by a method consistent with the principles of Subsections (1) and (2).
2605 Section 37. Section **31A-17-508** is amended to read:
2606 **31A-17-508. Reserve valuation method -- Annuity and pure endowment benefits.**
2607 (1) This section shall apply to all annuity and pure endowment contracts other than group
2608 annuity and pure endowment contracts purchased under a retirement plan or plan of deferred
2609 compensation, established or maintained by an employer, including a partnership or sole
2610 proprietorship, or by an employee organization, or by both, other than a plan providing individual
2611 retirement accounts or individual retirement annuities under [~~26 U.S.C. Sec. 408, as amended~~]
2612 Section 408, Internal Revenue Code.
2613 (2) Reserves according to the commissioner's annuity reserve method for benefits under
2614 annuity or pure endowment contracts, excluding any [~~disability~~] accident and health and accidental
2615 death benefits in such contracts, shall be the greatest of the respective excesses of the present
2616 values, at the date of valuation, of the future guaranteed benefits, including guaranteed
2617 nonforfeiture benefits, provided for by such contracts at the end of each respective contract year,
2618 over the present value, at the date of valuation, of any future valuation considerations derived from
2619 future gross considerations, required by the terms of such contract, that become payable prior to
2620 the end of such respective contract year. The future guaranteed benefits shall be determined by
2621 using the mortality table, if any, and the interest rate, or rates, specified in such contracts for
2622 determining guaranteed benefits. The valuation considerations are the portions of the respective
2623 gross considerations applied under the terms of such contracts to determine nonforfeiture values.
2624 Section 38. Section **31A-17-509** is amended to read:
2625 **31A-17-509. Minimum reserves.**
2626 (1) In no event shall a company's aggregate reserves for all life insurance policies,
2627 excluding [~~disability~~] accident and health and accidental death benefits, issued on or after January
2628 1, 1994, be less than the aggregate reserves calculated in accordance with the methods set forth in
2629 Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-512 and the mortality table or tables

2630 and rate or rates of interest used in calculating nonforfeiture benefits for such policies.
2631 (2) In no event shall the aggregate reserves for all policies, contracts, and benefits be less
2632 than the aggregate reserves determined by the qualified actuary to be necessary to render the
2633 opinion required by Section 31A-17-503.
2634 Section 39. Section **31A-17-513** is amended to read:
2635 **31A-17-513. Minimum standards for accident and health plans.**
2636 The commissioner shall promulgate a rule containing the minimum standards applicable
2637 to the valuation of [~~disability~~] accident and health plans.
2638 Section 40. Section **31A-17-601** is amended to read:
2639 **31A-17-601. Definitions.**
2640 As used in this part:
2641 (1) "Adjusted RBC report" means an RBC report that has been adjusted by the
2642 commissioner in accordance with Subsection 31A-17-602[~~(4)~~] (5).
2643 (2) "Corrective order" means an order issued by the commissioner specifying corrective
2644 action that the commissioner determines is required.
2645 (3) "Health organization" means:
2646 (a) an entity that is authorized under Chapter 7 or 8; and
2647 (b) that is:
2648 (i) a health maintenance organization;
2649 (ii) a limited health service organization;
2650 (iii) a dental or vision plan;
2651 (iv) a hospital, medical, and dental indemnity or service corporation; or
2652 (v) other managed care organization.
2653 [~~(3)~~] (4) "Life or [~~disability~~] accident and health insurer" means:
2654 (a) an insurance company licensed to write life insurance, disability insurance, or both; or
2655 (b) a licensed property casualty insurer writing only disability insurance.
2656 [~~(4)~~] (5) "Property and casualty insurer" means any insurance company licensed to write
2657 lines of insurance other than life but does not include a monoline mortgage guaranty insurer,
2658 financial guaranty insurer, or title insurer.
2659 [~~(5)~~] (6) "RBC" means risk-based capital.
2660 [~~(6)~~] (7) "RBC instructions" means the RBC report including risk-based capital

2661 instructions adopted by the department by rule.
2662 [(7)] (8) "RBC level" means an insurer's or health organization's authorized control level
2663 RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.
2664 (a) "Authorized control level RBC" means the number determined under the risk-based
2665 capital formula in accordance with the RBC instructions;
2666 (b) "Company action level RBC" means the product of 2.0 and its authorized control level
2667 RBC;
2668 (c) "Mandatory control level RBC" means the product of .70 and the authorized control
2669 level RBC; and
2670 (d) "Regulatory action level RBC" means the product of 1.5 and its authorized control
2671 level RBC.
2672 [(8)] (9) (a) "RBC plan" means a comprehensive financial plan containing the elements
2673 specified in Subsection 31A-17-603(2). [If]
2674 (b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:
2675 (i) the commissioner rejects the RBC plan[,]; and [it]
2676 (ii) the plan is revised by the insurer or health organization, with or without the
2677 commissioner's recommendation[, the plan shall be called the "Revised RBC Plan."].
2678 [(9)] (10) "RBC report" means the report required in Section 31A-17-602.
2679 Section 41. Section **31A-17-602** is amended to read:
2680 **31A-17-602. RBC reports -- RBC of life and accident and health insurers -- RBC of**
2681 **property and casualty insurers.**
2682 (1) Every domestic life or [disability] accident and health insurer [and], every domestic
2683 property and casualty insurer, and every domestic health organization shall:
2684 (a) on or before March 1, prepare and submit to the commissioner a report of its RBC
2685 levels as of the end of the calendar year just ended, in a form and containing the information as is
2686 required by the RBC instructions; [and]
2687 (b) file its RBC report with the insurance commissioner in any state in which the insurer
2688 or health organization is authorized to do business, if the insurance commissioner of that state
2689 notifies the insurer or health organization of its request in writing, in which case the insurer or
2690 health organization may file its RBC report not later than the later of:
2691 (i) 15 days from the receipt of notice to file its RBC report with that state; or

2692 (ii) March 1[~~.~~]; and
2693 (c) file the documents described in Subsections (1)(a) and (b) with the National
2694 Association of Insurance Commissioners in accordance with RBC instructions.
2695 (2) A life and [~~disability~~] accident and health insurer's RBC shall be determined in
2696 accordance with the formula set forth in the RBC instructions. The formula shall take into account
2697 and may adjust for the covariance between:
2698 (a) the risk with respect to the insurer's assets;
2699 (b) the risk of adverse insurance experience with respect to the insurer's liabilities and
2700 obligations;
2701 (c) the interest rate risk with respect to the insurer's business; and
2702 (d) all other business risks and other relevant risks as set forth in the RBC instructions.
2703 (3) A property and casualty insurer's RBC shall be determined in accordance with the
2704 formula set forth in the RBC instructions. The formula shall take the following into account and
2705 may adjust for the covariance between:
2706 (a) asset risk;
2707 (b) credit risk;
2708 (c) underwriting risk; and
2709 (d) all other business risks and the other relevant risks as set forth in the RBC instructions.
2710 (4) A health organization's RBC shall be determined in accordance with the formula set
2711 forth in the RBC instructions. The formula shall take the following into account and may adjust
2712 for the covariance between:
2713 (a) asset risk;
2714 (b) credit risk;
2715 (c) underwriting risk; and
2716 (d) all other business risks and such other relevant risks as are set forth in the RBC
2717 instructions.
2718 [~~(4)~~] (5) (a) If a domestic insurer files an RBC report that the commissioner determines
2719 is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall
2720 notify the insurer of the adjustment.
2721 (b) The notice under Subsection [~~(4)~~] (5)(a) shall contain a statement of the reason for the
2722 adjustment.

2723 (6) The commissioner may make rules to assist in applying the provisions of this part to
2724 health organizations.
2725 Section 42. Section **31A-17-603** is amended to read:
2726 **31A-17-603. Company action level event.**
2727 (1) "Company action level event" means any of the following events:
2728 (a) the filing of an RBC report by an insurer or health organization that indicates that:
2729 (i) the insurer's or health organization's total adjusted capital is greater than or equal to its
2730 regulatory action level RBC but less than its company action level RBC; or
2731 (ii) if a life or [~~disability~~] accident and health insurer, the insurer has:
2732 (A) total adjusted capital that is greater than or equal to its company action level RBC but
2733 less than the product of its authorized control level RBC and 2.5; and
2734 (B) a negative trend, determined in accordance with the "trend test calculation" included
2735 in the RBC instructions;
2736 (b) the notification by the commissioner to the insurer or health organization of an adjusted
2737 RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization
2738 does not challenge the adjusted RBC report under Section 31A-17-607; or
2739 (c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an
2740 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the
2741 commissioner to the insurer or health organization that after a hearing the commissioner rejects
2742 the insurer's or health organization's challenge.
2743 (2) (a) In the event of a company action level event, the insurer or health organization shall
2744 prepare and submit to the commissioner an RBC plan that shall:
2745 (i) identify the conditions that contribute to the company action level event;
2746 (ii) contain proposals of corrective actions that the insurer or health organization intends
2747 to take and that are expected to result in the elimination of the company action level event;
2748 (iii) provide projections of the insurer's or health organization's financial results in the
2749 current year and at least the four succeeding years, both in the absence of proposed corrective
2750 actions and giving effect to the proposed corrective actions, including projections of:
2751 (A) statutory operating income[~~,~~];
2752 (B) net income[~~,~~];
2753 (C) capital[~~, and~~];

2754 (D) surplus; and
2755 (E) RBC levels;
2756 (iv) identify the key assumptions impacting the insurer's or health organization's
2757 projections and the sensitivity of the projections to the assumptions; and
2758 (v) identify the quality of, and problems associated with, the insurer's or health
2759 organization's business, including its assets, anticipated business growth and associated surplus
2760 strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.
2761 (b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal
2762 business may include separate projections for each major line of business and separately identify
2763 each significant income, expense, and benefit component.
2764 (3) The RBC plan shall be submitted:
2765 (a) within 45 days of the company action level event; or
2766 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to
2767 Section 31A-17-607, within 45 days after notification to the insurer or health organization that
2768 after a hearing the commissioner rejects the insurer's or health organization's challenge.
2769 (4) (a) Within 60 days after the submission by an insurer or health organization of an RBC
2770 plan to the commissioner, the commissioner shall notify the insurer or health organization whether
2771 the RBC plan:
2772 (i) shall be implemented; or
2773 (ii) is unsatisfactory.
2774 (b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the
2775 insurer or health organization shall set forth the reasons for the determination, and may propose
2776 revisions that will render the RBC plan satisfactory. Upon notification from the commissioner,
2777 the insurer or health organization shall:
2778 (i) prepare a revised RBC plan that incorporates any revision proposed by the
2779 commissioner; and
2780 (ii) submit the revised RBC plan to the commissioner:
2781 (A) within 45 days after the notification from the commissioner; or
2782 (B) if the insurer challenges the notification from the commissioner under Section
2783 31A-17-607, within 45 days after a notification to the insurer or health organization that after a
2784 hearing the commissioner rejects the insurer's or health organization's challenge.

2785 (5) In the event of a notification by the commissioner to an insurer or health organization
2786 that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the
2787 commissioner may specify in the notification that the notification constitutes a regulatory action
2788 level event subject to the insurer's or health organization's right to a hearing under Section
2789 31A-17-607.
2790 (6) Every domestic insurer or health organization that files an RBC plan or revised RBC
2791 plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the
2792 insurance commissioner in any state in which the insurer or health organization is authorized to
2793 do business if:
2794 (a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and
2795 (b) the insurance commissioner of that state notifies the insurer or health organization of
2796 its request for the filing in writing, in which case the insurer or health organization shall file a copy
2797 of the RBC plan or revised RBC plan in that state no later than the later of:
2798 (i) 15 days after the receipt of notice to file a copy of its RBC plan or revised RBC plan
2799 with that state; or
2800 (ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and
2801 (4).
2802 Section 43. Section **31A-17-604** is amended to read:
2803 **31A-17-604. Regulatory action level event.**
2804 (1) "Regulatory action level event" means with respect to any insurer or health
2805 organization, any of the following events:
2806 (a) the filing of an RBC report by the insurer or health organization that indicates that the
2807 insurer's or health organization's total adjusted capital is greater than or equal to its authorized
2808 control level RBC but less than its regulatory action level RBC;
2809 (b) the notification by the commissioner to an insurer or health organization of an adjusted
2810 RBC report that indicates the event in Subsection (1)(a), provided the insurer or health
2811 organization does not challenge the adjusted RBC report under Section 31A-17-607;
2812 (c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an
2813 adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the
2814 commissioner to the insurer or health organization that after a hearing the commissioner rejects
2815 the insurer's or health organization's challenge;

2816 (d) the failure of the insurer or health organization to file an RBC report by March 1,
2817 unless the insurer or health organization has:
2818 (i) provided an explanation for the failure that is satisfactory to the commissioner; and
2819 (ii) cured the failure within ten days after March 1;
2820 (e) the failure of the insurer or health organization to submit an RBC plan to the
2821 commissioner within the time period set forth in Subsection 31A-17-603(3);
2822 (f) notification by the commissioner to the insurer or health organization that:
2823 (i) the RBC plan or revised RBC plan submitted by the insurer or health organization is
2824 unsatisfactory; and
2825 (ii) the notification constitutes a regulatory action level event with respect to the insurer
2826 or health organization, provided the insurer has not challenged the determination under Section
2827 31A-17-607;
2828 (g) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a
2829 determination by the commissioner under Subsection (1)(f), the notification by the commissioner
2830 to the insurer or health organization that after a hearing the commissioner rejects the challenge;
2831 or
2832 (h) notification by the commissioner to the insurer or health organization that the insurer
2833 or health organization has failed to adhere to its RBC plan or revised RBC plan, but only if:
2834 (i) the failure has a substantial adverse effect on the ability of the insurer or health
2835 organization to eliminate the company action level event in accordance with its RBC plan or
2836 revised RBC plan; and
2837 (ii) the commissioner has so stated in the notification, provided the insurer or health
2838 organization has not challenged the determination under Section 31A-17-607; or
2839 (iii) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a
2840 determination by the commissioner under Subsection (1)(h), the notification by the commissioner
2841 to the insurer or health organization that after a hearing the commissioner rejects the challenge.
2842 (2) In the event of a regulatory action level event the commissioner shall:
2843 (a) require the insurer or health organization to prepare and submit an RBC plan or, if
2844 applicable, a revised RBC plan;
2845 (b) perform any examination or analysis the commissioner considers necessary of the
2846 assets, liabilities, and operations of the insurer or health organization, including a review of its

2847 RBC plan or revised RBC plan; and
2848 (c) subsequent to the examination or analysis, issue a corrective order specifying the
2849 corrective action the commissioner determines is required.
2850 (3) In determining a corrective action, the commissioner may take into account such
2851 factors the commissioner considers relevant with respect to the insurer or health organization based
2852 upon the commissioner's examination or analysis of the assets, liabilities, and operations of the
2853 insurer or health organization, including the results of any sensitivity tests undertaken pursuant to
2854 the RBC instructions. The RBC plan or revised RBC plan shall be submitted:
2855 (a) within 45 days after the occurrence of the regulatory action level event;
2856 (b) if the insurer or health organization challenges an adjusted RBC report pursuant to
2857 Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45
2858 days after the notification to the insurer or health organization that after a hearing the
2859 commissioner rejects the insurer's or health organization's challenge; or
2860 (c) if the insurer or health organization challenges a revised RBC plan pursuant to Section
2861 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after
2862 the notification to the insurer or health organization that after a hearing the commissioner rejects
2863 the insurer's or health organization's challenge.
2864 Section 44. Section **31A-17-605** is amended to read:
2865 **31A-17-605. Authorized control level event.**
2866 (1) "Authorized control level event" means any of the following events:
2867 (a) the filing of an RBC report by the insurer or health organization that indicates that the
2868 insurer's or health organization's total adjusted capital is greater than or equal to its mandatory
2869 control level RBC but less than its authorized control level RBC;
2870 (b) the notification by the commissioner to the insurer or health organization of an adjusted
2871 RBC report that indicates the event in Subsection (1)(a), provided the insurer or health
2872 organization does not challenge the adjusted RBC report under Section 31A-17-607;
2873 (c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an
2874 adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner
2875 to the insurer or health organization that after a hearing the commissioner rejects the insurer's or
2876 health organization's challenge;
2877 (d) the failure of the insurer or health organization to respond, in a manner satisfactory to

2878 the commissioner, to a corrective order, provided the insurer or health organization has not
2879 challenged the corrective order under Section 31A-17-607; or
2880 (e) if the insurer or health organization has challenged a corrective order under Section
2881 31A-17-607 and the commissioner after a hearing rejects the challenge or modifies the corrective
2882 order, the failure of the insurer or health organization to respond, in a manner satisfactory to the
2883 commissioner, to the corrective order subsequent to rejection or modification by the commissioner.
2884 (2) (a) In the event of an authorized control level event with respect to an insurer or health
2885 organization, the commissioner shall:
2886 (i) take any action required under Section 31A-17-604 regarding an insurer or health
2887 organization with respect to which a regulatory action level event has occurred; or
2888 (ii) take any action as is necessary to cause the insurer or health organization to be placed
2889 under regulatory control under Section 31A-27-201 if the commissioner considers it to be in the
2890 best interests of:
2891 (A) the policyholders [~~and~~] or members;
2892 (B) creditors of the insurer or health organization; and
2893 (C) the public.
2894 (b) In the event the commissioner takes an action described in Subsection (2)(a), the
2895 authorized control level event is sufficient grounds for the commissioner to take action under
2896 Section 31A-27-201, and the commissioner shall have the rights, powers, and duties with respect
2897 to the insurer or health organization set forth in Section 31A-27-201.
2898 (c) If the commissioner takes an action under Subsection (2)(a) pursuant to an adjusted
2899 RBC report, the insurer or health organization is entitled to the protections afforded to [~~insurers~~]
2900 an insurer or health organization under Section 31A-27-203 pertaining to summary proceedings.
2901 Section 45. Section **31A-17-606** is amended to read:
2902 **31A-17-606. Mandatory control level event.**
2903 (1) "Mandatory control level event" means any of the following events:
2904 (a) the filing of an RBC report that indicates that the insurer's or health organization's total
2905 adjusted capital is less than its mandatory control level RBC;
2906 (b) notification by the commissioner to the insurer or health organization of an adjusted
2907 RBC report that indicates the event in Subsection (1)(a), provided the insurer or health
2908 organization does not challenge the adjusted RBC report under Section 31A-17-607; or

2909 (c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an
2910 adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner
2911 to the insurer or health organization that after a hearing the commissioner rejects the insurer's or
2912 health organization's challenge.
2913 (2) (a) [~~(i)~~] In the event of a mandatory control level event with respect to [~~a life~~] an
2914 insurer or health organization, the commissioner shall take any actions necessary to place the
2915 insurer under regulatory control under Section 31A-27-201.
2916 [~~(ii)~~] (b) The mandatory control level event is sufficient grounds for the commissioner to
2917 take action under Section 31A-27-201, and the commissioner shall have the rights, powers, and
2918 duties with respect to the insurer or health organization as are set forth in Section 31A-27-201.
2919 [~~(iii)~~] (c) If the commissioner takes an action pursuant to an adjusted RBC report, the
2920 insurer or health organization is entitled to the protections of Section 31A-27-203 pertaining to
2921 summary proceedings.
2922 [~~(iv)~~] (d) Notwithstanding the other provisions of Subsection (2), the commissioner may
2923 forego action for up to 90 days after the mandatory control level event if the commissioner finds
2924 there is a reasonable expectation that the mandatory control level event may be eliminated within
2925 the 90-day period.
2926 [~~(b) (i) In the event of a mandatory control level with respect to a property and casualty~~
2927 ~~insurer, the commissioner shall take any action necessary to place the insurer under regulatory~~
2928 ~~control under Section 31A-27-201.~~]
2929 [~~(ii) The mandatory control level event is sufficient grounds for the commissioner to take~~
2930 ~~action under Section 31A-27-201 and the commissioner shall have the rights, powers, and duties~~
2931 ~~with respect to the insurer set forth in Section 31A-27-201.~~]
2932 [~~(iii) If the commissioner takes actions pursuant to an adjusted RBC report, the insurer~~
2933 ~~shall be entitled to the protections of Section 31A-27-203 pertaining to summary proceedings.~~]
2934 [~~(iv) Notwithstanding any other provision of this section, the commissioner may forego~~
2935 ~~action for up to 90 days after the mandatory control level event if the commissioner finds there is~~
2936 ~~a reasonable expectation that the mandatory control level event may be eliminated within the~~
2937 ~~90-day period.~~]
2938 Section 46. Section **31A-17-607** is amended to read:
2939 **31A-17-607. Hearings.**

2940 (1) (a) Following receipt of a notice described in Subsection (2), the insurer or health
2941 organization shall have the right to a confidential departmental hearing at which the insurer or
2942 health organization may challenge any determination or action by the commissioner.
2943 (b) The insurer or health organization shall notify the commissioner of its request for a
2944 hearing within five days after the notification by the commissioner under Subsections
2945 31A-17-604(1), (2), and (3).
2946 (c) Upon receipt of the insurer's or health organization's request for a hearing, the
2947 commissioner shall set a date for the hearing, which date shall be no less than ten nor more than
2948 30 days after the date of the insurer's or health organization's request.
2949 (2) An insurer or health organization has the right to a hearing under Subsection (1) after:
2950 (a) notification to an insurer or health organization by the commissioner of an adjusted
2951 RBC report;
2952 (b) notification to an insurer or health organization by the commissioner that:
2953 (i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory;
2954 and
2955 (ii) the notification constitutes a regulatory action level event with respect to the insurer
2956 or health organization;
2957 (c) notification to any insurer or health organization by the commissioner that the insurer
2958 or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure
2959 has substantial adverse effect on the ability of the insurer or health organization to eliminate the
2960 company action level event with respect to the insurer or health organization in accordance with
2961 its RBC plan or revised RBC plan; or
2962 (d) notification to an insurer or health organization by the commissioner of a corrective
2963 order with respect to the insurer or health organization.
2964 Section 47. Section **31A-17-608** is amended to read:
2965 **31A-17-608. Confidentiality -- Prohibition on announcements -- Prohibition on use**
2966 **in ratemaking.**
2967 (1) (a) The commissioner shall keep confidential to the extent that information in a report
2968 or plan is not required to be included in a publicly available annual statement schedule, any detail
2969 in an RBC report or RBC plan including the results or report of any examination or analysis of an
2970 insurer or health organization performed pursuant to this part, that is filed by a domestic or foreign

2971 insurer or health organization with the commissioner or any corrective order issued by the
2972 commissioner pursuant to examination or analysis.
2973 (b) Information kept confidential under Subsection (1)(a) may not be made public or be
2974 subject to subpoena, other than by the commissioner and then only for the purpose of enforcement
2975 actions taken by the commissioner pursuant to this part or any other provision of the insurance
2976 laws of this state.
2977 (2) (a) Except as otherwise required under this part, any insurer or health organization,
2978 agent, broker, or other person engaged in any manner in the insurance business may not publish,
2979 disseminate, circulate or place before the public, or cause, directly or indirectly, the publishing,
2980 disseminating, circulating or placing before the public including, in a newspaper, magazine, other
2981 publication, a notice, circular, pamphlet, letter, or poster, or over any radio or television station,
2982 an advertisement, announcement, or statement containing an assertion, representation, or statement
2983 with regard to the RBC levels of any insurer or health organization, or of any component derived
2984 in the calculation.
2985 (b) If any materially false statement with respect to the comparison regarding an insurer's
2986 or health organization's total adjusted capital to its RBC levels, or an inappropriate comparison of
2987 any other amount to the insurer's or health organization's RBC levels is published in any written
2988 publication and the insurer or health organization is able to demonstrate to the commissioner with
2989 substantial proof the falsity of the statement or the inappropriateness, the insurer or health
2990 organization may publish an announcement in a written publication if the sole purpose of the
2991 announcement is to rebut the materially false statement or inappropriate comparison.
2992 (3) The commissioner may not use an RBC instruction, report, plan, or revised plan:
2993 (a) for ratemaking;
2994 (b) as evidence in any rate proceeding; or
2995 (c) to calculate or derive any element of an appropriate premium level or rate of return for
2996 any line of insurance or coverage that an insurer or health organization or any affiliate is authorized
2997 to write or cover.
2998 Section 48. Section **31A-17-609** is amended to read:
2999 **31A-17-609. Alternate adjusted capital.**
3000 (1) Except as provided in Section 31A-17-602, [~~insurers~~] an insurer or health organization
3001 licensed under Chapters 5, 7, 8, 9, and 14 shall maintain total adjusted capital as defined in Section

3002 31A-1-301 in an amount equal to the greater of:
3003 (a) 175% of the minimum required capital, or of the minimum permanent surplus in the
3004 case of nonassessable mutuals, required by Section 31A-5-211, 31A-7-201, 31A-8-209,
3005 31A-9-209, or 31A-14-205; or
3006 (b) the net total of:
3007 (i) 10% of net insurance premiums earned during the year; plus
3008 (ii) 5% of the admitted value of common stocks and real estate; plus
3009 (iii) 2% of the admitted value of all other invested assets, exclusive of cash deposits,
3010 short-term investments, policy loans, and premium notes; less
3011 (iv) the amount of any asset valuation reserve being maintained by the insurer or health
3012 organization, but not to exceed the sum of Subsections (1)(b)(ii) and (iii).
3013 (2) As used in Subsection (1)(b), "premiums earned" means premiums and other
3014 consideration earned for insurance in the 12-month period ending on the date the calculation is
3015 made.
3016 (3) The commissioner may consider an insurer or health organization to be financially
3017 hazardous under Subsection 31A-27-307(3), if the insurer or health organization does not have
3018 qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's
3019 liabilities and the total adjusted capital required by Subsection (1).
3020 (4) The commissioner shall consider an insurer or health organization to be financially
3021 hazardous under Subsection 31A-27-307(3) if the insurer or health organization does not have
3022 qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's
3023 liabilities and 70% of the total adjusted capital required by Subsection (1).
3024 Section 49. Section **31A-17-610** is amended to read:
3025 **31A-17-610. Foreign insurers.**
3026 (1) (a) Any foreign insurer or health organization shall, upon the written request of the
3027 commissioner, submit to the commissioner an RBC report as of the end of the most recent calendar
3028 year by the later of:
3029 (i) the date an RBC report would be required to be filed by a domestic insurer or health
3030 organization under this part; or
3031 (ii) 15 days after the request is received by the foreign insurer or health organization.
3032 (b) Any foreign insurer or health organization shall, at the written request of the

3033 commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the
3034 insurance commissioner of any other state.
3035 (2) (a) The commissioner may require a foreign insurer or health organization to file an
3036 RBC plan with the commissioner if:
3037 (i) there is a company action level event, regulatory action level event, or authorized
3038 control level event with respect to the foreign insurer or health organization as determined under:
3039 (A) the RBC statute applicable in the state of domicile of the insurer or health
3040 organization; or[~~,~~]
3041 (B) if no RBC statute is in force in that state, under [~~the provisions of~~] this part; and
3042 (ii) the insurance commissioner of the state of domicile of the foreign insurer or health
3043 organization fails to require the foreign insurer or health organization to file an RBC plan in the
3044 manner specified under:
3045 (A) that state's RBC statute; or[~~,~~]
3046 (B) if no RBC statute is in force in that state, under Section 31A-17-603.
3047 (b) If the commissioner requires a foreign insurer or health organization to file an RBC
3048 plan, the failure of the foreign insurer or health organization to file the RBC plan with the
3049 commissioner is grounds to order the insurer or health organization to cease and desist from
3050 writing new insurance business in this state.
3051 (3) The commissioner may make application to the Third District Court for Salt Lake
3052 County permitted under Section 31A-27-401 with respect to the liquidation of property of a foreign
3053 [~~insurers~~] insurer or health organization found in this state if:
3054 (a) a mandatory control level event occurs with respect to any foreign insurer or health
3055 organization; and
3056 (b) no domiciliary receiver has been appointed with respect to the foreign insurer or health
3057 organization under the rehabilitation and liquidation statute applicable in the state of domicile of
3058 the foreign insurer or health organization.
3059 Section 50. Section **31A-17-613** is amended to read:
3060 **31A-17-613. Effective date of notice.**
3061 A notice by the commissioner to an insurer or health organization that may result in
3062 regulatory action under this chapter is effective the sooner of:
3063 (1) the date the insurer or health organization receives the notice; or

3064 (2) three days after mailing the notice.

3065 Section 51. Section **31A-18-105** is amended to read:

3066 **31A-18-105. Permitted classes of investments.**

3067 The following classes of investment may be counted for the purposes specified under
3068 Chapter 17, Part 6, Risk-Based Capital:

3069 (1) bonds or other evidences of indebtedness of:

3070 (a) (i) governmental units in the United States or Canada[~~, or~~];

3071 (ii) instrumentalities of [~~those~~] the governmental units[~~,~~] described in Subsection (1)(a)(i);
3072 or [~~of~~]

3073 (iii) private corporations domiciled in the United States[~~,~~]; and

3074 (b) including demand deposits and certificates of deposits in solvent banks and savings and
3075 loan institutions;

3076 (2) equipment trust obligations or certificates [~~which~~] that are adequately secured
3077 instruments evidencing an interest in transportation equipment [~~which~~] that is located wholly or
3078 in part within the United States, with a right to receive determined portions of the rental, or to
3079 purchase other fixed obligatory payments for the use or purchase of the transportation equipment;

3080 (3) loans secured by:

3081 (a) mortgages[~~,~~];

3082 (b) trust deeds[~~,~~]; or

3083 (c) other statutorily authorized types of security interests in real estate located in the United
3084 States;

3085 (4) loans secured by pledged securities or evidences of debt eligible for investment under
3086 this section;

3087 (5) preferred stocks of United States corporations;

3088 (6) common stocks of United States corporations;

3089 (7) real estate which is used as the home office or branch office of the insurer;

3090 (8) real estate in the United States which produces substantial income;

3091 (9) loans upon the security of the insurer's own policies in amounts that are adequately
3092 secured by the policies and that do not exceed the surrender value of the policies;

3093 (10) financial futures contracts used for hedging and not for speculation, as approved under
3094 rules adopted by the commissioner;

3095 (11) investments in foreign securities of the classes permitted under this section as required
3096 for compliance with Section 31A-18-103;
3097 (12) investments permitted under Subsection 31A-18-102(2); and
3098 (13) other investments as the commissioner authorizes by rule.
3099 Section 52. Section **31A-19a-101** is amended to read:
3100 **31A-19a-101. Title -- Scope and purposes.**
3101 (1) This chapter is known as the "Utah Rate Regulation Act."
3102 (2) (a) (i) Except as provided in Subsection (2)(a)(ii), this chapter applies to all kinds and
3103 lines of direct insurance written on risks or operations in this state by an insurer authorized to do
3104 business in this state.
3105 (ii) This chapter does not apply to:
3106 (A) life insurance other than credit life insurance;
3107 (B) variable and fixed annuities;
3108 (C) health and [~~disability~~] accident and health insurance other than credit [~~disability~~]
3109 accident and health insurance; and
3110 (D) reinsurance.
3111 (b) This chapter applies to all insurers authorized to do any line of business, except those
3112 specified in Subsection (2)(a)(ii).
3113 (3) It is the purpose of this chapter to:
3114 (a) protect policyholders and the public against the adverse effects of excessive,
3115 inadequate, or unfairly discriminatory rates;
3116 (b) encourage independent action by and reasonable price competition among insurers so
3117 that rates are responsive to competitive market conditions;
3118 (c) provide formal regulatory controls for use if independent action and price competition
3119 fail;
3120 (d) provide regulatory procedures for the maintenance of appropriate data reporting
3121 systems;
3122 (e) authorize cooperative action among insurers in the rate-making process, and regulate
3123 that cooperation to prevent practices that bring about a monopoly or lessen or destroy competition;
3124 (f) encourage the most efficient and economic marketing practices; and
3125 (g) regulate the business of insurance in a manner that, under the McCarran-Ferguson Act,

3126 15 U.S.C. Secs. 1011 through 1015, will preclude application of federal antitrust laws.
3127 (4) Rate filings made prior to July 1, 1986, under former Title 31, Chapter 18, are
3128 continued. Rate filings made after July 1, 1986, are subject to the requirements of this chapter.
3129 Section 53. Section **31A-21-103** is amended to read:
3130 **31A-21-103. Capacity to contract.**
3131 Any person 16 years of age or older who is otherwise competent to contract under Utah
3132 law, and who is not subject to any legal disability, may contract for insurance. If there is a
3133 conservator appointed under Title 75, the conservator, rather than the person whose property is
3134 subject to the conservatorship, may contract for insurance to protect the property under
3135 conservatorship. In the case of a conservatorship over the person or property of a person under 16
3136 years of age, the conservator may invest funds of the estate in life or [~~disability~~] accident and
3137 health insurance or annuity contracts, but only with the approval of the court having jurisdiction
3138 over the conservatorship.
3139 Section 54. Section **31A-21-104** is amended to read:
3140 **31A-21-104. Insurable interest and consent.**
3141 (1) (a) An insurer may not knowingly provide insurance to a person who does not have or
3142 expect to have an insurable interest in the subject of the insurance.
3143 (b) A person may not knowingly procure, directly, by assignment, or otherwise, an interest
3144 in the proceeds of an insurance policy unless he has or expects to have an insurable interest in the
3145 subject of the insurance.
3146 (c) Except as provided in Subsections (6), (7), and (8), any insurance provided in violation
3147 of this subsection is subject to Subsection (5).
3148 (2) As used in this chapter:
3149 (a) "Insurable interest" in a person means, for persons closely related by blood or by law,
3150 a substantial interest engendered by love and affection, or in the case of other persons, a lawful and
3151 substantial interest in having the life, health, and bodily safety of the person insured continue.
3152 Policyholders in group insurance contracts need no insurable interest if certificate holders or
3153 persons other than group policyholders who are specified by the certificate holders are the
3154 recipients of the proceeds of the policies. Each person has an unlimited insurable interest in his
3155 own life and health. A shareholder or partner has an insurable interest in the life of other
3156 shareholders or partners for purposes of insurance contracts that are an integral part of a legitimate

3157 buy-sell agreement respecting shares or a partnership interest in the business.
3158 (b) "Insurable interest" in property or liability means any lawful and substantial economic
3159 interest in the nonoccurrence of the event insured against.
3160 (c) "Viatical settlement" means a written contract entered into by a person who is the
3161 policyholder of a life insurance policy insuring the life of a terminally ill person, under which the
3162 insured assigns, transfers ownership, irrevocably designates a specific person or otherwise
3163 alienates all control and right in the insurance policy to another person, when the proceeds of the
3164 contract is paid to the policyholder of the insurance policy or the policyholder's designee prior to
3165 the death of the subject.
3166 (3) Except as provided in Subsection (4), an insurer may not knowingly issue an individual
3167 life or [~~disability~~] accident and health insurance policy to a person other than the one whose life
3168 or health is at risk unless that person, who is 18 years of age or older and not under guardianship
3169 under Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, has given
3170 written consent to the issuance of the policy. The person shall express consent either by signing
3171 an application for the insurance with knowledge of the nature of the document, or in any other
3172 reasonable way. Any insurance provided in violation of this subsection is subject to Subsection (5).
3173 (4) (a) A life or [~~disability~~] accident and health insurance policy may be taken out without
3174 consent in the following cases:
3175 (i) A person may obtain insurance on a dependent who does not have legal capacity.
3176 (ii) A creditor may, at the creditor's expense, obtain insurance on the debtor in an amount
3177 reasonably related to the amount of the debt.
3178 (iii) A person may obtain life and [~~disability~~] accident and health insurance on immediate
3179 family members living with or dependent on the person.
3180 (iv) A person may obtain [~~a disability~~] an accident and health insurance policy on others
3181 that would merely indemnify the policyholder against expenses he would be legally or morally
3182 obligated to pay.
3183 (v) The commissioner may adopt rules permitting issuance of insurance for a limited term
3184 on the life or health of a person serving outside the continental United States who is in the public
3185 service of the United States, if the policyholder is related within the second degree by blood or by
3186 marriage to the person whose life or health is insured.
3187 (b) Consent may be given by another in the following cases:

3188 (i) A parent, a person having legal custody of a minor, or a guardian of the person under
3189 Title 75, Chapter 5, Protection of Persons Under Disability and Their Property, may consent to the
3190 issuance of a policy on a dependent child or on a person under guardianship under Title 75,
3191 Chapter 5, Protection of Persons Under Disability and Their Property.
3192 (ii) A grandparent may consent to the issuance of life or [~~disability~~] accident and health
3193 insurance on a grandchild.
3194 (iii) A court of general jurisdiction may give consent to the issuance of a life or [~~disability~~]
3195 accident and health insurance policy on an ex parte application showing facts the court considers
3196 sufficient to justify the issuance of that insurance.
3197 (5) An insurance policy is not invalid because the policyholder lacks insurable interest or
3198 because consent has not been given, but a court with appropriate jurisdiction may order the
3199 proceeds to be paid to some person who is equitably entitled to them, other than the one to whom
3200 the policy is designated to be payable, or it may create a constructive trust in the proceeds or a part
3201 of them on behalf of such a person, subject to all the valid terms and conditions of the policy other
3202 than those relating to insurable interest or consent.
3203 (6) This section does not prevent any organization described under 26 U.S.C. Sec.
3204 501(c)(3), (e), or (f), as amended, and the regulations made under this section, and which is
3205 regulated under Title 13, Chapter 22, Charitable Solicitations Act, from soliciting and procuring,
3206 by assignment or designation as beneficiary, a gift or assignment of an interest in life insurance on
3207 the life of the donor or assignor or from enforcing payment of proceeds from that interest.
3208 (7) This section does not prevent:
3209 (a) any policyholder of life insurance, whether or not the policyholder is also the subject
3210 of the insurance, from entering into a viatical settlement;
3211 (b) any person from soliciting a person to enter into a viatical settlement; or
3212 (c) a person from enforcing payment of proceeds from the interest obtained under a viatical
3213 settlement.
3214 (8) Notwithstanding Subsection (1), an insurer authorized under this title to issue a
3215 workers' compensation policy may issue a workers' compensation policy to a sole proprietorship,
3216 corporation, or partnership that elects not to include any owner, corporate officer, or partner as an
3217 employee under the policy even if at the time the policy is issued the sole proprietorship,
3218 corporation, or partnership has no employees.

3219 Section 55. Section **31A-21-201** is amended to read:

3220 **31A-21-201. Filing and approval of forms.**

3221 (1) (a) A form subject to Subsection 31A-21-101(1), except as exempted under
3222 Subsections 31A-21-101(2) through (6), may not be used, sold, or offered for sale unless it has
3223 been filed with the commissioner.

3224 (b) A form is considered filed with the commissioner when the commissioner receives:

3225 (i) the form;

3226 (ii) the applicable filing fee as prescribed under Section 31A-3-103; and

3227 (iii) the applicable transmittal forms as required by the commissioner.

3228 (2) In filing a form for use in this state the insurer is responsible for assuring that the form
3229 is in compliance with this title and rules adopted by the commissioner.

3230 (3) (a) The commissioner may [~~disapprove~~] prohibit the use of a form at any time upon
3231 a finding that:

3232 (i) it is:

3233 (A) inequitable;

3234 (B) unfairly discriminatory;

3235 (C) misleading;

3236 (D) deceptive;

3237 (E) obscure;

3238 (F) unfair;

3239 (G) encourages misrepresentation; or

3240 (H) not in the public interest;

3241 (ii) it provides benefits or contains other provisions that endanger the solidity of the
3242 insurer;

3243 (iii) in the case of the basic policy and the application for a basic policy, it fails to
3244 conspicuously, as defined by rule, provide:

3245 (A) the exact name of the insurer [~~and~~];

3246 (B) its state of domicile; and

3247 (C) for life insurance and annuity policies only, the address of its administrative office.

3248 (iv) it violates a statute or a rule adopted by the commissioner; or

3249 (v) it is otherwise contrary to law.

3250 (b) Subsection (3)(a)(iii) does not apply to riders and endorsements to a basic policy.
3251 (c) (i) Whenever the commissioner [~~disapproves~~] prohibits the use of a form under
3252 Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after
3253 the order, the use of the form be discontinued.
3254 (ii) Once a form has been [~~disapproved~~] prohibited, it may not be used unless appropriate
3255 changes are filed with and [~~approved~~] reviewed by the commissioner.
3256 (iii) Whenever the commissioner [~~disapproves~~] prohibits the use a form under Subsection
3257 (3)(a), the commissioner may require the insurer to disclose contract deficiencies to existing
3258 policyholders.
3259 (d) The commissioner's [~~disapproval~~] prohibition under this Subsection (3) shall:
3260 (i) be in writing [~~and constitutes~~];
3261 (ii) constitute an order[~~. The order shall~~]; and
3262 (iii) state the reasons for [~~disapproval~~] the prohibition.
3263 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the
3264 commissioner may require by rule or order that certain forms be subject to the commissioner's
3265 approval prior to their use.
3266 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures
3267 for the forms if different than stated in this section.
3268 (c) The types of forms that may be addressed under Subsection (4)(a) include:
3269 (i) forms for a particular class of insurance;
3270 (ii) forms for a specific line of insurance;
3271 (iii) a specific type of form; or
3272 (iv) forms for a specific market segment.
3273 Section 56. Section **31A-21-301** is amended to read:
3274 **31A-21-301. Clauses required to be in a prominent position.**
3275 (1) The following portions of insurance policies shall appear conspicuously in the policy:
3276 (a) [~~the name and state of domicile of the insurer~~] as required by Subsection 31A-21-201
3277 (3)(a)(iii)[~~;~~]:
3278 (i) the exact name of the insurer;
3279 (ii) the state of domicile of the insurer; and
3280 (iii) for life insurance and annuity policies only, the address of the administrative office

3281 of the insurer;

3282 (b) information that two or more insurers under Subsection (1)(a) undertake only several

3283 liability, as required by Section 31A-21-306;

3284 (c) if a policy is assessable, a statement of that;

3285 (d) a statement that benefits are variable, as required by Subsection 31A-22-411(1);

3286 however, the methods of calculation need not be in a prominent position;

3287 (e) the right to return a life or [~~disability~~] accident and health insurance policy under

3288 Sections 31A-22-423 and 31A-22-606; and

3289 (f) the beginning and ending dates of insurance protection.

3290 (2) Each clause listed in Subsection (1) shall be displayed conspicuously and separately

3291 from any other clause.

3292 Section 57. Section **31A-21-303** is amended to read:

3293 **31A-21-303. Termination of insurance policies by insurers.**

3294 (1) (a) Except as otherwise provided in this section, in other statutes, or by rule under

3295 Subsection (1)(c), this section applies to all policies of insurance other than life and [~~disability~~]

3296 accident and health insurance and annuities, if the policies of insurance are issued on forms that

3297 are subject to filing and approval under Subsection 31A-21-201(1).

3298 (b) A policy may provide terms more favorable to insureds than this section requires.

3299 (c) The commissioner may by rule totally or partially exempt from this section classes of

3300 insurance policies in which the insureds do not need protection against arbitrary or unannounced

3301 termination.

3302 (d) The rights provided by this section are in addition to and do not prejudice any other

3303 rights the insureds may have at common law or under other statutes.

3304 (2) (a) As used in this Subsection (2), "grounds" means:

3305 (i) material misrepresentation;

3306 (ii) substantial change in the risk assumed, unless the insurer should reasonably have

3307 foreseen the change or contemplated the risk when entering into the contract;

3308 (iii) substantial breaches of contractual duties, conditions, or warranties;

3309 (iv) attainment of the age specified as the terminal age for coverage, in which case the

3310 insurer may cancel by notice under Subsection (2)(c), accompanied by a tender of proportional

3311 return of premium; or

3312 (v) in the case of automobile insurance, revocation or suspension of the driver's license of
3313 the named insured or any other person who customarily drives the car.
3314 (b) (i) Except as provided in Subsection (2)(e) or unless the conditions of Subsection
3315 (2)(b)(ii) are met, an insurance policy may not be canceled by the insurer before the earlier of:
3316 (A) the expiration of the agreed term; or
3317 (B) one year from the effective date of the policy or renewal.
3318 (ii) Notwithstanding Subsection (2)(b)(i), an insurance policy may be canceled by the
3319 insurer for:
3320 (A) nonpayment of a premium when due; or
3321 (B) on grounds defined in Subsection (2)(a).
3322 (c) (i) The cancellation provided by Subsection (2)(b), except cancellation for nonpayment
3323 of premium, is effective no sooner than 30 days after the delivery or first-class mailing of a written
3324 notice to the policyholder.
3325 (ii) Cancellation for nonpayment of premium is effective no sooner than ten days after
3326 delivery or first class mailing of a written notice to the policyholder.
3327 (d) (i) Notice of cancellation for nonpayment of premium shall include a statement of the
3328 reason for cancellation.
3329 (ii) Subsection (6) applies to the notice required for grounds of cancellation other than
3330 nonpayment of premium.
3331 (e) (i) Subsections (2)(a) through (d) do not apply to any insurance contract that has not
3332 been previously renewed if the contract has been in effect less than 60 days when the written notice
3333 of cancellation is mailed or delivered.
3334 (ii) A cancellation under this Subsection (2)(e) may not be effective until at least ten days
3335 after the delivery to the insured of a written notice of cancellation.
3336 (iii) If the notice required by this Subsection (2)(e) is sent by first-class mail, postage
3337 prepaid, to the insured at the insured's last-known address, delivery is considered accomplished
3338 after the passing, since the mailing date, of the mailing time specified in the Utah Rules of Civil
3339 Procedure.
3340 (iv) A policy cancellation subject to this Subsection (2)(e) is not subject to the procedures
3341 described in Subsection (6).
3342 (3) A policy may be issued for a term longer than one year or for an indefinite term if the

3343 policy includes a clause providing for cancellation by the insurer by giving notice as provided in
3344 Subsection (4)(b)(i) 30 days prior to any anniversary date.
3345 (4) (a) Subject to Subsections (2), (3), and (4)(b), a policyholder has a right to have the
3346 policy renewed:
3347 (i) on the terms then being applied by the insurer to similar risks; and
3348 (ii) (A) for an additional period of time equivalent to the expiring term if the agreed term
3349 is one year or less; or
3350 (B) for one year if the agreed term is longer than one year.
3351 (b) Except as provided in Subsection (4)(c), the right to renewal under Subsection (4)(a)
3352 is extinguished if:
3353 (i) at least 30 days prior to the policy expiration or anniversary date a notice of intention
3354 not to renew the policy beyond the agreed expiration or anniversary date is delivered or sent by
3355 first-class mail by the insurer to the policyholder at the policyholder's last-known address;
3356 (ii) not more than 45 nor less than 14 days prior to the due date of the renewal premium,
3357 the insurer delivers or sends by first-class mail a notice to the policyholder at the policyholder's
3358 last-known address, clearly stating:
3359 (A) the renewal premium;
3360 (B) how it may be paid; and
3361 (C) that failure to pay the renewal premium by the due date extinguishes the policyholder's
3362 right to renewal;
3363 (iii) the policyholder has:
3364 (A) accepted replacement coverage; or
3365 (B) requested or agreed to nonrenewal; or
3366 (iv) the policy is expressly designated as nonrenewable.
3367 (c) Unless the conditions of Subsection (4)(b)(iii) or (iv) apply, an insurer may not fail to
3368 renew an insurance policy as a result of a telephone call or other inquiry that:
3369 (i) references a policy coverage; and
3370 (ii) does not result in a claim being filed or paid.
3371 (5) (a) (i) Subject to Subsection (5)(b), if the insurer offers or purports to renew the policy,
3372 but on less favorable terms or at higher rates, the new terms or rates take effect on the renewal date
3373 if the insurer delivered or sent by first-class mail to the policyholder notice of the new terms or

3374 rates at least 30 days prior to the expiration date of the prior policy.

3375 (ii) If the insurer did not give the prior notification described in Subsection (5)(a)(i) to the
3376 policyholder the new terms or rates do not take effect until 30 days after the notice is delivered or
3377 sent by first-class mail, in which case the policyholder may elect to cancel the renewal policy at
3378 any time during the 30-day period.

3379 (iii) Return premiums or additional premium charges shall be calculated proportionately
3380 on the basis that the old rates apply.

3381 (b) Subsection (5)(a) does not apply if the only change in terms that is adverse to the
3382 policyholder is:

3383 (i) a rate increase generally applicable to the class of business to which the policy belongs;

3384 (ii) a rate increase resulting from a classification change based on the altered nature or
3385 extent of the risk insured against; or

3386 (iii) a policy form change made to make the form consistent with Utah law.

3387 (6) (a) If a notice of cancellation or nonrenewal under Subsection (2)(c) does not state with
3388 reasonable precision the facts on which the insurer's decision is based, the insurer shall send by
3389 first-class mail or deliver that information within ten working days after receipt of a written request
3390 by the policyholder.

3391 (b) A notice under Subsection (2)(c) is not effective unless it contains information about
3392 the policyholder's right to make the request.

3393 (7) If a risk-sharing plan under Section 31A-2-214 exists for the kind of coverage provided
3394 by the insurance being cancelled or nonrenewed, a notice of cancellation or nonrenewal required
3395 under Subsection (2)(c) or (4)(b)(i) may not be effective unless it contains instructions to the
3396 policyholder for applying for insurance through the available risk-sharing plan.

3397 (8) There is no liability on the part of, and no cause of action against, any insurer, its
3398 authorized representatives, agents, employees, or any other person furnishing to the insurer
3399 information relating to the reasons for cancellation or nonrenewal or for any statement made or
3400 information given by them in complying or enabling the insurer to comply with this section unless
3401 actual malice is proved by clear and convincing evidence.

3402 (9) This section does not alter any common law right of contract rescission for material
3403 misrepresentation.

3404 Section 58. Section **31A-21-307** is amended to read:

3405 **31A-21-307. Other insurance.**
3406 (1) When two or more policies promise to indemnify an insured against the same loss
3407 without intending cumulative coverage, no "other insurance" provisions of the policies may reduce
3408 the aggregate protection of the insured below the lesser of the actual insured loss suffered by the
3409 insured and the maximum indemnification promised by any policy without regard to any "other
3410 insurance" provision.
3411 (2) Subject to Subsection (1), the policies may by their terms define the extent to which
3412 each insurance is primary and each is excess, but if the "other insurance" terms of the policies are
3413 inconsistent, there is joint and several liability to the insured on any coverage which overlaps and
3414 which has inconsistent terms. Subsequent settlement among the insurers does not alter any rights
3415 of the insured. The commissioner may adopt rules consistent with this section concerning "other
3416 insurance."
3417 (3) This section does not apply to [~~disability~~] accident and health insurance policies. Refer
3418 to Section 31A-22-619 for the coordination of [~~disability~~] accident and health benefits.
3419 Section 59. Section **31A-21-401** is amended to read:
3420 **31A-21-401. Scope and construction of part.**
3421 This part applies to all mass marketed life or [~~disability~~] accident and health insurance,
3422 notwithstanding Subsection 31A-1-103(3)[~~(h)~~]. This part may not be construed to limit the
3423 application of other provisions of this title to insurers effecting mass marketed life or [~~disability~~]
3424 accident and health insurance policies on persons in this state.
3425 Section 60. Section **31A-21-402** is amended to read:
3426 **31A-21-402. Definitions.**
3427 As used in this part:
3428 (1) "Direct response solicitation" means any offer by an insurer to persons in this state,
3429 either directly or through a third party, to effect life or [~~disability~~] accident and health insurance
3430 coverage which enables the individual to apply or enroll for the insurance on the basis of the offer.
3431 Direct response solicitation does not include solicitations for insurance through an employee
3432 benefit plan exempt from state regulation under preemptive federal law, nor does it include
3433 solicitations through the individual's creditor with respect to credit life or credit [~~disability~~]
3434 accident and health insurance.
3435 (2) "Mass marketed life or [~~disability~~] accident and health insurance" means the insurance

3436 under any individual, franchise, group, or blanket policy of life or [~~disability~~] accident and health
3437 insurance which is offered by means of direct response solicitation through a sponsoring
3438 organization or through the mails or other mass communications media and under which the
3439 person insured pays all or substantially all of the cost of his insurance.
3440 Section 61. Section **31A-21-403** is amended to read:
3441 **31A-21-403. Orders terminating effectiveness of policies.**
3442 Upon the commissioner's order, no mass marketed life or [~~disability~~] accident and health
3443 insurance issued by an insurer may continue to be effected on persons in this state. The
3444 commissioner may issue an order under this section only if he finds, after a hearing, that the total
3445 charges for the insurance to the persons insured are unreasonable in relation to the benefits
3446 provided. The commissioner's findings under this section must be in writing. Orders under this
3447 section may direct the insurer to cease effecting the insurance until the total charges for the
3448 insurance are found by the commissioner to be reasonable in relation to the benefits provided.
3449 Section 62. Section **31A-21-404** is amended to read:
3450 **31A-21-404. Out-of-state insurers.**
3451 Any insurer extending mass marketed life or [~~disability~~] accident and health insurance
3452 under a group or blanket policy issued outside of this state to residents of this state shall, with
3453 respect to the mass marketed life or [~~disability~~] accident and health insurance policy:
3454 (1) comply with Sections 31A-23-302 and 31A-23-303 and Part III of Chapter 26; and
3455 (2) upon the commissioner's request, deliver to the commissioner a copy of any mass
3456 marketed life or [~~disability~~] accident and health insurance policy, certificates issued under these
3457 policies, and advertising material used in this state in connection with the policy.
3458 Section 63. Section **31A-21-501** is amended to read:
3459 **31A-21-501. Definitions.**
3460 For purposes of this part:
3461 (1) "Applicant" means:
3462 (a) in the case of an individual life or [~~disability~~] accident and health policy, the person
3463 who seeks to contract for insurance benefits; or
3464 (b) in the case of a group life or [~~disability~~] accident and health policy, the proposed
3465 certificate holder.
3466 (2) "Cohabitant" means an emancipated individual pursuant to Section 15-2-1 or an

3467 individual who is 16 years of age or older who:
3468 (a) is or was a spouse of the other party;
3469 (b) is or was living as if a spouse of the other party;
3470 (c) is related by blood or marriage to the other party;
3471 (d) has one or more children in common with the other party; or
3472 (e) resides or has resided in the same residence as the other party.
3473 (3) "Child abuse" means the commission or attempt to commit against a child a criminal
3474 offense described in:
3475 (a) Title 76, Chapter 5, Part 1, Assault and Related Offenses;
3476 (b) Title 76, Chapter 5, Part 4, Sexual Offenses;
3477 (c) Subsections 76-9-702(1) through (4), Lewdness- Sexual battery; or
3478 (d) Section 76-9-702.5, Lewdness Involving a Child.
3479 (4) "Domestic violence" means any criminal offense involving violence or physical harm
3480 or threat of violence or physical harm, or any attempt, conspiracy, or solicitation to commit a
3481 criminal offense involving violence or physical harm, when committed by one cohabitant against
3482 another and includes commission or attempt to commit, any of the following offenses by one
3483 cohabitant against another:
3484 (a) aggravated assault, as described in Section 76-5-103;
3485 (b) assault, as described in Section 76-5-102;
3486 (c) criminal homicide, as described in Section 76-5-201;
3487 (d) harassment, as described in Section 76-5-106;
3488 (e) telephone harassment, as described in Section 76-9-201;
3489 (f) kidnaping, child kidnaping, or aggravated kidnaping, as described in Sections 76-5-301,
3490 76-5-301.1, and 76-5-302;
3491 (g) mayhem, as described in Section 76-5-105;
3492 (h) sexual offenses, as described in Title 76, Chapter 5, Part 4, and Title 76, Chapter 5a;
3493 (i) stalking, as described in Section 76-5-106.5;
3494 (j) unlawful detention, as described in Section 76-5-304;
3495 (k) violation of a protective order or ex parte protective order, as described in Section
3496 76-5-108;
3497 (l) any offense against property described in Title 76, Chapter 6, Part 1, 2, or 3;

3498 (m) possession of a deadly weapon with intent to assault, as described in Section
3499 76-10-507; or
3500 (n) discharge of a firearm from a vehicle, near a highway, or in the direction of any person,
3501 building, or vehicle, as described in Section 76-10-508.
3502 (5) "Subject of domestic abuse" means an individual who is, has been, may currently be,
3503 or may have been subject to domestic violence or child abuse.
3504 Section 64. Section **31A-21-502** is amended to read:
3505 **31A-21-502. Scope of part.**
3506 This part applies to only life and [~~disability~~] accident and health insurance.
3507 Section 65. Section **31A-21-503** is amended to read:
3508 **31A-21-503. Discrimination based on domestic violence or child abuse prohibited.**
3509 (1) Except as provided in Subsection (2), an insurer of life or [~~disability~~] accident and
3510 health insurance may not consider whether an insured or applicant is the subject of domestic abuse
3511 as a factor to:
3512 (a) refuse to insure the applicant;
3513 (b) refuse to continue to insure the insured;
3514 (c) refuse to renew or reissue a policy to insure the insured or applicant;
3515 (d) limit the amount, extent, or kind of coverage available to the insured or applicant;
3516 (e) charge a different rate for coverage to the insured or applicant;
3517 (f) exclude or limit benefits or coverage under an insurance policy or contract for losses
3518 incurred;
3519 (g) deny a claim; or
3520 (h) terminate coverage or fail to provide conversion privileges in violation of Sections
3521 31A-22-612 and 31A-22-710 under a group [~~disability~~] accident and health policy for the insured
3522 because the coverage was issued in the name of the perpetrator of the domestic violence or abuse.
3523 (2) (a) Notwithstanding Subsection (1), an insurer may underwrite based on the physical
3524 or mental condition of an insured or applicant if the underwriting is based on a determination that
3525 there is a correlation between the medical or mental condition and a material increase in insurance
3526 risk.
3527 (b) For purposes of Subsection (2)(a), the fact that an insured or applicant is a subject of
3528 domestic abuse is not a mental or physical condition.

3529 (c) The determination required by Subsection (2)(a) shall be made in conformance with
3530 sound actuarial principles.
3531 (d) Within 30 days after receiving an oral or written request from an insured or applicant,
3532 an insurer shall disclose in writing:
3533 (i) the basis of an action permitted under Subsection (2)(a); and
3534 (ii) if the policy has been issued or modified, the extent the action taken will impact the
3535 amount, extent, or kind of coverage or benefits available to the insured.
3536 Section 66. Section **31A-21-505** is amended to read:
3537 **31A-21-505. Limit on liability.**
3538 An insurer that issues a life or [~~disability~~] accident and health insurance policy to an
3539 individual who is the subject of domestic abuse is not liable civilly or criminally for the death of
3540 or any injuries to the insured as a result of domestic violence or child abuse beyond the obligations
3541 of the insurer under:
3542 (1) the insurance policy; or
3543 (2) this title.
3544 Section 67. Section **31A-22-307** is amended to read:
3545 **31A-22-307. Personal injury protection coverages and benefits.**
3546 (1) Personal injury protection coverages and benefits include:
3547 (a) the reasonable value of all expenses for necessary medical, surgical, X-ray, dental,
3548 rehabilitation, including prosthetic devices, ambulance, hospital, and nursing services, not to
3549 exceed a total of $3,000 per person;
3550 (b) (i) the lesser of $250 per week or 85% of any loss of gross income and loss of earning
3551 capacity per person from inability to work, for a maximum of 52 consecutive weeks after the loss,
3552 except that this benefit need not be paid for the first three days of disability, unless the disability
3553 continues for longer than two consecutive weeks after the date of injury; and
3554 (ii) a special damage allowance not exceeding $20 per day for a maximum of 365 days,
3555 for services actually rendered or expenses reasonably incurred for services that, but for the injury,
3556 the injured person would have performed for his household, except that this benefit need not be
3557 paid for the first three days after the date of injury unless the person's inability to perform these
3558 services continues for more than two consecutive weeks;
3559 (c) funeral, burial, or cremation benefits not to exceed a total of $1,500 per person; and

3560 (d) compensation on account of death of a person, payable to his heirs, in the total of
3561 $3,000.
3562 (2) (a) To determine the reasonable value of the medical expenses provided for in
3563 Subsection (1) and under Subsection 31A-22-309 (1)(e), the commissioner shall conduct a relative
3564 value study of services and accommodations for the diagnosis, care, recovery, or rehabilitation of
3565 an injured person in the most populous county in the state to assign a unit value and determine the
3566 75th percentile charge for each type of service and accommodation. The study shall be updated
3567 every other year. In conducting the study, the department may consult or contract with appropriate
3568 public and private medical and health agencies or other technical experts. The costs and expenses
3569 incurred in conducting, maintaining, and administering the relative value study shall be funded by
3570 the tax created under Section 59-9-105. Upon completion of the study, the department shall
3571 prepare and publish a relative value study which sets forth the unit value and the 75th percentile
3572 charge assigned to each type of service and accommodation.
3573 (b) The reasonable value of any service or accommodation is determined by applying the
3574 unit value and the 75th percentile charge assigned to the service or accommodation under the
3575 relative value study. If a service or accommodation is not assigned a unit value or the 75th
3576 percentile charge under the relative value study, the value of the service or accommodation shall
3577 equal the reasonable cost of the same or similar service or accommodation in the most populous
3578 county of this state.
3579 (c) This ĥ [~~subsection~~] **SUBSECTION (2)** ĥ does not preclude the department from adopting a
3579a schedule already
3580 established or a schedule prepared by persons outside the department, if it meets the requirements
3581 of this ĥ [~~subsection~~] **SUBSECTION (2)** ĥ .
3582 (d) Every insurer shall report to the Commissioner of Insurance any patterns of
3583 overcharging, excessive treatment, or other improper actions by a health provider within 30 days
3584 after such insurer has knowledge of such pattern.
3585 (e) (i) In disputed cases, a court on its own motion or on the motion of either party may
3586 designate an impartial medical panel of not more than three licensed physicians to examine the
3587 claimant and testify on the issue of the reasonable value of the claimant's medical services or
3588 expenses.
3589 (ii) An impartial medical panel designated under Subsection (2)(e)(i) shall consist of a
3590 majority of health care professionals within the same license classification and specialty as the

3591 provider of the claimant's medical services or expenses.
3592 (3) Medical expenses as provided for in Subsection (1)(a) and in Subsection 31A-22-309
3593 (1)(e) include expenses for any nonmedical remedial care and treatment rendered in accordance
3594 with a recognized religious method of healing.
3595 (4) The insured may waive for the named insured and the named insured's spouse only the
3596 loss of gross income benefits of Subsection (1)(b)(i) if the insured states in writing that:
3597 (a) within 31 days of applying for coverage, neither the insured nor the insured's spouse
3598 received any earned income from regular employment; and
3599 (b) for at least 180 days from the date of the writing and during the period of insurance,
3600 neither the insured nor the insured's spouse will receive earned income from regular employment.
3601 (5) This section does not prohibit the issuance of policies of insurance providing coverages
3602 greater than the minimum coverage required under this chapter nor does it require the segregation
3603 of those minimum coverages from other coverages in the same policy.
3604 (6) Deductibles are not permitted with respect to the insurance coverages required under
3605 this section.
3606 Section 68. Section **31A-22-403** is amended to read:
3607 **31A-22-403. Incontestability.**
3608 (1) This section does not apply to group policies.
3609 (2) Each life insurance policy is, and shall state that, after it has been in force during the
3610 lifetime of the insured for a period of two years from its date of issue, it is incontestable except for
3611 the following:
3612 (a) The policy may be contested for nonpayment of premiums.
3613 (b) The policy may be contested as to:
3614 (i) provisions relating to [~~disability~~] accident and health benefits allowed under Section
3615 31A-22-609[~~,~~]; and [~~as to~~]
3616 (ii) additional benefits in the event of death by accident [~~or accidental means~~].
3617 (c) If the policy allows the insured, after the policy's issuance and for an additional
3618 premium, to obtain a death benefit which is larger than when the policy was originally issued, then
3619 the payment of the additional increment of benefit is contestable until two years after the
3620 incremental increase of benefits, but the only ground of contest that may arise is in connection with
3621 the incremental increase.

3622 (3) A reinstated life insurance policy or annuity contract may be contested for two years
3623 following reinstatement on the same basis as at original issuance, but only as to matters arising in
3624 connection with the reinstatement. Any grounds for contest available at original issuance continue
3625 to be available for contest until the policy has been in force for a total of two years during the
3626 lifetime of the insured.
3627 (4) The limitations on incontestability under this section preclude only a contest of the
3628 validity of the policy, and do not preclude the good faith assertion at any time of defenses based
3629 upon provisions in the policy which exclude or qualify coverage, whether or not those
3630 qualifications or exclusions are specifically excepted in the policy's incontestability clause.
3631 Provisions on which the contestable period would normally run may not be reformulated as
3632 coverage exclusions or restrictions to take advantage of this Subsection (4).
3633 Section 69. Section **31A-22-404** is amended to read:
3634 **31A-22-404. Suicide.**
3635 (1) (a) Suicide is not a defense to a claim under a life insurance policy that has been in
3636 force as to a policyholder or certificate holder for two years from the date [~~the coverage is~~
3637 ~~effective~~] of issuance of the policy, whether:
3638 (i) the suicide was voluntary or involuntary; or
3639 (ii) the insured was sane or insane.
3640 (b) If a suicide occurs within the two-year period described in Subsection (1)(a), the
3641 insurer shall pay to the beneficiary an amount not less than the premium paid for the life insurance
3642 policy.
3643 (2) (a) If after a life insurance policy is in effect the policy allows the insured to obtain a
3644 death benefit that is larger than when the policy was originally effective for an additional premium,
3645 the payment of the additional increment of benefit may be limited in the event of a suicide within
3646 a two-year period beginning on the date the increment increase takes effect.
3647 (b) If a suicide occurs within the two-year period described in Subsection (2)(a), the
3648 insurer shall pay to the beneficiary an amount not less than the additional premium paid for the
3649 additional increment of benefit.
3650 (3) This section does not apply to:
3651 (a) policies insuring against death by accident only; or
3652 (b) the accident or double indemnity provisions of an insurance policy.

3653 Section 70. Section **31A-22-415** is amended to read:
3654 **31A-22-415. Simultaneous death.**
3655 Section 75-2-702 applies to all policies of life and [~~disability~~] accident and health
3656 insurance.
3657 Section 71. Section **31A-22-423** is amended to read:
3658 **31A-22-423. Policy and annuity examination period.**
3659 (1) (a) Except as provided under Subsection (2), all life insurance policies and annuities
3660 shall contain a notice prominently printed on or attached to the cover or front page stating that the
3661 policyholder has the right to return the policy for any reason on or before:
3662 (i) ten days after delivery; or
3663 (ii) in case of a replacement policy, 20 days after the replacement policy is delivered.
3664 (b) For purposes of this section, "return" means a written statement on the policy or an
3665 accompanying writing that the policy is being returned for termination of coverage that is delivered
3666 to or mailed first class to the insurer or its agent.
3667 (c) A policy returned under this section is void from the date of [~~return~~] issuance.
3668 (d) A policyholder returning a policy is entitled to a refund of any premium paid[~~, except~~
3669 ~~that the insurer may retain an amount not exceeding that determined by rule adopted by the~~
3670 ~~commissioner~~].
3671 (2) This section does not apply to:
3672 (a) group policies; and
3673 (b) other classes of life insurance policies that the commissioner specifies by rule after
3674 finding that a right to return those policies would be impracticable or unnecessary to protect the
3675 policyholder's interests.
3676 Section 72. Section **31A-22-424** is enacted to read:
3677 **31A-22-424. Documents constituting entire life insurance policy.**
3678 (1) A life insurance policy shall contain a provision that defines the documents and
3679 agreements that constitute the entire contract between the parties.
3680 (2) Except as permitted by Section 31A-21-106, all documents and agreements defined
3681 under Subsection (1) shall be attached to the policy.
3682 Section 73. Section **31A-22-510** is amended to read:
3683 **31A-22-510. Requirements for group life insurance delivered in another jurisdiction.**

3684 (1) [No] A Utah resident may not be enrolled in a policy of group life insurance delivered
3685 in another jurisdiction in violation of Subsection (2) or (3), notwithstanding any contrary provision
3686 in Subsection 31A-1-103(3) [(h)].
3687 (2) Unless specifically authorized by the commissioner under Section 31A-22-509,
3688 coverage under a group life insurance policy delivered in another jurisdiction may not be initially
3689 provided to any person unless the policy conforms substantially to one of the types of groups
3690 specified under Sections 31A-22-502 through 31A-22-508.
3691 (3) [No coverage] Coverage may not be initially provided to any person in Utah under a
3692 group life policy issued in another jurisdiction by an insurer not authorized to engage in life
3693 insurance business in Utah unless the policyholder conforms substantially to the type of group
3694 specified under Section 31A-22-502, 31A-22-503, or 31A-22-504.
3695 Section 74. Section **31A-22-517** is amended to read:
3696 **31A-22-517. Conversion on termination of eligibility.**
3697 (1) If any portion of the insurance on a person covered under the policy ceases because of
3698 termination of employment or of membership in the classes eligible for coverage, the person is
3699 entitled to be issued by the insurer, without evidence of insurability, an individual policy of life
3700 insurance without [disability] accident and health or other supplementary benefits, if an application
3701 for the individual policy is made and the first premium paid to the insurer within 31 days after the
3702 termination.
3703 (2) The individual policy shall, at the option of the person entitled, be on any form then
3704 customarily issued by the insurer at the age and for the amount applied for, except that the group
3705 policy may exclude the option to elect term insurance.
3706 (3) The individual policy shall be for an amount not in excess of the life insurance which
3707 ceases because of the termination, less the amount of any life insurance for which the person is
3708 eligible because of the termination and within 30 days after it. Any amount of insurance which
3709 matures on or before the termination, as an endowment payable to the person insured, whether in
3710 one sum, in installments, or in the form of an annuity, is not included in the amount which is
3711 considered to cease because of the termination.
3712 (4) The premium on the individual policy shall be at the insurer's customary rate at the
3713 time of termination, which is applicable to the form and amount of the individual policy, to the
3714 class of risk to which the person belonged when terminated from the group policy, and to the age

3715 attained on the effective date of the individual policy.
3716 (5) Subject to the conditions of this section, the conversion privilege is available:
3717 (a) to a surviving dependent, if any, at the death of the employee or member, with respect
3718 to the survivor's coverage under the group policy which terminates by reason of the death; and
3719 (b) to the dependent of the employee or member upon termination of coverage of the
3720 dependent, while the employee or member remains insured, because the dependent ceases to be
3721 a qualified dependent under the group policy.
3722 Section 75. Section **31A-22-518** is amended to read:
3723 **31A-22-518. Conversion on termination of policy.**
3724 [If] (1) Subject to Subsection (2), if the group policy terminates or is amended to terminate
3725 the insurance of any class of covered persons, every insured person whose insurance terminates,
3726 including the insured dependent of a covered person who has been insured for at least five years
3727 prior to the termination date, is entitled to have the insurer issue to [him] the person an individual
3728 policy of life insurance, subject to the conditions and limitations in Section 31A-22-517[, except
3729 that the].
3730 (2) The group policy [may] described in Subsection (1) shall provide [either] that[: (1)
3731 The] the amount of the individual policy may not [exceed] be less than the smaller of:
3732 (a) the amount of the person's life insurance protection ceasing because of the termination
3733 or amendment of the group policy, less the amount of any life insurance for which [he] the person
3734 is eligible under any group policy issued or reinstated by the same or another insurer within 30
3735 days after the termination[. (2) The amount of the individual policy may not exceed]; or
3736 (b) $10,000.
3737 Section 76. Section **31A-22-520** is amended to read:
3738 **31A-22-520. Continuation of coverage during total disability.**
3739 (1) An insured person in a group life insurance policy may continue coverage during the
3740 total disability of the insured person or dependent by timely payment to the policyholder of that
3741 portion, if any, of the premium that would have been required on behalf of the insured person in
3742 the absence of total disability.
3743 (2) The continuation shall be on a premium paying basis until the earlier of:
3744 (a) six months from the date of total disability;
3745 (b) approval by the insurer of continuation of the coverage under any disability provision

3746 the group insurance policy may contain; or
3747 (c) the discontinuance of the group insurance policy.
3748 (3) If the group policy has a waiting period for [~~a disability~~] an accident and health benefit,
3749 the continuation extends to the end of the waiting period, even if the group policy is otherwise
3750 discontinued.
3751 Section 77. Section **31A-22-522** is enacted to read:
3752 **31A-22-522. Required provision for notice of termination.**
3753 (1) A policy for group or blanket life insurance coverage issued or renewed after July 1,
3754 2001, shall include a provision that obligates the policyholder to notify each employee or group
3755 member:
3756 (a) in writing;
3757 (b) 30 days before the date the coverage is terminated; and
3758 (c) (i) that the group or blanket life insurance coverage is being terminated; and
3759 (ii) the rights the employee or group member has to continue coverage upon termination.
3760 (2) For a policy for group or blanket life insurance coverage described in Subsection (1),
3761 an insurer shall:
3762 (a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's
3763 monthly notice to the policyholder of premium payments due; and
3764 (b) provide a sample notice to the policyholder at least once a year.
3765 Section 78. Section **31A-22-600** is amended to read:
3766 **31A-22-600. Scope of Part VI.**
3767 (1) [~~This~~] Except where a provision's application is otherwise specifically limited, this part
3768 applies to all [~~disability~~]:
3769 (a) accident and health insurance contracts, including credit [~~disability,~~] accident and
3770 health;
3771 (b) franchise[~~, and~~];
3772 (c) group contracts[~~, except where a provision's application is otherwise specifically~~
3773 ~~limited.~~]; and
3774 (d) a life insurance and annuity policy, but only if:
3775 (i) it includes supplemental benefits and riders including accelerated benefits; and
3776 (ii) receipt of benefits in contingent on morbidity requirements.

3777 (2) Nothing in this part applies to or affects:
3778 (a) workers' compensation insurance;
3779 (b) reinsurance; or
3780 [~~(c) annuities or life insurance, or their supplemental contracts which contain only those~~
3781 ~~provisions relating to disability insurance which provide additional benefits in case of~~
3782 ~~dismemberment or loss of sight by accident, safeguard the contract against lapse, or give a special~~
3783 ~~surrender value or special benefit or an annuity if the insured or annuitant becomes totally and~~
3784 ~~permanently disabled, as defined by the contract or supplemental contract; (d) disability~~]
3785 (c) accident and health insurance when it is part of or supplemental to liability, steam
3786 boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided
3787 the loss, damage, or expense arises out of a hazard directly related to the other insurance.
3788 (3) Except as provided in Subsection (1), this part does not apply to or affect a life
3789 insurance or annuity policy including a life insurance policy:
3790 (a) with a rider or supplemental benefit that accelerates the death benefit contingent upon
3791 a mortality risk specifically for one or more of the qualifying events of:
3792 (i) terminal illness;
3793 (ii) medical conditions requiring extraordinary medical intervention; or
3794 (iii) permanent institutional confinement; and
3795 (b) that provides the option of a lump-sum payment for those benefits.
3796 Section 79. Section **31A-22-601** is amended to read:
3797 **31A-22-601. Applicability of life insurance provisions.**
3798 Sections 31A-22-412 through 31A-22-417 apply to death benefits in [~~disability~~] accident
3799 and health insurance policies.
3800 Section 80. Section **31A-22-602** is amended to read:
3801 **31A-22-602. Premium rates.**
3802 (1) This section does not apply to group [~~disability~~] accident and health insurance.
3803 (2) The benefits in [~~a disability~~] an accident and health insurance policy shall be
3804 reasonable in relation to the premiums charged.
3805 (3) The commissioner shall disapprove [~~a disability~~] an accident and health insurance
3806 policy form if it does not satisfy Subsection (2).
3807 Section 81. Section **31A-22-603** is amended to read:

3808 **31A-22-603. Persons insured under an individual accident and health policy.**
3809 A policy of individual [~~disability~~] accident and health insurance may insure only one
3810 person, except that originally or by subsequent amendment, upon the application of an adult
3811 policyholder, a policy may insure any two or more eligible members of the policyholder's family,
3812 including husband, wife, dependent children, and any other person dependent upon the
3813 policyholder.
3814 Section 82. Section **31A-22-604** is amended to read:
3815 **31A-22-604. Reimbursement by insurers of Medicaid benefits.**
3816 (1) As used in this section, "Medicaid" means the program under Title XIX of the federal
3817 Social Security Act.
3818 (2) Any [~~disability~~] accident and health insurer, including a group [~~disability~~] accident and
3819 health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security
3820 Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited
3821 from considering the availability or eligibility for medical assistance in this or any other state under
3822 Medicaid, when considering eligibility for coverage or making payments under its plan for eligible
3823 enrollees, subscribers, policyholders, or certificate holders.
3824 (3) To the extent that payment for covered expenses has been made under the state
3825 Medicaid program for health care items or services furnished to an individual in any case when a
3826 third party has a legal liability to make payments, the state is considered to have acquired the rights
3827 of the individual to payment by any other party for those health care items or services.
3828 (4) Title 26, Chapter 19, Medical Benefits Recovery Act, applies to reimbursement of
3829 insurers of Medicaid benefits.
3830 Section 83. Section **31A-22-605** is amended to read:
3831 **31A-22-605. Accident and health insurance standards.**
3832 (1) The purposes of this section include:
3833 (a) reasonable standardization and simplification of terms and coverages of individual and
3834 franchise [~~disability~~] accident and health insurance policies, including [~~disability~~] accident and
3835 health insurance contracts of insurers licensed under Chapters 7 and 8, to facilitate public
3836 understanding and comparison in purchasing;
3837 (b) elimination of provisions contained in individual and franchise [~~disability~~] accident
3838 and health insurance contracts [~~which~~] that may be misleading or confusing in connection with

3839 either the purchase of those types of coverages or the settlement of claims; and

3840 (c) full disclosure in the sale of individual and franchise [~~disability~~] accident and health

3841 insurance contracts.

3842 (2) As used in this section:

3843 (a) "Direct response insurance policy" means an individual insurance policy solicited and

3844 sold without the policyholder having direct contact with a natural person intermediary.

3845 (b) "Medicare" is defined in Subsection 31A-22-620(1)(e).

3846 (c) "Medicare supplement policy" is defined in Subsection 31A-22-620(1)(f).

3847 (3) This section applies to all individual and franchise [~~disability~~] accident and health

3848 policies.

3849 (4) The commissioner shall adopt rules relating to the following matters:

3850 (a) standards for the manner and content of policy provisions, and disclosures to be made

3851 in connection with the sale of policies covered by this section, dealing with at least the following

3852 matters:

3853 (i) terms of renewability;

3854 (ii) initial and subsequent conditions of eligibility;

3855 (iii) nonduplication of coverage provisions;

3856 (iv) coverage of dependents;

3857 (v) preexisting conditions;

3858 (vi) termination of insurance;

3859 (vii) probationary periods;

3860 (viii) limitations;

3861 (ix) exceptions;

3862 (x) reductions;

3863 (xi) elimination periods;

3864 (xii) requirements for replacement;

3865 (xiii) recurrent conditions;

3866 (xiv) coverage of persons eligible for Medicare; and

3867 (xv) definition of terms;

3868 (b) minimum standards for benefits under each of the following categories of coverage in

3869 policies covered in this section:

3870 (i) basic hospital expense coverage;
3871 (ii) basic medical-surgical expense coverage;
3872 (iii) hospital confinement indemnity coverage;
3873 (iv) major medical expense coverage;
3874 (v) [~~disability~~] income [~~protection~~] replacement coverage;
3875 (vi) accident only coverage;
3876 (vii) specified disease or specified accident coverage;
3877 (viii) limited benefit health coverage; and
3878 (ix) nursing home and long-term care coverage;
3879 (c) the content and format of the outline of coverage, in addition to that required under
3880 Subsection (6); [~~and~~]
3881 (d) the method of identification of policies and contracts based upon coverages
3882 provided[~~.~~]; and
3883 (e) rating practices.
3884 (5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories
3885 of coverage in that subsection provided that any combination of categories meets the standards of
3886 a component category of coverage.
3887 (6) The commissioner may adopt rules relating to the following matters:
3888 (a) establishing disclosure requirements for insurance policies covered in this section,
3889 designed to adequately inform the prospective insured of the need for and extent of the coverage
3890 offered, and requiring that this disclosure be furnished to the prospective insured with the
3891 application form, unless it is a direct response insurance policy;
3892 (b) (i) prescribing caption or notice requirements designed to inform prospective insureds
3893 that particular insurance coverages are not Medicare Supplement coverages;
3894 (ii) the requirements of Subsection (6)(b)(i) apply to all [~~disability~~] insurance policies and
3895 certificates sold to persons eligible for Medicare; and
3896 (c) requiring the disclosures or information brochures to be furnished to the prospective
3897 insured on direct response insurance policies, upon his request or, in any event, no later than the
3898 time of the policy delivery.
3899 (7) A policy covered by this section may be issued only if it meets the minimum standards
3900 established by the commissioner under Subsection (4), an outline of coverage accompanies the

3901 policy or is delivered to the applicant at the time of the application, and, except with respect to
3902 direct response insurance policies, an acknowledged receipt is provided to the insurer. The outline
3903 of coverage shall include:
3904 (a) a statement identifying the applicable categories of coverage provided by the policy as
3905 prescribed under Subsection (4);
3906 (b) a description of the principal benefits and coverage;
3907 (c) a statement of the exceptions, reductions, and limitations contained in the policy;
3908 (d) a statement of the renewal provisions, including any reservation by the insurer of a
3909 right to change premiums;
3910 (e) a statement that the outline is a summary of the policy issued or applied for and that
3911 the policy should be consulted to determine governing contractual provisions; and
3912 (f) any other contents the commissioner prescribes.
3913 (8) If a policy is issued on a basis other than that applied for, the outline of coverage shall
3914 accompany the policy when it is delivered and it shall clearly state that it is not the policy for
3915 which application was made.
3916 (9) (a) Notwithstanding Subsection 31A-22-609(2), and except as provided under
3917 Subsection (9)(b), an insurer that elects to use an application form without questions concerning
3918 the insured's health history or medical treatment history, shall provide coverage under the policy
3919 for any loss which occurs more than 12 months after the effective date of the policy due to a
3920 preexisting condition which is not specifically excluded from coverage.
3921 (b) (i) An insurer that issues a specified disease policy, regardless of whether the basis of
3922 issuance is a detailed application form, a simplified application form, or an enrollment form, may
3923 not deny a claim for loss due to a preexisting condition which occurs more than six months after
3924 the effective date of coverage.
3925 (ii) A specified disease policy may not define a preexisting condition more restrictively
3926 than a condition which first manifested itself within six months prior to the effective date of
3927 coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.
3928 (iii) A specified disease policy may not include wording that provides a defense based
3929 upon a preexisting condition except as allowed under this Subsection (9).
3930 (10) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or
3931 certificates issued to persons eligible for Medicare shall contain a notice prominently printed on

3932 or attached to the cover or front page which states that the policyholder or certificate holder has
3933 the right to return the policy for any reason within 30 days after its delivery and to have the
3934 premium refunded.
3935 Section 84. Section **31A-22-606** is amended to read:
3936 **31A-22-606. Policy examination period.**
3937 (1) (a) Except as provided in Subsection (2), all [~~disability~~] accident and health policies
3938 shall contain a notice prominently printed on or attached to the cover or front page stating that the
3939 policyholder has the right to return the policy for any reason within ten days after its delivery.
3940 (b) "Return" means delivery to the insurer or its agent or mailing of the policy to either,
3941 properly addressed and stamped for first class handling, with a written statement on the policy or
3942 an accompanying communication that it is being returned for termination of coverage. A policy
3943 returned under Subsection (1) is void from the beginning and a policyholder returning his policy
3944 is entitled to a refund of any premium paid.
3945 (2) This section does not apply to:
3946 (a) group policies;
3947 (b) policies issued to persons entitled to a 30-day examination period under Subsection
3948 31A-22-605(10);
3949 (c) single premium nonrenewable policies issued for terms not longer than 60 days;
3950 (d) policies covering accidents only or accidental bodily injury only; and
3951 (e) other classes of policies which the commissioner by rule specifies after a finding that
3952 a right to return those policies would be impracticable or unnecessary to protect the policyholder's
3953 interests.
3954 Section 85. Section **31A-22-607** is amended to read:
3955 **31A-22-607. Grace period.**
3956 (1) Every individual or franchise [~~disability~~] accident and health insurance policy shall
3957 contain clauses providing for a grace period of at least seven days for weekly premium policies,
3958 ten days for monthly premium policies and 30 days for all other policies, for each premium after
3959 the first. During the grace period, the policy continues in force.
3960 (2) Every group or blanket [~~disability~~] accident and health policy shall provide for a grace
3961 period of at least 30 days, unless the policyholder gives written notice of discontinuance prior to
3962 the date of discontinuance, in accordance with the policy terms. In group or blanket policies, the

3963 policy may provide for payment of a pro rata premium for the period the policy is in effect during
3964 the grace period under this [~~subsection~~] Subsection (2).
3965 (3) If the insurer has not guaranteed the insured a right to renew [~~a disability~~] an accident
3966 and health policy, any grace period beyond the expiration or anniversary date may, if provided in
3967 the policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).
3968 Section 86. Section **31A-22-608** is amended to read:
3969 **31A-22-608. Reinstatement of individual or franchise accident and health insurance**
3970 **policies.**
3971 (1) Every individual or franchise [~~disability~~] accident and health insurance policy shall
3972 contain a provision which reads as follows:
3973 "REINSTATEMENT: If any renewal premium is not paid within the time granted the
3974 insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly
3975 authorized by the insurer to accept the premium, without also requiring an application for
3976 reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application
3977 for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be
3978 reinstated upon approval of this application from the insurer or, lacking this approval, upon the
3979 45th day following the date of the conditional receipt, unless the insurer has previously notified
3980 the insured in writing of its disapproval of the application. The reinstated policy shall cover only
3981 loss resulting from such accidental injury as may be sustained after the date of reinstatement and
3982 loss due to such sickness as may begin more than ten days after that date. In all other respects the
3983 insured and insurer have the same rights under the reinstated policy as they had under the policy
3984 immediately before the due date of the defaulted premium, subject to any provisions endorsed on
3985 or attached to this policy in connection with the reinstatement. Any premium accepted in
3986 connection with a reinstatement shall be applied to a period for which premium has not been
3987 previously paid, but not to any period more than 60 days prior to the date of reinstatement."
3988 (2) The last sentence of the provision set forth in Subsection (1) may be omitted from any
3989 policy [~~which~~] that the insured has the right to continue in force subject to its terms by the timely
3990 payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least
3991 five years from its date of issue.
3992 Section 87. Section **31A-22-609** is amended to read:
3993 **31A-22-609. Incontestability for accident and health insurance.**

3994 (1) [~~No~~] (a) A statement made by an applicant in the application for individual or
3995 franchise [~~disability~~] accident and health insurance coverage [~~and no~~] or statement made relating
3996 to the person's insurability by a person insured under a group policy, except fraudulent
3997 misrepresentation, [~~is~~] may not be a basis for avoidance of the policy or denial of a claim for loss
3998 incurred or disability commencing after the coverage has been in effect for two years.
3999 (b) The insurer has the burden of proving fraud by clear and convincing evidence.
4000 (c) The policy may provide for incontestability even for fraudulent misstatements.
4001 (2) Except as otherwise provided under Subsection 31A-22-605(9), [~~no~~] a claim for loss
4002 incurred or disability commencing after two years from the date of issue of the policy may not be
4003 reduced or denied on the ground that a disease or physical condition existed prior to the effective
4004 date of coverage, unless the condition was excluded from coverage by name or specific description
4005 in a provision [~~which~~] that was in effect on the date of loss.
4006 Section 88. Section **31A-22-610** is amended to read:
4007 **31A-22-610. Dependent coverage from moment of birth or adoption.**
4008 (1) As used in this section:
4009 (a) "Child" means, in connection with any adoption, or placement for adoption of the child,
4010 an individual who is younger than 18 years of age as of the date of the adoption or placement for
4011 adoption.
4012 (b) "Placement for adoption" means the assumption and retention by a person of a legal
4013 obligation for total or partial support of a child in anticipation of the adoption of the child.
4014 (2) (a) If any [~~disability~~] accident and health insurance policy provides coverage for any
4015 members of the policyholder's or certificate holder's family, the policy shall also provide that any
4016 health insurance benefits applicable to dependents of the insured are applicable on the same basis
4017 to a newly born child from the moment of birth, and to an adopted child:
4018 (i) beginning from the moment of birth if placement for adoption occurs within 30 days
4019 of the child's birth; or
4020 (ii) beginning from the date of placement if placement for adoption occurs 30 days or more
4021 after the child's birth.
4022 (b) This coverage is not subject to any preexisting conditions, and includes any injury or
4023 sickness, including the necessary care and treatment of medically diagnosed congenital defects and
4024 birth abnormalities or prematurity.

4025 (c) If the payment of a specific premium is required to provide coverage for a child of the
4026 policyholder or certificate holder, the policy may require that the insurer be notified of the birth
4027 or placement for the purpose of adoption, and that the required premium be paid within 30 days
4028 after the date of birth or placement for the purpose of adoption, in order to have the coverage
4029 extend beyond that 30-day period.
4030 (3) The coverage required by Subsection (2) as to children placed for the purpose of
4031 adoption with a policyholder or certificate holder continues in the same manner as it would with
4032 respect to a child of the policyholder or certificate holder unless the placement is disrupted prior
4033 to legal adoption and the child is removed from placement. The coverage requirement ends if the
4034 child is removed from placement prior to being legally adopted.
4035 (4) The provisions of this section apply to employee welfare benefit plans as defined in
4036 Section 26-19-2.
4037 Section 89. Section **31A-22-610.2** is amended to read:
4038 **31A-22-610.2. Maternity stay minimum limits.**
4039 (1) (a) If an insured has coverage for maternity benefits, the policy may not be limited to
4040 a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.
4041 (b) If an insured has coverage for maternity benefits, the policy may not be limited to a less
4042 than 96-hour benefit for both mother and newborn with a caesarean section delivery.
4043 (2) Subsection (1) applies to [~~a disability~~] an accident and health insurer who offers
4044 maternity coverage.
4045 Section 90. Section **31A-22-610.5** is amended to read:
4046 **31A-22-610.5. Dependent coverage.**
4047 (1) As used in this section, "child" has the same meaning as defined in Section 78-45-2.
4048 (2) (a) Any individual or group health insurance policy or health maintenance organization
4049 contract that provides coverage for a policyholder's or certificate holder's dependent shall not
4050 terminate coverage of an unmarried dependent by reason of the dependent's age before the
4051 dependent's 26th birthday and shall, upon application, provide coverage for all unmarried
4052 dependents up to age 26.
4053 (b) The cost of coverage for unmarried dependents 19 to 26 years of age shall be included
4054 in the premium on the same basis as other dependent coverage.
4055 (c) This section does not prohibit the employer from requiring the employee to pay all or

4056 part of the cost of coverage for unmarried dependents.

4057 (3) An individual or group health insurance policy or health maintenance organization
4058 contract shall reinstate dependent coverage, and for purposes of all exclusions and limitations,
4059 shall treat the dependent as if the coverage had been in force since it was terminated; if:

4060 (a) the dependent has not reached the age of 26 by July 1, 1995;

4061 (b) the dependent had coverage prior to July 1, 1994;

4062 (c) prior to July 1, 1994, the dependent's coverage was terminated solely due to the age of
4063 the dependent; and

4064 (d) the policy has not been terminated since the dependent's coverage was terminated.

4065 (4) (a) When a parent is required by a court or administrative order to provide health
4066 insurance coverage for a child, [~~a disability~~] an accident and health insurer may not deny
4067 enrollment of a child under the [~~disability~~] accident and health insurance plan of the child's parent
4068 on the grounds the child:

4069 (i) was born out of wedlock and is entitled to coverage under Subsection (6);

4070 (ii) was born out of wedlock and the custodial parent seeks enrollment for the child under
4071 the custodial parent's policy;

4072 (iii) is not claimed as a dependent on the parent's federal tax return; or

4073 (iv) does not reside with the parent or in the insurer's service area.

4074 (b) [~~A disability~~] An accident and health insurer providing enrollment under Subsection
4075 (4)(a)(iv) is subject to the requirements of Subsection (5).

4076 (5) A health maintenance organization or a preferred provider organization may use
4077 alternative delivery systems or indemnity insurers to provide coverage under Subsection (4)(a)(iv)
4078 outside its service area. [~~The provisions of~~] Section 31A-8-408 [~~do~~] does not apply to this
4079 Subsection (5).

4080 (6) When a child has [~~disability~~] accident and health coverage through an insurer of a
4081 noncustodial parent the insurer shall:

4082 (a) provide information to the custodial parent as necessary for the child to obtain benefits
4083 through that coverage, but the insurer or employer, or the agents or employees of either of them,
4084 are not civilly or criminally liable for providing information in compliance with this Subsection
4085 (6)(a), whether the information is provided pursuant to a verbal or written request;

4086 (b) permit the custodial parent or the service provider, with the custodial parent's approval,

4087 to submit claims for covered services without the approval of the noncustodial parent; and
4088 (c) make payments on claims submitted in accordance with Subsection (6)(b) directly to
4089 the custodial parent, the provider, or the state Medicaid agency.
4090 (7) When a parent is required by a court or administrative order to provide health coverage
4091 for a child, and the parent is eligible for family health coverage, the insurer shall:
4092 (a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible
4093 for the coverage without regard to an enrollment season restrictions;
4094 (b) if the parent is enrolled but fails to make application to obtain coverage for the child,
4095 enroll the child under family coverage upon application of the child's other parent, the state agency
4096 administering the Medicaid program, or the state agency administering 42 U.S.C. 651 through 669,
4097 the child support enforcement program; and
4098 (c) not disenroll or eliminate coverage of the child unless the insurer is provided
4099 satisfactory written evidence that:
4100 (i) the court or administrative order is no longer in effect; or
4101 (ii) the child is or will be enrolled in comparable [~~disability~~] accident and health coverage
4102 through another insurer which will take effect not later than the effective date of disenrollment.
4103 (8) An insurer may not impose requirements on a state agency [~~which~~] that has been
4104 assigned the rights of an individual eligible for medical assistance under Medicaid and covered for
4105 [~~disability~~] accident and health benefits from the insurer that are different from requirements
4106 applicable to an agent or assignee of any other individual so covered.
4107 (9) Insurers may not reduce their coverage of pediatric vaccines below the benefit level
4108 in effect on May 1, 1993.
4109 (10) When a parent is required by a court or administrative order to provide health
4110 coverage, which is available through an employer doing business in this state, the employer shall:
4111 (a) permit the parent to enroll under family coverage any child who is otherwise eligible
4112 for coverage without regard to any enrollment season restrictions;
4113 (b) if the parent is enrolled but fails to make application to obtain coverage of the child,
4114 enroll the child under family coverage upon application by the child's other parent, by the state
4115 agency administering the Medicaid program, or the state agency administering 42 U.S.C. 651
4116 through 669, the child support enforcement program;
4117 (c) not disenroll or eliminate coverage of the child unless the employer is provided

4118 satisfactory written evidence that:
4119 (i) the court order is no longer in effect;
4120 (ii) the child is or will be enrolled in comparable coverage which will take effect no later
4121 than the effective date of disenrollment; or
4122 (iii) the employer has eliminated family health coverage for all of its employees; and
4123 (d) withhold from the employee's compensation the employee's share, if any, of premiums
4124 for health coverage and to pay this amount to the insurer.
4125 (11) An order issued under Section 62A-11-326.1 may be considered a "qualified medical
4126 support order" for the purpose of enrolling a dependent child in a group [~~disability~~] accident and
4127 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security
4128 Act of 1974.
4129 (12) This section does not affect any insurer's ability to require as a precondition of any
4130 child being covered under any policy of insurance that:
4131 (a) the parent continues to be eligible for coverage;
4132 (b) the child shall be identified to the insurer; and
4133 (c) the premium shall be paid when due.
4134 (13) The provisions of this section apply to employee welfare benefit plans as defined in
4135 Section 26-19-2.
4136 Section 91. Section **31A-22-611** is amended to read:
4137 **31A-22-611. Policy extension for handicapped children.**
4138 (1) Every [~~disability~~] accident and health insurance policy or contract that provides that
4139 coverage of a dependent child of a person insured under the policy shall terminate upon reaching
4140 a limiting age as specified in the policy, shall also provide that the age limitation does not
4141 terminate the coverage of a dependent child while the child is and continues to be both:
4142 (a) incapable of self-sustaining employment because of mental retardation or physical
4143 handicap; and
4144 (b) chiefly dependent upon the person insured under the policy for support and
4145 maintenance.
4146 (2) The insurer may require proof of the incapacity and dependency be furnished by the
4147 person insured under the policy within 30 days of the date the child attains the limiting age, and
4148 at any time thereafter, except that the insurer may not require proof more often than annually after

4149 the two-year period immediately following attainment of the limiting age by the child.
4150 Section 92. Section **31A-22-612** is amended to read:
4151 **31A-22-612. Conversion privileges for insured former spouse.**
4152 (1) [~~No disability~~] An accident and health insurance policy, which in addition to covering
4153 the insured also provides coverage to the spouse of the insured, may not contain a provision for
4154 termination of coverage of a spouse covered under the policy, except by entry of a valid decree of
4155 divorce or annulment between the parties.
4156 (2) Every policy which contains this type of provision shall provide that upon the entry of
4157 the divorce decree the spouse is entitled to have issued an individual policy of [~~disability~~] accident
4158 and health insurance without evidence of insurability, upon application to the company and
4159 payment of the appropriate premium. The policy shall provide the coverage being issued which
4160 is most nearly similar to the terminated coverage. Probationary or waiting periods in the policy
4161 are considered satisfied to the extent the coverage was in force under the prior policy.
4162 (3) When the insurer receives actual notice that the coverage of a spouse is to be
4163 terminated because of a divorce or annulment, the insurer shall promptly provide the spouse
4164 written notification of the right to obtain individual coverage as provided in Subsection (2), the
4165 premium amounts required, and the manner, place, and time in which premiums may be paid. The
4166 premium is determined in accordance with the insurer's table of premium rates applicable to the
4167 age and class of risk of the persons to be covered and to the type and amount of coverage provided.
4168 If the spouse applies and tenders the first monthly premium to the insurer within 30 days after
4169 receiving the notice provided by this subsection, the spouse shall receive individual coverage that
4170 commences immediately upon termination of coverage under the insured's policy.
4171 (4) This section does not apply to [~~disability~~] accident and health insurance policies
4172 offered on a group blanket basis.
4173 Section 93. Section **31A-22-613** is amended to read:
4174 **31A-22-613. Permitted provisions for accident and health insurance policies.**
4175 The following provisions may be contained in [~~a disability~~] an accident and health
4176 insurance policy, but if they are in that policy, they shall conform to at least the [~~following~~]
4177 minimum requirements for the policyholder [~~:~~] in this section.
4178 (1) Any provision respecting change of occupation may provide only for a lower maximum
4179 benefit payment and for reduction of loss payments proportionate to the change in appropriate

4180 premium rates, if the change is to a higher rated occupation, and this provision shall provide for
4181 retroactive reduction of premium rates from the date of change of occupation or the last policy
4182 anniversary date, whichever is the more recent, if the change is to a lower rated occupation.
4183 (2) Section 31A-22-405 applies to misstatement of age in [~~disability~~] <u>accident and health</u>
4184 policies, with the appropriate modifications of terminology.
4185 (3) Any policy which contains a provision establishing, as an age limit or otherwise, a date
4186 after which the coverage provided by the policy is not effective, and if that date falls within a
4187 period for which a premium is accepted by the insurer or if the insurer accepts a premium after that
4188 date, the coverage provided by the policy continues in force, subject to any right of cancellation,
4189 until the end of the period for which the premium was accepted. This Subsection (3) does not
4190 apply if the acceptance of premium would not have occurred but for a misstatement of age by the
4191 insured.
4192 (4) Any provision dealing with preexisting conditions shall be consistent with Subsections
4193 31A-22-605(9)(a) and 31A-22-609(2), and any applicable rule adopted by the commissioner.
4194 (5) (a) If an insured is otherwise eligible for maternity benefits, a policy may not contain
4195 language which requires an insured to obtain any additional preauthorization or preapproval for
4196 customary and reasonable maternity care expenses or for the delivery of the child after an initial
4197 preauthorization or preapproval has been obtained from the insurer for prenatal care. A
4198 requirement for notice of admission for delivery is not a requirement for preauthorization or
4199 preapproval, however, the maternity benefit may not be denied or diminished for failure to provide
4200 admission notice. The policy may not require the provision of admission notice by only the
4201 insured patient.
4202 (b) This Subsection (5) does not prohibit an insurer from:
4203 (i) requiring a referral before maternity care can be obtained;
4204 (ii) specifying a group of providers or a particular location from which an insured is
4205 required to obtain maternity care; or
4206 (iii) limiting reimbursement for maternity expenses and benefits in accordance with the
4207 terms and conditions of the insurance contract so long as such terms do not conflict with
4208 Subsection (5)(a).
4209 (6) An insurer may only represent that a policy:
4210 (a) offers a vision benefit if the policy:

4211 (i) charges a premium for the benefit; and
4212 (ii) provides reimbursement for materials or services provided under the policy; and
4213 (b) covers laser vision correction, whether photorefractive keratectomy, laser assisted
4214 in-situ keratomelusis, or related procedure, if the policy:
4215 (i) charges a premium for the benefit; and
4216 (ii) the procedure is at least a partially covered benefit.
4217 Section 94. Section **31A-22-613.5** is amended to read:
4218 **31A-22-613.5. Price and value comparisons of health insurance.**
4219 (1) This section applies generally to all health insurance policies and health maintenance
4220 organization contracts.
4221 (2) (a) Immediately after the effective date of this section, the commissioner shall appoint
4222 a Health Benefit Plan Committee.
4223 (b) The committee shall be composed of representatives of carriers, employers, employees,
4224 health care providers, consumers, and producers.
4225 (c) A member of the committee shall be appointed to a four-year term.
4226 (d) Notwithstanding the requirements of Subsection (2)(c), the commissioner shall, at the
4227 time of appointment or reappointment, adjust the length of terms to ensure that the terms of
4228 committee members are staggered so that approximately half of the committee is appointed every
4229 two years.
4230 (3) When a vacancy occurs in the membership for any reason, the replacement shall be
4231 appointed for the unexpired term.
4232 (4) (a) Members shall receive no compensation or benefits for their services, but may
4233 receive per diem and expenses incurred in the performance of the member's official duties at the
4234 rates established by the Division of Finance under Sections 63A-3-106 and 63A-3-107.
4235 (b) Members may decline to receive per diem and expenses for their service.
4236 (5) [~~(a)~~] The committee shall[~~: (i)~~] serve as an advisory committee to the commissioner[~~;~~
4237 ~~and~~].
4238 [~~(ii) recommend for two or more designated health care plans to be marketed in the state:~~]
4239 [~~(A) services to be covered;~~]
4240 [~~(B) copays;~~]
4241 [~~(C) deductibles;~~]

4242 [(D) levels of coinsurance;]
4243 [(E) annual out-of-pocket maximums;]
4244 [(F) exclusions; and]
4245 [(G) limitations.]
4246 [(b) The plans recommended by the committee may include reasonable benefit differentials
4247 applicable to participating and nonparticipating providers.]
4248 [(c) The plans recommended by the committee may not prohibit the use of the following
4249 cost management techniques by an insurer:]
4250 [(i) preauthorization of health care services;]
4251 [(ii) concurrent review of health care services;]
4252 [(iii) case management of health care services;]
4253 [(iv) retrospective review of medical appropriateness;]
4254 [(v) selective contracting with hospitals, physicians, and other health care providers to the
4255 extent permitted by law; and]
4256 [(vi) other reasonable techniques intended to manage health care costs.]
4257 [(d) The committee shall submit the plans to the commissioner within 180 days after the
4258 appointment of the committee in accordance with this section.]
4259 [(e) The commissioner shall adopt two or more health benefit plans within 60 days after
4260 the committee submits recommendations.]
4261 [(f) (i) If the committee fails to submit recommendations to the commissioner within 180
4262 days after appointment, the commissioner shall, within 90 days, develop two or more designated
4263 health benefit plans.]
4264 [(ii) The commissioner shall, after notice and hearing, adopt two or more designated health
4265 benefit plans.]
4266 [(iii) The commissioner shall provide incentives for personal management of health care
4267 expenses by adopting:]
4268 [(A) one plan that applies deductibles in the amount of $1,500; and]
4269 [(B) another plan that applies deductibles in the amount of $2,500.]
4270 [(iv) The plans described in Subsection (5)(f)(iii) may include:]
4271 [(A) illustrations and explanations showing the premium savings generated by the high
4272 deductibles being applied to a medical savings account for the insured that can be used to pay:]

4273 [~~(I) medical expenses up to the plan deductible;~~]
4274 [~~(II) any other medical expenses not covered by the insurance; or~~]
4275 [~~(III) both the medical expenses described in Subsections (5)(f)(iv)(A)(I) and (II); and~~]
4276 [~~(B) an explanation that any funds in the savings account belong to the insured.~~]
4277 [~~(g) The commissioner may reconvene a Health Benefit Plan Committee in accordance~~
4278 ~~with Subsections (2) and (5) to recommend revisions to the designated benefit plans adopted by~~
4279 ~~the commissioner.~~]
4280 [~~(6) (a) Within 180 days after the adoption of the designated benefit plans by the~~
4281 ~~commissioner, or any changes in the designated plans, an insurer offering health insurance policies~~
4282 ~~for sale in this state shall, at the request of a potential buyer, offer the current designated plans at~~
4283 ~~a premium based on factors such as that buyer's previous claims experience, group size,~~
4284 ~~demographic characteristics, and health status.~~]
4285 [~~(b) This section does not prohibit an insurer from refusing to insure, under any plan, a~~
4286 ~~person or group. However, if the insurer offers any policy or contract to that person or group, the~~
4287 ~~insurer shall offer the designated plans.~~]
4288 [~~(7) The designated benefit plans, described in Subsection (5) are intended to facilitate~~
4289 ~~price and value comparisons by consumers. The designated benefit plans are not minimum~~
4290 ~~standards for health insurance policies. An insurer offering the designated benefit plans may offer~~
4291 ~~policies that provide more or less coverage than the designated benefit plans.~~]
4292 [~~(8)~~] (6) (a) The commissioner shall convene or reconvene a Health Benefit Plan
4293 Committee for the purpose of developing a Basic Health Care Plan to be offered under the open
4294 enrollment provisions of Chapter 30.
4295 (b) The commissioner shall adopt a Basic Health Care Plan within 60 days after the
4296 committee submits recommendations, or if the committee fails to submit recommendations to the
4297 commissioner within 180 days after appointment, the commissioner shall, within 90 days, adopt
4298 a Basic Health Care Plan.
4299 (c) (i) Before adoption of a plan under Subsection [~~(8)~~](6)(b), the commissioner shall
4300 submit the proposed Basic Health Care Plan to the Health and Human Services Interim Committee
4301 for review and recommendations.
4302 (ii) After the commissioner adopts the Basic Health Care Plan, the Health and Human
4303 Services Interim Committee:

4304 (A) shall provide legislative oversight of the Basic Health Care Plan; and
4305 (B) may recommend legislation to modify the Basic Health Care Plan adopted by the
4306 commissioner.
4307 (d) The committee's recommendations for the Basic Health Care Plan shall be advisory
4308 to the commissioner.
4309 [~~(9)~~] (7) (a) The commissioner shall promote informed consumer behavior and responsible
4310 health insurance and health plans by requiring an insurer issuing health insurance policies or health
4311 maintenance organization contracts to provide to all enrollees, prior to enrollment in the health
4312 benefit plan or health insurance policy, written disclosure of:
4313 (i) restrictions or limitations on prescription drugs and biologics including the use of a
4314 formulary and generic substitution; and
4315 (ii) coverage limits under the plan.
4316 (b) In addition to the requirements of Subsections [~~(9)~~] (7)(a) and (d), an insurer described
4317 in Subsection [~~(9)~~] (7)(a) shall submit the written disclosure required by this Subsection [~~(9)~~] (7)
4318 to the commissioner:
4319 (i) [~~annually~~] upon commencement of operations in the state; and
4320 (ii) anytime the insurer amends any of the following described in Subsection [~~(9)~~] (7)(a):
4321 (A) treatment policies;
4322 (B) practice standards;
4323 (C) restrictions; or
4324 (D) coverage limits of the insurer's health benefit plan or health insurance policy.
4325 (c) The commissioner may adopt rules to implement the disclosure requirements of this
4326 Subsection [~~(9)~~] (7), taking into account:
4327 (i) business confidentiality of the insurer;
4328 (ii) definitions of terms; and
4329 (iii) the method of disclosure to enrollees.
4330 (d) If under Subsection [~~(9)~~] (7)(a)(i) a formulary is used, the insurer shall make available
4331 to prospective enrollees and maintain evidence of the fact of the disclosure of:
4332 (i) the drugs included;
4333 (ii) the patented drugs not included; and
4334 (iii) any conditions that exist as a precedent to coverage.

4335 [(10) (a) The commissioner shall annually publish a table comparing the rates charged by
4336 insurers for the designated health plans and other health insurance plans in this state.]
4337 [(b) The comparison required by Subsection (10)(a) shall list:]
4338 [(i) the top 20 insurers writing the greatest volume by premium dollar per calendar year;
4339 and]
4340 [(ii) others requesting inclusion in the comparison.]
4341 [(c) In conjunction with the rate comparison described in this Subsection (10), the
4342 commissioner shall publish for each of the listed health insurers a table comparing the complaints
4343 filed and the combined loss and expense ratio as described in Subsections 31A-2-208.5(2) and (3).]
4344 Section 95. Section **31A-22-614** is amended to read:
4345 **31A-22-614. Claims under accident and health policies.**
4346 (1) Section 31A-21-312 applies generally to claims under [disability] accident and health
4347 policies.
4348 (2) (a) Subject to Subsection (1), [no disability] an accident and health insurance policy
4349 may not contain a claim notice requirement less favorable to the insured than one which requires
4350 written notice of the claim within 20 days after the occurrence or commencement of any loss
4351 covered by the policy. The policy shall specify to whom claim notices may be given.
4352 (b) If a loss of time benefit under a policy may be paid for a period of at least two years,
4353 an insurer may require periodic notices that the insured continues to be disabled, unless the insured
4354 is legally incapacitated. The insured's delay in giving that notice does not impair the insured's or
4355 beneficiary's right to any indemnity which would otherwise have accrued during the six months
4356 preceding the date on which that notice is actually given.
4357 (3) [No disability] An accident and health insurance policy may not contain a time limit
4358 on proof of loss which is more restrictive to the insured than a provision requiring written proof
4359 of loss, delivered to the insurer, within the following time:
4360 (a) for a claim where periodic payments are contingent upon continuing loss, within 90
4361 days after the termination of the period for which the insurer is liable;
4362 (b) for any other claim, within 90 days after the date of the loss.
4363 (4) (a) (i) Section 31A-26-301 applies generally to the payment of claims.
4364 (ii) Indemnity for loss of life is paid in accordance with the beneficiary designation
4365 effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid

4366 to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the
4367 insured's estate.
4368 (b) Reasonable facility of payment clauses, specified by the commissioner by rule or in
4369 approving the policy form, are permitted. Payment made in good faith and in accordance with
4370 those clauses discharges the insurer's obligation to pay those claims.
4371 (c) All or a portion of any indemnities provided under [~~a disability~~] an accident and health
4372 policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option,
4373 be paid directly to the hospital or person rendering the services.
4374 Section 96. Section **31A-22-617** is amended to read:
4375 **31A-22-617. Preferred provider contract provisions.**
4376 Health insurance policies may provide for insureds to receive services or reimbursement
4377 under the policies in accordance with preferred health care provider contracts as follows:
4378 (1) Subject to restrictions under this section, any insurer or third party administrator may
4379 enter into contracts with health care providers as defined in Section 78-14-3 under which the health
4380 care providers agree to supply services, at prices specified in the contracts, to persons insured by
4381 an insurer. [~~The~~]
4382 (a) A health care provider contract may require the health care provider to accept the
4383 specified payment as payment in full, relinquishing the right to collect additional amounts from
4384 the insured person.
4385 (b) The insurance contract may reward the insured for selection of preferred health care
4386 providers by:
4387 (i) reducing premium rates[~~,~~];
4388 (ii) reducing deductibles[~~,~~];
4389 (iii) coinsurance[~~, or~~];
4390 (iv) other copayments[~~,~~]; or
4391 (v) in any other reasonable manner.
4392 (c) If the insurer is a managed care organization, as defined in Subsection
4393 31A-27-311.5(1)(f):
4394 (i) the insurance contract Ş **AND THE HEALTH CARE PROVIDER CONTRACT** ĥ shall provide
4394a that in the event the managed care organization
4395 becomes insolvent, the rehabilitator or liquidator may:
4396 (A) require the health care provider to continue to provide health care services under the

4397 contract until the later of:
4398 (I) 90 days from the date of the filing of a petition for rehabilitation or the petition for
4399 liquidation; or
4400 (II) the date the term of the contract ends; and
4401 (B) subject to Subsection (1)(c)(v), reduce the fees the provider is otherwise entitled to
4402 receive from the managed care organization during the time period described in Subsection
4403 (1)(c)(i)(A);
4404 (ii) the provider is required to:
4405 (A) accept the reduced payment under Subsection (1)(c)(i)(B) as payment in full; and
4406 (B) relinquish the right to collect additional amounts from the insolvent managed care
4407 organization's enrollee, as defined in Section 31A-27-311.5(1)(b);
4408 (iii) if the contract between the health care provider and the managed care organization has
4409 not been reduced to writing, or the contract fails to contain the language required by Subsection
4410 (1)(c)(i), the provider may not collect or attempt to collect from the enrollee:
4411 (A) sums owed by the Ş **INSOLVENT** ĥ managed care organization; or
4412 (B) the amount of the regular fee reduction authorized under Subsection (1)(c)(i)(B);
4413 (iv) the following may not bill or maintain any action at law against an enrollee to collect
4414 sums owed by the Ş **INVOLVENT** ĥ managed care organization or the amount of the regular fee
4414a reduction authorized
4415 under Subsection (1)(c)(i)(B):
4416 (A) a provider;
4417 (B) an agent;
4418 (C) a trustee; or
4419 (D) an assignee of a person described in Subsections (1)(c)(iv)(A) through (C); and
4420 (v) notwithstanding Subsection (1)(c)(i):
4421 (A) a rehabilitator or liquidator may not reduce a fee by less than 75% of the provider's
4422 regular fee set forth in the contract; and
4423 (B) the enrollee shall continue to pay the copayments, deductibles, and other payments for
4424 services received from the provider that the enrollee was required to pay before the filing of:
4425 (I) a petition for rehabilitation; or
4426 (II) a petition for liquidation.
4427 (2) (a) Subject to Subsections (2)(b) through (2)(f), an insurer using preferred health care

4428 provider contracts shall pay for the services of health care providers not under the contract, unless
4429 the illnesses or injuries treated by the health care provider are not within the scope of the insurance
4430 contract. As used in this section, "class of health care providers" means all health care providers
4431 licensed or licensed and certified by the state within the same professional, trade, occupational, or
4432 facility licensure or licensure and certification category established pursuant to Titles 26 and 58.
4433 (b) When the insured receives services from a health care provider not under contract, the
4434 insurer shall reimburse the insured for at least 75% of the average amount paid by the insurer for
4435 comparable services of preferred health care providers who are members of the same class of
4436 health care providers. The commissioner may adopt a rule dealing with the determination of what
4437 constitutes 75% of the average amount paid by the insurer for comparable services of preferred
4438 health care providers who are members of the same class of health care providers.
4439 (c) When reimbursing for services of health care providers not under contract, the insurer
4440 may make direct payment to the insured.
4441 (d) Notwithstanding Subsection (2)(b), an insurer using preferred health care provider
4442 contracts may impose a deductible on coverage of health care providers not under contract.
4443 (e) When selecting health care providers with whom to contract under Subsection (1), an
4444 insurer may not unfairly discriminate between classes of health care providers, but may
4445 discriminate within a class of health care providers, subject to Subsection (7).
4446 (f) For purposes of this section, unfair discrimination between classes of health care
4447 providers shall include:
4448 (i) refusal to contract with class members in reasonable proportion to the number of
4449 insureds covered by the insurer and the expected demand for services from class members; and
4450 (ii) refusal to cover procedures for one class of providers that are:
4451 (A) commonly utilized by members of the class of health care providers for the treatment
4452 of illnesses, injuries, or conditions;
4453 (B) otherwise covered by the insurer; and
4454 (C) within the scope of practice of the class of health care providers.
4455 (3) Before the insured consents to the insurance contract, the insurer shall fully disclose
4456 to the insured that it has entered into preferred health care provider contracts. The insurer shall
4457 provide sufficient detail on the preferred health care provider contracts to permit the insured to
4458 agree to the terms of the insurance contract. The insurer shall provide at least the following

4459 information:
4460 (a) a list of the health care providers under contract and if requested their business
4461 locations and specialties;
4462 (b) a description of the insured benefits, including any deductibles, coinsurance, or other
4463 copayments;
4464 (c) a description of the quality assurance program required under Subsection (4); and
4465 (d) a description of the grievance procedures required under Subsection (5).
4466 (4) (a) An insurer using preferred health care provider contracts shall maintain a quality
4467 assurance program for assuring that the care provided by the health care providers under contract
4468 meets prevailing standards in the state.
4469 (b) The commissioner in consultation with the executive director of the Department of
4470 Health may designate qualified persons to perform an audit of the quality assurance program. The
4471 auditors shall have full access to all records of the organization and its health care providers,
4472 including medical records of individual patients.
4473 (c) The information contained in the medical records of individual patients shall remain
4474 confidential. All information, interviews, reports, statements, memoranda, or other data furnished
4475 for purposes of the audit and any findings or conclusions of the auditors are privileged. The
4476 information is not subject to discovery, use, or receipt in evidence in any legal proceeding except
4477 hearings before the commissioner concerning alleged violations of this section.
4478 (5) An insurer using preferred health care provider contracts shall provide a reasonable
4479 procedure for resolving complaints and grievances initiated by the insureds and health care
4480 providers.
4481 (6) An insurer may not contract with a health care provider for treatment of illness or
4482 injury unless the health care provider is licensed to perform that treatment.
4483 (7) (a) [~~No~~] A health care provider or insurer may not discriminate against a preferred
4484 health care provider for agreeing to a contract under Subsection (1).
4485 (b) Any health care provider licensed to treat any illness or injury within the scope of the
4486 health care provider's practice, who is willing and able to meet the terms and conditions established
4487 by the insurer for designation as a preferred health care provider, shall be able to apply for and
4488 receive the designation as a preferred health care provider. Contract terms and conditions may
4489 include reasonable limitations on the number of designated preferred health care providers based

4490 upon substantial objective and economic grounds, or expected use of particular services based
4491 upon prior provider-patient profiles.
4492 (8) Upon the written request of a provider excluded from a provider contract, the
4493 commissioner may hold a hearing to determine if the insurer's exclusion of the provider is based
4494 on the criteria set forth in Subsection (7)(b).
4495 (9) Insurers are subject to the provisions of Sections 31A-22-613.5, 31A-22-614.5, and
4496 31A-22-618.
4497 (10) Nothing in this section is to be construed as to require an insurer to offer a certain
4498 benefit or service as part of a health benefit plan.
4499 (11) This section does not apply to catastrophic mental health coverage provided in
4500 accordance with Section 31A-22-625.
4501 Section 97. Section **31A-22-619** is amended to read:
4502 **31A-22-619. Coordination of benefits.**
4503 (1) The commissioner shall adopt rules concerning the coordination of benefits between
4504 [~~disability~~] accident and health insurance policies.
4505 (2) Rules adopted by the commissioner under Subsection (1):
4506 (a) may not prohibit coordination of benefits with individual [~~disability~~] accident and
4507 health insurance policies; and
4508 (b) shall apply equally to all [~~disability~~] accident and health insurance policies without
4509 regard to whether the policies are group or individual policies.
4510 Section 98. Section **31A-22-620** is amended to read:
4511 **31A-22-620. Medicare Supplement Insurance Minimum Standards Act.**
4512 (1) As used in this section:
4513 (a) "Applicant" means:
4514 (i) in the case of an individual Medicare supplement policy, the person who seeks to
4515 contract for insurance benefits; and
4516 (ii) in the case of a group Medicare supplement policy, the proposed certificate holder.
4517 (b) "Certificate" means any certificate delivered or issued for delivery in this state under
4518 a group Medicare supplement policy.
4519 (c) "Certificate form" means the form on which the certificate is delivered or issued for
4520 delivery by the issuer.

4521 (d) "Issuer" includes insurance companies, fraternal benefit societies, health care service
4522 plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in
4523 this state, Medicare supplement policies or certificates.
4524 (e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social
4525 Security Amendments of 1965, as then constituted or later amended.
4526 (f) "Medicare Supplement Policy" means a group or individual policy of disability
4527 insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social
4528 Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project
4529 specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or designed primarily as
4530 a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses
4531 of persons eligible for Medicare.
4532 (g) "Policy Form" means the form on which the policy is delivered or issued for delivery
4533 by the issuer.
4534 (2) (a) Except as otherwise specifically provided, this section applies to:
4535 (i) all Medicare supplement policies delivered or issued for delivery in this state on or after
4536 the effective date of this section;
4537 (ii) all certificates issued under group Medicare supplement policies, that have been
4538 delivered or issued for delivery in this state on or after the effective date of this section; and
4539 (iii) policies or certificates that were in force prior to the effective date of this section, with
4540 respect to requirements for benefits, claims payment, and policy reporting practice under
4541 Subsection (3)(d), and loss ratios under Subsection (4).
4542 (b) This section does not apply to a policy of one or more employers or labor
4543 organizations, or of the trustees of a fund established by one or more employers or labor
4544 organizations, or a combination of employers and labor unions, for employees or former employees
4545 or a combination of employees and former employees, or for members or former members of the
4546 labor organizations, or a combination of members and former members of labor organizations.
4547 (c) This section does not prohibit, nor does it apply to insurance policies or health care
4548 benefit plans, including group conversion policies, provided to Medicare eligible persons that are
4549 not marketed or held out to be Medicare supplement policies or benefit plans.
4550 (3) (a) A Medicare supplement policy or certificate in force in the state may not contain
4551 benefits that duplicate benefits provided by Medicare.

4552 (b) Notwithstanding any other provision of law of this state, a Medicare supplement policy
4553 or certificate may not exclude or limit benefits for loss incurred more than six months from the
4554 effective date of coverage because it involved a preexisting condition. The policy or certificate
4555 may not define a preexisting condition more restrictively than: "A condition for which medical
4556 advice was given or treatment was recommended by or received from a physician within six
4557 months before the effective date of coverage."
4558 (c) The commissioner shall adopt rules to establish specific standards for policy provisions
4559 of Medicare supplement policies and certificates. The standards adopted shall be in addition to
4560 and in accordance with applicable laws of this state. A requirement of this title relating to
4561 minimum required policy benefits, other than the minimum standards contained in this section,
4562 may not apply to Medicare supplement policies and certificates. The standards may include:
4563 (i) terms of renewability;
4564 (ii) initial and subsequent conditions of eligibility;
4565 (iii) nonduplication of coverage;
4566 (iv) probationary periods;
4567 (v) benefit limitations, exceptions, and reductions;
4568 (vi) elimination periods;
4569 (vii) requirements for replacement;
4570 (viii) recurrent conditions; and
4571 (ix) definitions of terms.
4572 (d) The commissioner shall adopt rules establishing minimum standards for benefits,
4573 claims payment, marketing practices, compensation arrangements, and reporting practices for
4574 Medicare supplement policies and certificates.
4575 (e) The commissioner may adopt such rules as are necessary to conform Medicare
4576 supplement policies and certificates to the requirements of federal law and regulations promulgated
4577 thereunder, including:
4578 (i) requiring refunds or credits if the policies do not meet loss ratio requirements;
4579 (ii) establishing a uniform methodology for calculating and reporting loss ratios;
4580 (iii) assuring public access to policies, premiums, and loss ratio information of issuers of
4581 Medicare supplement insurance;
4582 (iv) establishing a process for approving or disapproving policy forms and certificate forms

4583 and proposed premium increases;
4584 (v) establishing a policy for holding public hearings prior to approval of premium
4585 increases; and
4586 (vi) establishing standards for Medicare select policies and certificates.
4587 (f) The commissioner may adopt rules that prohibit policy provisions not otherwise
4588 specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or
4589 unfairly discriminatory to any person insured or proposed to be insured under a Medicare
4590 supplement policy or certificate.
4591 (4) Medicare supplement policies shall return to policyholders benefits that are reasonable
4592 in relation to the premium charged. The commissioner shall make rules to establish minimum
4593 standards for loss ratios of Medicare supplement policies on the basis of incurred claims
4594 experience, or incurred health care expenses where coverage is provided by a health maintenance
4595 organization on a service basis rather than on a reimbursement basis, and earned premiums in
4596 accordance with accepted actuarial principles and practices.
4597 (5) (a) To provide for full and fair disclosure in the sale of Medicare supplement policies,
4598 a Medicare supplement policy or certificate may not be delivered in this state unless an outline of
4599 coverage is delivered to the applicant at the time application is made.
4600 (b) The commissioner shall prescribe the format and content of the outline of coverage
4601 required by Subsection (5)(a).
4602 (c) For purposes of this section, "format" means style arrangements and overall
4603 appearance, including such items as the size, color, and prominence of type and arrangement of
4604 text and captions. The outline of coverage shall include:
4605 (i) a description of the principal benefits and coverage provided in the policy;
4606 (ii) a statement of the renewal provisions, including any reservation by the issuer of a right
4607 to change premiums; and disclosure of the existence of any automatic renewal premium increases
4608 based on the policyholder's age; and
4609 (iii) a statement that the outline of coverage is a summary of the policy issued or applied
4610 for and that the policy should be consulted to determine governing contractual provisions.
4611 (d) The commissioner may make rules for captions or notice if the commissioner finds that
4612 the rules are:
4613 (i) in the public interest; and

4614 (ii) designed to inform prospective insureds that particular insurance coverages are not
4615 Medicare supplement coverages, for all accident and health insurance policies sold to persons
4616 eligible for Medicare, other than:
4617 (A) a medicare supplement policy; or
4618 (B) a disability income policy.
4619 [~~(d)~~] (e) The commissioner may prescribe by rule a standard form and the contents of an
4620 informational brochure for persons eligible for Medicare, that is intended to improve the buyer's
4621 ability to select the most appropriate coverage and improve the buyer's understanding of Medicare.
4622 Except in the case of direct response insurance policies, the commissioner may require by rule that
4623 the informational brochure be provided concurrently with delivery of the outline of coverage to
4624 any prospective insureds eligible for Medicare. With respect to direct response insurance policies,
4625 the commissioner may require by rule that the prescribed brochure be provided upon request to any
4626 prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.
4627 [~~(e)~~] (f) The commissioner may adopt reasonable rules to govern the full and fair
4628 disclosure of the information in connection with the replacement of [~~disability~~] accident and health
4629 policies, subscriber contracts, or certificates by persons eligible for Medicare.
4630 (6) Notwithstanding Subsection (1), Medicare supplement policies and certificates shall
4631 have a notice prominently printed on the first page of the policy or certificate, or attached to the
4632 front page, stating in substance that the applicant has the right to return the policy or certificate
4633 within 30 days of its delivery and to have the premium refunded if, after examination of the policy
4634 or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this
4635 section shall be paid directly to the applicant by the issuer in a timely manner.
4636 (7) Every issuer of Medicare supplement insurance policies or certificates in this state shall
4637 provide a copy of any Medicare supplement advertisement intended for use in this state, whether
4638 through written or broadcast medium, to the commissioner for review.
4639 Section 99. Section **31A-22-623** is amended to read:
4640 **31A-22-623. Coverage of inborn metabolic errors.**
4641 (1) As used in this section:
4642 (a) "Dietary products" means medical food or a low protein modified food product that:
4643 (i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;
4644 (ii) is not a natural food that is naturally low in protein; and

4645 (iii) is used under the direction of a physician.
4646 (b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an
4647 inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more
4648 amino acid.
4649 (2) The commissioner shall establish, by rule, minimum standards of coverage for dietary
4650 products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels
4651 consistent with the major medical benefit provided under [~~a disability~~] an accident and health
4652 insurance policy.
4653 Section 100. Section **31A-22-624** is amended to read:
4654 **31A-22-624. Primary care physician.**
4655 [~~A disability~~] An accident and health insurance policy that requires an insured to select a
4656 primary care physician to receive optimum coverage:
4657 (1) shall permit an insured to select a participating provider who is an
4658 obstetrician/gynecologist and is qualified and willing to provide primary care services, as defined
4659 by the health care plan, as the insured's provider from whom primary care services are received;
4660 (2) shall clearly state in literature explaining the policy the option available to female
4661 insureds under Subsection (1); and
4662 (3) may not impose a higher premium, higher copayment requirement, or any other
4663 additional expense on an insured by virtue of the insured selecting a primary care physician in
4664 accordance with Subsection (1).
4665 Section 101. Section **31A-22-626** is amended to read:
4666 **31A-22-626. Coverage of diabetes.**
4667 (1) As used in this section, "diabetes" includes individuals with:
4668 (a) complete insulin deficiency or type 1 diabetes;
4669 (b) insulin resistant with partial insulin deficiency or type 2 diabetes; and
4670 (c) elevated blood glucose levels induced by pregnancy or gestational diabetes.
4671 (2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes
4672 for [~~disability~~] accident and health insurance policies that provide a health insurance benefit before
4673 July 1, 2000.
4674 (3) In making rules under Subsection (2), the commissioner shall require rules:
4675 (a) with durational limits, amount limits, deductibles, and coinsurance for the treatment

4676 of diabetes equitable or identical to coverage provided for the treatment of other illnesses or
4677 diseases; and
4678 (b) that provide coverage for:
4679 (i) diabetes self-management training and patient management, including medical nutrition
4680 therapy as defined by rule, provided by an accredited or certified program and referred by an
4681 attending physician within the plan and consistent with the health plan provisions for
4682 self-management education:
4683 (A) recognized by the federal Health Care Financing [~~Agency~~] Administration; or
4684 (B) certified by the Department of Health; and
4685 (ii) the following equipment, supplies, and appliances to treat diabetes when medically
4686 necessary:
4687 (A) blood glucose monitors, including those for the legally blind;
4688 (B) test strips for blood glucose monitors;
4689 (C) visual reading urine and ketone strips;
4690 (D) lancets and lancet devices;
4691 (E) insulin;
4692 (F) injection aides, including those adaptable to meet the needs of the legally blind, and
4693 infusion delivery systems;
4694 (G) syringes;
4695 (H) prescriptive oral agents for controlling blood glucose levels; and
4696 (I) glucagon kits.
4697 (4) (a) Before October 1, 2003, the commissioner shall report to the Health and Human
4698 Services Interim Committee on the effects of Section 31A-22-626. The report shall be based on
4699 three years of data and shall include, to the extent possible:
4700 (i) a review of the rules established under Subsection (3);
4701 (ii) the change in availability of coverage resulting from this section;
4702 (iii) the extent to which persons have been benefitted by the provisions of this section; and
4703 (iv) the impact of this section on premiums.
4704 (b) The Legislature shall consider the results of the report under Subsection (4)(a) when
4705 determining whether to reauthorize the provisions of this section.
4706 Section 102. Section **31A-22-630** is amended to read:

4707 **31A-22-630. Mastectomy coverage.**
4708 (1) If an insured has coverage that provides medical and surgical benefits with respect to
4709 a mastectomy, it shall provide coverage, with consultation of the attending physician and the
4710 patient, for:
4711 (a) reconstruction of the breast on which the mastectomy has been performed;
4712 (b) surgery and reconstruction of the breast on which the mastectomy was not performed
4713 to produce symmetrical appearance; and
4714 (c) prostheses and physical complications with regards to all stages of mastectomy,
4715 including lymphedemas.
4716 (2) (a) This section does not prevent [~~a disability~~] an accident and health insurer from
4717 imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing
4718 measures are not greater than those imposed on any other medical condition.
4719 (b) For purposes of this Subsection (2), cost-sharing measures include imposing a
4720 deductible or coinsurance requirement.
4721 (3) Written notice of the availability of the coverage described in Subsection (1) shall be
4722 delivered to the participant:
4723 (a) upon enrollment; and
4724 (b) annually after the enrollment.
4725 Section 103. Section **31A-22-631** is enacted to read:
4726 **31A-22-631. Policy summary or illustration.**
4727 (1) (a) Except as provided in Subsection (1)(b), at the time a life insurance policy is
4728 delivered, a policy summary or illustration shall be delivered for the life insurance policy if:
4729 (i) the life insurance policy includes riders or supplemental benefits, including accelerated
4730 benefits; and
4731 (ii) receipt of benefits under the life insurance policy is contingent upon morbidity
4732 requirements.
4733 (b) In the case of a direct response solicitation, the insurer shall deliver the policy summary
4734 or illustration at the sooner of:
4735 (i) the applicant's request; or
4736 (ii) at the time of policy delivery regardless of whether the applicant requests a policy
4737 summary or illustration.

4738 (2) In addition to complying with all applicable requirements, the policy summary or
4739 illustration shall include:
4740 (a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with
4741 other components of the policy, including deductions from death benefits and policy values;
4742 (b) an illustration for each covered person of:
4743 (i) the amount of benefits;
4744 (ii) the length of benefits; and
4745 (iii) the guaranteed lifetime benefits, if any;
4746 (c) a disclosure of the maximum premiums for the rider or supplemental benefit;
4747 (d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental
4748 benefit; and
4749 (e) if applicable to the policy type:
4750 (i) a disclosure of the effects of exercising other rights under the policy; and
4751 (ii) guaranteed maximum lifetime benefits.
4752 Section 104. Section **31A-22-632** is enacted to read:
4753 **31A-22-632. Report to policy holder.**
4754 (1) An insurer shall provide the policyholder a monthly report if an accident and health
4755 rider or supplemental benefit is:
4756 (a) funded through a life insurance vehicle by acceleration of the death benefit; and
4757 (b) in benefit payment status.
4758 (2) The report required by Subsection (1) shall include:
4759 (a) any rider or supplemental benefits paid out during the month;
4760 (b) an explanation of any changes in the policy due to rider or supplemental benefits being
4761 paid out such as:
4762 (i) death benefits; or
4763 (ii) cash values; and
4764 (c) the amount of the rider or supplemental benefits existing or remaining.
4765 Section 105. Section **31A-22-701** is amended to read:
4766 **Part VII. Group Accident and Health Insurance**
4767 **31A-22-701. Groups eligible for group or blanket insurance.**
4768 (1) A group or blanket [~~disability~~] accident and health insurance policy may be issued to:

4769 (a) any group to which a group life insurance policy may be issued under Sections
4770 31A-22-502 through 31A-22-507;
4771 (b) a policy issued pursuant to a conversion privilege under Part VII; or
4772 (c) a group specifically authorized by the commissioner upon a finding that:
4773 (i) authorization is not contrary to the public interest;
4774 (ii) the proposed group is actuarially sound;
4775 (iii) formation of the proposed group may result in economies of scale in administrative,
4776 marketing, and brokerage costs; and
4777 (iv) the health insurance policy, certificate, or other indicia of coverage that will be offered
4778 to the proposed group is substantially equivalent to policies that are otherwise available to similar
4779 groups.
4780 (2) Blanket policies may also be issued to:
4781 (a) any common carrier or any operator, owner, or lessee of a means of transportation, as
4782 policyholder, covering persons who may become passengers as defined by reference to their travel
4783 status;
4784 (b) an employer, as policyholder, covering any group of employees, dependents, or guests,
4785 as defined by reference to specified hazards incident to any activities of the policyholder;
4786 (c) an institution of learning, including a school district, school jurisdictional units, or the
4787 head, principal, or governing board of any of those units, as policyholder, covering students,
4788 teachers, or employees;
4789 (d) any religious, charitable, recreational, educational, or civic organization, or branch of
4790 those organizations, as policyholder, covering any group of members or participants as defined by
4791 reference to specified hazards incident to the activities sponsored or supervised by the
4792 policyholder;
4793 (e) a sports team, camp, or sponsor of the team or camp, as policyholder, covering
4794 members, campers, employees, officials, or supervisors;
4795 (f) any volunteer fire department, first aid, civil defense, or other similar volunteer
4796 organization, as policyholder, covering any group of members or participants as defined by
4797 reference to specified hazards incident to activities sponsored, supervised, or participated in by the
4798 policyholder;
4799 (g) a newspaper or other publisher, as policyholder, covering its carriers;

4800 (h) an association, including a labor union, which has a constitution and bylaws and which
4801 has been organized in good faith for purposes other than that of obtaining insurance, as
4802 policyholder, covering any group of members or participants as defined by reference to specified
4803 hazards incident to the activities or operations sponsored or supervised by the policyholder;
4804 (i) a health insurance purchasing association organized and controlled solely by
4805 participating employers as defined in Section 31A-34-103; and
4806 (j) any other class of risks which, in the judgment of the commissioner, may be properly
4807 eligible for blanket [~~disability~~] accident and health insurance.
4808 (3) The judgment of the commissioner may be exercised on the basis of:
4809 (a) individual risks [~~or~~];
4810 (b) class of risks; or
4811 (c) both Subsections (3)(a) and (b).
4812 Section 106. Section **31A-22-702** is amended to read:
4813 **31A-22-702. Adjustment of premium rate and application of dividends or rate**
4814 **reductions.**
4815 Any group [~~disability~~] accident and health insurance policy may provide for the adjustment
4816 of the rate of premium based upon the experience under the contract. If a policy dividend is
4817 declared or a reduction in rate is made or continued for the first or any subsequent year of
4818 insurance under any policy of group [~~disability~~] accident and health insurance, the excess, if any,
4819 of the aggregate dividends or rate reductions under the policy and all other group insurance policies
4820 of the policyholder over the aggregate expenditure for insurance under those policies made from
4821 funds contributed by the policyholder, including expenditures made in connection with the
4822 administration of the policies, shall be applied by the policyholder for the sole benefit of insured
4823 employees or members unless the insured employee or member explicitly elects otherwise.
4824 Section 107. Section **31A-22-703** is amended to read:
4825 **31A-22-703. Conversion rights on termination of group accident and health**
4826 **insurance coverage.**
4827 (1) Except as provided in Subsections (2) through (5), all policies of [~~disability~~] accident
4828 and health insurance offered on a group basis under this title or Title 49, Chapter 8, Group
4829 Insurance Program Act, shall provide that a person whose insurance under the group policy has
4830 been terminated for any reason, and who has been continuously insured under the group policy or

4831 its predecessor for at least six months immediately prior to termination, is entitled to choose
4832 [~~either~~] a converted individual [~~or group~~] policy of [~~disability~~] accident and health insurance from
4833 the insurer which conforms to Section 31A-22-708 or an extension of benefits under the group
4834 policy as provided in Section 31A-22-714.
4835 (2) Subsection (1) does not apply if the policy:
4836 (a) provides catastrophic, aggregate stop loss, or specific stop loss benefits;
4837 (b) provides benefits for specific diseases or for accidental injuries only, or for dental
4838 service; or
4839 (c) is [~~a disability~~] an income replacement policy.
4840 (3) An employee or group member does not have conversion rights under Subsection (1)
4841 if:
4842 (a) termination of the group coverage occurred because of failure of the group member to
4843 pay any required individual contribution;
4844 (b) the individual group member acquires other group coverage covering all preexisting
4845 conditions including maternity, if the coverage existed under the replaced group coverage; or
4846 (c) the person [~~who would be covered is or could be covered by Medicare~~] has:
4847 (i) performed an act or practice that constitutes fraud; or
4848 (ii) made an intentional misrepresentation of material fact under the terms of the coverage.
4849 (4) Notwithstanding Subsections (1), (2), and (3), an employee or group member does not
4850 have conversion rights under Subsection (1) if the individual or group member qualifies to
4851 continue coverage under his existing group policy in accordance with the terms of his policy.
4852 (5) (a) Notwithstanding Subsection 31A-22-613(1), an insurer may reduce benefits under
4853 a converted [~~disability~~] policy covering any person to the extent the benefits provided or available
4854 to that person under one or more of the sources listed under Subsection (5)(b), together with the
4855 benefits provided by the converted policy, would result in [~~overinsurance according to the insurer's~~
4856 ~~standards. The insurer's standards shall bear a reasonable relationship to actual health care costs~~
4857 ~~in the area in which the insured lives at the time of conversion and shall be filed with the~~
4858 ~~commissioner prior to their use in denying~~] coverage that would result in payment of more than
4859 100% of the amount of the claim.
4860 (b) The benefits sources referred to under Subsection (5)(a) include:
4861 (i) benefits under another insurance policy; and

4862 (ii) benefits under any arrangement of coverage for individuals in a group, whether on an
4863 insured or an uninsured basis[; and].
4864 [(iii) benefits provided for or available to that person, in accordance with the requirements
4865 of any state or federal law.]
4866 (6) (a) The conversion policy shall provide maternity benefits equal to the lesser of the
4867 maternity benefits of the group policy or the conversion policy until termination of pregnancy that
4868 exists on the date of conversion if:
4869 (i) one of the following is pregnant on the date of the conversion:
4870 (A) the insured;
4871 (B) a spouse of the insured; or
4872 (C) a dependent of the insured; and
4873 (ii) the accident and health policy had maternity benefits.
4874 (b) The requirements of this Subsection (6) do not apply to a pregnancy that occurs after
4875 the date of conversion.
4876 Section 108. Section **31A-22-704** is amended to read:
4877 **31A-22-704. Conversion rules and procedures.**
4878 (1) Written application for the converted policy shall be made and the first premium paid
4879 to the insurer no later than 60 days after termination of the group [disability] accident and health
4880 insurance.
4881 (2) The converted policy shall be issued without evidence of insurability.
4882 (3) (a) The initial premium for the converted policy for the first 12 months and subsequent
4883 renewal premiums shall be determined in accordance with premium rates applicable to age, class
4884 of risk of the person, and the type and amount of insurance provided[.]; and
4885 (b) the initial premium for the first 12 months may not be raised based on pregnancy of
4886 a covered insured.
4887 (4) Conditions pertaining to health are not an acceptable basis for classification under this
4888 section.
4889 (5) The premium for converted [disability] policies shall be payable monthly or quarterly
4890 as required by the insurer for the policy form and plan selected, unless another mode of premium
4891 payment is mutually agreed upon.
4892 (6) The converted policy becomes effective at the time the insurance under the group

4893 policy terminates.
4894 (7) The converted policy covers the employee or member and the dependents who were
4895 covered by the group policy on the date of termination of insurance. At the option of the insurer,
4896 a separate converted policy may be issued to cover any dependent.
4897 Section 109. Section **31A-22-705** is amended to read:
4898 **31A-22-705. Provisions in conversion policies.**
4899 (1) A converted policy may include a provision under which the insurer may request from
4900 the person covered, information in advance of any premium due date as to whether there is other
4901 coverage as specified under Subsection 31A-22-703(4).
4902 (2) The converted policy may provide that the insurer may refuse to renew the policy or
4903 the coverage of any person insured:
4904 [~~(a) if the insured could be covered by Medicare;~~]
4905 [~~(b) the converted policy creates an unreasonable over-insurance position;~~]
4906 [~~(c)~~] (a) for fraud or [~~material~~] intentional misrepresentation of a material fact in applying
4907 for any benefits under the converted policy; or
4908 [~~(d)~~] (b) for any other reason approved by the commissioner by rule or order.
4909 (3) [~~No~~] An insurer may not be required to issue a converted policy which provides
4910 benefits in excess of those provided under the group policy from which conversion is made.
4911 (4) [~~No~~] A converted policy may not exclude a preexisting condition not excluded under
4912 the group policy.
4913 (5) During the first policy year, the converted policy may provide that the benefits payable
4914 under the converted policy, together with the benefits paid for the individual under the group
4915 policy, do not exceed those that would have been payable had the individual's insurance under the
4916 group policy remained in force and effect.
4917 Section 110. Section **31A-22-715** is amended to read:
4918 **31A-22-715. Optional rider for alcohol and drug dependency treatment.**
4919 Each group [~~disability~~] accident and health insurance policy shall contain an optional rider
4920 allowing certificate holders to obtain coverage for alcohol or drug dependency treatment in
4921 programs licensed by the Department of Human Services, under Title 62A, Chapter 2, inpatient
4922 hospitals accredited by the joint commission on the accreditation of hospitals, or facilities licensed
4923 by the Department of Health.

4924 Section 111. Section **31A-22-716** is amended to read:

4925 **31A-22-716. Required provision for notice of termination.**

4926 (1) Every policy for group or blanket [~~disability~~] accident and health coverage issued or
4927 renewed after July 1, 1990, shall include a provision that obligates the policyholder to give 30 days
4928 prior written notice of termination to each employee or group member and to notify each employee
4929 or group member of his rights to continue coverage upon termination.

4930 (2) An insurer's monthly notice to the policyholder of premium payments due shall include
4931 a statement of the policyholder's obligations as set forth in Subsection (1). Insurers shall provide
4932 a sample notice to the policyholder at least once a year.

4933 Section 112. Section **31A-22-717** is amended to read:

4934 **31A-22-717. Provisions pertaining to service members and their families affected by**
4935 **Operation Desert Shield and Operation Desert Storm.**

4936 For any group or blanket [~~disability~~] accident and health coverage, an insurer:

4937 (1) may not refuse to reinstate an insured or his family whose coverage lapsed due to the
4938 insured's participation in Operation Desert Shield or Operation Desert Storm provided application
4939 is made within 180 days of release from active duty;

4940 (2) shall reinstate an insured in full upon payment of the first premium without the
4941 requirement of a waiting period or exclusion for preexisting conditions or any other underwriting
4942 requirements that were covered previously; and

4943 (3) may not increase the insured's premium in excess of what it would have been increased
4944 in the normal course of time had the insured not participated in Operation Desert Shield or
4945 Operation Desert Storm.

4946 Section 113. Section **31A-22-720** is amended to read:

4947 **31A-22-720. Mental health parity.**

4948 (1) (a) A group [~~disability~~] accident and health plan offered by an insurer shall comply
4949 with Subsection (1)(b) if the group disability plan:

4950 (i) applies an aggregate lifetime limit to plan payments for medical or surgical services
4951 covered by the group [~~disability~~] accident and health plan; and

4952 (ii) provides a mental health benefit.

4953 (b) A group [~~disability~~] accident and health plan described in Subsection (1)(a) shall:

4954 (i) include in the aggregate lifetime limit for medical or surgical services covered by the

4955 group [~~disability~~] accident and health plan the payments made under the plan for mental health
4956 services; or
4957 (ii) establish a separate aggregate lifetime limit to plan payments for mental health services
4958 covered by the group [~~disability~~] accident and health plan, but only if the dollar amount of the
4959 aggregate lifetime limit for mental health services covered by that plan is equal to or greater than
4960 the dollar amount of the aggregate lifetime limit for medical or surgical services covered by that
4961 plan.
4962 (2) (a) A group [~~disability~~] accident and health plan offered by an insurer shall comply
4963 with Subsection (2)(b) if the group [~~disability~~] accident and health plan:
4964 (i) applies an annual limit to plan payments for medical or surgical services covered by the
4965 group [~~disability~~] accident and health plan; and
4966 (ii) provides a mental health benefit.
4967 (b) A group [~~disability~~] accident and health plan described in Subsection (2)(a) shall:
4968 (i) include in the annual limit for medical or surgical services covered by the group
4969 [~~disability~~] accident and health plan the payments made under the plan for mental health services;
4970 or
4971 (ii) establish a separate annual limit to plan payments for mental health services covered
4972 by the group [~~disability~~] accident and health plan, but only if the dollar amount of the annual limit
4973 for mental health services covered by that plan is equal to or greater than the dollar amount of the
4974 annual limit for medical or surgical services covered by that plan.
4975 (3) This section does not prohibit a group [~~disability~~] accident and health plan offered by
4976 an insurer from:
4977 (a) using other forms of cost containment not prohibited under Subsection (1); or
4978 (b) applying requirements that make distinctions between acute care and chronic care.
4979 (4) This section does not apply to:
4980 (a) benefits for:
4981 (i) substance abuse; or
4982 (ii) chemical dependency; or
4983 (b) [~~disability~~] accident and health benefits or plans paid under Title XVII or XIX of the
4984 Social Security Act.
4985 (5) (a) This section does not apply to plans maintained by employers that employ less than

4986 50 employees.
4987 (b) For purposes of determining whether an employer is exempt under Subsection (5)(a):
4988 (i) if the employer was not in existence throughout the preceding calendar year, the number
4989 of employees of the employer is determined based on the average number of employees that the
4990 employer is reasonably expected to employ on business days in the calendar year for which the
4991 determination is made; and
4992 (ii) as used in this Subsection (5), "employer" includes a predecessor of the employer.
4993 Section 114. Section **31A-22-801** is amended to read:
4994 **31A-22-801. Scope of part.**
4995 (1) Except as provided under Subsection (2), all life insurance and [~~disability~~] accident and
4996 health insurance in connection with loans or other credit transactions are subject to this part.
4997 (2) (a) Insurance in connection with a loan or other credit transaction of more than ten
4998 years duration is not subject to this part, but is subject to other provisions of this title.
4999 (b) Isolated transactions on the part of an insurer [~~which~~] that are not related to an
5000 agreement or plan for insuring debtors of the creditor are not subject to this part.
5001 Section 115. Section **31A-22-802** is amended to read:
5002 **31A-22-802. Definitions.**
5003 As used in Part VIII:
5004 (1) "Credit [~~disability~~] accident and health insurance" means [~~disability~~] insurance on a
5005 debtor to provide indemnity for payments coming due on a specific loan or other credit transaction
5006 while the debtor is disabled.
5007 (2) "Credit life insurance" means life insurance on the life of a debtor in connection with
5008 a specific loan or credit transaction.
5009 (3) "Credit transaction" means any transaction under which the payment for money loaned
5010 or for goods, services, or properties sold or leased is to be made on future dates.
5011 (4) "Creditor" means the lender of money or the vendor or lessor of goods, services, or
5012 property, for which payment is arranged through a credit transaction, or any successor to the right,
5013 title, or interest of any lender or vendor.
5014 (5) "Debtor" means a borrower of money or a purchaser, including a lessee under a lease
5015 intended as security, of goods, services, or property, for which payment is arranged through a credit
5016 transaction.

5017 (6) "Indebtedness" means the total amount payable by a debtor to a creditor in connection
5018 with a credit transaction, including principal finance charges and interest.
5019 (7) "Net indebtedness" means the total amount required to liquidate the indebtedness,
5020 exclusive of any unearned interest, any insurance on the monthly outstanding balance coverage,
5021 or any finance charge.
5022 (8) "Net written premiums" means gross written premiums minus refunds on termination.
5023 Section 116. Section **31A-22-803** is amended to read:
5024 **31A-22-803. Forms of insurance permitted.**
5025 Credit life insurance and credit [~~disability~~] accident and health insurance may be issued
5026 only in the following forms:
5027 (1) individual policies of term life insurance issued to debtors;
5028 (2) individual policies of term [~~disability~~] accident and health insurance issued to debtors,
5029 or [~~disability~~] accident and health benefit provisions in individual policies of credit life insurance;
5030 (3) group policies of term life insurance issued to creditors, providing insurance upon the
5031 lives of debtors;
5032 (4) group policies of term [~~disability~~] accident and health insurance issued to creditors
5033 insuring debtors, or [~~disability~~] accident and health benefit provisions in group credit life insurance
5034 policies.
5035 Section 117. Section **31A-22-804** is amended to read:
5036 **31A-22-804. Limitations on amounts of insurance.**
5037 (1) Except as provided under Subsection (2), the initial amount of credit life insurance on
5038 the life of any one debtor may not exceed the total amount repayable under the contract of
5039 indebtedness. Where an indebtedness is repayable in substantially equal periodic installments,
5040 the amount of insurance may not exceed the scheduled or actual amount of unpaid indebtedness,
5041 whichever is greater.
5042 (2) Subsection (1) does not apply to:
5043 (a) insurance on agricultural credit transaction commitments not exceeding the
5044 commitment period, which may be written for the amount of the commitment on a nondecreasing
5045 or level term plan;
5046 (b) insurance on educational credit transaction commitments, which may be written to
5047 include the portion of the commitment that has not been advanced by the creditor;

5048 (c) insurance on preauthorized lines of credit not exceeding the commitment period which
5049 may be written for the preauthorized amount on a nondecreasing or level term plan, whether
5050 secured or unsecured[.]; and
5051 (d) insurance on any other class of lawful credit transaction or commitment, which in the
5052 commissioner's opinion does not require the application of the restrictions under Subsection (1),
5053 in which case the commissioner may authorize by rule a class exception to Subsection (1).
5054 (3) The total amount of indemnity payable by credit [disability] accident and health
5055 insurance in the event of disability, as defined in the policy, may not exceed the aggregate of the
5056 periodic scheduled unpaid installments of the indebtedness. The amount of each periodic
5057 indemnity payment may not exceed the total amount repayable under the contract of indebtedness
5058 divided by the number of periodic installments.
5059 Section 118. Section **31A-22-805** is amended to read:
5060 **31A-22-805. Beginning date of insurance.**
5061 (1) Except as provided under Subsection (2), any credit life insurance or credit [disability]
5062 accident and health insurance, subject to acceptance by the insurer, commences on the date when
5063 the debtor becomes obligated to the creditor.
5064 (2) (a) Where a group policy provides coverage for existing obligations, the insurance on
5065 a debtor with respect to that indebtedness commences on the effective date of the policy.
5066 (b) Where evidence of insurability is required and the evidence is furnished more than 30
5067 days after the debtor becomes obligated to the creditor, the insurance may commence when the
5068 insurance company determines the evidence of insurability to be satisfactory. In this event, the
5069 insurer shall make an appropriate refund or adjustment of any charge to the debtor for insurance.
5070 (3) The insurance may not extend more than 15 days beyond the scheduled maturity date
5071 of the indebtedness, unless it does so at no additional cost to the debtor.
5072 (4) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled
5073 maturity date, the insurance in force shall terminate before any new insurance may be issued in
5074 connection with the renewed or refinanced indebtedness. In all cases of termination prior to
5075 scheduled maturity, a refund shall be paid or credited as provided in Section 31A-22-808.
5076 Section 119. Section **31A-22-806** is amended to read:
5077 **31A-22-806. Provisions of policies and certificates.**
5078 (1) All credit life insurance and credit [disability] accident and health insurance shall be

5079 evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance
5080 delivered to the debtor.
5081 (2) Each of these types of policies or certificates shall, in addition to satisfying the
5082 requirements of Chapter 21, set forth:
5083 (a) the name and home office address of the insurer;
5084 (b) the identity, by name or otherwise, of the persons insured;
5085 (c) the rate, premium, or amount of payment by the debtor, if any, given separately for
5086 credit life insurance and credit [~~disability~~] accident and health insurance;
5087 (d) a description of the amount, term, and coverage, including any exceptions, limitations,
5088 and restrictions;
5089 (e) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid
5090 indebtedness; and
5091 (f) that whenever the amount of insurance exceeds the unpaid indebtedness, that excess
5092 is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.
5093 (3) Except as provided in Subsection (4), the policy or certificate shall be delivered to the
5094 debtor within 30 days after the date when the indebtedness is incurred.
5095 (4) (a) If the policy or certificate is not delivered to the debtor within 30 days after the date
5096 the indebtedness is incurred, a copy of the application for the policy or a notice of proposed
5097 insurance shall be delivered to the debtor.
5098 (b) The application or the notice shall be signed by the debtor and shall set forth:
5099 (i) the name and home office address of the insurer;
5100 (ii) the name of the debtor;
5101 (iii) the premium or amount of payment by the debtor, if any, separately for credit life
5102 insurance and credit [~~disability~~] accident and health insurance; and
5103 (iv) the amount, term, and a brief description of the coverage provided.
5104 (c) The copy of the application for or notice of proposed insurance, shall also refer
5105 exclusively to insurance coverage, and shall be separate from the loan, sale, or other credit
5106 statement of account or instrument, unless the information required by this Subsection (4)(c) is
5107 prominently set forth therein.
5108 (d) Upon acceptance of the insurance by the insurer and within 60 days after the later of
5109 the date on which the indebtedness is incurred or the date on which the credit life or credit

5110 [~~disability~~] accident and health policy was purchased, the insurer shall deliver the individual policy
5111 or group certificate of insurance to the debtor.
5112 (e) The application or notice shall state that upon acceptance by the insurer, the insurance
5113 is effective as provided in Section 31A-22-805.
5114 (5) If the named insurer does not accept the risk, the debtor shall receive a policy or
5115 certificate of insurance setting forth the name and home office address of the substituted insurer
5116 and the amount of the premium to be charged. If the premium is less than that set forth in the
5117 notice of proposed insurance, an appropriate refund shall be made.
5118 (6) If a creditor makes available to the debtors more than one plan of credit life or credit
5119 [~~disability~~] accident and health insurance, all debtors must be informed of the plans applicable to
5120 the specific type of loan transaction for which the debtor is applying.
5121 Section 120. Section **31A-22-807** is amended to read:
5122 **31A-22-807. Filing and approval of forms -- Loss ratio standards.**
5123 (1) All forms of policies, certificates of insurance, statements of insurance, endorsements,
5124 and riders intended for use in Utah are subject to Section 31A-21-201.
5125 (2) In addition to the grounds for disapproval under Subsection 31A-21-201(3), it is a
5126 ground for disapproval that the benefits provided in the form are not reasonable in relation to the
5127 premium charge.
5128 (3) In ascertaining whether the benefits are reasonable in relation to the premium charged,
5129 the commissioner shall consider the mortality cost of the life insurance and the morbidity cost of
5130 the [~~disability~~] accident and health insurance, and the reserves set up for the payment of claims
5131 unreported or in the process of settlement. The benefits are considered reasonable in relation to
5132 the premium charged if the premium rate charged develops or may reasonably be expected to
5133 develop a loss ratio of not less than 50% for credit life insurance and not less than 55% for credit
5134 [~~disability~~] accident and health insurance given the above costs.
5135 (4) Benefits are considered reasonable in relation to premium charged if the ratio of claims
5136 incurred to premium earned during the most recent four-year period at the rates in use produces
5137 a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).
5138 (5) If the minimum loss ratio test produces a loss ratio that exceeds Subsection (4)'s
5139 minimum loss ratio standard by five percentage points or more, the insurer may file for approval
5140 and use rates that are higher than prima facie rates, if it can be expected that the use of those higher

5141 rates will continue to produce a loss ratio for the accounts to which they are applied that will
5142 satisfy the minimum loss ratio test.
5143 (6) If the minimum loss ratio test produces a loss ratio that is lower than Subsection (4)'s
5144 minimum loss standard by five percentage points or more, the commissioner may require that the
5145 insurer file adjusted rates that can be expected to produce a loss ratio that will satisfy the minimum
5146 loss ratio test, or to submit reasons acceptable to the commissioner why the insurer should not be
5147 required to file these adjusted rates.
5148 Section 121. Section **31A-22-808** is amended to read:
5149 **31A-22-808. Premiums and refunds.**
5150 (1) Each policy, certificate, or statement of insurance shall provide that in the event of
5151 termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund
5152 of an amount paid by the debtor for insurance shall be paid or credited promptly to the person
5153 entitled to it. The formula used in computing the refund shall be filed with and approved by the
5154 commissioner under Chapter 21, Part II. No refund is required if it would be less than $5.
5155 (2) If a creditor requires a debtor to make any payment for credit life or credit [~~disability~~]
5156 accident and health insurance and an individual policy, certificate, or statement of insurance is not
5157 issued, the creditor shall immediately give written notice to the debtor and credit the account.
5158 (3) The amount charged the debtor for credit life or [~~disability~~] accident and health
5159 insurance may not exceed the premiums charged by the insurer as computed at the time the charge
5160 to the debtor is determined.
5161 Section 122. Section **31A-22-809** is amended to read:
5162 **31A-22-809. Right of debtor to choose insurer.**
5163 When credit life insurance or credit [~~disability~~] accident and health insurance is required
5164 as security for any indebtedness, the creditor shall inform the debtor of the debtor's option to
5165 furnish the required insurance through existing policies of insurance owned or controlled by the
5166 debtor or to procure and furnish the required coverage through any insurer authorized to transact
5167 life or [~~disability~~] accident and health insurance in Utah.
5168 Section 123. Section **31A-22-1002** is amended to read:
5169 **31A-22-1002. Duration of coverage.**
5170 (1) Any insurer assuming a workers' compensation risk shall carry it until the policy is
5171 canceled, either:

5172 (a) by agreement between the Division of Industrial Accidents in the Labor Commission,
5173 the insurer, and the employer; or
5174 (b) after:
5175 (i) [~~30 days~~] notice by the insurer to the employer as provided in Section 31A-21-303; and
5176 (ii) notice to the Division of Industrial Accidents in the Labor Commission as provided
5177 in Section 34A-2-205.
5178 (2) Subsection (1) does not affect the requirements of Section 31A-22-1001.
5179 Section 124. Section **31A-22-1101** is amended to read:
5180 **31A-22-1101. Combination of lines.**
5181 (1) Legal expense insurance may be transacted alone or together with life insurance,
5182 [~~disability~~] accident and health insurance, or casualty insurance.
5183 (2) [~~No~~] An insurer may not transact liability insurance and also issue legal expense
5184 insurance policies providing coverage for the expense of enforcing claims against third persons,
5185 unless the requirements of Subsection (3) are met and the commissioner is satisfied that the
5186 interests of policyholders of legal expense insurance policies are not endangered by potential
5187 conflicts of interest within the insurer.
5188 (3) Adequate precautions shall be taken to make sure that the handling of an insured's
5189 claim for legal assistance in enforcing a claim against a third person is not affected by the insurer's
5190 actual or potential obligation as a liability insurer to pay the claim for the third person. These
5191 precautions may include:
5192 (a) a provision in the policy that claims against third persons shall be handled exclusively
5193 by attorneys selected by the insureds themselves rather than by the insurer, that no information
5194 about the case other than the name of the defendant and the nature of the claim may be made
5195 available to the insurer, and that the insurer may not interfere with the handling of the case; or
5196 (b) organizational separation between the legal expense and the liability insurance
5197 departments with respect to management, accounting, record keeping, and claims handling, with
5198 appropriate rules and procedures, satisfactory to the commissioner, to prevent the exchange of
5199 information between the two departments about details of cases.
5200 Section 125. Section **31A-22-1401** is amended to read:
5201 **31A-22-1401. Application.**
5202 (1) The requirements of this part apply to individual policies and to group policies and

5203 certificates marketed in this state on or after July 1, [~~1991~~] 2001, other than employee and labor
5204 union group policies and certificates.
5205 (2) Entities subject to this part shall comply with other applicable insurance laws and rules
5206 unless they are in conflict with this part.
5207 (3) The laws, regulations, and rules designed and intended to apply to Medicare
5208 supplement insurance policies may not be applied to long-term care insurance.
5209 (4) Any policy or rider advertised, marketed, or offered as long-term care or nursing home
5210 insurance shall comply with the provisions of this part.
5211 Section 126. Section **31A-22-1402** is amended to read:
5212 **31A-22-1402. Definitions.**
5213 Unless the context requires otherwise, the following definitions apply in this part:
5214 (1) "Applicant" means:
5215 (a) in the case of an individual long-term care insurance policy, the person who seeks to
5216 contract for benefits; and
5217 (b) in the case of a group long-term care insurance policy, the proposed certificate holder.
5218 [~~(2) (a) "Long-term care insurance" means any insurance policy or rider advertised,~~
5219 ~~marketed, offered, or designed to provide coverage:~~]
5220 [~~(i) for not less than 12 consecutive months for each covered person on an expense~~
5221 ~~incurred, indemnity, prepaid, or other basis;~~]
5222 [~~(ii) for one or more necessary or medically necessary diagnostic, preventive, therapeutic,~~
5223 ~~rehabilitative, maintenance, or personal care service, provided in a setting other than an acute care~~
5224 ~~unit of a hospital.~~]
5225 [~~(b) The term includes group and individual annuities and life insurance policies or riders~~
5226 ~~which provide directly or supplement long-term care insurance. The term also includes a policy~~
5227 ~~or rider which provides for payment of benefits based upon cognitive impairment or the loss of~~
5228 ~~functional capacity.~~]
5229 [~~(c) Long-term care insurance does not include any insurance policy which is offered~~
5230 ~~primarily to provide basic Medicare supplement coverage, basic hospital expense coverage, basic~~
5231 ~~medical-surgical expense coverage, hospital confinement indemnity coverage, major medical~~
5232 ~~expense coverage, disability income or related asset-protection coverage, accident only coverage,~~
5233 ~~specified disease or specified accident coverage, or limited benefit health coverage.~~]

5234 (2) Notwithstanding Section 31A-1-301,"certificate" means a certificate issued under a
5235 group long-term care insurance policy if the group long-term care insurance policy is delivered or
5236 issued for delivery in this state.
5237 (3) Notwithstanding Section 31A-1-301, "policy" means a policy, contract subscriber
5238 agreement, rider, or endorsement, if the policy, contract subscriber agreement, rider, or
5239 endorsement is delivered or issued:
5240 (a) in this state; and
5241 (b) by:
5242 (i) an insurer;
5243 (ii) a fraternal benefit society;
5244 (iii) a nonprofit health, hospital, or medical service corporation;
5245 (iv) a prepaid health plan;
5246 (v) a health maintenance organization; or
5247 (vi) an entity similar to an entity described in Subsections (4)(b)(i) through (v).
5248 Section 127. Section **31A-22-1407** is amended to read:
5249 **31A-22-1407. Restricted conditional terms.**
5250 (1) A long-term care insurance policy may not contain a provision that conditions
5251 eligibility:
5252 (a) [~~conditions eligibility~~] for any benefits on a prior hospitalization requirement; [~~or~~]
5253 (b) [~~conditions eligibility~~] for benefits provided in an institutional care setting on the
5254 receipt of a higher level of institutional care[~~.~~]; or
5255 (c) for any benefits on a prior institutionalization requirement except for eligibility for:
5256 (i) waiver of premium;
5257 (ii) post confinement;
5258 (iii) post-acute care; or
5259 (iv) recuperative benefits.
5260 (2) A long-term care insurance policy containing [~~any limitations or conditions for~~
5261 ~~eligibility other than those prohibited in Subsection (1)~~] post confinement, post-acute care, or
5262 recuperative benefits shall clearly label the limitations or conditions, including any required
5263 number of days of confinement in a separate paragraph of the policy or certificate that is entitled
5264 "Limitations or Conditions on Eligibility for Benefits."

5265 [~~(3) A long-term care insurance policy containing a benefit advertised, marketed, or~~
5266 ~~offered as a home health care benefit may not condition receipt of benefits on a prior~~
5267 ~~institutionalization.~~]
5268 [~~(4) A long-term care insurance policy or rider that provides benefits only following~~
5269 ~~institutionalization may not condition the benefits upon admission to a facility for the same or~~
5270 ~~related conditions within a period of less than 30 days after discharge from the institution.~~]
5271 (3) A long-term care insurance policy or rider that conditions eligibility of noninstitutional
5272 benefits on the prior receipt of institutional care may not require a prior institutional stay of more
5273 than 30 days.
5274 Section 128. Section **31A-22-1409** is amended to read:
5275 **31A-22-1409. Statements of coverage.**
5276 (1) An outline of coverage shall be delivered to a prospective applicant for long-term care
5277 insurance at the time of initial solicitation through means which prominently direct the attention
5278 of the applicant to the document and its purpose.
5279 (2) The commissioner may prescribe a standard format of an outline of coverage, including
5280 style, arrangement, and overall appearance, and the content.
5281 (3) In the case of agent solicitations an agent must deliver the outline of coverage prior to
5282 the presentation of any application or enrollment form.
5283 (4) In the case of direct response solicitations, the outline of coverage must be presented
5284 in conjunction with any application or enrollment form.
5285 (5) An outline of coverage under this section shall include:
5286 (a) a description of the principal benefits and coverage provided in the policy;
5287 (b) a statement of the principal exclusions, reductions, and limitations contained in the
5288 policy;
5289 (c) a statement of the terms under which the policy or certificate, or both, may be
5290 continued in force or discontinued, including any reservation in the policy of a right to change
5291 premium;
5292 (d) a specific description of continuation or conversion provisions of group coverage;
5293 (e) a statement that the outline of coverage is not a contract of insurance but a summary
5294 only and that the policy or group master policy contains governing contractual provisions;
5295 (f) a description of the terms under which the policy or certificate may be returned and

5296 premium refunded; [~~and~~]

5297 (g) a brief description of the relationship of cost of care and benefits[~~.~~]; and

5298 (h) a statement that discloses to the policyholder or certificate holder whether the policy

5299 is intended to be a federally tax-qualified, long-term care insurance contract under Section

5300 7702B(b), Internal Revenue Code.

5301 (6) A certificate issued pursuant to a group long-term care insurance policy, which policy

5302 is delivered or issued for delivery in this state, shall include:

5303 (a) a description of the principal benefits and coverage provided in the policy;

5304 (b) a statement of the principal exclusions, reductions, and limitations contained in the

5305 policy; [~~and~~]

5306 (c) a statement that the group master policy determines governing contractual

5307 provisions[~~.~~]; and

5308 (d) a statement that any long-term care inflation protection option required by rule is not

5309 available under the policy.

5310 (7) If an application for a long-term care contract or certificate is approved, the issuer shall

5311 deliver the contract or certificate of insurance to the applicant no later than 30 days after the date

5312 of approval.

5313 [~~(7)~~] (8) At the time of policy delivery, a policy summary shall be delivered for an

5314 individual life insurance policy which provides long-term care benefits within the policy or by

5315 rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon

5316 the applicant's request. However, the insurer shall deliver the summary to the applicant no later

5317 than at the time of policy delivery regardless of request. In addition to complying with all

5318 applicable requirements, the summary shall also include:

5319 (a) an explanation of how the long-term care benefit interacts with other components of

5320 the policy, including deductions from death benefits;

5321 (b) an illustration for each covered person of the amount of benefits, the length of benefit,

5322 and the guaranteed lifetime benefits if any;

5323 (c) any exclusions, reductions, and limitations on benefits of long-term care; and

5324 (d) if applicable to the policy type, the summary shall also include:

5325 (i) a disclosure of the effects of exercising other rights under the policy;

5326 (ii) a disclosure of guarantees related to long-term care costs of insurance charges; and

5327 (iii) current and projected maximum lifetime benefits.
5328 (9) The provisions of the policy summary required under Subsection (8) may be
5329 incorporated into:
5330 (a) a basic illustration; or
5331 (b) the life insurance policy summary required to be delivered in accordance with rule.
5332 Section 129. Section **31A-22-1412** is amended to read:
5333 **31A-22-1412. Nonforfeiture benefits.**
5334 (1) (a) A long-term care insurance policy or certificate may not be delivered or issued for
5335 delivery in this state unless the [~~issuer of the policy or certificate offers nonforfeiture benefits to~~
5336 ~~the defaulting or surrendering policyholder or certificate holder~~] policyholder or certificate holder
5337 has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit.
5338 (b) The offer of a nonforfeiture benefit under Subsection (1)(a) may be in the form of a
5339 rider that is attached to the policy.
5340 (c) If the policyholder or certificate holder declines the nonforfeiture benefit offered under
5341 this Subsection (1), the insurer shall provide a contingent benefit upon lapse of the policy or
5342 certificate that is available for a specified period of time following a substantial increase in
5343 premium rates.
5344 (d) (i) Except as provided in Subsection (1)(d)(ii), if a group long-term care insurance
5345 policy is issued, the offer required in this Subsection (1) shall be made to the group policyholder.
5346 (ii) If the policy is issued to a group authorized under Section 31A-22-509, the offer
5347 required under this Subsection (1) shall be made to each proposed certificate holder.
5348 (2) The commissioner shall make rules:
5349 (a) specifying the types of nonforfeiture benefits [~~and~~] to be offered as part of a long-term
5350 care insurance policy or certificate;
5351 (b) specifying the standards for [~~the~~] nonforfeiture benefits [~~to be included in the policies~~
5352 ~~and certificates.~~]; and
5353 (c) regarding contingent benefits upon lapse, including a determination of:
5354 (i) the specified period of time during which a contingent benefit upon lapse will be
5355 available as provided in Subsection (1); and
5356 (ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as
5357 provided in Subsection (1).

5358 Section 130. Section **31A-22-1413** is enacted to read:

5359 **31A-22-1413. Claim information.**

5360 If a claim under a long-term care insurance contract is denied, within 60 days of the date

5361 a written request by the policyholder or a representative of a policyholder is filed with the insurer,

5362 the insurer shall:

5363 (1) provide a written explanation of the reason for the denial; and

5364 (2) make available all information directly related to the denial.

5365 Section 131. Section **31A-22-1414** is enacted to read:

5366 **31A-22-1414. Marketing.**

5367 A policy or rider shall comply with this part if it is advertised, marketed, or offered as:

5368 (1) long-term care insurance; or

5369 (2) nursing home insurance.

5370 Section 132. Section **31A-23-101** is amended to read:

5371 **31A-23-101. Purposes.**

5372 The purposes of this chapter include:

5373 (1) promoting the professional competence of insurance agents, brokers, and consultants;

5374 (2) providing maximum freedom of marketing methods for insurance, consistent with the

5375 interests of the Utah public;

5376 (3) preserving and encouraging competition at the consumer level; [and]

5377 (4) regulating insurance marketing practices in conformity with the general purposes of

5378 [the Insurance Code.] this title; and

5379 (5) governing the qualifications and procedures for the licensing of insurance producers.

5380 Section 133. Section **31A-23-102** is amended to read:

5381 **31A-23-102. Definitions.**

5382 As used in this chapter:

5383 [(1) Except as provided in Subsection (2):]

5384 [(a) "Escrow" is a license category that allows a person to conduct escrows, settlements,

5385 or closings on behalf of a title insurance agency or a title insurer.]

5386 [(b) "Limited license" means a license that is issued for a specific product of insurance and

5387 limits an individual or agency to transact only for those products.]

5388 [(c) "Search" is a license category that allows a person to issue title insurance

5389 ~~commitments or policies on behalf of a title insurer.~~]
5390 [~~(d) "Title marketing representative" means a person who:~~]
5391 [~~(i) represents a title insurer in soliciting, requesting, or negotiating the placing of:~~]
5392 [~~(A) title insurance; or~~]
5393 [~~(B) escrow, settlement, or closing services; and~~]
5394 [~~(ii) does not have a search or escrow license.~~]
5395 [~~(2) The following persons are not acting as agents, brokers, title marketing~~
5396 ~~representatives, or consultants when acting in the following capacities:~~]
5397 [~~(a) any regular salaried officer, employee, or other representative of an insurer or licensee~~
5398 ~~under this chapter who devotes substantially all of the officer's, employee's, or representative's~~
5399 ~~working time to activities other than those described in Subsection (1) and Subsections~~
5400 ~~31A-1-301(51), (52), and (54) including the clerical employees of persons required to be licensed~~
5401 ~~under this chapter;~~]
5402 [~~(b) a regular salaried officer or employee of a person seeking to purchase insurance, who~~
5403 ~~receives no compensation that is directly dependent upon the amount of insurance coverage~~
5404 ~~purchased;~~]
5405 [~~(c) a person who gives incidental advice in the normal course of a business or professional~~
5406 ~~activity, other than insurance consulting, if neither that person nor that person's employer receives~~
5407 ~~direct or indirect compensation on account of any insurance transaction that results from that~~
5408 ~~advice;~~]
5409 [~~(d) a person who, without special compensation, performs incidental services for another~~
5410 ~~at the other's request, without providing advice or technical or professional services of a kind~~
5411 ~~normally provided by an agent, broker, or consultant;~~]
5412 [~~(e) a holder of a group insurance policy, or any other person involved in mass marketing,~~
5413 ~~but only:~~]
5414 [~~(i) with respect to administrative activities in connection with that type of policy,~~
5415 ~~including the collection of premiums; and~~]
5416 [~~(ii) if the person receives no compensation for the activities described in Subsection~~
5417 ~~(2)(e)(i) beyond reasonable expenses including a fair payment for the use of capital; and~~]
5418 [~~(f) a person who gives advice or assistance without direct or indirect compensation or any~~
5419 ~~expectation of direct or indirect compensation.~~]

5420 [(3)] (1) "Actuary" means a person who is a member in good standing of the American
5421 Academy of Actuaries.
5422 [(4)] (2) "Agency" means a person other than an individual, and includes a sole
5423 proprietorship by which a natural person does business under an assumed name.
5424 [(5)] (3) "Broker" means an insurance broker or any other person, firm, association, or
5425 corporation that for any compensation, commission, or other thing of value acts or aids in any
5426 manner in soliciting, negotiating, or procuring the making of any insurance contract on behalf of
5427 an insured other than itself.
5428 [(6)] (4) "Bail bond agent" means [any] an individual:
5429 (a) appointed by an authorized bail bond surety insurer or appointed by a licensed bail
5430 bond surety company to execute or countersign undertakings of bail in connection with judicial
5431 proceedings; and
5432 (b) who receives or is promised money or other things of value for this service.
5433 [(7)] (5) "Captive insurer" means:
5434 (a) an insurance company owned by another organization whose exclusive purpose is to
5435 insure risks of the parent organization and affiliated companies; or
5436 (b) in the case of groups and associations, an insurance organization owned by the insureds
5437 whose exclusive purpose is to insure risks of member organizations, group members, and their
5438 affiliates.
5439 [(8)] (6) "Controlled insurer" means a licensed insurer that is either directly or indirectly
5440 controlled by a broker.
5441 [(9)] (7) "Controlling broker" means a broker who either directly or indirectly controls an
5442 insurer.
5443 [(10)] (8) "Controlling person" means any person, firm, association, or corporation that
5444 directly or indirectly has the power to direct or cause to be directed, the management, control, or
5445 activities of a reinsurance intermediary.
5446 (9) "Escrow" means a license category that allows a person to conduct escrows,
5447 settlements, or closings on behalf of:
5448 (a) a title insurance agency; or
5449 (b) a title insurer.
5450 (10) "Home state" means any state or territory of the United States or the District of

5451 Columbia in which an insurance producer:
5452 (a) maintains the insurance producer's principal:
5453 (i) place of residence; or
5454 (ii) place of business; and
5455 (b) is licensed to act as an insurance producer.
5456 (11) "Insurer" is as defined in Section 31A-1-301, except the following persons or similar
5457 persons are not insurers for purposes of Part 6, Broker Controlled Insurers:
5458 (a) all risk retention groups as defined in:
5459 (i) the Superfund Amendments and Reauthorization Act of 1986, Pub. L. No. 99-499;
5460 (ii) the Risk Retention Act, 15 U.S.C. Sec. 3901 et seq.; and
5461 (iii) [~~Title 31A,~~] Chapter 15, Part II, Risk Retention Groups Act;
5462 (b) all residual market pools and joint underwriting authorities or associations; and
5463 (c) all captive insurers.
5464 (12) "License" is defined in Section 31A-1-301.
5465 (13) "Limited license" means a license that:
5466 (a) is issued for a specific product of insurance; and
5467 (b) limits an individual or agency to transact only for that product or insurance.
5468 (14) "Limited line insurance" includes:
5469 (a) bail bond;
5470 (b) credit life;
5471 (c) credit disability;
5472 (d) credit property;
5473 (e) credit unemployment;
5474 (f) involuntary unemployment;
5475 (g) legal expense;
5476 (h) mortgage life;
5477 (i) mortgage guaranty;
5478 (j) mortgage disability;
5479 (k) motor club;
5480 (l) rental car-related;
5481 (m) travel insurance; and

5482 (n) any other form of limited insurance or insurance offered in connection with an
5483 extension of credit that:
5484 (i) is limited to partially or wholly extinguishing that credit obligation; and
5485 (ii) the commissioner determines should be designated a form of limited line insurance.
5486 [~~(12)~~] (15) (a) "Managing general agent" means any person, firm, association, or
5487 corporation that:
5488 (i) manages all or part of the insurance business of an insurer, including the management
5489 of a separate division, department, or underwriting office;
5490 (ii) acts as an agent for the insurer whether it is known as a managing general agent,
5491 manager, or other similar term;
5492 (iii) with or without the authority, either separately or together with affiliates, directly or
5493 indirectly produces and underwrites an amount of gross direct written premium equal to, or more
5494 than 5% of, the policyholder surplus as reported in the last annual statement of the insurer in any
5495 one quarter or year; and
5496 (iv) [~~either~~] (A) adjusts or pays claims in excess of an amount determined by the
5497 commissioner[~~,~~]; or [~~that~~]
5498 (B) negotiates reinsurance on behalf of the insurer.
5499 (b) Notwithstanding Subsection [~~(12)~~] (15)(a), the following persons may not be
5500 considered as managing general agent for the purposes of this chapter:
5501 (i) an employee of the insurer;
5502 (ii) a [~~U.S.~~] United States manager of the United States branch of an alien insurer;
5503 (iii) an underwriting manager that, pursuant to contract:
5504 (A) manages all the insurance operations of the insurer;
5505 (B) is under common control with the insurer;
5506 (C) is subject to [~~Title 31A,~~] Chapter 16, Insurance Holding Companies; and
5507 (D) is not compensated based on the volume of premiums written; and
5508 (iv) the attorney-in-fact authorized by and acting for the subscribers of a reciprocal insurer
5509 or inter-insurance exchange under powers of attorney.
5510 (16) "Negotiate" means the act of conferring directly with or offering advice directly to a
5511 purchaser or prospective purchaser of a particular contract of insurance concerning any of the
5512 substantive benefits, terms or conditions of the contract if the person engaged in that act:

5513 (a) sells insurance; or
5514 (b) obtains insurance from insurers for purchasers.
5515 [~~(13)~~] (17) "Producer" [~~is~~] means a person [~~who arranges for insurance coverages between~~
5516 ~~insureds and insurers~~] required to be licensed under the laws of this state to sell, solicit, or
5517 negotiate insurance.
5518 [~~(14)~~] (18) "Qualified [~~U.S.~~] United States financial institution" means an institution that:
5519 (a) is organized or, in the case of a [~~U.S.~~] United States office of a foreign banking
5520 organization licensed, under the laws of the United States or any state;
5521 (b) is regulated, supervised, and examined by [~~U.S.~~] United States federal or state
5522 authorities having regulatory authority over banks and trust companies; and
5523 (c) [~~has been determined by either the commissioner, or the Securities Valuation Office~~
5524 ~~of the National Association of Insurance Commissioners, to meet~~] meets the standards of financial
5525 condition and standing that are considered necessary and appropriate to regulate the quality of
5526 financial institutions whose letters of credit will be acceptable to the commissioner[~~.~~] as
5527 determined by:
5528 (i) the commissioner; or
5529 (ii) the Securities Valuation Office of the National Association of Insurance
5530 Commissioners.
5531 [~~(15)~~] (19) "Reinsurance intermediary" means a reinsurance intermediary-broker or a
5532 reinsurance intermediary-manager as these terms are defined in Subsections [~~(16)~~] (20) and [~~(17)~~]
5533 (21).
5534 [~~(16)~~] (20) "Reinsurance intermediary-broker" means a person other than an officer or
5535 employee of the ceding insurer, firm, association, or corporation who solicits, negotiates, or places
5536 reinsurance cessions or retrocessions on behalf of a ceding insurer without the authority or power
5537 to bind reinsurance on behalf of the insurer.
5538 [~~(17)~~] (21) (a) "Reinsurance intermediary-manager" means a person, firm, association, or
5539 corporation who:
5540 (i) has authority to bind or who manages all or part of the assumed reinsurance business
5541 of a reinsurer, including the management of a separate division, department, or underwriting
5542 office; and
5543 (ii) acts as an agent for the reinsurer whether the person, firm, association, or corporation

5544 is known as a reinsurance intermediary-manager, manager, or other similar term.
5545 (b) Notwithstanding Subsection [~~(17)~~] (21)(a), the following persons may not be
5546 considered reinsurance intermediary-managers for the purpose of this chapter with respect to the
5547 reinsurer:
5548 (i) an employee of the reinsurer;
5549 (ii) a [~~U.S.~~] United States manager of the United States branch of an alien reinsurer;
5550 (iii) an underwriting manager that, pursuant to contract:
5551 (A) manages all the reinsurance operations of the reinsurer;
5552 (B) is under common control with the reinsurer;
5553 (C) is subject to [~~Title 31A,~~] Chapter 16, Insurance Holding Companies; and
5554 (D) is not compensated based on the volume of premiums written; and
5555 (iv) the manager of a group, association, pool, or organization of insurers that:
5556 (A) engage in joint underwriting or joint reinsurance; and
5557 (B) are subject to examination by the insurance commissioner of the state in which the
5558 manager's principal business office is located.
5559 [~~(18)~~] (22) "Reinsurer" means any person, firm, association, or corporation duly licensed
5560 in this state as an insurer with the authority to assume reinsurance.
5561 (23) "Search" means a license category that allows a person to issue title insurance
5562 commitments or policies on behalf of a title insurer.
5563 (24) "Sell" means to exchange a contract of insurance:
5564 (a) by any means;
5565 (b) for money or its equivalent; and
5566 (c) on behalf of an insurance company.
5567 (25) "Solicit" means:
5568 (a) attempting to sell insurance; or
5569 (b) asking or urging a person to apply:
5570 (i) for a particular kind of insurance; and
5571 (ii) from a particular insurance company.
5572 [~~(19)~~] (26) "Surplus lines broker" means a person licensed under Subsection
5573 31A-23-204(5) to place insurance with unauthorized insurers in accordance with Section
5574 31A-15-103.

5575 (27) "Terminate" means:
5576 (a) the cancellation of the relationship between:
5577 (i) an insurance producer; and
5578 (ii) a particular insurer; or
5579 (b) the termination of the producer's authority to transact insurance on behalf of a
5580 particular insurance company.
5581 (28) "Title marketing representative" means a person who:
5582 (a) represents a title insurer in soliciting, requesting, or negotiating the placing of:
5583 (i) title insurance; or
5584 (ii) escrow, settlement, or closing services; and
5585 (b) does not have a search or escrow license.
5586 [(20)] (29) "Underwrite" means the authority to accept or reject risk on behalf of the
5587 insurer.
5588 (30) "Uniform application" means the version of the National Association of Insurance
5589 Commissioner's uniform application for resident and nonresident producer licensing at the time
5590 the application is filed.
5591 (31) "Uniform business entity application" means the version of the National Association
5592 of Insurance Commissioner's uniform business entity application for resident and nonresident
5593 business entities at the time the application is filed.
5594 Section 134. Section **31A-23-201** is amended to read:
5595 **31A-23-201. Requirement of license.**
5596 (1) (a) Unless exempted from the licensing requirement under [Subsection (2) or] Section
5597 31A-23-201.5 or 31A-23-214, a person may not perform, offer to perform, or advertise any service
5598 as an agent, broker, or consultant in Utah, without a valid license under Section 31A-23-203.
5599 (b) A person may not utilize the services of another as an agent, broker, or consultant if
5600 [he] that person knows or should know that the other does not have a license as required by law.
5601 [(2) The commissioner may by rule exempt certain classes of persons from the license
5602 requirement of Subsection (1) if either of these circumstances exist:]
5603 [(a) the functions they perform do not require special competence, trustworthiness, or the
5604 regulatory surveillance made possible by licensing; or]
5605 [(b) other existing safeguards make regulation unnecessary.]

5606 (2) This part may not be construed to require an insurer to obtain an insurance producer
5607 license.
5608 (3) [~~No~~] An insurance contract is not invalid as a result of a violation of this section.
5609 Section 135. Section **31A-23-201.5** is enacted to read:
5610 **31A-23-201.5. Exceptions to licensing.**
5611 (1) The commissioner may not require a license as an insurance producer of:
5612 (a) an officer, director, or employee of an insurer or of an insurance producer if:
5613 (i) the officer, director, or employee does not receive any commission on a policy written
5614 or sold to insure risks residing, located, or to be performed in this state; and
5615 (ii) (A) the officer's, director's, or employee's activities are:
5616 (I) executive, administrative, managerial, clerical, or a combination of these activities; and
5617 (II) only indirectly related to the sale, solicitation, or negotiation of insurance;
5618 (B) the officer's, director's, or employee's function relates to:
5619 (I) underwriting;
5620 (II) loss control;
5621 (III) inspection; or
5622 (IV) the processing, adjusting, investigating or settling of a claim on a contract of
5623 insurance; or
5624 (C) (I) the officer, director, or employee is acting in the capacity of a special agent or
5625 agency supervisor assisting an insurance producer;
5626 (II) the officer's, director's, or employee's activities are limited to providing technical
5627 advice and assistance to a licensed insurance producer; and
5628 (III) the officer's, director's, or employee's activities do not include the sale, solicitation,
5629 or negotiation of insurance;
5630 (b) a person who:
5631 (i) is paid no commission for the services described in Subsection (1)(b)(ii); and
5632 (ii) secures and furnishes information for the purpose of:
5633 (A) group life insurance;
5634 (B) group property and casualty insurance;
5635 (C) group annuities;
5636 (D) group or blanket accident and health insurance;

5637 (E) enrolling individuals under plans;
5638 (F) issuing certificates under plans; or
5639 (G) otherwise assisting in administering plans;
5640 (c) a person who:
5641 (i) is paid no commission for the services described in Subsection (1)(c)(ii); and
5642 (ii) performs administrative services related to mass marketed property and casualty
5643 insurance;
5644 (d) (i) any of the following if the conditions of Subsection (1)(d)(ii) are met:
5645 (A) an employer or association; or
5646 (B) an officer, director, employee, or trustee of an employee trust plan;
5647 (ii) a person listed in Subsection (1)(d)(i):
5648 (A) to the extent that the employer, officer, employee, director, or trustee is engaged in the
5649 administration or operation of a program of employee benefits for:
5650 (I) the employer's or association's own employees; or
5651 (II) the employees of a subsidiary or affiliate of an employer or association;
5652 (B) the program involves the use of insurance issued by an insurer; and
5653 (C) the employer, association, officer, director, employee, or trustee is not in any manner
5654 compensated, directly or indirectly, by the company issuing the contract;
5655 (e) an employee of an insurer or organization employed by an insurer who:
5656 (i) is engaging in:
5657 (A) the inspection, rating, or classification of risks; or
5658 (B) the supervision of the training of insurance producers; and
5659 (ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;
5660 (f) a person whose activities in this state are limited to advertising:
5661 (i) without the intent to solicit insurance in this state;
5662 (ii) through communications in mass media including:
5663 (A) a printed publication; or
5664 (B) a form of electronic mass media;
5665 (iii) that is distributed to residents outside of the state; and
5666 (iv) if the person does not sell, solicit, or negotiate insurance that would insure risks
5667 residing, located, or to be performed in this state;

5668 (g) a person who:
5669 (i) is not a resident of this state;
5670 (ii) sells, solicits, or negotiates a contract of insurance:
5671 (A) for commercial property and casualty risks to an insured with risks located in more
5672 than one state insured under that contract; and
5673 (B) insures risks located in a state in which the person is licensed as provided in
5674 Subsection (1)(g)(iii); and
5675 (iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in the
5676 state where the insured maintains its principal place of business;
5677 (h) if the employee does not sell, solicit, or receive a commission for a contract of
5678 insurance, a salaried full-time employee who counsels or advises the employee's employer relating
5679 to the insurance interests of:
5680 (i) the employer; or
5681 (ii) a subsidiary or business affiliate of the employer.
5682 (2) The commissioner may by rule exempt a class of persons from the license requirement
5683 of Subsection 31A-23-201(1) if:
5684 (a) the functions performed by the class of persons does not require:
5685 (i) special competence;
5686 (ii) special trustworthiness; or
5687 (iii) regulatory surveillance made possible by licensing; or
5688 (b) other existing safeguards make regulation unnecessary.
5689 Section 136. Section **31A-23-202** is amended to read:
5690 **31A-23-202. Application for license.**
5691 (1) [~~The~~] (a) Subject to Subsection (2) the application for a resident license as an agent,
5692 a broker, or a consultant shall be:
5693 (i) made to the commissioner on forms and in a manner [~~he~~] the commissioner prescribes[~~.~~
5694 ~~The~~]; and
5695 (ii) accompanied by an applicable fee that is not refunded if the application is denied; and
5696 (b) the application for a nonresident license as an agent, a broker, or a consultant shall be:
5697 (i) made on the uniform application; and
5698 (ii) accompanied by an applicable fee that is not refunded if the application is denied.

5699 (2) An application described in Subsection (1) shall provide:
5700 (a) information about the applicant's identity[;];
5701 (b) the applicant's:
5702 (i) social security number[;]; or
5703 (ii) federal employer identification number;
5704 (c) the applicant's personal history, experience, education, and business record[, and];
5705 (d) if the applicant is a natural person, whether the applicant is 18 years of age or older;
5706 (e) whether the applicant has committed an act that is a ground for denial, suspension, or
5707 revocation as set forth in Section 31A-23-216; and
5708 (f) any other information the commissioner reasonably requires.
5709 (3) The commissioner may require any documents reasonably necessary to verify the
5710 information contained in an application.
5711 [(2)] (4) [An applicant's social security number is a] The following are private [record]
5712 records under Subsection 63-2-302(1)(g)[.] an applicant's:
5713 (a) social security number; or
5714 (b) federal employer identification number.
5715 Section 137. Section **31A-23-203** is amended to read:
5716 **31A-23-203. General requirements for license issuance and renewal.**
5717 (1) The commissioner shall issue or renew a license to act as an agent, broker, or
5718 consultant to any person who, as to the license classification applied for under Section
5719 31A-23-204:
5720 (a) has satisfied the character requirements under Section 31A-23-205;
5721 (b) has satisfied any applicable continuing education requirements under Section
5722 31A-23-206;
5723 (c) has satisfied any applicable examination requirements under Section 31A-23-207;
5724 (d) has satisfied any applicable training period requirements under Section 31A-23-208;
5725 (e) if a nonresident:
5726 (i) has complied with Section 31A-23-209; and
5727 (ii) holds an active similar license in that person's state of residence;
5728 (f) as to applicants for licenses to act as title insurance agents, has satisfied the
5729 requirements of Section 31A-23-211; and

5730 (g) has paid the applicable fees under Section 31A-3-103.
5731 (2) (a) This Subsection (2) applies to the following persons:
5732 (i) an applicant for a pending producer's license; or
5733 (ii) a licensed producer.
5734 (b) A person described in Subsection (2)(a) shall report to the commissioner:
5735 (i) any administrative action taken against the person:
5736 (A) in another jurisdiction; or
5737 (B) by another regulatory agency in this state; and
5738 (ii) any criminal prosecution taken against the person in any jurisdiction.
5739 (c) The report required by Subsection (2)(b) shall:
5740 (i) be filed:
5741 (A) at the time the person files the application for a producer's license; or
5742 (B) within 30 days of the initiation of an action or prosecution described in Subsection
5743 (2)(b); and
5744 (ii) include a copy of the complaint or other relevant legal documents related to the action
5745 or prosecution described in Subsection (2)(b).
5746 [~~(2)~~] (3) (a) The department may request:
5747 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2,
5748 from the Bureau of Criminal Identification; and
5749 (ii) complete Federal Bureau of Investigation criminal background checks through the
5750 national criminal history system.
5751 (b) Information obtained by the department from the review of criminal history records
5752 received under Subsection [~~(2)~~] (3)(a) shall be used by the department for the purposes of:
5753 (i) determining if a person satisfies the character requirements under Section 31A-23-205
5754 for issuance or renewal of a license;
5755 (ii) determining if a person has failed to maintain the character requirements under Section
5756 31A-23-205; and
5757 (iii) preventing persons who violate the federal Violent Crime Control and Law
5758 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of
5759 insurance in the state.
5760 (c) If the department requests the criminal background information, the department shall:

5761 (i) pay to the Department of Public Safety the costs incurred by the Department of Public
5762 Safety in providing the department criminal background information under Subsection [(2)]
5763 (3)(a)(i);
5764 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of
5765 Investigation in providing the department criminal background information under Subsection[(2)]
5766 (3)(a)(ii); and
5767 (iii) charge the person applying for a license or for renewal of a license a fee equal to the
5768 aggregate of Subsections [(2)] (3)(c)(i) and (ii).
5769 Section 138. Section **31A-23-204** is amended to read:
5770 **31A-23-204. License classifications.**
5771 [Licenses] A resident or nonresident license issued under this chapter shall be issued under
5772 the classifications described under Subsections (1) through (6). These classifications are intended
5773 to describe the matters to be considered under any education, examination, and training required
5774 of license applicants under Sections 31A-23-206 through 31A-23-208.
5775 (1) [Agent] An agent and broker license [classifications include] classification includes:
5776 (a) life insurance, including nonvariable [annuities] contracts;
5777 (b) variable [annuities] contracts;
5778 (c) [disability] accident and health insurance, including contracts issued to policyholders
5779 under Chapter 7 or 8;
5780 (d) property/liability insurance, which includes:
5781 (i) property insurance;
5782 (ii) liability insurance;
5783 (iii) surety and other bonds; and
5784 (iv) policies containing any combination of these coverages;
5785 (e) title insurance under one of the following categories:
5786 (i) search, including authority to act as a title marketing representative;
5787 (ii) escrow, including authority to act as a title marketing representative;
5788 (iii) search and escrow, including authority to act as a title marketing representative; and
5789 (iv) title marketing representative only; and
5790 (f) workers' compensation insurance.
5791 (2) [Limited] A limited license [product] classification includes:

5792 (a) credit life and credit [~~disability~~] accident and health insurance;
5793 (b) travel insurance;
5794 (c) motor club insurance;
5795 (d) car rental related insurance;
5796 (e) credit involuntary unemployment insurance [~~and~~];
5797 (f) credit property insurance;
5798 [~~(f)~~] (g) bail bond agent; and
5799 [~~(g)~~] (h) customer service representative.
5800 (3) [~~Consultant~~] A consultant license classification includes:
5801 (a) life insurance, including nonvariable [~~annuities~~] contracts;
5802 (b) variable [~~annuities~~] contracts;
5803 (c) [~~disability~~] accident and health insurance, including contracts issued to policyholders
5804 under Chapter 7 or 8;
5805 (d) property/liability insurance, which includes:
5806 (i) property insurance;
5807 (ii) liability insurance;
5808 (iii) surety and other bonds; and
5809 (iv) policies containing any combination of these coverages; and
5810 (e) workers' compensation insurance.
5811 (4) A holder of licenses under Subsections (1)(a) and (1)(c) has all qualifications necessary
5812 to act as a holder of a license under Subsection (2)(a).
5813 (5) (a) Upon satisfying the additional applicable requirements, a holder of a brokers license
5814 may obtain a license to act as a surplus lines broker.
5815 (b) A license to act as a surplus lines broker gives the holder the authority to arrange
5816 insurance contracts with unauthorized insurers under Section 31A-15-103, but only as to the types
5817 of insurance under Subsection (1) for which the broker holds a brokers license.
5818 (6) The commissioner may by rule recognize other agent, broker, limited license, or
5819 consultant license classifications as to kinds of insurance not listed under Subsections (1), (2), and
5820 (3).
5821 Section 139. Section **31A-23-206** is amended to read:
5822 **31A-23-206. Continuing education requirements -- Regulatory authority.**

5823 (1) The commissioner shall by rule prescribe the continuing education requirements for
5824 each class of agent's license under Subsection 31A-23-204(1), except that the commissioner may
5825 not impose a continuing education requirement on a holder of a license under:
5826 (a) Subsection 31A-23-204(2); or
5827 (b) a license classification other than under Subsection 31A-23-204(2) that is recognized
5828 by the commissioner by rule as provided in Subsection 31A-23-204(6).
5829 (2) (a) The commissioner may not state a continuing education requirement in terms of
5830 formal education.
5831 (b) The commissioner may state a continuing education requirement in terms of classroom
5832 hours, or their equivalent, of insurance-related instruction received.
5833 (c) Insurance-related formal education may be a substitute, in whole or in part, for
5834 classroom hours, or their equivalent, required under Subsection (2)(b).
5835 (3) (a) The commissioner shall impose continuing education requirements in accordance
5836 with a two-year licensing period in which the licensee meets the requirements of this Subsection
5837 (3).
5838 (b) Except as provided in Subsection (3)(c), for a two-year licensing period described in
5839 Subsection (3)(a) the commissioner shall require that the licensee for each line of authority held
5840 by the licensee:
5841 (i) receive six hours of continuing education; or
5842 (ii) pass a line of authority continuing education examination.
5843 (c) Notwithstanding Subsection (3)(b):
5844 (i) the commissioner may not require continuing education for more than four lines of
5845 authority held by the licensee;
5846 (ii) the commissioner shall require:
5847 (A) a minimum of:
5848 (I) 12 hours of continuing education;
5849 (II) passage of two line of authority continuing education examinations; or
5850 (III) a combination of Subsections (3)(c)(ii)(A)(I) and (II);
5851 (B) that the minimum continuing education requirement of Subsection (3)(c)(ii)(A)
5852 include:
5853 (I) at least six hours or one line of authority continuing education examination for each line

5854 of authority held by the licensee not to exceed four lines of authority held by the licensee; and
5855 (II) three hours of ethics training, which may be taken in place of three hours of the hours
5856 required for a line of authority.
5857 (d) (i) If a licensee completes the licensee's continuing education requirement without
5858 taking a line of authority continuing education examination, the licensee shall complete at least 1/2
5859 of the required hours through classroom hours of insurance-related instruction.
5860 (ii) The hours not completed through classroom hours in accordance with Subsection
5861 (3)(d)(i) may be obtained through:
5862 (A) home study;
5863 (B) video tape;
5864 (C) experience credit; or
5865 (D) other method provided by rule.
5866 (e) (i) A licensee may obtain continuing education hours at any time during the two-year
5867 licensing period.
5868 (ii) The licensee may not take a line of authority continuing education examination more
5869 than 90 calendar days before the date on which the licensee's license is renewed.
5870 (f) The commissioner shall make rules for the content and procedures for line of authority
5871 continuing education examinations.
5872 (g) (i) Beginning May 3, 1999, a licensee is exempt from continuing education
5873 requirements under this section if:
5874 (A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;
5875 (B) the licensee requests an exemption from the department; and
5876 (C) the department approves the exemption.
5877 (ii) If the department approves the exemption under Subsection (3)(g)(i), the licensee is
5878 not required to apply again for the exemption.
5879 (h) A licensee with a variable [~~annuity~~] contract line of authority is exempt from the
5880 requirement for continuing education for that line of authority so long as the:
5881 (i) National Association of Securities Dealers requires continuing education for licensees
5882 having a securities license; and
5883 (ii) licensee complies with the National Association of Securities Dealers' continuing
5884 education requirements for securities licensees.

5885 (i) The commissioner shall, by rule:
5886 (i) publish a list of insurance professional designations whose continuing education
5887 requirements can be used to meet the requirements for continuing education under Subsection
5888 (3)(c); and
5889 (ii) authorize professional agent associations to:
5890 (A) offer qualified programs for all classes of licenses on a geographically accessible basis;
5891 and
5892 (B) collect reasonable fees for funding and administration of the continuing education
5893 program, subject to the review and approval of the commissioner.
5894 (j) (i) The fees permitted under Subsection (3)(i)(ii) that are charged to fund and administer
5895 the program shall reasonably relate to the costs of administering the program.
5896 (ii) Nothing in this section prohibits a provider of continuing education programs or
5897 courses from charging fees for attendance at courses offered for continuing education credit.
5898 (iii) The fees permitted under Subsection (3)(i)(ii) that are charged for attendance at a
5899 professional agent association program may be less for an association member, based on the
5900 member's affiliation expense, but shall preserve the right of a nonmember to attend without
5901 affiliation.
5902 (4) The commissioner shall designate courses, including those presented by insurers,
5903 which satisfy the requirements of this section.
5904 (5) The requirements of this section apply only to applicants who are natural persons.
5905 [~~(6) The commissioner may waive the requirements of this section as to any person who~~
5906 ~~has been an active insurance agent or broker in another state for two years immediately prior to~~
5907 ~~applying for a license in this state, but only if the applicant's state of residence has imposed upon~~
5908 ~~the applicant education requirements which are substantially as rigorous as those of this state.~~]
5909 (6) A nonresident producer is considered to have satisfied this state's continuing education
5910 requirements if:
5911 (a) the nonresident producer satisfies the nonresident producer's home state's continuing
5912 education requirements for a licensed insurance producer; and
5913 (b) on the same basis as under this Subsection (6) the nonresident producer's home state
5914 considers satisfaction of Utah's continuing education requirements for a producer as satisfying the
5915 continuing education requirements of the home state.

5916 Section 140. Section **31A-23-207** is amended to read:
5917 **31A-23-207. Examination requirements.**
5918 (1) (a) The commissioner may require applicants for any particular class of license under
5919 Section 31A-23-204 to pass an examination as a requirement for a license, except that [~~no~~] an
5920 examination may not be required of applicants for:
5921 (i) licenses under Subsection 31A-23-204(2); or
5922 (ii) other license classifications recognized by the commissioner by rule as provided in
5923 Subsection 31A-23-204(6).
5924 (b) The examination described in Subsection (1)(a):
5925 (i) shall reasonably relate to the specific classes for which it is prescribed[~~. The~~
5926 ~~examination~~]; and
5927 (ii) may be administered by the commissioner or as otherwise specified by rule.
5928 (2) The commissioner [~~may~~] shall waive the requirement of an examination for a
5929 nonresident applicant who [~~has held a similar license in his home state for the two years~~
5930 ~~immediately preceding application in this state, but only if the applicant's state of residence has~~
5931 ~~imposed upon the applicant examination requirements which are substantially as rigorous as those~~
5932 ~~of this state.~~]:
5933 (a) applies for an insurance producer license in this state;
5934 (b) has been licensed for the same line of authority in another state; and
5935 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
5936 applies for an insurance producer license in this state; or
5937 (ii) if the application is received within 90 days of the cancellation of the applicant's
5938 previous license:
5939 (A) the prior state certifies that at the time of cancellation, the applicant was in good
5940 standing in that state; or
5941 (B) the state's producer database records maintained by the National Association of
5942 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
5943 subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority
5944 requested.
5945 (3) (a) To become a resident licensee in accordance with Sections 31A-23-202 and
5946 31A-23-203, a person licensed as an insurance producer in another state who moves to this state

5947 shall make application within 90 days of establishing legal residence in this state.
5948 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be required
5949 to meet prelicensing education or examination requirements to obtain any line of authority
5950 previously held in the prior state unless:
5951 (i) the prior state would require a prior resident of this state to meet the prior state's
5952 prelicensing education or examination requirements to become a resident licensee; or
5953 (ii) the commissioner imposes the requirements by rule.
5954 [~~(3)~~] (4) This section's requirement may only be applied to applicants who are natural
5955 persons.
5956 Section 141. Section **31A-23-209** is amended to read:
5957 **31A-23-209. Nonresident jurisdictional agreement.**
5958 (1) (a) [~~Nonresident applicants for licenses under this chapter shall~~] If a nonresident
5959 license applicant has a valid license from the nonresident license applicant's home state and the
5960 conditions of Subsection (1)(b) are met, the commissioner shall:
5961 (i) waive any license requirement for a license under this chapter; and
5962 (ii) issue the nonresident license applicant a nonresident producer license.
5963 (b) Subsection (1)(a) applies if:
5964 (i) the nonresident license applicant:
5965 (A) is licensed as a resident in the nonresident license applicant's home state at the time
5966 the nonresident license applicant applies for a nonresident producer license;
5967 (B) has submitted the proper request for licensure;
5968 (C) has submitted to the commissioner:
5969 (I) the application for licensure that the nonresident license applicant submitted to the
5970 applicant's home state; or
5971 (II) a completed uniform application; and
5972 (D) has paid the applicable fees under Section 31A-3-103;
5973 (ii) the nonresident license applicant's license in the applicant's home state is in good
5974 standing; and
5975 (iii) the nonresident license applicant's home state awards nonresident producer licenses
5976 to residents of this state on the same basis as this state awards licenses to residents of that home
5977 state.

5978 (2) A nonresident applicant shall execute, in a form acceptable to the commissioner, an
5979 agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter
5980 related to the applicant's insurance activities in this state, on the basis of:
5981 (a) service of process under Sections 31A-2-309 and 31A-2-310; or [other]
5982 (b) service authorized:
5983 (i) in the Utah Rules of Civil Procedure; or
5984 (ii) under Section 78-27-25.
5985 (3) The commissioner may verify the producer's licensing status through the producer
5986 database maintained by:
5987 (a) the National Association of Insurance Commissioners; or
5988 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
5989 (4) The commissioner may not assess a greater fee for an insurance license or related
5990 service to a person not residing in this state solely on the fact that the person does not reside in this
5991 state.
5992 Section 142. Section **31A-23-211.7** is amended to read:
5993 **31A-23-211.7. Special requirements for variable annuity line of authority.**
5994 (1) Before applying for a variable [annuity] contracts line of authority, an agent, broker,
5995 or consultant shall be licensed under Section 61-1-3 as a:
5996 (a) broker-dealer; or
5997 (b) agent.
5998 (2) An agent's, broker's, or consultant's variable [annuity] contracts line of authority is
5999 revoked on the day on which an agent's, broker's, or consultant's license under Section 61-1-3 is
6000 no longer valid.
6001 Section 143. Section **31A-23-212** is amended to read:
6002 **31A-23-212. Form and contents of license.**
6003 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes and
6004 shall set forth:
6005 (a) the name, address, and telephone number of the licensee;
6006 (b) the license classifications under Section 31A-23-204;
6007 (c) the date of license issuance; and
6008 (d) any other information the commissioner considers necessary.

6009 (2) An insurance producer doing business under any other name than the producer's legal
6010 name shall notify the commissioner prior to using the assumed name in this state.
6011 [~~(2)~~] (3) (a) An agency shall be licensed as an agency if the agency acts as:
6012 (i) an agent;
6013 (ii) a broker;
6014 (iii) a surplus lines broker;
6015 (iv) a managing general agent; or
6016 (v) a consultant.
6017 (b) The agency license [~~required~~] issued under [~~Subsections (2)~~] Subsection (3)(a) shall
6018 set forth the names of all natural persons licensed under this chapter who are authorized to act in
6019 those capacities for the agency in this state.
6020 [~~(3)~~] (4) (a) So far as is practicable, the commissioner shall issue a single license to each
6021 agent, broker, or consultant for a single fee.
6022 (b) For purposes of the fee described in Subsection (4)(a), the less expensive license is
6023 included within the most expensive license.
6024 Section 144. Section **31A-23-216** is amended to read:
6025 **31A-23-216. Termination of license.**
6026 (1) A license issued under this chapter remains in force until:
6027 (a) revoked, suspended, or limited under Subsection (2);
6028 (b) lapsed under Subsection (3);
6029 (c) surrendered to and accepted by the commissioner; or
6030 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
6031 Part 3, Guardians of Incapacitated Persons or Part 4, Protection of Property of Persons Under
6032 Disability and Minors.
6033 [~~(2) (a) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative~~
6034 ~~Procedures Act, the commissioner may revoke, suspend, or limit in whole or in part the license of~~
6035 ~~any agent, broker, surplus lines broker, or consultant who is found:~~]
6036 [~~(i) to be unqualified;~~]
6037 [~~(ii) to have violated an insurance statute, valid rule under Subsection 31A-2-201(3), or~~
6038 ~~a valid order under Subsection 31A-2-201(4); or~~]
6039 [~~(iii) if the licensee's methods and practices in the conduct of business endanger the~~

6040 ~~legitimate interests of customers and the public.~~]

6041 [~~(b) Every order suspending a license issued under this chapter shall specify the period for~~

6042 ~~which the suspension is effective, but in no event may the period exceed 12 months.~~]

6043 (2) (a) If the commissioner makes a finding under Subsection (2)(b), after an adjudicative

6044 proceeding under Title 63, Chapter 46b, Administrative Procedures Act, the commissioner may:

6045 (i) revoke a license of an agent, broker, surplus lines broker, or consultant;

6046 (ii) suspend for a specified period of 12 months or less a license of an agent, broker,

6047 surplus lines broker, or consultant; or

6048 (iii) limit in whole or in part the license of any agent, broker, surplus lines broker, or

6049 consultant.

6050 (b) The commissioner may take an action described in Subsection (2)(a) if the

6051 commissioner finds that the licensee:

6052 (i) is unqualified for a license under Section 31A-23-203;

6053 (ii) has violated:

6054 (A) an insurance statute;

6055 (B) a rule that is valid under Subsection 31A-2-201(3); or

6056 (C) an order that is valid under Subsection 31A-2-201(4);

6057 (iii) is insolvent or the subject of receivership, conservatorship, rehabilitation, or other

6058 delinquency proceedings in any state;

6059 (iv) fails to pay any final judgment rendered against the person in this state within 60 days

6060 after the day the judgment became final;

6061 (v) fails to meet the same good faith obligations in claims settlement that is required of

6062 admitted insurers;

6063 (vi) is affiliated with and under the same general management or interlocking directorate

6064 or ownership as another insurance producer that transacts business in this state without a license;

6065 (vii) refuses to be examined or to produce its accounts, records, and files for examination;

6066 (viii) has an officer who refuses to:

6067 (A) give information with respect to the administrator's affairs; or

6068 (B) perform any other legal obligation as to an examination;

6069 (ix) provided information in the license application that is:

6070 (A) incorrect;

6071 (B) misleading;
6072 (C) incomplete; or
6073 (D) materially untrue;
6074 (x) has violated any insurance law, valid rule, or valid order of another state's insurance
6075 department;
6076 (xi) has obtained or attempted to obtain a license through misrepresentation or fraud;
6077 (xii) has improperly withheld, misappropriated, or converted any monies or properties
6078 received in the course of doing insurance business;
6079 (xiii) has intentionally misrepresented the terms of an actual or proposed:
6080 (A) insurance contract; or
6081 (B) application for insurance;
6082 (xiv) has been convicted of a felony;
6083 (xv) has admitted or been found to have committed any insurance unfair trade practice or
6084 fraud;
6085 (xvi) in the conduct of business in this state or elsewhere has:
6086 (A) used fraudulent, coercive, or dishonest practices; or
6087 (B) demonstrated incompetence, untrustworthiness, or financial irresponsibility;
6088 (xvii) has had an insurance license, or its equivalent, denied, suspended, or revoked in any
6089 other state, province, district, or territory;
6090 (xviii) has forged another's name to:
6091 (A) an application for insurance; or
6092 (B) any document related to an insurance transaction;
6093 (xix) has improperly used notes or any other reference material to complete an
6094 examination for an insurance license;
6095 (xx) has knowingly accepted insurance business from an individual who is not licensed;
6096 (xxi) has failed to comply with an administrative or court order imposing a child support
6097 obligation;
6098 (xxii) has failed to:
6099 (A) pay state income tax; or
6100 (B) comply with any administrative or court order directing payment of state income tax;
6101 (xxiii) has violated or permitted others to violate the federal Violent Crime Control and

6102 Law Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
6103 (xxiv) has engaged in methods and practices in the conduct of business that endanger the
6104 legitimate interests of customers and the public.
6105 (3) (a) Any license issued under this chapter shall lapse if the licensee fails to pay when
6106 due a fee under Section 31A-3-103.
6107 (b) A licensee whose license lapses due to military service or some other extenuating
6108 circumstances such as long-term medical disability may request:
6109 (i) reinstatement of the license; and
6110 (ii) waiver of any of the following imposed for failure to comply with renewal procedures:
6111 (A) an examination requirement;
6112 (B) a fine; or
6113 (C) other sanction imposed for failure to comply with renewal procedures.
6114 (c) The commissioner shall by rule prescribe the license renewal and reinstatement
6115 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
6116 (4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who
6117 continues to act as a licensee, is subject to the penalties for acting as a licensee without a license.
6118 (5) Any person licensed in this state shall immediately report to the commissioner:
6119 (a) a suspension or revocation of that person's license in any other state, District of
6120 Columbia, or territory of the United States;
6121 (b) the imposition of a disciplinary sanction imposed on that person by any other state,
6122 District of Columbia, or territory of the United States; and
6123 (c) a judgment or injunction entered against that person on the basis of conduct involving
6124 fraud, deceit, misrepresentation, or violation of an insurance law or rule.
6125 (6) An order revoking a license under Subsection (2) may specify a time, not to exceed five
6126 years, within which the former licensee may not apply for a new license. If no time is specified,
6127 the former licensee may not apply for a new license for five years without express approval by the
6128 commissioner.
6129 (7) Any person whose license is suspended or revoked under Subsection (2) shall, when
6130 the suspension ends or a new license is issued, pay all fees that would have been payable if the
6131 license had not been suspended or revoked, unless the commissioner by order waives the payment
6132 of the interim fees. If a new license is issued more than three years after the revocation of a similar

6133 license, this subsection applies only to the fees that would have accrued during the three years
6134 immediately following the revocation.
6135 (8) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license
6136 issued under this part if so ordered by a court.
6137 Section 145. Section **31A-23-218** is amended to read:
6138 **31A-23-218. Temporary insurance producer license -- Trustee for terminated**
6139 **licensee's business.**
6140 (1) (a) [~~Upon the request of the spouse, guardian, conservator, or personal representative~~
6141 ~~of a deceased or disabled agent or broker, or upon the request of a person whose license has been~~
6142 ~~terminated under Section 31A-23-216, the commissioner may appoint a trustee to provide~~
6143 ~~continuing service to the insureds who procured insurance through the deceased, disabled, or~~
6144 ~~unlicensed person.~~] The commissioner may issue a temporary insurance producer license:
6145 (i) to a person listed in Subsection (1)(b):
6146 (A) if the commissioner considers that the temporary license is necessary:
6147 (I) for the servicing of an insurance business in the public interest; and
6148 (II) to provide continued service to the insureds who procured insurance in a circumstance
6149 described in Subsection (1)(b);
6150 (B) for a period not to exceed 180 days; and
6151 (C) without requiring an examination; or
6152 (ii) in any other circumstance:
6153 (A) if the commissioner considers the public interest will best be served by issuing the
6154 temporary license;
6155 (B) for a period not to exceed 180 days; and
6156 (C) without requiring an examination.
6157 (b) The commissioner may issue a temporary insurance producer license in accordance
6158 with Subsection (1)(a) to:
6159 (i) the surviving spouse or court-appointed personal representative of a licensed insurance
6160 producer who dies or becomes mentally or physically disabled to allow adequate time for:
6161 (A) the sale of the insurance business owned by the producer;
6162 (B) recovery or return of the producer to the business; or
6163 (C) the training and licensing of new personnel to operate the producer's business;

6164 (ii) to a member or employee of a business entity licensed as an insurance producer upon
6165 the death or disability of an individual designated in:
6166 (A) the business entity application; or
6167 (B) the license; or
6168 (iii) the designee of a licensed insurance producer entering active service in the armed
6169 forces of the United States of America.
6170 (2) If a person's license is terminated under Section 31A-23-216, the commissioner may
6171 appoint a trustee to provide in the public interest continuing service to the insureds who procured
6172 insurance through the person whose license is terminated:
6173 (a) at the request of the person whose license is terminated; or
6174 (b) upon the commissioner's own initiative.
6175 (3) This section does not apply if the deceased or disabled agent or broker [owned or owns
6176 no] does not or did not own any ownership interest in the accounts and associated expiration lists
6177 [which] that were previously serviced by the agent or broker. [Any]
6178 (4) (a) A person issued a temporary license under Subsection (1) receives the license and
6179 shall perform the duties under the license subject to the commissioner's authority to:
6180 (i) require a temporary licensee to have a suitable sponsor who:
6181 (A) is a licensed producer; and
6182 (B) assumes responsibility for all acts of the temporary licensee; or
6183 (ii) impose other requirements that are:
6184 (A) designed to protect the insureds and the public; and
6185 (B) similar to the condition described in Subsection (4)(a)(i).
6186 (b) A trustee appointed under [this section] Subsection (2) shall [receive his appointment]
6187 be appointed and perform [his] the trustee's duties subject to the [following] terms and
6188 conditions[:] described in Subsections (4)(b)(i) through (vi).
6189 [(1) Trustees] (i) (A) A trustee appointed under [this section] Subsection (2) shall be
6190 licensed under this chapter to perform the services required by the trustor's clients.
6191 (B) When possible, the commissioner shall appoint a trustee who is no longer actively
6192 engaged on [his] the trustee's own behalf in business as an agent or broker.
6193 (C) The commissioner shall only select [persons] a person to act as trustee who [are] is
6194 trustworthy and competent to perform the necessary services.

6195 [(2)] (ii) (A) If the deceased, disabled, or unlicensed person for whom the trustee is acting
6196 was an agent, the insurers through which the former agent's business was written shall cooperate
6197 with the trustee in allowing [him] the trustee to service the policies written through the insurer.
6198 (B) The trustee shall abide by the terms of the agency agreement between the former agent
6199 and the issuing insurer, except that terms in those agreements terminating the agreement upon the
6200 death, disability, or license termination of the former agent do not bar the trustee from continuing
6201 to act under the agreement.
6202 [(3)] (iii) (A) The commissioner shall set the trustee's compensation, which:
6203 (I) may be stated in terms of a percentage of commissions[, but which is required to]; and
6204 (II) shall be equitable.
6205 (B) The compensation shall be paid exclusively from:
6206 (I) the commissions generated by the former agent or broker's insurance accounts serviced
6207 by the trustee; and [from]
6208 (II) other funds the former agent or broker or [his] the agent's or broker's successor in
6209 interest agree to pay.
6210 (C) The trustee has no special priority to commissions over the former agent or broker's
6211 creditors.
6212 [(4) Neither the] (iv) (A) The commissioner [nor] or the state [of Utah] may not be held
6213 liable for errors or omissions of:
6214 (I) the former agent or broker; or
6215 (II) the trustee.
6216 (B) The trustee may not be held liable for errors and omissions [which] that were caused
6217 in any material way by the negligence of the former agent or broker.
6218 (C) The trustee may be held liable for errors and omissions which arise solely from the
6219 trustee's negligence.
6220 (D) The trustee's compensation level shall be sufficient to allow the trustee to purchase
6221 errors and omissions coverage, if that coverage is not provided the trustee by:
6222 (I) the former agent or broker; or [his]
6223 (II) the agent's or broker's successor in interest.
6224 [(5)] (v) (A) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's
6225 clients, either directly or indirectly.

6226 (B) The trustee may not purchase the accounts or expiration lists of the former agent or
6227 broker, unless the commissioner expressly ratifies the terms of the sale.
6228 (C) The commissioner may adopt rules [which] that:
6229 (I) further define the trustee's fiduciary duties; and
6230 (II) explain how the trustee is to carry out [his] the trustee's responsibilities.
6231 [(6)] (vi) (A) The trust may be terminated by:
6232 (I) the commissioner; or [by]
6233 (II) the person that requested the trust be established.
6234 (B) The trust is terminated by written notice being delivered to:
6235 (I) the trustee; and
6236 (II) the commissioner.
6237 (5) (a) The commissioner may by order:
6238 (i) limit the authority of any temporary licensee or trustee in any way the commissioner
6239 considers necessary to protect insureds and the public; and
6240 (ii) revoke a temporary license or trustee's appointment if the commissioner finds that the
6241 insureds or the public are endangered.
6242 (b) A temporary license or trustee's appointment may not continue after the owner or
6243 personal representative disposes of the business.
6244 Section 146. Section **31A-23-302** is amended to read:
6245 **31A-23-302. Unfair marketing practices.**
6246 (1) (a) (i) [A person who is or should be licensed under this title, an employee or agent of
6247 that licensee or person who should be licensed, a person whose primary interest is as a competitor
6248 of a person licensed under this title, and a person on behalf of any of these persons] Any of the
6249 following may not make or cause to be made any communication that contains false or misleading
6250 information, relating to an insurance contract, any insurer, or other licensee under this title,
6251 including information that is false or misleading because it is incomplete[.]:
6252 (A) a person who is or should be licensed under this title;
6253 (B) an employee or agent of a person described in Subsection (1)(a)(i)(A);
6254 (C) a person whose primary interest is as a competitor of a person licensed under this title;
6255 and
6256 (D) a person on behalf of any of the persons listed in this Subsection (1)(a)(i).

6257 (ii) As used in this Subsection (1), "false or misleading information" includes:
6258 (A) assuring the nonobligatory payment of future dividends or refunds of unused
6259 premiums in any specific or approximate amounts, but reporting fully and accurately past
6260 experience is not false or misleading information; and
6261 (B) with intent to deceive a person examining it, filing a report, making a false entry in a
6262 record, or wilfully refraining from making a proper entry in a record.
6263 (iii) An insurer or other licensee under this title may not:
6264 (A) use any business name, slogan, emblem, or related device that is misleading or likely
6265 to cause the insurer or other licensee to be mistaken for another insurer or other licensee already
6266 in business[.]; or
6267 (B) use any advertisement or other insurance promotional material that would cause a
6268 reasonable person to mistakenly believe that a state or federal government agency:
6269 (I) is responsible for the insurance sales activities of the person;
6270 (II) stands behind the credit of the person;
6271 (III) guarantees any returns on insurance products of or sold by the person; or
6272 (IV) is a source of payment of any insurance obligation of or sold by the person.
6273 (iv) A person who is not an insurer may not assume or use any name that deceptively
6274 implies or suggests that it is an insurer.
6275 (v) A person other than persons licensed as health maintenance organizations under
6276 Chapter 8 may not use the term "Health Maintenance Organization" or "HMO" in referring to
6277 itself.
6278 (b) If an insurance agent or third party administrator distributes cards or documents,
6279 exhibits a sign, or publishes an advertisement that violates Subsection (1) (a), with reference to a
6280 particular insurer that the agent represents, or for whom the third party administrator processes
6281 claims, and if the cards, documents, signs, or advertisements are supplied or approved by that
6282 insurer, the agent's or the third party administrator's violation creates a rebuttable presumption that
6283 the violation was also committed by the insurer.
6284 (2) (a) (i) An insurer or licensee under this chapter, or an officer or employee of either may
6285 not induce any person to enter into or continue an insurance contract or to terminate an existing
6286 insurance contract by offering benefits not specified in the policy to be issued or continued,
6287 including premium or commission rebates.

6288 (ii) An insurer may not make or knowingly allow any agreement of insurance that is not
6289 clearly expressed in the policy to be issued or renewed.
6290 (iii) Subsection (2)(a) does not preclude:
6291 (A) insurers from reducing premiums because of expense savings;
6292 (B) the usual kinds of social courtesies not related to particular transactions; or
6293 (C) an insurer from receiving premiums under an installment payment plan.
6294 (b) An agent, broker, or insurer may not absorb the tax under Section 31A-3-301.
6295 (c) (i) A title insurer or agent or any officer or employee of either may not pay, allow, give,
6296 or offer to pay, allow, or give, directly or indirectly, as an inducement to obtaining any title
6297 insurance business, any rebate, reduction, or abatement of any rate or charge made incident to the
6298 issuance of the insurance, any special favor or advantage not generally available to others, or any
6299 money or other consideration or material inducement.
6300 (ii) "Charge made incident to the issuance of the insurance" includes escrow, settlement,
6301 and closing charges, and any other services that are prescribed by the commissioner.
6302 (iii) An insured or any other person connected, directly or indirectly, with the transaction,
6303 including a mortgage lender, real estate broker, builder, attorney, or any officer, employee, or agent
6304 of any of them, may not knowingly receive or accept, directly or indirectly, any benefit referred
6305 to in Subsection (2)(c)(i).
6306 (3) (a) An insurer may not unfairly discriminate among policyholders by charging different
6307 premiums or by offering different terms of coverage, except on the basis of classifications related
6308 to the nature and the degree of the risk covered or the expenses involved.
6309 (b) Rates are not unfairly discriminatory if they are averaged broadly among persons
6310 insured under a group, blanket, or franchise policy, and the terms of those policies are not unfairly
6311 discriminatory merely because they are more favorable than in similar individual policies.
6312 (4) A person who is or should be licensed under this title, an employee or agent of that
6313 licensee or person who should be licensed, a person whose primary interest is as a competitor of
6314 a person licensed under this title, and one acting on behalf of any of these persons, may not commit
6315 or enter into any agreement to participate in any act of boycott, coercion, or intimidation that tends
6316 to produce an unreasonable restraint of the business of insurance or a monopoly in that business.
6317 (5) (a) A person may not restrict in the choice of an insurer or insurance agent or broker,
6318 another person who is required to pay for insurance as a condition for the conclusion of a contract

6319 or other transaction or for the exercise of any right under a contract. The person requiring the
6320 coverage may, however, reserve the right to disapprove the insurer or the coverage selected on
6321 reasonable grounds.
6322 (b) The form of corporate organization of an insurer authorized to do business in this state
6323 is not a reasonable ground for disapproval, and the commissioner may by rule specify additional
6324 grounds that are not reasonable. This Subsection (5) does not bar an insurer from declining an
6325 application for insurance.
6326 (6) A person may not make any charge other than insurance premiums and premium
6327 financing charges for the protection of property or of a security interest in property, as a condition
6328 for obtaining, renewing, or continuing the financing of a purchase of the property or the lending
6329 of money on the security of an interest in the property.
6330 (7) (a) An agent may not refuse or fail to return promptly all indicia of agency to the
6331 principal on demand.
6332 (b) A licensee whose license is suspended, limited, or revoked under Section 31A-2-308,
6333 31A-23-216, or 31A-23-217 may not refuse or fail to return the license to the commissioner on
6334 demand.
6335 (8) A person may not engage in any other unfair method of competition or any other unfair
6336 or deceptive act or practice in the business of insurance, as defined by the commissioner by rule,
6337 after a finding that they are misleading, deceptive, unfairly discriminatory, provide an unfair
6338 inducement, or unreasonably restrain competition.
6339 Section 147. Section **31A-23-303** is amended to read:
6340 **31A-23-303. Inherent unsuitability.**
6341 [~~In the event~~] (1) If the commissioner finds after a hearing that a certain type of [~~disability~~]
6342 accident and health insurance, life insurance, or annuity product is inherently unsuitable for
6343 persons of certain ages or in certain conditions of health, the commissioner shall [~~promulgate~~]
6344 make a rule declaring [~~this disability~~] the accident and health insurance, life insurance, or annuity
6345 product as inherently unsuitable for persons of certain ages or in certain conditions of health. [~~No~~
6346 ~~disability~~]
6347 (2) An accident and health insurance, life insurance, or annuity product that is subject to
6348 the rule may not be sold to a person for whom the product has been determined as inherently
6349 unsuitable unless that person purchasing the product signs a receipt acknowledging having

6350 received a statement [~~which~~] that expresses that the product has been determined by the
6351 commissioner to be inherently unsuitable for persons of certain ages or in certain conditions of
6352 health.
6353 (3) Unless the insurer or its agent establishes that its sale of coverage [~~which~~] is
6354 inconsistent with the rule made under Subsection (1) is due to excusable neglect, the purchaser
6355 may treat the sale as voidable, if acted upon by the insured within a two-year period from the date
6356 of sale.
6357 Section 148. Section **31A-23-307** is amended to read:
6358 **31A-23-307. Title insurance agents' business.**
6359 A title insurance agent may engage in the escrow, settlement, or closing business, or any
6360 combination of such businesses, and operate as escrow, settlement, or closing agent provided that
6361 all the following exist:
6362 (1) The title insurance agent is properly licensed under this chapter.
6363 (2) (a) (i) All funds deposited with the agent in connection with any escrow, settlement,
6364 or closing are deposited in a federally insured financial institution in separate trust accounts, with
6365 the funds being the property of the persons entitled to them under the provisions of the escrow,
6366 settlement, or closing.
6367 (ii) The funds shall be segregated escrow by escrow, settlement by settlement, or closing
6368 by closing in the records of the agent. [~~These funds~~]
6369 (iii) Earnings on funds held in escrow may be paid out of the escrow account to any person
6370 in accordance with the provisions of the escrow agreement if the agreement does not otherwise
6371 provide for payment of the earnings or any portion of the earnings on the escrow funds.
6372 (iv) Funds held in escrow:
6373 (A) are not subject to any debts of the agent; and
6374 (B) may only be used to fulfill the terms of the individual escrow, settlement, or closing
6375 under which the funds were accepted. [~~None of the funds~~]
6376 (v) Funds held in escrow may not be used until all conditions of the escrow, settlement,
6377 or closing have been met.
6378 [~~(b) Any interest received on funds deposited with the agent in connection with any~~
6379 ~~escrow, settlement, or closing shall be paid over to the depositing party to the escrow, settlement,~~
6380 ~~or closing and may not be transferred to the account of the agent.~~]

6381 (b) Assets or property other than escrow funds received by an agent in accordance with an
6382 escrow agreement shall be maintained in a manner that will:
6383 (i) reasonably preserve and protect the asset or property from loss, theft, or damages; and
6384 (ii) otherwise comply with all general duties and responsibilities of a fiduciary or bailee.
6385 (c) [~~No~~] A check may not be drawn, executed or dated, or funds otherwise disbursed
6386 unless the segregated escrow account from which funds are to be disbursed contains a sufficient
6387 credit balance consisting of collected or cleared funds at the time the check is drawn, executed or
6388 dated, or funds are otherwise disbursed.
6389 (d) As used in this Subsection (2), funds are considered to be "collected or cleared," and
6390 may be disbursed as follows:
6391 (i) cash may be disbursed on the same day it is deposited;
6392 (ii) wire transfers may be disbursed on the same day they are deposited;
6393 (iii) cashier's checks, certified checks, teller's checks, U.S. Postal Service money orders,
6394 and checks drawn on a Federal Reserve Bank or Federal Home Loan Bank may be disbursed on
6395 the day following the date of deposit; and
6396 (iv) other checks or deposits may be disbursed within the time limits provided under the
6397 Expedited Funds Availability Act, 12 U.S.C. Section 4001 et seq., as amended, and related
6398 regulations of the Federal Reserve System or upon written notification from the financial
6399 institution to which the funds have been deposited, that final settlement has occurred on the
6400 deposited item.
6401 (3) The title insurance agent shall maintain records of all receipts and disbursements of
6402 escrow, settlement, and closing funds.
6403 (4) The title insurance agent shall comply with any rules adopted by the commissioner
6404 governing escrows, settlements, or closings.
6405 Section 149. Section **31A-23-310** is amended to read:
6406 **31A-23-310. Trust obligation for funds collected.**
6407 (1) Every agent or broker is a trustee for all funds received or collected as an agent or
6408 broker for forwarding to insurers or to insureds. Except for amounts necessary to pay bank
6409 charges, and except for funds paid by insureds and belonging in part to the agent or broker as fees
6410 or commissions, an agent or broker may not commingle trust funds with the agent or broker's own
6411 funds or with funds held in any other capacity. Except as provided under Subsection (4), every

6412 agent or broker owes to insureds and insurers the fiduciary duties of a trustee with respect to
6413 money to be forwarded to insurers or insureds through the agent or broker. Unless the funds are
6414 sent to the appropriate payee by the close of the next business day after their receipt, the licensee
6415 shall deposit them in an account authorized under Subsection (2). Funds so deposited shall remain
6416 in an account authorized under Subsection (2) until sent to the appropriate payee.
6417 (2) Funds required to be deposited under Subsection (1) shall be deposited:
6418 (a) in a federally insured trust account with a financial institution located in this state; or
6419 (b) in some other account, approved by the commissioner by rule or order, providing safety
6420 comparable to federally insured trust accounts.
6421 (3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the
6422 amount of the federal insurance on the accounts.
6423 (4) A trust account into which funds are deposited may be interest bearing. [Except as
6424 provided under Subsection 31A-23-307(2)(b), the] The interest accrued on the account may be
6425 paid to the agent or broker, so long as the agent or broker otherwise complies with this section and
6426 with the contract with the insurer.
6427 (5) A financial institution or other organization holding trust funds under this section may
6428 not offset or impound trust account funds against debts and obligations incurred by the agent or
6429 broker.
6430 (6) Any licensee who, not being lawfully entitled thereto, diverts or appropriates any
6431 portion of the funds held under Subsection (1) to the licensee's own use, is guilty of theft under
6432 Title 76, Chapter 6, Part 4. Section 76-6-412 applies in determining the classification of the
6433 offense. Sanctions under Section 31A-2-308 also apply.
6434 Section 150. Section **31A-23-312** is amended to read:
6435 **31A-23-312. Place of business and residence address -- Records.**
6436 (1) (a) All licensees under this chapter shall register with the commissioner the address
6437 and telephone numbers of their principal place of business.
6438 (b) If the licensee is an individual, [he] in addition to complying with Subsection (1)(a)
6439 the individual shall [also] provide [his] to the commissioner the individual's residence address and
6440 telephone number. [Licensees]
6441 (c) A licensee shall notify the commissioner, in writing, within 30 days of any change of
6442 address or telephone number.

6443 (2) (a) Except as provided under Subsection (3), every licensee under this chapter shall
6444 keep at the principal place of business address registered under Subsection (1), [a record] separate
6445 and distinct books and records of all transactions consummated under the Utah license. [The
6446 record]
6447 (b) The books and records described in Subsection (2)(a) shall:
6448 (i) be in an organized form;
6449 (ii) be available to the commissioner for inspection upon reasonable notice; and [shall]
6450 (iii) include all of the following:
6451 [(a)] (A) if the licensee is an agent or broker:
6452 [(i)] (I) a record of each insurance contract procured by or issued through the licensee, with
6453 the names of insurers and insureds, the amount of premium and commissions or other
6454 compensation, and the subject of the insurance;
6455 [(ii)] (II) the names of any other agents or brokers from whom business is accepted, and
6456 of persons to whom commissions or allowances of any kind are promised or paid; and
6457 (III) a record of all consumer complaints forwarded to the licensee by an insurance
6458 regulator;
6459 [(b)] (B) if the licensee is a consultant, a record of each agreement outlining the work
6460 performed and the fee for the work; and
6461 [(c)] (C) any additional information which:
6462 (I) is customary for a similar business[,]; or [which]
6463 (II) may reasonably be required by the commissioner by rule.
6464 (3) Subsection (2) is satisfied if the books and records specified in [that] Subsection (2)
6465 can be obtained immediately from a central storage place or elsewhere by on-line computer
6466 terminals located at the registered address.
6467 (4) An agent who represents only a single insurer satisfies Subsection (2) if the insurer
6468 maintains the books and records pursuant to Subsection (2) at a place satisfying Subsections (1)
6469 and (5).
6470 (5) (a) The books and records maintained [as to a transaction] under Subsection (2) or
6471 Section 31A-23-313 shall be available for the inspection of the commissioner during all business
6472 hours for a period of time after the date of the transaction as specified by the commissioner by rule,
6473 but in no case for less than three years.

6474 (b) Discarding books and records after the applicable record retention period has expired
6475 does not place the licensee in violation of a later-adopted longer record retention period.
6476 Section 151. Section **31A-23-317** is enacted to read:
6477 **31A-23-317. Financial services insurance activities regulation.**
6478 (1) It is the intent of the Legislature that the regulation of insurance activities of any person
6479 in this state be based on functional regulation principles established in the Gramm-Leach-Bliley
6480 Act of 1999, Pub. L. No. 106-102.
6481 (2) The insurance activities of any person in this state shall be functionally regulated by
6482 the commissioner subject to Sections 104, 301-308, 501-507, and 509 of the Gramm-Leach-Bliley
6483 Act of 1999, Pub. L. No. 106-102.
6484 (3) Under Title 63, Chapter 46a, Utah Administrative Rulemaking Act, the commissioner
6485 **Ş [~~shall~~] MAY ĥ** adopt rules consistent with Section 104(d) of the Gramm-Leach-Bliley Act of
6485a 1999, Pub. L.
6486 No. 106-102, and the functional regulation of insurance activities of any person otherwise subject
6487 to the jurisdiction of the commissioner in this state described in Subsection (2).
6488 (4) The commissioner shall consult and coordinate with the commissioner of the
6489 Department of Financial Institutions and the director of the Division of Securities for the purpose
6490 of assuring, to the extent possible, that the rules prescribed by the department are consistent and
6491 comparable with federal regulations governing the insurance, banking, and securities industries.
6492 Section 152. Section **31A-23-404** is amended to read:
6493 **31A-23-404. Sharing commissions.**
6494 (1) (a) Except as provided in Subsection 31A-15-103(3), a licensee under this chapter or
6495 an insurer may only pay consideration or reimburse out-of-pocket expenses to a person if the
6496 licensee knows that the person is licensed under this chapter to act as an agent or broker in Utah
6497 as to the particular type of insurance.
6498 (b) A person may only accept commission compensation or other compensation as an
6499 agent, broker, or consultant that is directly or indirectly the result of any insurance transaction if
6500 that person is licensed under this chapter to act as an agent or broker as to the particular type of
6501 insurance.
6502 (2) (a) Except as provided in Section 31A-23-301, a consultant may not pay or receive any
6503 commission or other compensation that is directly or indirectly the result of any insurance
6504 transaction.

6505 (b) A consultant may share a consultant fee or other compensation received for consulting
6506 services performed within Utah only with another consultant licensed under this chapter, and only
6507 to the extent that the other consultant contributed to the services performed.
6508 (3) This section does not prohibit the payment of renewal commissions to former licensees
6509 under this chapter, former Title 31, Chapter 17, or their successors in interest under a deferred
6510 compensation or agency sales agreement.
6511 (4) This section does not prohibit compensation paid to or received by an individual for
6512 referral of a potential customer that seeks to purchase or obtain an opinion or advice on an
6513 insurance product if:
6514 (a) the person is not licensed to sell insurance;
6515 (b) the person sells or provides opinions or advice on the product; and
6516 (c) the compensation does not depend on whether the referral results in a purchase or sale.
6517 [~~(4)~~] (5) In selling any policy of title insurance, no sharing of commissions under
6518 Subsection (1) may occur if it will result in an unlawful rebate, or in compensation in connection
6519 with controlled business, or in payment of a forwarding fee or finder's fee. A person may share
6520 compensation for the issuance of a title insurance policy only to the extent that he contributed to
6521 the search and examination of the title or other services connected with it.
6522 [~~(5)~~] (6) This section does not apply to bail bond agents or bail enforcement agents as
6523 defined in Section 31A-35-102.
6524 Section 153. Section **31A-23-503** is amended to read:
6525 **31A-23-503. Duties of insurers.**
6526 (1) The insurer shall have on file an independent financial examination, in a form
6527 acceptable to the commissioner, of each managing general agent with which it has done business.
6528 (2) If a managing general agent establishes loss reserves, the insurer shall annually obtain
6529 the opinion of an actuary attesting to the adequacy of loss reserves established for losses incurred
6530 and outstanding on business produced by the managing general agent. This is in addition to any
6531 other required loss reserve certification.
6532 (3) The insurer shall at least semiannually conduct an on-site review of the underwriting
6533 and claims processing operations of the managing general agent.
6534 (4) Binding authority for all reinsurance contracts or participation in insurance or
6535 reinsurance syndicates shall rest with an officer of the insurer, who may not be affiliated with the

6536 managing general agent.
6537 (5) Within 30 days after entering into or terminating a contract with a managing general
6538 agent, the insurer shall provide written notification of the appointment or termination to the
6539 commissioner. A notice of appointment of a managing general agent shall include:
6540 (a) a statement of duties that the applicant is expected to perform on behalf of the insurer;
6541 (b) the lines of insurance for which the applicant is to be authorized to act; and
6542 (c) any other information the commissioner may request.
6543 (6) An insurer shall review its books and records each quarter to determine if any producer,
6544 as defined by Subsection 31A-23-102[~~(13)~~](20), has become a managing general agent as defined
6545 in Subsection 31A-23-102[~~(12)~~](17). If the insurer determines that a producer has become a
6546 managing general agent, the insurer shall promptly notify the producer and the commissioner of
6547 the determination. The insurer and producer shall fully comply with the provisions of this chapter
6548 within 30 days.
6549 (7) An insurer may not appoint officers, directors, employees, subproducers, or controlling
6550 shareholders of its managing general agents to its board of directors. This Subsection (7) does not
6551 apply to relationships governed by Title 31A, Chapter 16, Insurance Holding Companies, or
6552 Chapter 23, Part 6, Broker Controlled Insurers, if it applies.
6553 Section 154. Section **31A-23-601** is amended to read:
6554 **31A-23-601. Applicability.**
6555 This part applies to licensed insurers, as defined in Subsection 31A-23-102[~~(11)~~](12),
6556 which are either domiciled in this state or domiciled in a state that does not have a substantially
6557 similar law. All provisions of Title 31A, Chapter 16, Insurance Holding Companies, to the extent
6558 they are not superseded by this part, continue to apply to all parties within holding company
6559 systems subject to this part.
6560 Section 155. Section **31A-23-702** is amended to read:
6561 **31A-23-702. Required contract provisions -- Reinsurance intermediary-broker.**
6562 Transactions between a reinsurance intermediary-broker and the insurer it represents in that
6563 capacity may only be entered into pursuant to a written authorization, which specifies the
6564 responsibilities of each party. The authorization shall, at a minimum, provide that the reinsurance
6565 intermediary-broker:
6566 (1) may have his authority terminated by the insurer at any time;

6567 (2) will render accounts to the insurer accurately detailing all material transactions,
6568 including information necessary to support all commissions, charges and other fees received by,
6569 or owing to the reinsurance intermediary-broker, and that he will remit all funds due to the insurer
6570 within 30 days of receipt;
6571 (3) shall hold, in a fiduciary capacity, all funds collected for the insurer's account in a bank,
6572 which is a qualified [~~U.S.~~] United States financial institution;
6573 (4) will comply with Section 31A-23-703;
6574 (5) will comply with the written standards established by the insurer for the cession or
6575 retrocession of all risks; and
6576 (6) will disclose to the insurer any relationship with any reinsurer to which business will
6577 be ceded or retroceded.
6578 Section 156. Section **31A-23-705** is amended to read:
6579 **31A-23-705. Required contract provisions -- Reinsurance intermediary-manager.**
6580 Transactions between a reinsurance intermediary-manager and the reinsurer it represents
6581 in that capacity may only be entered into pursuant to a written contract, which specifies the
6582 responsibilities of each party, and which shall be approved by the reinsurer's board of directors.
6583 At least 30 days before the reinsurer assumes or cedes business through the producer, a true copy
6584 of the approved contract shall be filed with the commissioner for approval. The contract shall, at
6585 a minimum, provide or require the following:
6586 (1) The reinsurer may terminate the contract for cause upon written notice to the
6587 reinsurance intermediary-manager. The reinsurer may immediately suspend the authority of the
6588 reinsurance intermediary-manager to assume or cede business during the pendency of any dispute
6589 regarding the cause for termination.
6590 (2) The reinsurance intermediary-manager will render accounts to the reinsurer accurately
6591 detailing all material transactions, including information necessary to support all commissions,
6592 charges, and other fees received by, or owing to the reinsurance intermediary-manager, and he shall
6593 remit all funds due under the contract to the reinsurer at least monthly.
6594 (3) All funds collected for the reinsurer's account will be held by the reinsurance
6595 intermediary-manager in a fiduciary capacity in a bank which is a qualified [~~U.S.~~] United States
6596 financial institution. The reinsurance intermediary-manager may retain no more than three months
6597 estimated claims payments and allocated loss adjustment expenses. The reinsurance

6598 intermediary-manager shall maintain a separate bank account for each reinsurer that it represents.
6599 (4) For at least ten years after expiration of each contract of reinsurance transacted by the
6600 reinsurance intermediary-manager, he shall keep a complete record for each transactions showing:
6601 (a) the type of contract, limits, underwriting restrictions, classes of risks, and territory;
6602 (b) period of coverage, including effective and expiration dates, cancellation provisions
6603 and notice required of cancellation, and disposition of outstanding reserves on covered risks;
6604 (c) reporting and settlement requirements of balances;
6605 (d) rates used to compute the reinsurance premium;
6606 (e) names and addresses of reinsurers;
6607 (f) rates of all reinsurance commissions, including the commissions on any retrocessions
6608 handled by the reinsurance intermediary-manager;
6609 (g) related correspondence and memoranda;
6610 (h) proof of placement;
6611 (i) details regarding retrocessions handled by the reinsurance intermediary-manager, as
6612 permitted by Subsection 31A-23-707 (4), including the identity of retrocessionaires and percentage
6613 of each contract assumed or ceded;
6614 (j) financial records, including premium and loss accounts; and
6615 (k) when the reinsurance intermediary-manager places a reinsurance contract on behalf of
6616 a ceding insurer:
6617 (i) directly from any assuming reinsurer, written evidence that the assuming reinsurer has
6618 agreed to assume the risk; or
6619 (ii) if placed through a representative of the assuming reinsurer, other than an employee,
6620 written evidence that the reinsurer has delegated binding authority to the representative.
6621 (5) The reinsurer will have access and the right to copy all accounts and records
6622 maintained by the reinsurance intermediary-manager which are related to its business, in a form
6623 usable by the reinsurer.
6624 (6) The contract cannot be assigned in whole or in part by the reinsurance
6625 intermediary-manager.
6626 (7) The reinsurance intermediary-manager will comply with the written underwriting and
6627 rating standards established by the insurer for the acceptance, rejection, or cession of all risks.
6628 (8) The contract shall set forth the rates, terms, and purposes of commissions, charges, and

6629 other fees which the reinsurance intermediary-manager may levy against the reinsurer.
6630 (9) If the contract permits the reinsurance intermediary-manager to settle claims on behalf
6631 of the reinsurer:
6632 (a) All claims will be reported to the reinsurer in a timely manner.
6633 (b) A copy of the claim file will be sent to the reinsurer at its request or as soon as it
6634 becomes known that the claim:
6635 (i) has the potential to exceed the lesser of an amount determined by the commissioner or
6636 the limit set by the reinsurer;
6637 (ii) involves a coverage dispute;
6638 (iii) may exceed the reinsurance intermediary-manager claims settlement authority;
6639 (iv) is open for more than six months; or
6640 (v) is closed by payment of the lesser of an amount set by the commissioner or an amount
6641 set by the reinsurer.
6642 (c) All claim files will be the joint property of the reinsurer and reinsurance
6643 intermediary-manager. However, upon an order of liquidation of the reinsurer the files shall
6644 become the sole property of the reinsurer or its estate. The reinsurance intermediary-manager shall
6645 have reasonable access to and the right to copy the files on a timely basis.
6646 (d) Any settlement authority granted to the reinsurance intermediary-manager may be
6647 terminated for cause upon the reinsurer's written notice to the reinsurance intermediary-manager,
6648 or upon the termination of the contract. The reinsurer may suspend the settlement authority during
6649 the pendency of the dispute regarding the cause of termination.
6650 (10) If the contract provides for a sharing of interim profits by the reinsurance
6651 intermediary-manager, that the contract shall provide interim profits will not be paid until one year
6652 after the end of each underwriting period for property business and five years after the end of each
6653 underwriting period for casualty business, or a later time period set by the commissioner for
6654 specified lines of insurance, and not until the adequacy of reserves on remaining claims has been
6655 verified pursuant to Subsection 31A-23-707 (3).
6656 (11) The reinsurance intermediary-manager will annually provide the reinsurer with a
6657 statement of its financial condition prepared by an independent certified public accountant.
6658 (12) The reinsurer shall at least semi-annually conduct an on-site review of the
6659 underwriting and claims processing operations of the reinsurance intermediary-manager.

6660 (13) The reinsurance intermediary-manager will disclose to the reinsurer any relationship
6661 it has with any insurer prior to ceding or assuming any business with the insurer pursuant to this
6662 contract.
6663 (14) Within the scope of its actual or apparent authority the acts of the reinsurance
6664 intermediary-manager shall be considered to be the acts of the reinsurer on whose behalf it is
6665 acting.
6666 Section 157. Section **31A-25-102** is amended to read:
6667 **31A-25-102. Scope and purposes.**
6668 (1) This chapter applies to all third party administrators.
6669 (2) The purposes of this chapter include:
6670 (a) encouraging disclosure of contracts between insurers and third party administrators,
6671 both to potential insureds and to the commissioner;
6672 (b) promoting the financial responsibility of [~~insurance~~] third party administrators;
6673 (c) subjecting persons administering insurance in Utah to the jurisdiction of the Utah
6674 commissioner and courts; [~~and~~]
6675 (d) regulating [~~insurance~~] third party administrators' practices in conformity with the
6676 general purposes of [~~the Insurance Code.~~] this title; and
6677 (e) governing the qualifications and procedures for the licensing of third party
6678 administrators.
6679 Section 158. Section **31A-25-202** is amended to read:
6680 **31A-25-202. Application for license.**
6681 (1) (a) An application for a license as a third party administrator shall be:
6682 (i) made to the commissioner on forms and in a manner [~~he~~] the commissioner
6683 prescribes[~~,~~]; and [~~be~~]
6684 (ii) accompanied by the applicable fee, which is not refundable if the application is denied.
6685 (b) The application for a license as a third party administrator shall:
6686 (i) state the applicant's:
6687 (A) social security number; or
6688 (B) federal employer identification number;
6689 (ii) provide information about:
6690 (A) the applicant's identity[~~,~~];

6691 (B) the applicant's personal history, experience, education, and business record[,];

6692 (C) if the applicant is a natural person, whether the applicant is 18 years of age or older;

6693 and

6694 (D) whether the applicant has committed an act that is a ground for denial, suspension, or

6695 revocation as set forth in Section 31A-25-208; and

6696 (iii) any other information as the commissioner reasonably requires.

6697 (2) The commissioner may require documents reasonably necessary to verify the

6698 information contained in the application.

6699 (3) The following are private records under Subsection 63-2-302(1)(g):

6700 (a) an applicant's social security number; and

6701 (b) an applicant's federal employer identification number.

6702 Section 159. Section **31A-25-203** is amended to read:

6703 **31A-25-203. General requirements for license issuance.**

6704 (1) The commissioner shall issue a license to act as a third party administrator to any

6705 person who has:

6706 (a) satisfied the character requirements under Section 31A-25-204;

6707 (b) satisfied the financial responsibility requirement under Section 31A-25-205;

6708 (c) if a nonresident, complied with Section 31A-25-206; and

6709 (d) paid the applicable fees under Section 31A-3-103.

6710 (2) The license of each third party administrator licensed under former Title 31, Chapter

6711 15a, is continued under this chapter.

6712 (3) (a) This Subsection (3) applies to the following persons:

6713 (i) an applicant for a third party administrator's license; or

6714 (ii) a licensed third party administrator.

6715 (b) A person described in Subsection (3)(a) shall report to the commissioner:

6716 (i) any administrative action taken against the person:

6717 (A) in another jurisdiction; or

6718 (B) by another regulatory agency in this state; and

6719 (ii) any criminal prosecution taken against the person in any jurisdiction.

6720 (c) The report required by Subsection (3)(b) shall:

6721 (i) be filed:

6722 (A) at the time the person applies for a third party administrator's license; or
6723 (B) within 30 days of the initiation of an action or prosecution described in Subsection
6724 (3)(b); and
6725 (ii) include a copy of the complaint or other relevant legal documents related to the action
6726 or prosecution described in Subsection (3)(b).
6727 (4) (a) The department may request concerning a person applying for a third party
6728 administrator's license:
6729 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2,
6730 from the Bureau of Criminal Identification; and
6731 (ii) complete Federal Bureau of Investigation criminal background checks through the
6732 national criminal history system.
6733 (b) Information obtained by the department from the review of criminal history records
6734 received under Subsection (4)(a) shall be used by the department for the purposes of:
6735 (i) determining if a person satisfies the character requirements under Section 31A-25-204
6736 for issuance or renewal of a license;
6737 (ii) determining if a person has failed to maintain the character requirements under Section
6738 31A-25-204; and
6739 (iii) preventing persons who violate the federal Violent Crime Control and Law
6740 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of
6741 insurance in the state.
6742 (c) If the department requests the criminal background information, the department shall:
6743 (i) pay to the Department of Public Safety the costs incurred by the Department of Public
6744 Safety in providing the department criminal background information under Subsection (4)(a)(i);
6745 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of
6746 Investigation in providing the department criminal background information under Subsection
6747 (4)(a)(ii); and
6748 (iii) charge the person applying for a license or for renewal of a license a fee equal to the
6749 aggregate of Subsections (4)(c)(i) and (ii).
6750 Section 160. Section **31A-25-205** is amended to read:
6751 **31A-25-205. Financial responsibility.**
6752 (1) Every person licensed under this chapter shall, while licensed and for one year after

6753 that date, maintain an insurance policy or surety bond, issued by an authorized insurer, in an
6754 amount specified under Subsection (2), on a policy or contract form which is acceptable under
6755 Subsection (3).
6756 (2) (a) Insurance policies or surety bonds satisfying the requirement of Subsection (1) shall
6757 be in a face amount equal to at least 10% of the total funds handled by the administrator.
6758 However, no policy or bond under this [~~subsection~~] Subsection (2)(a) may be in a face amount of
6759 less than $5,000 nor more than $500,000.
6760 (b) In fixing the policy or bond face amount under Subsection (2)(a), the total funds
6761 handled is:
6762 (i) the greater of:
6763 (A) the premiums received during the previous calendar year; or
6764 (B) claims paid through the administrator during the previous calendar year[~~,~~]; or[~~,~~]
6765 (ii) if no funds were handled during the preceding year, the total funds reasonably
6766 anticipated to be handled by the administrator during the current calendar year.
6767 (c) This section does not prohibit any person dealing with the administrator from requiring,
6768 by contract, insurance coverage in amounts greater than required under this section.
6769 (3) Insurance policies or surety bonds issued to satisfy Subsection (1) shall be on forms
6770 approved by the commissioner. The policies or bonds shall require the insurer to pay, up to the
6771 policy or bond face amount, any judgment obtained by participants in or beneficiaries of plans
6772 administered by the insured licensee which arise from the negligence or culpable acts of the
6773 licensee or any employee or agent of the licensee in connection with the activities described under
6774 Subsection 31A-1-301[~~(90)~~](111). The commissioner may require that policies or bonds issued
6775 to satisfy the requirements of this section require the insurer to give the commissioner 20 day prior
6776 notice of policy cancellation.
6777 (4) The commissioner shall establish annual reporting requirements and forms to monitor
6778 compliance with this section.
6779 (5) This section may not be construed as limiting any cause of action an insured would
6780 otherwise have against the insurer.
6781 Section 161. Section **31A-25-206** is amended to read:
6782 **31A-25-206. Nonresident jurisdictional agreement.**
6783 (1) (a) [~~Nonresident applicants for licenses under this chapter~~] If a nonresident license

6784 applicant has a valid license from the nonresident license applicant's home state and the conditions
6785 of Subsection (1)(b) are met, the commissioner shall:
6786 (i) waive any license requirement for a license under this chapter; and
6787 (ii) issue the nonresident license applicant a nonresident third party administrator license.
6788 (b) Subsection (1)(a) applies if:
6789 (i) the nonresident license applicant:
6790 (A) is licensed as a resident in the nonresident license applicant's home state at the time
6791 the nonresident license applicant applies for a nonresident third party administrator license;
6792 (B) has submitted the proper request for licensure;
6793 (C) has submitted to the commissioner:
6794 (I) the application for licensure that the nonresident license applicant submitted to the
6795 applicant's home state; or
6796 (II) a completed uniform application; and
6797 (D) has paid the applicable fees under Section 31A-3-103;
6798 (ii) the nonresident license applicant's license in the applicant's home state is in good
6799 standing; and
6800 (iii) the nonresident license applicant's home state awards nonresident third party
6801 administrator licenses to residents of this state on the same basis as this state awards licenses to
6802 residents of that home state.
6803 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an
6804 agreement to be subject to the jurisdiction of the Utah commissioner and courts on any matter
6805 related to [his] the applicant's insurance activities in Utah, on the basis of:
6806 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
6807 (b) other service authorized in the Utah Rules of Civil Procedure.
6808 (3) The commissioner may verify the third party administrator's licensing status through
6809 the database maintained by:
6810 (a) the National Association of Insurance Commissioners; or
6811 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
6812 (4) The commissioner may not assess a greater fee for an insurance license or related
6813 service to a person not residing in this state based solely on the fact that the person does not reside
6814 in this state.

6815 Section 162. Section **31A-25-207** is amended to read:

6816 **31A-25-207. Form and contents of license.**

6817 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes and
6818 shall set forth:

6819 [(1)] (a) the name, address, and telephone number of the licensee;

6820 [(2)] (b) the date of license issuance; and

6821 [(3)] (c) any other information the commissioner considers advisable.

6822 (2) A third party administrator doing business under any other name than the
6823 administrator's legal name shall notify the commissioner prior to using the assumed name in this
6824 state.

6825 (3) (a) An organization shall be licensed as an agency if the organization acts as a third
6826 party administrator.

6827 (b) An agency license issued under Subsection (3)(a) shall set forth the names of all natural
6828 persons licensed under this chapter who are authorized to act in those capacities for the
6829 organization in this state.

6830 Section 163. Section **31A-25-208** is amended to read:

6831 **31A-25-208. Termination of license.**

6832 (1) A license issued under this chapter remains in force until:

6833 (a) revoked, suspended, or limited under Subsection (2);

6834 (b) lapsed under Subsection (3);

6835 (c) surrendered to and accepted by the commissioner; or

6836 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
6837 Part 3 or 4.

6838 (2) After [a hearing] an adjudicative proceeding under Title 63, Chapter 46b,
6839 Administrative Procedures Act, the commissioner may revoke, suspend for a specified period of
6840 [less than] 12 months or less, or limit in whole or in part the license of any administrator, found
6841 to:

6842 (a) be unqualified for a license under Section 31A-25-203;

6843 (b) have violated an insurance statute, valid rule under Subsection 31A-2-201(3), or a valid
6844 order under Subsection 31A-2-201(4);

6845 (c) be insolvent, or the subject of receivership, conservatorship, rehabilitation, or other

6846 delinquency proceedings in any state;
6847 (d) have failed to pay any final judgment rendered against it in this state within 60 days
6848 after the judgment became final;
6849 (e) have failed to meet the same good faith obligations in claims settlement as that required
6850 of admitted insurers;
6851 (f) be affiliated with and under the same general management or interlocking directorate
6852 or ownership as another administrator which transacts business in this state without a license; [~~or~~]
6853 (g) have refused to be examined or to produce its accounts, records, and files for
6854 examination, or have officers who have refused to give information with respect to the
6855 administrator's affairs or to perform any other legal obligation as to an examination; [~~or~~]
6856 (h) have provided incorrect, misleading, incomplete, or materially untrue information in
6857 the license application;
6858 (i) have violated an insurance law, valid rule, or valid order of another state's insurance
6859 department;
6860 (j) have obtained or attempted to obtain a license through misrepresentation or fraud;
6861 (k) have improperly withheld, misappropriated, or converted any monies or properties
6862 received in the course of doing insurance business;
6863 (l) have intentionally misrepresented the terms of an actual or proposed insurance contract
6864 or application for insurance;
6865 (m) have been convicted of a felony;
6866 (n) have admitted or been found to have committed any insurance unfair trade practice or
6867 fraud;
6868 (o) have used fraudulent, coercive, or dishonest practices in this state or elsewhere;
6869 (p) have demonstrated incompetence, untrustworthiness, or financial irresponsibility in the
6870 conduct of business in this state or elsewhere;
6871 (q) have had an insurance license or its equivalent, denied, suspended, or revoked in any
6872 other state, province, district, or territory;
6873 (r) have forged another's name to:
6874 (i) an application for insurance; or
6875 (ii) a document related to an insurance transaction;
6876 (s) have improperly used notes or any other reference material to complete an examination

6877 for an insurance license;
6878 (t) have knowingly accepted insurance business from an individual who is not licensed;
6879 (u) have failed to comply with an administrative or court order imposing a child support
6880 obligation;
6881 (v) have failed to:
6882 (i) pay state income tax; or
6883 (ii) comply with any administrative or court order directing payment of state income tax;
6884 (w) have violated or permitted others to violate the federal Violent Crime Control and Law
6885 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
6886 [~~(h)~~] (x) have engaged in methods and practices in the conduct of business [~~which~~] that
6887 endanger the legitimate interests of customers and the public.
6888 (3) (a) Any license issued under this chapter lapses if the licensee fails to:
6889 (i) pay the fee due under Section 31A-3-103[~~,~~]; or [~~if the licensee fails to~~]
6890 (ii) produce, when due, evidence of compliance with the financial responsibility
6891 requirement under Section 31A-25-205. [~~A~~]
6892 (b) Subject to Subsection (3)(c) a license [~~which~~] that has lapsed under this Subsection (3)
6893 may be reinstated if the licensee[~~, within 90 days after license lapse,~~] cures the deficiency or
6894 deficiencies [~~which~~] that brought about the license lapse within 90 days after the date the license
6895 lapsed.
6896 (c) The licensee shall pay twice the applicable license renewal fee if the cause of the
6897 license lapse was failure to pay the usual renewal fee.
6898 (4) Notwithstanding Subsection (3), a licensee whose license lapses due to military service
6899 or some other extenuating circumstance such as a long-term medical disability may request:
6900 (a) reinstatement; and
6901 (b) a waiver of any of the following imposed for failure to comply with renewal
6902 procedures:
6903 (i) an examination requirement;
6904 (ii) a fine; or
6905 (iii) other sanction.
6906 (5) The commissioner shall by rule prescribe the license renewal and reinstatement
6907 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

6908 [(4)] (6) A licensee under this chapter whose license is suspended, revoked, or lapsed, but
6909 who continues to act as a licensee, is subject to the penalties for acting as an administrator without
6910 a license.
6911 [(5)] (7) An order revoking a license under Subsection (2) may specify a time, not to
6912 exceed five years, within which the former licensee may not apply for a new license. If no time
6913 is specified, the former licensee may not apply for five years without the express approval of the
6914 commissioner.
6915 [(6)] (8) Any person whose license is suspended or revoked under Subsection (2) shall,
6916 when the suspension ends or a new license is issued, pay all the fees that would have been payable
6917 if the license had not been suspended or revoked, unless the commissioner by order waives the
6918 payment of the interim fees. If a new license is issued more than three years after the revocation
6919 of a similar license, this subsection applies only to the fees that would have accrued during the
6920 three years immediately following the revocation.
6921 (9) If ordered by a court, the commissioner shall promptly withhold, suspend, restrict, or
6922 reinstate the use of a license issued under this part.
6923 Section 164. Section **31A-26-101** is amended to read:
6924 **31A-26-101. Purposes.**
6925 The purposes of this chapter are:
6926 (1) to promote the professional competence of those engaged in claims adjusting;
6927 (2) to encourage fair and rapid settlement of claims;
6928 (3) to protect claimants under insurance policies from unfair claims adjustment practices;
6929 [and]
6930 (4) to prevent compensation arrangements for insurance adjusters that endanger the
6931 fairness of claim settlements[.]; and
6932 (5) to govern the qualifications and procedures for the licensing of insurance adjustors.
6933 Section 165. Section **31A-26-202** is amended to read:
6934 **31A-26-202. Application for license.**
6935 (1) (a) The application for a license as an independent adjuster or public adjuster shall be:
6936 (i) made to the commissioner on forms and in a manner [he] the commissioner
6937 prescribes[.]; and
6938 (ii) accompanied by the applicable fee, which is not refunded if the application is denied.

6939 (b) The application shall provide:
6940 (i) information about the identity[;];
6941 (ii) the applicant's:
6942 (A) social security number[;]; or
6943 (B) federal employer identification number;
6944 (iii) the applicant's personal history, experience, education, and business record[, and];
6945 (iv) if the applicant is a natural person, whether the applicant is 18 years of age or older;
6946 (v) whether the applicant has committed an act that is a ground for denial, suspension, or
6947 revocation as set forth in Section 31A-25-208; and
6948 (vi) any other information as the commissioner reasonably requires.
6949 (2) The commissioner may require documents reasonably necessary to verify the
6950 information contained in the application.
6951 [(b)] (3) [An applicant's social security number is a] The following are private [record]
6952 records under Subsection 63-2-302(1)(g)[.]:
6953 [(2) Insurance adjusters' licenses issued under former Title 31 remain in effect until their
6954 expiration date, but they are subject to any requirement or limitation generally imposed under this
6955 title on similar licenses issued after July 1, 1986. Upon timely payment of the license continuation
6956 fee under Section 31A-3-103, the commissioner shall issue to adjusters licensed under the former
6957 title new licenses conforming to the provisions of this title and rules adopted under it.]
6958 (a) the applicant's social security number; and
6959 (b) the applicant's federal employer identification number.
6960 Section 166. Section **31A-26-203** is amended to read:
6961 **31A-26-203. Adjuster's license required.**
6962 (1) The commissioner shall issue a license to act as an independent adjuster or public
6963 adjuster to any person who, as to the license classification applied for under Section 31A-26-204,
6964 has:
6965 [(1)] (a) satisfied the character requirements under Section 31A-26-205;
6966 [(2)] (b) satisfied the applicable continuing education requirements under Section
6967 31A-26-206;
6968 [(3)] (c) satisfied the applicable examination requirements under Section 31A-26-207;
6969 [(4)] (d) if a nonresident, complied with Section 31A-26-208; and

6970 [(5)] (e) paid the applicable fees under Section 31A-3-103.
6971 (2) (a) This Subsection (2) applies to the following persons:
6972 (i) an applicant for:
6973 (A) an independent adjuster's license; or
6974 (B) a public adjuster's license;
6975 (ii) a licensed independent adjuster; or
6976 (iii) a licensed public adjuster.
6977 (b) A person described in Subsection (2)(a) shall report to the commissioner:
6978 (i) any administrative action taken against the person:
6979 (A) in another jurisdiction; or
6980 (B) by another regulatory agency in this state; and
6981 (ii) any criminal prosecution taken against the person in any jurisdiction.
6982 (c) The report required by Subsection (2)(b) shall:
6983 (i) be filed:
6984 (A) at the time the person applies for a third party administrator's license; or
6985 (B) within 30 days of the initiation of an action or prosecution described in Subsection
6986 (2)(b); and
6987 (ii) include a copy of the complaint or other relevant legal documents related to the action
6988 or prosecution described in Subsection (2)(b).
6989 (3) (a) The department may request concerning a person applying for an independent or
6990 public adjuster's license:
6991 (i) criminal background information maintained pursuant to Title 53, Chapter 10, Part 2,
6992 from the Bureau of Criminal Identification; and
6993 (ii) complete Federal Bureau of Investigation criminal background checks through the
6994 national criminal history system.
6995 (b) Information obtained by the department from the review of criminal history records
6996 received under Subsection (3)(a) shall be used by the department for the purposes of:
6997 (i) determining if a person satisfies the character requirements under Section 31A-26-205
6998 for issuance or renewal of a license;
6999 (ii) determining if a person has failed to maintain the character requirements under Section
7000 31A-25-204; and

7001 (iii) preventing persons who violate the federal Violent Crime Control and Law
7002 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034, from engaging in the business of
7003 insurance in the state.
7004 (c) If the department requests the criminal background information, the department shall:
7005 (i) pay to the Department of Public Safety the costs incurred by the Department of Public
7006 Safety in providing the department criminal background information under Subsection (3)(a)(i);
7007 (ii) pay to the Federal Bureau of Investigation the costs incurred by the Federal Bureau of
7008 Investigation in providing the department criminal background information under Subsection
7009 (3)(a)(ii); and
7010 (iii) charge the person applying for a license or for renewal of a license a fee equal to the
7011 aggregate of Subsections (3)(c)(i) and (ii).
7012 Section 167. Section **31A-26-204** is amended to read:
7013 **31A-26-204. License classifications.**
7014 [~~Licenses~~] A resident or nonresident license issued under this chapter shall be issued under
7015 the classifications described under Subsections (1), (2), and (3). These classifications are intended
7016 to describe the matters to be considered under any prerequisite education and examination required
7017 of license applicants under Sections 31A-26-206 and 31A-26-207.
7018 (1) Independent adjuster license classifications include:
7019 (a) [~~disability~~] accident and health insurance, including related service insurance under
7020 Chapter 7 or 8;
7021 (b) property and liability insurance, which includes:
7022 (i) property insurance;
7023 (ii) liability insurance;
7024 (iii) surety bonds; and
7025 (iv) policies containing combinations or variations of these coverages;
7026 (c) service insurance;
7027 (d) title insurance;
7028 (e) credit insurance; and
7029 (f) workers' compensation insurance.
7030 (2) Public adjuster license classifications include:
7031 (a) [~~disability~~] accident and health insurance, including related service insurance under

7032 Chapter 7 or 8;

7033 (b) property and liability insurance, which includes:

7034 (i) property insurance;

7035 (ii) liability insurance;

7036 (iii) surety bonds; and

7037 (iv) policies containing combinations or variations of these coverages;

7038 (c) service insurance;

7039 (d) title insurance;

7040 (e) credit insurance; and

7041 (f) workers' compensation insurance.

7042 (3) The commissioner may by rule recognize other independent adjuster or public adjuster

7043 license classifications as to other kinds of insurance not listed under Subsection (1). The

7044 commissioner may also by rule create license classifications which grant only part of the authority

7045 arising under another license class.

7046 Section 168. Section **31A-26-206** is amended to read:

7047 **31A-26-206. Continuing education requirements.**

7048 (1) The commissioner shall by rule prescribe continuing education requirements for each

7049 class of license under Section 31A-26-204.

7050 (2) (a) The commissioner shall impose continuing education requirements in accordance

7051 with a two-year licensing period in which the licensee meets the requirements of this Subsection

7052 (2).

7053 (b) Except as provided in Subsection (2)(c), for a two-year licensing period described in

7054 Subsection (2)(a) the commissioner shall require that the licensee for each line of authority held

7055 by the licensee:

7056 (i) receive six hours of continuing education; or

7057 (ii) pass a line of authority continuing education examination.

7058 (c) Notwithstanding Subsection (2)(b):

7059 (i) the commissioner may not require continuing education for more than four lines of

7060 authority held by the licensee;

7061 (ii) the commissioner shall require:

7062 (A) a minimum of:

7063 (I) 12 hours of continuing education;
7064 (II) passage of two line of authority continuing education examinations; or
7065 (III) a combination of Subsection (2)(c)(ii)(A)(I) and (II);
7066 (B) that the minimum continuing education requirement of Subsection (2)(c)(ii)(A)
7067 include:
7068 (I) at least six hours or one line of authority continuing education examination for each line
7069 of authority held by the licensee not to exceed four lines of authority held by the licensee; and
7070 (II) three hours of ethics training, which may be taken in place of three hours of the hours
7071 required for a line of authority.
7072 (d) (i) If a licensee completes the licensee's continuing education requirement without
7073 taking a line of authority continuing education examination, the licensee shall complete at least 1/2
7074 of the required hours through classroom hours of insurance-related instruction.
7075 (ii) The hours not completed through classroom hours in accordance with Subsection
7076 (2)(d)(i) may be obtained through:
7077 (A) home study;
7078 (B) video tape;
7079 (C) experience credit; or
7080 (D) other method provided by rule.
7081 (e) (i) A licensee may obtain continuing education hours at any time during the two-year
7082 licensing period.
7083 (ii) The licensee may not take a line of authority continuing education examination more
7084 than 90 calendar days before the date on which the licensee's license is renewed.
7085 (f) The commissioner shall make rules for the content and procedures for line of authority
7086 continuing education examinations.
7087 (g) (i) Beginning May 3, 1999, a licensee is exempt from the continuing education
7088 requirements of this section if:
7089 (A) as of April 1, 1990, the licensee has completed 20 years of licensure in good standing;
7090 (B) the licensee requests an exemption from the department; and
7091 (C) the department approves the exemption.
7092 (ii) If the department approves the exemption under Subsection (2)(g)(i), the licensee is
7093 not required to apply again for the exemption.

7094 (h) A licensee with a variable annuity line of authority is exempt from the requirement for
7095 continuing education for that line of authority so long as:
7096 (i) the National Association of Securities Dealers requires continuing education for
7097 licensees having a securities license; and
7098 (ii) the licensee complies with the National Association of Securities Dealers' continuing
7099 education requirements for securities licensees.
7100 (i) The commissioner shall by rule:
7101 (i) publish a list of insurance professional designations whose continuing education
7102 requirements can be used to meet the requirements for continuing education under Subsection
7103 (2)(c); and
7104 (ii) authorize professional adjuster associations to:
7105 (A) offer qualified programs for all classes of licenses on a geographically accessible basis;
7106 and
7107 (B) collect reasonable fees for funding and administration of the continuing education
7108 programs, subject to the review and approval of the commissioner.
7109 (j) (i) The fees permitted under Subsection (2)(i) that are charged to fund and administer
7110 a program shall reasonably relate to the costs of administering the program.
7111 (ii) Nothing in this section shall prohibit a provider of continuing education programs or
7112 courses from charging fees for attendance at courses offered for continuing education credit.
7113 (iii) The fees permitted under Subsection (2)(i)(ii) that are charged for attendance at an
7114 association program may be less for an association member, based on the member's affiliation
7115 expense, but shall preserve the right of a nonmember to attend without affiliation.
7116 (3) The requirements of this section apply only to licensees who are natural persons.
7117 (4) The requirements of this section do not apply to members of the Utah State Bar.
7118 (5) The commissioner shall designate courses that satisfy the requirements of this section,
7119 including those presented by insurers.
7120 <u>(6) A nonresident adjuster is considered to have satisfied this state's continuing education</u>
7121 <u>requirements if:</u>
7122 <u>(a) the nonresident adjuster satisfies the nonresident producer's home state's continuing</u>
7123 <u>education requirements for a licensed insurance adjuster; and</u>
7124 <u>(b) on the same basis the nonresident adjuster's home state considers satisfaction of Utah's</u>

7125 continuing education requirements for a producer as satisfying the continuing education
7126 requirements of the home state.
7127 Section 169. Section **31A-26-207** is amended to read:
7128 **31A-26-207. Examination requirements.**
7129 (1) The commissioner may require applicants for any particular class of license under
7130 Section 31A-26-204 to pass an examination as a requirement to receiving a license. The
7131 examination shall reasonably relate to the specific license class for which it is prescribed. The
7132 examinations may be administered by the commissioner or as specified by rule.
7133 (2) The commissioner [may] shall waive the requirement of an examination for a
7134 nonresident applicant who [has held a similar license in his home state for the two years
7135 immediately preceding application in this state, but only if the applicant's state of residence has
7136 imposed upon the applicant examination requirements which are substantially as rigorous as those
7137 of this state.]:
7138 (a) applies for an insurance adjuster license in this state;
7139 (b) has been licensed for the same line of authority in another state; and
7140 (c) (i) is licensed in the state described in Subsection (2)(b) at the time the applicant
7141 applies for an insurance producer license in this state; or
7142 (ii) if the application is received within 90 days of the cancellation of the applicant's
7143 previous license:
7144 (A) the prior state certifies that at the time of cancellation, the applicant was in good
7145 standing in that state; or
7146 (B) the state's producer database records maintained by the National Association of
7147 Insurance Commissioners or the National Association of Insurance Commissioner's affiliates or
7148 subsidiaries, indicates that the producer is or was licensed in good standing for the line of authority
7149 requested.
7150 (3) (a) To become a resident licensee in accordance with Sections 31A-26-202 and
7151 31A-26-203, a person licensed as an insurance producer in another state who moves to this state
7152 shall make application within 90 days of establishing legal residence in this state.
7153 (b) A person who becomes a resident licensee under Subsection (3)(a) may not be required
7154 to meet prelicensing education or examination requirements to obtain any line of authority
7155 previously held in the prior state unless:

7156 (i) the prior state would require a prior resident of this state to meet the prior state's
7157 prelicensing education or examination requirements to become a resident licensee; or
7158 (ii) the commissioner imposes the requirements by rule.
7159 [(3)] (4) The requirements of this section only apply to applicants who are natural persons.
7160 [(4)] (5) The requirements of this section do not apply to members of the Utah State Bar.
7161 Section 170. Section **31A-26-208** is amended to read:
7162 **31A-26-208. Nonresident jurisdictional agreement.**
7163 (1) (a) [Nonresident applicants for licenses under this chapter] If a nonresident license
7164 applicant has a valid license from the nonresident license applicant's home state and the conditions
7165 of Subsection (1)(b) are met, the commissioner shall:
7166 (i) waive any license requirement for a license under this chapter; and
7167 (ii) issue the nonresident license applicant a nonresident adjuster's license.
7168 (b) Subsection (1)(a) applies if:
7169 (i) the nonresident license applicant:
7170 (A) is licensed as a resident in the nonresident license applicant's home state at the time
7171 the nonresident license applicant applies for a nonresident adjuster license;
7172 (B) has submitted the proper request for licensure;
7173 (C) has submitted to the commissioner:
7174 (I) the application for licensure that the nonresident license applicant submitted to the
7175 applicant's home state; or
7176 (II) a completed uniform application; and
7177 (D) has paid the applicable fees under Section 31A-3-103;
7178 (ii) the nonresident license applicant's license in the applicant's home state is in good
7179 standing; and
7180 (iii) the nonresident license applicant's home state awards nonresident adjuster licenses to
7181 residents of this state on the same basis as this state awards licenses to residents of that home state.
7182 (2) A nonresident applicant shall execute in a form acceptable to the commissioner an
7183 agreement to be subject to the jurisdiction of the commissioner and courts of this state on any
7184 matter related to [his] the adjuster's insurance activities in this state, on the basis of:
7185 (a) service of process under Sections 31A-2-309 and 31A-2-310; or
7186 (b) other service authorized under the Utah Rules of Civil Procedure or Section 78-27-25.

7187 (3) The commissioner may verify the third party administrator's licensing status through
7188 the database maintained by:
7189 (a) the National Association of Insurance Commissioners; or
7190 (b) an affiliate or subsidiary of the National Association of Insurance Commissioners.
7191 (4) The commissioner may not assess a greater fee for an insurance license or related
7192 service to a person not residing in this state based solely on the fact that the person does not reside
7193 in this state.
7194 Section 171. Section **31A-26-209** is amended to read:
7195 **31A-26-209. Form and contents of license.**
7196 (1) Licenses issued under this chapter shall be in the form the commissioner prescribes and
7197 shall set forth:
7198 (a) the name, address, and telephone number of the licensee;
7199 (b) the license classifications under Section 31A-26-204;
7200 (c) the date of license issuance; and
7201 (d) any other information the commissioner considers advisable.
7202 (2) An adjuster doing business under any other name than the adjuster's legal name shall
7203 notify the commissioner prior to using the assumed name in this state.
7204 [~~(2)~~] (3) (a) An organization [~~acting~~] shall be licensed as an agency if the organization acts
7205 as:
7206 (i) an independent adjuster [~~shall be licensed under this chapter as an organization.~~]; or
7207 (ii) a public adjuster.
7208 (b) The [~~organization~~] agency license issued under Subsection (3)(a) shall set forth the
7209 names of all natural persons licensed under this chapter who are authorized to act in those
7210 capacities for the organization in this state.
7211 (3) (a) So far as is practicable, the commissioner shall issue a single license to each
7212 licensed adjuster for a single fee.
7213 (b) For fee purposes, the less expensive license is [~~subsumed~~] included within the most
7214 expensive license.
7215 Section 172. Section **31A-26-213** is amended to read:
7216 **31A-26-213. Termination of license.**
7217 (1) A license issued under this chapter remains in force until:

7218 (a) revoked, suspended, or limited under Subsection (2);
7219 (b) lapsed under Subsection (3);
7220 (c) surrendered to and accepted by the commissioner; or
7221 (d) the licensee dies or is adjudicated incompetent as defined under Title 75, Chapter 5,
7222 Part 3 or 4.
7223 [~~(2) After a hearing, the commissioner may revoke, suspend, or limit in whole or in part~~
7224 ~~the license of any person licensed under this chapter whom the commissioner finds is unqualified~~
7225 ~~for his license or who has violated an insurance statute, valid rule under Subsection 31A-2-201(3),~~
7226 ~~or a valid order under Subsection 31A-2-201(4), or if the licensee's methods and practices in the~~
7227 ~~conduct of business endanger the legitimate interests of customers and the public. Every order~~
7228 ~~suspending a license issued under this chapter shall specify the period for which the suspension~~
7229 ~~is to be effective, but in no event may the period exceed 12 months.~~]
7230 (2) After an adjudicative proceeding under Title 63, Chapter 46b, Administrative
7231 Procedures Act, the commissioner may revoke, suspend for a specified period of 12 months or less,
7232 or limit in whole or in part the license of any adjuster, found to:
7233 (a) be unqualified for a license under Section 31A-26-203;
7234 (b) have violated:
7235 (i) an insurance statute;
7236 (ii) a valid rule under Subsection 31A-2-201(3); or
7237 (iii) a valid order under Subsection 31A-2-201(4);
7238 (c) be insolvent, or the subject of receivership, conservatorship, rehabilitation, or other
7239 delinquency proceedings in any state;
7240 (d) fail to pay any final judgment rendered against it in this state within 60 days after the
7241 judgment became final;
7242 (e) fail to meet the same good faith obligations in claims settlement as that required of
7243 admitted insurers;
7244 (f) be affiliated with and under the same general management or interlocking directorate
7245 or ownership as another adjuster which transacts business in this state without a license;
7246 (g) refuse to be examined or to produce its accounts, records, and files for examination;
7247 (h) have an officer who:
7248 (i) refuses to give information with respect to the administrator's affairs; or

7249 (ii) to perform any other legal obligation as to an examination;
7250 (i) have provided incorrect, misleading, incomplete, or materially untrue information in
7251 the license application;
7252 (j) have violated any insurance law, valid rule, or valid order of another state's insurance
7253 department;
7254 (k) have obtained or attempted to obtain a license through misrepresentation or fraud;
7255 (l) have improperly withheld, misappropriated, or converted any monies or properties
7256 received in the course of doing insurance business;
7257 (m) have intentionally misrepresented the terms of an actual or proposed insurance
7258 contract or application for insurance;
7259 (n) have been convicted of a felony;
7260 (o) have admitted or been found to have committed any insurance unfair trade practice or
7261 fraud;
7262 (p) have used fraudulent, coercive, or dishonest practices in the conduct of business in this
7263 state or elsewhere;
7264 (q) have demonstrated incompetence, untrustworthiness, or financial irresponsibility in the
7265 conduct of business in this state or elsewhere;
7266 (r) have had an insurance license, or its equivalent, denied, suspended, or revoked in any
7267 other state, province, district, or territory;
7268 (s) have forged another's name to:
7269 (i) an application for insurance; or
7270 (ii) any document related to an insurance transaction;
7271 (t) have improperly used notes or any other reference material to complete an examination
7272 for an insurance license;
7273 (u) have knowingly accepted insurance business from an individual who is not licensed;
7274 (v) have failed to comply with an administrative or court order imposing a child support
7275 obligation;
7276 (w) have failed to:
7277 (i) pay state income tax; or
7278 (ii) comply with any administrative or court order directing payment of state income tax;
7279 (x) have violated or permitted others to violate the federal Violent Crime Control and Law

7280 Enforcement Act of 1994, 18 U.S.C. Secs. 1033 and 1034; or
7281 (y) have engaged in methods and practices in the conduct of business which endanger the
7282 legitimate interests of customers and the public.
7283 (3) (a) Any license issued under this chapter lapses if the licensee fails to pay when due
7284 any fee under Section 31A-3-103.
7285 (b) A licensee whose license lapses due to military service or some other extenuating
7286 circumstance such as a long-term medical disability may request:
7287 (i) reinstatement; and
7288 (ii) a waiver of any of the following imposed for failure to comply with renewal
7289 procedures:
7290 (A) an examination requirement;
7291 (B) a fine; or
7292 (C) other sanction.
7293 (c) The commissioner shall by rule prescribe the license renewal and reinstatement
7294 procedures, in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.
7295 (4) A licensee under this chapter whose license is suspended, revoked, or lapsed, but who
7296 continues to act as a licensee, is subject to the penalties for conducting an insurance business
7297 without a license.
7298 (5) An order revoking a license under Subsection (2) may specify a time not to exceed five
7299 years within which the former licensee may not apply for a new license. If no time is specified,
7300 the former licensee may not apply for a new license for five years without the express approval of
7301 the commissioner.
7302 (6) Any person whose license is suspended or revoked under Subsection (2) shall, when
7303 the suspension ends or a new license is issued, pay all fees that would have been payable if the
7304 license had not been suspended or revoked, unless the commissioner by order waives the payment
7305 of the interim fees. If a new license is issued more than three years after the revocation of a similar
7306 license, this subsection applies only to the fees that would have accrued during the three years
7307 immediately following the revocation.
7308 (7) The division shall promptly withhold, suspend, restrict, or reinstate the use of a license
7309 issued under this part if so ordered by a court.
7310 Section 173. Section **31A-26-215** is enacted to read:

7311 **31A-26-215. Temporary license -- Appointment of trustee for terminated licensee's**
7312 **business.**
7313 (1) (a) The commissioner may issue a temporary insurance adjuster license:
7314 (i) to a person listed in Subsection (1)(b):
7315 (A) if the commissioner considers that the temporary license is necessary:
7316 (I) for the servicing of an insurance business in the public interest; and
7317 (II) to provide continued service to the insureds who are being serviced in a circumstance
7318 described in Subsection (1)(b);
7319 (B) for a period not to exceed 180 days; and
7320 (C) without requiring an examination; or
7321 (ii) in any other circumstance:
7322 (A) if the commissioner considers the public interest will best be served by issuing the
7323 temporary license;
7324 (B) for a period not to exceed 180 days; and
7325 (C) without requiring an examination.
7326 (b) The commissioner may issue a temporary insurance producer license in accordance
7327 with Subsection (1)(a) to:
7328 (i) the surviving spouse or court-appointed personal representative of a licensed insurance
7329 adjuster who dies or becomes mentally or physically disabled to allow adequate time for:
7330 (A) the sale of the insurance business owned by the adjuster;
7331 (B) recovery or return of the adjuster to the business; or
7332 (C) the training and licensing of new personnel to operate the adjuster's business;
7333 (ii) to a member or employee of a business entity licensed as an insurance adjuster upon
7334 the death or disability of an individual designated in:
7335 (A) the business entity application; or
7336 (B) the license; or
7337 (iii) the designee of a licensed insurance adjuster entering active service in the armed
7338 forces of the United States of America.
7339 (2) If a person's license is terminated under Section 31A-26-213, the commissioner may
7340 appoint a trustee to provide in the public interest continuing service to the insureds who procured
7341 insurance through the person whose license is terminated:

7342 (a) at the request of the person whose license is terminated; or
7343 (b) upon the commissioner's own initiative.
7344 (3) This section does not apply if the deceased or disabled adjuster has not owned or does
7345 not own an ownership interest in the accounts and associated expiration lists that were previously
7346 serviced by the adjuster.
7347 (4) (a) A person issued a temporary license under Subsection (1) receives the license and
7348 shall perform the duties under the license subject to the commissioner's authority to:
7349 (i) require a temporary licensee to have a suitable sponsor who:
7350 (A) is a licensed producer; and
7351 (B) assumes responsibility for all acts of the temporary licensee; or
7352 (ii) impose other requirements that are:
7353 (A) designed to protect the insureds and the public; and
7354 (B) similar to the condition described in Subsection (4)(a)(i).
7355 (b) A trustee appointed under Subsection (2) shall receive the trustee's appointment and
7356 perform the trustee's duties subject to the conditions listed in Subsections (4)(b)(i) through (xv).
7357 (i) A trustee appointed under this section shall be licensed under this chapter to perform
7358 the services required by the trustor's clients.
7359 (ii) When possible, the commissioner shall appoint a trustee who is no longer actively
7360 engaged on the trustee's own behalf in business as an adjuster.
7361 (iii) The commissioner shall only select a person to act as trustee who is trustworthy and
7362 competent to perform the necessary services.
7363 (iv) If the deceased, disabled, or unlicenced person for whom the trustee is acting is an
7364 associated adjuster, the insurers through or with which the former adjuster's business was
7365 associated shall cooperate with the trustee in allowing the trustee to service the claims associated
7366 with or through the insurer.
7367 (v) The trustee shall abide by the terms of any agreement between the former adjuster and
7368 the associated insurer, except that terms in those agreements terminating the agreement upon the
7369 death, disability, or license termination of the former agent do not bar the trustee from continuing
7370 to act under the agreement.
7371 (vi) The commissioner shall set the trustee's compensation which:
7372 (A) may be stated in terms of a percentage of commissions;

7373 (B) shall be equitable; and
7374 (C) paid exclusively from:
7375 (I) the commissions generated by the former adjuster's accounts serviced by the trustee;
7376 and
7377 (II) other funds the former adjuster or the former adjuster's successor in interest agree to
7378 pay.
7379 (vii) The trustee has no special priority to commissions over the former adjuster's creditors.
7380 (viii) The following may not be held liable for errors or omissions of the former adjuster
7381 or the trustee:
7382 (A) the commissioner; or
7383 (B) the state.
7384 (ix) The trustee may not be held liable for errors and omissions that were caused in any
7385 material way by the negligence of the former adjuster.
7386 (x) The trustee may be held liable for errors and omissions that arise solely from the
7387 trustee's negligence.
7388 (xi) The trustee's compensation level shall be sufficient to allow the trustee to purchase
7389 errors and omissions coverage, if that coverage is not provided to the trustee by:
7390 (A) the former adjuster; or
7391 (B) the former adjuster's successor in interest.
7392 (xii) It is a breach of the trustee's fiduciary duty to capture the accounts of trustor's clients,
7393 either directly or indirectly.
7394 (xiii) The trustee may not purchase the accounts or expiration lists of the former adjuster,
7395 unless the commissioner expressly ratifies the terms of the sale.
7396 (xiv) The commissioner may adopt rules that:
7397 (A) further define the trustee's fiduciary duties; and
7398 (B) explain how the trustee is to carry out the trustee's responsibilities.
7399 (xv) The trust may be terminated by:
7400 (A) the commissioner; or
7401 (B) the person that requested the trust be established.
7402 (c) A person described in Subsection (4)(b)(vi)(B) shall terminate the trust by sending
7403 written notice to:

7404 (i) the trustee; and
7405 (ii) the commissioner.
7406 (5) (a) The commissioner may by order limit the authority of any temporary licensee or
7407 trustee in any way considered necessary to protect:
7408 (i) persons being serviced; and
7409 (ii) the public.
7410 (b) The commissioner may by order revoke a temporary license or trustee's appointment
7411 if the interest of persons being serviced or the public are endangered.
7412 (c) A temporary license or trustee's appointment may not continue after the owner or
7413 personal representative disposes of the business.
7414 Section 174. Section **31A-26-302** is amended to read:
7415 **31A-26-302. Settlement of claims in credit life and accident and health insurance.**
7416 (1) The creditor shall promptly report all claims to the insurer or its designated claim
7417 representative. The insurer shall maintain adequate claims files. All claims shall be settled as
7418 soon as possible in accordance with the terms of the insurance contract.
7419 (2) The insurer shall pay all claims either by draft drawn upon the insurer or by check of
7420 the insurer to the order of the claimant to whom payment of the claim is due pursuant to the policy
7421 provisions, or upon direction of that claimant to another.
7422 (3) [~~No~~] A person other than the insurer or its designated claim representative may not
7423 settle or adjust claims. The creditor may not be designated as a claims representative.
7424 Section 175. Section **31A-27-311.5** is repealed and reenacted to read:
7425 **31A-27-311.5. Continuance of coverage -- Health maintenance organizations.**
7426 (1) As used in this section:
7427 (a) "basic health care services" is as defined in Section 31A-8-101;
7428 (b) "enrollee" is as defined in Section 31A-8-101;
7429 (c) "health care" is as defined in Section 31A-1-301;
7430 (d) "health maintenance organization" is as defined in Section 31A-8-101;
7431 (e) "limited health plan" is as defined in Section 31A-8-101;
7432 (f) (i) "managed care organization" means any entity licensed by, or holding a certificate
7433 of authority from, the department to furnish health care services or health insurance;
7434 (ii) "managed care organization" includes:

7435 (A) a limited health plan;
7436 (B) a health maintenance organization;
7437 (C) a preferred provider organization;
7438 (D) a fraternal benefit society; or
7439 (E) any entity similar to an entity described in Subsections (1)(f)(ii)(A) through (D);
7440 (iii) "managed care organization" does not include:
7441 (A) an insurer or other person that is eligible for membership in a guaranty association
7442 under Chapter 28;
7443 (B) a mandatory state pooling plan;
7444 (C) a mutual assessment company or any entity that operates on an assessment basis; or
7445 (D) any entity similar to an entity described in Subsections (1)(f)(iii)(A) through (C);
7446 (g) "participating provider" means a provider who, under a contract with a managed care
7447 organization authorized under Section 31A-8-407, has agreed to provide health care services to
7448 enrollees with an expectation of receiving payment, directly or indirectly, from the managed care
7449 organization, other than copayment;
7450 (h) "participating provider contract" means the agreement between a participating provider
7451 and a managed care organization authorized under Section 31A-8-407;
7452 (i) "preferred provider" means a provider who agrees to provide health care services under
7453 an agreement authorized under Subsection 31A-22-617(1);
7454 (j) "preferred provider contract" means the written agreement between a preferred provider
7455 and a managed care organization authorized under Subsection 31A-22-617(1);
7456 (k) "preferred provider organization" means any person, other than an insurer licensed
7457 under Chapter 7 or an individual who contracts to render professional or personal services that the
7458 individual performs himself, that:
7459 (i) furnishes at a minimum, through preferred providers, basic health care services to an
7460 enrollee in return for prepaid periodic payments in an amount agreed to prior to the time during
7461 which the health care may be furnished;
7462 (ii) is obligated to the enrollee to arrange for the services described in Subsection (1)(k)(i);
7463 and
7464 (iii) permits the enrollee to obtain health care services from providers who are not
7465 preferred providers;

7466 (l) "provider" is as defined in Section 31A-8-101; and
7467 (m) "uncovered expenditure" means the costs of health care services that are covered by
7468 an organization for which an enrollee is liable in the event of the managed care organization's
7469 insolvency.
7470 (2) The rehabilitator or liquidator may take one or more of the actions described in
7471 Subsections (2)(a) through (f) to assure continuation of health care coverage for enrollees of an
7472 insolvent managed care organization.
7473 (a) (i) Subject to Subsection (2)(a)(ii), a rehabilitator or liquidator may require a
7474 participating provider and preferred provider of health care services to continue to provide the
7475 health care services the provider is required to provide under the respective participating provider
7476 contract or preferred provider contract until the later of:
7477 (A) 90 days from the date of the filing of a petition for rehabilitation or the petition for
7478 liquidation; or
7479 (B) the date the term of the contract ends.
7480 (ii) A requirement by the rehabilitator or liquidator under Subsection (2)(a)(i) that a
7481 participating provider or preferred provider continue to provide health care services under a
7482 provider's participating provider contract or preferred providers contract expires when health care
7483 coverage for all enrollees of the insolvent managed care organization is obtained from another
7484 managed care organization or insurer.
7485 (b) (i) Subject to Subsection (2)(b)(ii), a rehabilitator or liquidator may reduce the fees a
7486 participating provider or preferred provider is otherwise entitled to receive from the managed care
7487 organization under its participating provider contract or preferred provider contract during the time
7488 period in Subsection (2)(a)(i).
7489 (ii) Notwithstanding Subsection (2)(b)(i) a rehabilitator or liquidator may not reduce a fee
7490 to less than 75% of the regular fee set forth in the respective participating provider contract or
7491 preferred provider contract.
7492 (iii) An enrollee shall continue to pay the same copayments, deductibles, and other
7493 payments for services received from the participating provider or preferred provider that the
7494 enrollee was required to pay before the date of filing of:
7495 (A) the petition for rehabilitation; or
7496 (B) the petition for liquidation.

7497 (c) (i) A participating provider or preferred provider shall:
7498 (A) accept the amounts specified in Subsection (2)(b) as payment in full; and
7499 (B) relinquish the right to collect additional amounts from the insolvent managed care
7500 organization's enrollee.
7501 (ii) Subsection (2)(b) and Subsections (2)(c)(i)(A) and (B) shall apply to the fees paid to
7502 a provider who agrees to provide health care services to an enrollee but is not a preferred or
7503 participating provider.
7504 (d) If the managed care organization is a health maintenance organization, Subsections
7505 (2)(d)(i) through (v) apply.
7506 (i) Subject to Subsections (2)(d)(ii) and (iv), upon notification from and subject to the
7507 direction of the rehabilitator or liquidator of a health maintenance organization licensed under
7508 Chapter 8, a solvent health maintenance organization licensed under Chapter 8 and operating
7509 within a portion of the insolvent health maintenance organization's service area shall extend to the
7510 enrollees all rights, privileges, and obligations of being an enrollee in the accepting health
7511 maintenance organization, except that the accepting health maintenance organization shall give
7512 credit to an enrollee for any waiting period already satisfied under the provisions of the enrollee's
7513 contract with the insolvent health maintenance organization.
7514 (ii) A health maintenance organization accepting an enrollee of an insolvent health
7515 maintenance organization under Subsection (2)(d)(i) shall charge the enrollee the premiums
7516 applicable to the existing business of the accepting health maintenance organization.
7517 (iii) A health maintenance organization's obligation to accept an enrollee under Subsection
7518 (2)(d)(i) is limited in number to its pro rata share of all health maintenance organization enrollees
7519 in this state, as determined after excluding the enrollees of the insolvent insurer.
7520 (iv) The rehabilitator or liquidator of an insolvent health maintenance organization shall
7521 take those measures that are possible to ensure that no health maintenance organization is required
7522 to accept more than its pro rata share of the adverse risk represented by the enrollees of the
7523 insolvent health maintenance organization. As long as the methodology used by the rehabilitator
7524 or liquidator to assign an enrollee is one which can be expected to produce a reasonably equitable
7525 distribution of adverse risk, that methodology and its results are acceptable under this Subsection
7526 (2)(d)(iv).
7527 (v) (A) Notwithstanding Section 31A-27-311, the rehabilitator or liquidator may require

7528 all solvent health maintenance organizations to pay for the covered claims incurred by the enrollees
7529 of the insolvent health maintenance organization.
7530 (B) As determined by the rehabilitator or liquidator, payments required under this
7531 Subsection (2)(d)(v) may:
7532 (I) begin as of the filing of the petition for reorganization or the petition for liquidation;
7533 and
7534 (II) continue for a maximum period through the time all enrollees are assigned pursuant
7535 to this section.
7536 (C) If the rehabilitator or liquidator makes an assessment under this Subsection (2)(d)(v),
7537 the rehabilitator or liquidator shall assess each solvent health maintenance organization its pro rata
7538 share of the total assessment based upon its premiums from the previous calendar year.
7539 (e) A rehabilitator or liquidator may transfer, through sale, or otherwise, the group and
7540 individual health care obligations of the insolvent managed care organization to other managed
7541 care organizations or other insurers, if those other managed care organizations and other insurers
7542 are licensed or have a certificate of authority to provide the same health care services in this state
7543 that the insolvent managed care organization has.
7544 (i) The rehabilitator or liquidator may combine group and individual health care
7545 obligations of the insolvent managed care organization in any manner the rehabilitator or liquidator
7546 considers best to provide for continuous health care coverage for the maximum number of
7547 enrollees of the insolvent managed care organization.
7548 (ii) If the terms of a proposed transfer of the same combination of group and individual
7549 policy obligations to more than one other managed care organization or insurer are otherwise
7550 equal, the rehabilitator or liquidator shall give preference to the transfer of the group and individual
7551 policy obligations of an insolvent managed care organization as follows:
7552 (A) from one category of managed care organization to another managed care organization
7553 of the same category, as follows:
7554 (I) from a limited health plan to a limited health plan;
7555 (II) from a health maintenance organization to a health maintenance organization;
7556 (III) from a preferred provider organization to a preferred provider organization;
7557 (IV) from a fraternal benefit society to a fraternal benefit society; and
7558 (V) from any entity similar to any of the above to a category that is similar;

7559 (B) from one category of managed care organization to another managed care organization,
7560 regardless of the category of the transferee managed care organization; and
7561 (C) from a managed care organization to a nonmanaged care provider of health care
7562 coverage, including insurers.
7563 (f) A rehabilitator or liquidator may use the insolvent managed care organization's required
7564 capital or permanent surplus, and compulsory surplus, to continue to provide coverage for the
7565 insolvent managed care organization's enrollees, including paying uncovered expenditures.
7566 Section 177. Section **31A-28-102** is amended to read:
7567 **31A-28-102. Purpose.**
7568 (1) The purpose of this part is to protect, subject to certain limitations, the persons
7569 specified in Subsection 31A-28-103(1) against failure in the performance of contractual
7570 obligations, under the life and [~~disability~~] accident and health insurance policies and annuity
7571 contracts specified in Subsection 31A-28-103(2), because of the impairment or insolvency of the
7572 member insurer that issued the policies or contracts.
7573 (2) To provide the protection described in Subsection (1), the Utah Life and Disability
7574 Insurance Guaranty Association, which currently exists, is continued in order to pay benefits and
7575 to continue coverages as limited in this part, and members of the association are subject to
7576 assessment to provide funds to carry out the purpose of this part.
7577 Section 178. Section **31A-28-103** is amended to read:
7578 **31A-28-103. Coverage and limitations.**
7579 (1) This part provides coverage for the policies and contracts specified in Subsection (2)
7580 to persons who are:
7581 (a) beneficiaries, assignees, or payees of the persons covered under Subsection (1)(b),
7582 regardless of where they reside, except for nonresident certificate holders under group policies or
7583 contracts;
7584 (b) owners of or certificate holders under such policies or contracts; or, in the case of
7585 unallocated annuity contracts, to the persons who are the contract holders, and who are:
7586 (i) residents of Utah; or
7587 (ii) not residents of Utah, but only under the following conditions:
7588 (A) the insurers which issued the policies or contracts are domiciled in this state;
7589 (B) the insurers never held a license or certificate of authority in the states in which the

7590 persons reside;
7591 (C) the states have associations similar to the association created by this chapter; and
7592 (D) the persons are not eligible for coverage by the associations described in Subsection
7593 (1)(b)(ii)(C).
7594 (2) (a) Except as otherwise limited by this part, this part provides coverage to the persons
7595 specified in Subsection (1) for direct, nongroup life, [~~disability~~] accident and health, annuity and
7596 supplemental policies or contracts, for certificates under direct group policies and contracts, and
7597 for unallocated annuity contracts issued by member insurers. Annuity contracts and certificates
7598 under group annuity contracts include guaranteed investment contracts, deposit administration
7599 contracts, unallocated funding agreements, structured settlement agreements, lottery contracts, and
7600 any immediate or deferred annuity contracts.
7601 (b) This part does not provide coverage for:
7602 (i) any portion of a policy or contract not guaranteed by the insurer, or under which the risk
7603 is borne by the policy or contract holder;
7604 (ii) any policy or contract of reinsurance, unless assumption certificates have been issued;
7605 (iii) any portion of a policy or contract to the extent that the rate of interest on which it is
7606 based:
7607 (A) averaged over the period of four years prior to the date on which the association
7608 becomes obligated with respect to the policy or contract, exceeds a rate of interest determined by
7609 subtracting two percentage points from Moody's Corporate Bond Yield Average averaged for that
7610 same four-year period or for the corresponding lesser period if the policy or contract was issued
7611 less than four years before the association became obligated; and
7612 (B) on or after the date on which the association becomes obligated with respect to the
7613 policy or contract, exceeds the rate of interest determined by subtracting three percentage points
7614 from Moody's Corporate Bond Yield Average as most recently available;
7615 (iv) any plan or program of an employer, association, or similar entity to provide life,
7616 [~~disability~~] accident and health, or annuity benefits to its employees or members to the extent that
7617 the plan or program is self-funded or uninsured, including benefits payable by an employer,
7618 association, or similar entity under:
7619 (A) a multiple employer welfare arrangement as defined in Section 514 of the Employee
7620 Retirement Income Security Act of 1974, as amended;

7621 (B) a minimum premium group insurance plan;
7622 (C) a stop-loss group insurance plan; or
7623 (D) an administrative services only contract;
7624 (v) any portion of a policy or contract to the extent that it provides dividends or experience
7625 rating credits, or provides that any fees or allowances be paid to any person, including the policy
7626 or contract holder, in connection with the service to or administration of the policy or contract;
7627 (vi) any policy or contract issued in this state by a member insurer at a time when it was
7628 not licensed or did not have a certificate of authority to issue the policy or contract in this state;
7629 (vii) any unallocated annuity contract issued to an employee benefit plan protected under
7630 the federal Pension Benefit Guaranty Corporation; and
7631 (viii) any portion of any unallocated annuity contract which is not issued to or in
7632 connection with a specific employee, union, or association of natural persons benefit plan or a
7633 government lottery.
7634 (c) The benefits for which the association may become liable shall in no event exceed the
7635 lesser of:
7636 (i) the contractual obligations for which the insurer is liable or would have been liable if
7637 it were not an impaired or insolvent insurer; or
7638 (ii) (A) with respect to any one life, regardless of the number of policies or contracts:
7639 (I) $300,000 in life insurance death benefits, but not more than $100,000 in net cash
7640 surrender and net cash withdrawal values for life insurance;
7641 (II) $100,000 in [~~disability~~] accident and health insurance benefits, including any net cash
7642 surrender and net cash withdrawal values;
7643 (III) $100,000 in the present value of annuity benefits, including net cash surrender and
7644 net cash withdrawal values;
7645 (B) with respect to each individual participating in a governmental retirement plan
7646 established under Section 401(k), 403(b), or 457 of the Internal Revenue Code covered by an
7647 unallocated annuity contract or the beneficiaries of each such individual if deceased, in the
7648 aggregate, $100,000 in present value of annuity benefits, including net cash surrender and net cash
7649 withdrawal values;
7650 (C) however, in no event shall the association be liable to expend more than $300,000 in
7651 the aggregate with respect to any one individual under Subsections (2)(c)(ii)(A) and (ii)(B);

7652 (iii) with respect to any one contract holder covered by any unallocated annuity contract
7653 not included in Subsection (2)(c)(ii)(B), $5,000,000 in benefits, irrespective of the number of
7654 contracts held by that contract holder.

7655 Section 179. Section **31A-28-106** is amended to read:

7656 **31A-28-106. Continuation of the association.**

7657 (1) There is continued under this chapter the nonprofit legal entity known as the Utah Life
7658 and Disability Insurance Guaranty Association created under former provisions of this title. All
7659 member insurers shall be and remain members of the association as a condition of their authority
7660 to transact business in this state. The association shall perform its functions under the plan of
7661 operation established and approved under Section 31A-28-110 and shall exercise its powers
7662 through a board of directors under the provisions of Section 31A-28-107. For purposes of
7663 administration and assessment the association shall maintain two accounts:

7664 (a) the life and annuity account, which includes the following subaccounts:

7665 (i) Life Insurance Account;

7666 (ii) Annuity Account; and

7667 (iii) Unallocated Annuity Account, which includes contracts qualified under Sections
7668 401(k), 403(b), or 457 of the Internal Revenue Code; and

7669 (b) the [~~disability~~] accident and health insurance account.

7670 (2) The association shall come under the immediate supervision of the commissioner and
7671 shall be subject to the applicable provisions of the insurance laws of this state. Meetings or records
7672 of the association may be opened to the public upon majority vote of the board of directors of the
7673 association.

7674 Section 180. Section **31A-28-108** is amended to read:

7675 **31A-28-108. Powers and duties of the association.**

7676 (1) If a member insurer is an impaired domestic insurer, the association in its discretion
7677 and subject to any conditions imposed by the association that do not impair the contractual
7678 obligations of the impaired insurer that are approved by the commissioner, and also by the
7679 impaired insurer, except in cases of court-ordered conservation or rehabilitation, may:

7680 (a) guarantee, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, any
7681 or all of the policies or contracts of the impaired insurer;

7682 (b) provide the necessary monies, pledges, notes, guarantees or other means to effectuate

7683 Subsection (1)(a) and assure payment of the contractual obligations of the impaired insurer
7684 pending action under Subsection (1)(a); or
7685 (c) loan money to the impaired insurer.
7686 (2) (a) If a member insurer is an impaired insurer, whether domestic, foreign, or alien, and
7687 the insurer is not paying claims timely, the association shall in its discretion and subject to the
7688 preconditions specified in Subsection (2)(b), either:
7689 (i) take any of the actions specified in Subsection (1), subject to the conditions specified
7690 in Subsection (1); or
7691 (ii) provide substitute benefits in lieu of the contractual obligations of the impaired insurer
7692 solely for [~~disability~~] accident and health claims, periodic annuity benefit payments, death benefits,
7693 supplemental benefits, and cash withdrawals for policy or contract owners who petition for such
7694 benefits under claims of emergency or hardship in accordance with the standards proposed by the
7695 association and approved by the commissioner.
7696 (b) The association is subject to the requirements of Subsection (2)(a) only if:
7697 (i) the laws of the impaired insurer's state of domicile provide that until all payments of,
7698 or an account of, the impaired insurer's contractual obligations by all guaranty associations, along
7699 with all expenses of the obligation and interest on all such payments and expenses, have been
7700 repaid to the guaranty associations or a plan of repayment by the impaired insurer has been
7701 approved by the guaranty associations:
7702 (A) the delinquency proceeding shall not be dismissed;
7703 (B) neither the impaired insurer nor its assets shall be returned to the control of its
7704 shareholders or private management;
7705 (C) it shall not be permitted to solicit or accept new business or have any suspended or
7706 revoked license restored; and
7707 (ii) (A) if the impaired insurer is a domestic insurer, it has been placed under an order of
7708 rehabilitation by a court of competent jurisdiction in this state; or
7709 (B) if the impaired insurer is a foreign or alien insurer:
7710 (I) it has been prohibited from soliciting or accepting new business in this state;
7711 (II) its certificate of authority has been suspended or revoked in this state; and
7712 (III) a petition for rehabilitation or liquidation has been filed in a court of competent
7713 jurisdiction in its state of domicile by the commissioner of the state.

7714 (3) If a member insurer is an insolvent insurer, the association in its discretion shall either:
7715 (a) (i) guaranty, assume, or reinsure, or cause to be guaranteed, assumed, or reinsured, the
7716 policies or contracts of the insolvent insurer; or
7717 (ii) assure payment of the contractual obligations of the insolvent insurer; and
7718 (iii) provide such monies, pledges, guarantees, or other means as are reasonably necessary
7719 to discharge such duties; or
7720 (b) with respect only to [~~disability~~] accident and health insurance policies, provide benefits
7721 and coverages in accordance with Subsection (4).
7722 (4) When proceeding under Subsections (2)(a)(ii) or (3)(b), with respect only to [~~disability~~]
7723 accident and health insurance policies, the association shall:
7724 (a) assure payment of benefits for premiums identical to the premiums and benefits, except
7725 for terms of conversion and renewability, that would have been payable under the policies of the
7726 insolvent insurer, for claims incurred:
7727 (i) with respect to group policies, not later than the earlier of the next renewal date under
7728 the policies or contracts or 45 days, but in no event less than 30 days, after the date on which the
7729 association becomes obligated with respect to the policies;
7730 (ii) with respect to individual policies, not later than the earlier of the next renewal date,
7731 if any, under the policies or one year, but in no event less than 30 days, from the date on which the
7732 association becomes obligated with respect to the policies;
7733 (b) make diligent efforts to provide 30 days' notice of the termination of the benefits
7734 provided to all known insureds, or group policyholders with respect to group policies;
7735 (c) make available substitute coverage on an individual basis, in accordance with the
7736 provisions of Subsection (4)(d), to each known insured or owner under an individual policy, and
7737 to each individual formerly insured under a group policy who is not eligible for replacement group
7738 coverage, if the insured had a right under law or the terminated policy to convert coverage to
7739 individual coverage or to continue an individual policy in force until a specified age or for a
7740 specified time during which the insurer had no right unilaterally to make changes in any provision
7741 of the policy or had a right only to make changes in premium by class.
7742 (d) (i) In providing the substitute coverage required under Subsection (4)(c), the
7743 association may offer either to reissue the terminated coverage or to issue an alternative policy.
7744 (ii) Alternate or reissued policies shall be offered without requiring evidence of

7745 insurability, and shall not provide for any waiting period or exclusion that would not have applied
7746 under the terminated policy.
7747 (iii) The association may reinsure any alternative or reissued policy.
7748 (e) (i) Alternative policies adopted by the association shall be subject to the approval of
7749 the commissioner. The association may adopt alternative policies of various types for future
7750 issuance without regard to any particular impairment or insolvency.
7751 (ii) Alternative policies shall contain at least the minimum statutory provisions required
7752 in this state and provide benefits that are not unreasonable in relation to the premium charged. The
7753 association shall set the premium in accordance with its table of adopted rates. The premium shall
7754 reflect the amount of insurance to be provided and the age and class of risk of each insured. For
7755 alternative policies issued to insureds under individual policies of the impaired or insolvent
7756 insurer, age shall be determined in accordance with the original policy provisions and class of risk
7757 shall be the class of risk under the original policy. For alternative policies issued to individuals
7758 insured under a group policy, age and class of risk shall be determined by the association in
7759 accordance with the alternative policy provisions and risk classification standards approved by the
7760 commissioner. However, the premium may not reflect any changes in the health of the insured
7761 after the original policy was last underwritten.
7762 (iii) Any alternative policy issued by the association shall provide coverage of a type
7763 similar to that of the policy issued by the impaired or insolvent insurer, as determined by the
7764 association.
7765 (f) If the association elects to reissue terminated coverage at a premium rate different from
7766 that charged under the terminated policy, the premium shall be set by the association in accordance
7767 with the amount of insurance provided and the age and class of risk, subject to the approval of the
7768 commissioner or by a court of competent jurisdiction.
7769 (g) The association's obligations with respect to coverage under any policy of the impaired
7770 or insolvent insurer or under any reissued or alternative policy shall cease on the date the coverage
7771 or policy is replaced by another similar policy by the policyholder, the insured, or the association.
7772 (h) With respect to claims unpaid as of the date of insolvency and claims incurred during
7773 the period defined in Subsection (4)(a), a provider of health care services, by accepting a payment
7774 from the association upon a claim of the provider against an insured whose health care insurer is
7775 an insolvent member insurer, agrees to forgive the insured of 20% of the debt which otherwise

7776 would be paid by the insurer had it not been insolvent, subject to a maximum of $4,000 being
7777 required to be forgiven by any one provider as to each claimant. The obligations of solvent
7778 insurers to pay all or part of the covered claim are not diminished by the forgiveness provided for
7779 in this section.
7780 (5) When proceeding under Subsection (2)(a)(ii) or (3) with respect to any policy or
7781 contract carrying guaranteed minimum interest rates, the association shall assure the payment or
7782 crediting of a rate of interest consistent with Subsection 31A-28-103(2)(b)(iii).
7783 (6) Nonpayment of premiums within 31 days after the date required under the terms of any
7784 guaranteed, assumed, alternative, or reissued policy or contract or substitute coverage shall
7785 terminate the association's obligations under the policy or coverage under this chapter with respect
7786 to the policy or coverage, except with respect to any claims incurred or any net cash surrender
7787 value which may be due in accordance with the provisions of this chapter.
7788 (7) Premiums due for coverage after entry of an order of liquidation of an insolvent insurer
7789 shall belong to and be payable at the direction of the association, and the association shall be liable
7790 for unearned premiums due to policy or contract owners of the insurer after the entry of the order.
7791 (8) The protection provided by this chapter does not apply if any guaranty protection is
7792 provided to residents of this state by laws of the domiciliary state or jurisdiction of the impaired
7793 or insolvent insurer other than this state.
7794 (9) In carrying out its duties under this subsection and Subsections (2) and (3), and subject
7795 to approval by the court, the association may:
7796 (a) impose permanent policy or contract liens in connection with any guarantee,
7797 assumption, or reinsurance agreement, if the association finds that the amounts which can be
7798 assessed under this chapter are less than the amounts needed to assure full and prompt performance
7799 of the association's duties under this chapter, or that the economic or financial conditions as they
7800 affect member insurers are sufficiently adverse to render the imposition of the permanent policy
7801 or contract liens to be in the public interest;
7802 (b) impose temporary moratoriums or liens on payments of cash values and policy loans,
7803 or any other right to withdraw funds held in conjunction with policies or contracts, in addition to
7804 any contractual provisions for deferral of cash or policy loan value.
7805 (10) If the association fails to act within a reasonable period of time as provided in
7806 Subsections (2)(a)(ii), (3), and (4), the commissioner shall have the powers and duties of the

7807 association under this chapter with respect to impaired or insolvent insurers.
7808 (11) The association may render assistance and advice to the commissioner, upon his
7809 request, concerning rehabilitation, payment of claims, continuance of coverage, or the performance
7810 of other contractual obligations of any impaired or insolvent insurer.
7811 (12) The association has standing to appear before any court in this state with jurisdiction
7812 over an impaired or insolvent insurer concerning which the association is or may become obligated
7813 under this chapter. Standing extends to all matters germane to the powers and duties of the
7814 association, including proposals for reinsuring, modifying, or guaranteeing the policies or contracts
7815 of the impaired or insolvent insurer and the determination of the policies or contracts and
7816 contractual obligations. The association also has the right to appear or intervene before a court in
7817 another state with jurisdiction over an impaired or insolvent insurer for which the association is
7818 or may become obligated or with jurisdiction over a third party against whom the association may
7819 have rights through subrogation of the insurer's policyholders.
7820 (13) (a) Any person receiving benefits under this chapter shall be considered to have
7821 assigned the rights under, and any causes of action relating to the covered policy or contract to the
7822 association to the extent of the benefits received because of this chapter, whether the benefits are
7823 payments of, or on account of, contractual obligations, continuation of coverage, or provision of
7824 substitute or alternative coverages. The association may require an assignment to it of these rights
7825 and causes of action by any payee, policy or contract owner, beneficiary, insured, or annuitant as
7826 a condition precedent to the receipt of any right or benefits conferred by this chapter upon that
7827 person.
7828 (b) The subrogation rights obtained by the association under this subsection become third
7829 class claims under Section 31A-27-335.
7830 (c) In addition to Subsections (13)(a) and (b), the association has all common law rights
7831 of subrogation and any other equitable or legal remedy which would have been available to the
7832 impaired or insolvent insurer or holder of a policy or contract with respect to the policy or contract.
7833 (14) The association may:
7834 (a) enter into contracts which are necessary or proper to carry out the provisions and
7835 purposes of this chapter;
7836 (b) sue or be sued, including taking any legal actions necessary or proper to recover any
7837 unpaid assessments under Section 31A-28-109 and to settle claims or potential claims against it;

7838 (c) borrow money to effect the purposes of this chapter, and any notes or other evidence
7839 or indebtedness of the association not in default shall be legal investments for domestic insurers
7840 and may be carried as admitted assets;
7841 (d) employ or retain necessary staff members to handle the financial transactions of the
7842 association, and to perform other functions as become necessary or proper under this chapter;
7843 (e) take necessary legal action to avoid payment of improper claims;
7844 (f) exercise, for the purposes of this chapter and to the extent approved by the
7845 commissioner, the powers of a domestic life or health insurer, but in no case may the association
7846 issue insurance policies or annuity contracts other than those issued to perform its obligation under
7847 this chapter; or
7848 (g) act as a special deputy liquidator if appointed by the commissioner.
7849 (15) The association may join an organization of one or more other state associations of
7850 similar purposes to further the purposes and administer the powers and duties of the association.
7851 Section 181. Section **31A-28-109** is amended to read:
7852 **31A-28-109. Assessments.**
7853 (1) For the purpose of providing the funds necessary to carry out the powers and duties of
7854 the association, the board of directors shall assess the member insurers, separately for each
7855 account, at the time and for the amounts that the board finds necessary. Assessments are due not
7856 less than 30 days after prior written notice to the member insurers. Class B assessments, described
7857 in Subsection (2)(b), shall accrue interest at 10% per annum on and after the due date.
7858 (2) There are two classes of assessment:
7859 (a) Class A assessments shall be made for the purpose of meeting administrative and legal
7860 costs and other expenses and examinations conducted under the authority of Subsection
7861 31A-28-112(5). Class A assessments may be made whether or not related to a particular impaired
7862 or insolvent insurer.
7863 (b) Class B assessments shall be made to the extent necessary to carry out the powers and
7864 duties of the association under Section 31A-28-108 with regard to an impaired or an insolvent
7865 insurer.
7866 (3) (a) The amount of any Class A assessment shall be determined by the board and may
7867 be made on a pro rata or non-pro rata basis. If the assessment is pro rata, the board may credit the
7868 assessment against future Class B assessments. A non-pro rata assessment may not exceed $150

7869 per member insurer in any one calendar year.
7870 (b) The amount of any Class B assessment shall be allocated for assessment purposes
7871 among the accounts pursuant to an allocation formula which may be based on the premiums or
7872 reserves of the impaired or insolvent insurer or based on any other standard determined by the
7873 board in its sole discretion to be fair and reasonable under the circumstances.
7874 (c) (i) Class B assessments against member insurers for each account and subaccount shall
7875 be in the proportion that the premiums received on business in this state by each assessed member
7876 insurer bears to the premiums received on business in this state for the same calendar years by all
7877 assessed member insurers.
7878 (ii) "Premiums received" is based on policies or contracts covered by each account for the
7879 three most recent calendar years for which information is available, which precede the year in
7880 which the insurer became impaired or insolvent.
7881 (d) Assessments for funds to meet the requirements of the association with respect to an
7882 impaired or insolvent insurer may not be made until necessary to implement the purposes of this
7883 chapter. Classification of assessments under Subsection (3)(b) and computation of assessments
7884 under this Subsection (3) shall be made with a reasonable degree of accuracy, recognizing that
7885 exact determinations may not always be possible.
7886 (4) The association may abate or defer, in whole or in part, the assessment of a member
7887 insurer if, in the opinion of the board, payment of the assessment would endanger the ability of the
7888 member insurer to fulfill its contractual obligations. In the event an assessment against a member
7889 insurer is abated or deferred in whole or in part, the amount by which the assessment is abated or
7890 deferred may be assessed against the other member insurers in a manner consistent with the basis
7891 for assessments set forth in this section.
7892 (5) (a) The total of all assessments upon a member insurer for the life and annuity account,
7893 and for each subaccount, may not in any one calendar year exceed 2% and the [~~disability~~] accident
7894 and health account may not in any one calendar year exceed 2% of the insurer's yearly average
7895 premiums received in this state on the policies and contracts covered by the account during the
7896 three calendar years preceding the year in which the insurer became an impaired or insolvent
7897 insurer. If the maximum assessment, together with the other assets of the association in any
7898 account, does not provide in any one year in either account an amount sufficient to carry out the
7899 responsibilities of the association, the necessary additional funds shall be assessed as soon as

7900 permitted by this chapter.
7901 (b) The board may provide in the plan of operation a method of allocating funds among
7902 claims, whether relating to one or more impaired or insolvent insurers, when the maximum
7903 assessment will be insufficient to cover anticipated claims.
7904 (c) If a 1% assessment for any subaccount of the life and annuity account in any one year
7905 does not provide an amount sufficient to carry out the responsibilities of the association, the board
7906 shall assess all subaccounts of the life and annuity account for the necessary additional amount
7907 pursuant to Subsection (3)(b), subject to the maximum stated in Subsection (5)(a).
7908 (6) The board may, by an equitable method established in the plan of operation, refund to
7909 member insurers in proportion to the contribution of each insurer to that account the amount by
7910 which the assets of the account exceed the amount the board finds is necessary to carry out during
7911 the coming year the obligations of the association with regard to that account, including assets
7912 accruing from assignment, subrogation, net realized gains, and income from investments. A
7913 reasonable amount may be retained in any account to provide funds for the continuing expenses
7914 of the association and for future losses.
7915 (7) It shall be proper for any member insurer, in determining its premium rates and
7916 policyowner dividends as to any kind of insurance within the scope of this chapter, to consider the
7917 amount reasonably necessary to meet its assessment obligations under this chapter.
7918 (8) The association shall issue to each insurer paying an assessment under this chapter,
7919 other than a Class A assessment, a certificate of contribution, in a form approved by the
7920 commissioner, for the amount of the assessment so paid. All outstanding certificates shall be of
7921 equal dignity and priority without reference to amounts or dates of issue. A certificate of
7922 contribution may be shown by the insurer in its financial statement as an asset in such form and
7923 for such amount, if any, and period of time as the commissioner may approve.
7924 Section 182. Section **31A-28-202** is amended to read:
7925 **31A-28-202. Scope.**
7926 This part applies to protect resident policyowners and insureds under all types of direct
7927 insurance, except:
7928 (1) life[,];
7929 (2) title[,];
7930 (3) surety[~~, disability,~~];

7931 (4) accident and health;
7932 (5) credit, [(]including mortgage guarantee[),];
7933 (6) ocean marine insurance[,];
7934 (7) insurance of warranties or service contracts[,];
7935 (8) financial guarantee[,]; and
7936 (9) all insurance coverages guaranteed by the United States Government.
7937 Section 183. Section **31A-29-103** is amended to read:
7938 **31A-29-103. Definitions.**
7939 As used in this chapter:
7940 (1) "Board" means the board of directors of the pool created in Section 31A-29-104.
7941 (2) "Health care facility" means any entity providing health care services which is licensed
7942 under Title 26, Chapter 21.
7943 (3) "Health care provider" has the same meaning as provided in Section 78-14-3.
7944 (4) "Health care services" means any service or product used in furnishing to any
7945 individual medical care or hospitalization, or incidental to furnishing medical care or
7946 hospitalization, and any other service or product furnished for the purpose of preventing,
7947 alleviating, curing, or healing human illness or injury.
7948 (5) (a) "Health insurance" means any:
7949 (i) hospital and medical expense-incurred policy;
7950 (ii) nonprofit health care service plan contract; and
7951 (iii) health maintenance organization subscriber contract.
7952 (b) "Health insurance" does not include any insurance arising out of the Workers'
7953 Compensation Act or similar law, automobile medical payment insurance, or insurance under
7954 which benefits are payable with or without regard to fault and which is required by law to be
7955 contained in any liability insurance policy[;].
7956 (6) "Health maintenance organization" has the same meaning as provided in Section
7957 31A-8-101.
7958 (7) "Health plan" means any arrangement by which a person, including a dependent or
7959 spouse, covered or making application to be covered under the pool has access to hospital and
7960 medical benefits or reimbursement including group or individual insurance or subscriber contract;
7961 coverage through a health maintenance organization, preferred provider prepayment, group

7962 practice, or individual practice plan; coverage under an uninsured arrangement of group or
7963 group-type contracts including employer self-insured, cost-plus, or other benefits methodologies
7964 not involving insurance; coverage under a group type contract which is not available to the general
7965 public and can be obtained only because of connection with a particular organization or group; and
7966 coverage by medicare or other governmental benefit. The term includes coverage through health
7967 insurance.

7968 (8) "Insured" means an individual resident of this state who is eligible to receive benefits
7969 from any insurer, health maintenance organization, or other health plan.

7970 (9) "Insurer" means an insurance company authorized to transact [~~disability~~] accident and
7971 health insurance business in this state, health maintenance organization, and a self-insurer not
7972 subject to federal preemption.

7973 (10) "Medicaid" means coverage under Title XIX of the Social Security Act, 42 U.S.C.
7974 Sec. 1396 et seq., as amended.

7975 (11) "Medicare" means coverage under both Part A and B of Title XVIII of the Social
7976 Security Act, 42 U.S.C. 1395 et seq., as amended.

7977 (12) "Plan of operation" means the plan developed by the board in accordance with Section
7978 31A-29-105 and includes the articles, bylaws, and operating rules adopted by the board under
7979 Section 31A-29-106.

7980 (13) "Pool" means the Utah Comprehensive Health Insurance Pool created in Section
7981 31A-29-104.

7982 (14) "Pool Fund" means the Comprehensive Health Insurance Pool Enterprise Fund
7983 created in Section 31A-29-120.

7984 (15) "Pool policy" means an insurance policy issued under this chapter.

7985 (16) "Third-party administrator" has the same meaning as provided in Section 31A-1-301.

7986 Section 184. Section **31A-29-117** is amended to read:

7987 **31A-29-117. Premium rates.**

7988 (1) (a) Premium charges for coverage under the pool may not be unreasonable in relation
7989 to:

7990 (i) the benefits provided;

7991 (ii) the risk experience; and

7992 (iii) the reasonable expenses provided in the coverage.

7993 (b) Separate schedules of premium rates based on age and other appropriate demographic
7994 characteristics may apply for individual risks.
7995 (2) A small employer carrier shall annually inform the commissioner by April 1 of the
7996 carrier's:
7997 (a) small employer index premium rates as of March 1 of the current and preceding year[.];
7998 and
7999 (b) average percentage change in the index premium rate as of March 1, of the current and
8000 preceding year.
8001 (3) (a) Premium rates in effect as of January 1, 1997, shall be adjusted on July 1, 1997, and
8002 each following July 1 may be adjusted by the board.
8003 (b) In adjusting premium rates, the board shall:
8004 (i) consider the average increase in small employer index rates for the five largest small
8005 employer carriers submitted under Subsection (2); and
8006 (ii) be subject to Subsection (1).
8007 (4) The board may establish a premium scale based on income. The highest rate may not
8008 exceed the expected claims and expenses for the individual.
8009 (5) If a person is an eligible individual as defined in the Health Insurance Portability and
8010 Accountability Act, P.L. 104-191, 110 Stat. 1979, Sec. 2741(b), the maximum premium rate for
8011 that person may not exceed the amount permitted under P.L. 104-191, 110 Stat. 1986, Sec.
8012 2744(c)(2)(B).
8013 (6) All rates and rate schedules shall be submitted by the board to the commissioner for
8014 approval.
8015 Section 185. Section **31A-30-103** is amended to read:
8016 **31A-30-103. Definitions.**
8017 As used in this part:
8018 (1) "Actuarial certification" means a written statement by a member of the American
8019 Academy of Actuaries or other individual approved by the commissioner that a covered carrier is
8020 in compliance with the provisions of Section 31A-30-106, based upon the examination of the
8021 covered carrier, including review of the appropriate records and of the actuarial assumptions and
8022 methods utilized by the covered carrier in establishing premium rates for applicable health benefit
8023 plans.

8024 (2) "Affiliate" or "affiliated" means any entity or person who directly or indirectly through
8025 one or more intermediaries, controls or is controlled by, or is under common control with, a
8026 specified entity or person.
8027 (3) "Base premium rate" means, for each class of business as to a rating period, the lowest
8028 premium rate charged or that could have been charged under a rating system for that class of
8029 business by the covered carrier to covered insureds with similar case characteristics for health
8030 benefit plans with the same or similar coverage.
8031 (4) "Basic coverage" means the coverage provided in the Basic Health Care Plan
8032 established by the Health Benefit Plan Committee under Subsection 31A-22-613.5[~~(8)~~] (6).
8033 (5) "Carrier" means any person or entity that provides health insurance in this state
8034 including an insurance company, a prepaid hospital or medical care plan, a health maintenance
8035 organization, a multiple employer welfare arrangement, and any other person or entity providing
8036 a health insurance plan under this title.
8037 (6) "Case characteristics" means demographic or other objective characteristics of a
8038 covered insured that are considered by the carrier in determining premium rates for the covered
8039 insured. However, duration of coverage since the policy was issued, claim experience, and health
8040 status, are not case characteristics for the purposes of this chapter.
8041 (7) "Class of business" means all or a separate grouping of covered insureds established
8042 under Section 31A-30-105.
8043 (8) "Conversion policy" means a policy providing coverage under the conversion
8044 provisions required in Title 31A, Chapter 22, Part VII, Group [~~Disability~~] Accident and Health
8045 Insurance.
8046 (9) "Covered carrier" means any individual carrier or small employer carrier subject to this
8047 act.
8048 (10) "Covered individual" means any individual who is covered under a health benefit plan
8049 subject to this act.
8050 (11) "Covered insureds" means small employers and individuals who are issued a health
8051 benefit plan that is subject to this act.
8052 (12) "Dependent" means individuals to the extent they are defined to be a dependent by:
8053 (a) the health benefit plan covering the covered individual; and
8054 (b) the provisions of Chapter 22, Part VI, Disability Insurance.

8055 (13) (a) "Eligible employee" means:
8056 (i) an employee who works on a full-time basis and has a normal work week of 30 or more
8057 hours, and includes a sole proprietor, and a partner of a partnership, if the sole proprietor or partner
8058 is included as an employee under a health benefit plan of a small employer; or
8059 (ii) an independent contractor if the independent contractor is included under a health
8060 benefit plan of a small employer.
8061 (b) "Eligible employee" does not include:
8062 (i) an employee who works on a part-time, temporary, or substitute basis; or
8063 (ii) the spouse or dependents of the employer.
8064 (14) "Established geographic service area" means a geographical area approved by the
8065 commissioner within which the carrier is authorized to provide coverage.
8066 (15) "Health benefit plan" means any certificate under a group health insurance policy, or
8067 any health insurance policy, except that health benefit plan does not include coverage only for:
8068 (a) accident;
8069 (b) dental;
8070 (c) vision;
8071 (d) Medicare supplement;
8072 (e) long-term care; or
8073 (f) the following when offered and marketed as supplemental health insurance and not as
8074 a substitute for hospital or medical expense insurance or major medical expense insurance:
8075 (i) specified disease;
8076 (ii) hospital confinement indemnity; or
8077 (iii) limited benefit plan.
8078 (16) "Index rate" means, for each class of business as to a rating period for covered
8079 insureds with similar case characteristics, the arithmetic average of the applicable base premium
8080 rate and the corresponding highest premium rate.
8081 (17) "Individual carrier" means a carrier that offers health benefit plans covering insureds
8082 in this state under individual policies.
8083 <u>(18) "Individual conversion policy" means a conversion policy issued by a health benefit</u>
8084 <u>plan as defined in Subsection (15) to:</u>
8085 <u>(a) an individual; or</u>

8086 (b) an individual with a family.
8087 [(18)] (19) "Individual coverage count" means the number of natural persons covered
8088 under a carrier's health benefit plans that are individual policies.
8089 [(19)] (20) "Individual enrollment cap" means the percentage set by the commissioner in
8090 accordance with Section 31A-30-110.
8091 [(20)] (21) "New business premium rate" means, for each class of business as to a rating
8092 period, the lowest premium rate charged or offered, or that could have been charged or offered, by
8093 the carrier to covered insureds with similar case characteristics for newly issued health benefit
8094 plans with the same or similar coverage.
8095 [(21)] (22) "Premium" means all monies paid by covered insureds and covered individuals
8096 as a condition of receiving coverage from a covered carrier, including any fees or other
8097 contributions associated with the health benefit plan.
8098 [(22)] (23) "Rating period" means the calendar period for which premium rates established
8099 by a covered carrier are assumed to be in effect, as determined by the carrier. However, a covered
8100 carrier may not have more than one rating period in any calendar month, and no more than 12
8101 rating periods in any calendar year.
8102 [(23)] (24) "Resident" means an individual who has resided in this state for at least 12
8103 consecutive months immediately preceding the date of application.
8104 [(24)] (25) "Small employer" means any person, firm, corporation, partnership, or
8105 association actively engaged in business that, on at least 50% of its working days during the
8106 preceding calendar quarter, employed at least two and no more than 50 eligible employees, the
8107 majority of whom were employed within this state. In determining the number of eligible
8108 employees, companies that are affiliated or that are eligible to file a combined tax return for
8109 purposes of state taxation are considered one employer.
8110 [(25)] (26) "Small employer carrier" means a carrier that offers health benefit plans
8111 covering eligible employees of one or more small employers in this state.
8112 [(26)] (27) "Uninsurable" means an individual who:
8113 (a) is eligible for the Comprehensive Health Insurance Pool coverage under the
8114 underwriting criteria established in Subsection 31A-29-111(4); or
8115 (b) (i) is issued a certificate for coverage under Subsection 31A-30-108(3); and
8116 (ii) has a condition of health that does not meet consistently applied underwriting criteria

8117 as established by the commissioner in accordance with Subsections 31A-30-106(1)(k) and (l) for
8118 which coverage the applicant is applying.
8119 [~~(27)~~] (28) "Uninsurable percentage" for a given calendar year equals UC/CI where, for
8120 purposes of this formula:
8121 (a) "UC" means the number of uninsurable individuals who were issued an individual
8122 policy on or after July 1, 1997; and
8123 (b) "CI" means the carrier's individual coverage count as of December 31 of the preceding
8124 year.
8125 Section 186. Section **31A-30-104** is amended to read:
8126 **31A-30-104. Applicability and scope.**
8127 (1) This chapter applies to any:
8128 (a) health benefit plan that provides coverage to:
8129 (i) individuals;
8130 (ii) small employer groups; or
8131 (iii) both Subsections (1)(a)(i) and (ii); or
8132 (b) individual conversion policy for purposes of [~~Section~~] Sections 31A-30-106.5 and
8133 31A-30-107.
8134 (2) (a) Except as provided in Subsection (2)(b), for the purposes of this chapter, carriers
8135 that are affiliated companies or that are eligible to file a consolidated tax return shall be treated as
8136 one carrier and any restrictions or limitations imposed by this chapter shall apply as if all health
8137 benefit plans delivered or issued for delivery to covered insureds in this state by the affiliated
8138 carriers were issued by one carrier.
8139 (b) An affiliated carrier that is a health maintenance organization having a certificate of
8140 authority under this title may be considered to be a separate carrier for the purposes of this chapter.
8141 (c) Unless otherwise authorized by the commissioner, a covered carrier may not enter into
8142 one or more ceding arrangements with respect to health benefit plans delivered or issued for
8143 delivery to covered insureds in this state if such arrangements would result in less than 50% of the
8144 insurance obligation or risk for such health benefit plans being retained by the ceding carrier.
8145 (d) The provisions of Section 31A-22-1201 apply if a covered carrier cedes or assumes all
8146 of the insurance obligation or risk with respect to one or more health benefit plans delivered or
8147 issued for delivery to covered insureds in this state.

8148 (3) (a) A Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
8149 Labor Management Relations Act, or a carrier with the written authorization of such a trust, may
8150 make a written request to the commissioner for a waiver from the application of any of the
8151 provisions of Subsection 31A-30-106(1) with respect to a health benefit plan provided to the trust.
8152 (b) The commissioner may grant such a waiver if the commissioner finds that application
8153 with respect to the trust would:
8154 (i) have a substantial adverse effect on the participants and beneficiaries of the trust; and
8155 (ii) require significant modifications to one or more collective bargaining arrangements
8156 under which the trust is established or maintained.
8157 (c) A waiver granted under this Subsection (3) may not apply to an individual if the person
8158 participates in such a trust as an associate member of any employee organization.
8159 (4) A carrier who offers individual and small employer health benefit plans may use the
8160 small employer index rates to establish the rate limitations for individual policies, even if some
8161 individual policies are rated below the small employer base rate.
8162 (5) Sections 31A-30-106, 31A-30-106.5, 31A-30-106.7, 31A-30-107, 31A-30-108, and
8163 31A-30-111 apply to:
8164 (a) any insurer engaging in the business of insurance related to the risk of a small employer
8165 for medical, surgical, hospital, or ancillary health care expenses of its employees provided as an
8166 employee benefit; and
8167 (b) any contract of an insurer, other than a workers' compensation policy, related to the risk
8168 of a small employer for medical, surgical, hospital, or ancillary health care expenses of its
8169 employees provided as an employee benefit.
8170 (6) The commissioner may make rules requiring that the marketing practices be consistent
8171 with this chapter for:
8172 (a) an insurer and its agent;
8173 (b) an insurance broker; and
8174 (c) an insurance consultant.
8175 Section 187. Section **31A-30-106** is amended to read:
8176 **31A-30-106. Premiums -- Rating restrictions -- Disclosure.**
8177 (1) Premium rates for health benefit plans under this chapter are subject to the following
8178 provisions:

8179 (a) The index rate for a rating period for any class of business shall not exceed the index
8180 rate for any other class of business by more than 20%.
8181 (b) For a class of business, the premium rates charged during a rating period to covered
8182 insureds with similar case characteristics for the same or similar coverage, or the rates that could
8183 be charged to such employers under the rating system for that class of business, may not vary from
8184 the index rate by more than 30% of the index rate, except as provided in Section 31A-22-625.
8185 (c) The percentage increase in the premium rate charged to a covered insured for a new
8186 rating period, adjusted pro rata for rating periods less than a year, may not exceed the sum of the
8187 following:
8188 (i) the percentage change in the new business premium rate measured from the first day
8189 of the prior rating period to the first day of the new rating period. In the case of a health benefit
8190 plan into which the covered carrier is no longer enrolling new covered insureds, the covered carrier
8191 shall use the percentage change in the base premium rate, provided that such change does not
8192 exceed, on a percentage basis, the change in the new business premium rate for the most similar
8193 health benefit plan into which the covered carrier is actively enrolling new covered insureds;
8194 (ii) any adjustment, not to exceed 15% annually and adjusted pro rata for rating periods
8195 of less than one year, due to the claim experience, health status, or duration of coverage of the
8196 covered individuals as determined from the covered carrier's rate manual for the class of business,
8197 except as provided in Section 31A-22-625; and
8198 (iii) any adjustment due to change in coverage or change in the case characteristics of the
8199 covered insured as determined from the covered carrier's rate manual for the class of business.
8200 (d) Adjustments in rates for claims experience, health status, and duration from issue may
8201 not be charged to individual employees or dependents. Any such adjustment shall be applied
8202 uniformly to the rates charged for all employees and dependents of the small employer.
8203 (e) A covered carrier may utilize industry as a case characteristic in establishing premium
8204 rates, provided that the highest rate factor associated with any industry classification does not
8205 exceed the lowest rate factor associated with any industry classification by more than 15%.
8206 (f) In the case of health benefit plans issued prior to July 1, 1994, a premium rate for a
8207 rating period, adjusted pro rata for rating period of less than a year, may exceed the ranges under
8208 Subsections (1)(a) and (b) until July 1, 1996. In that case, the percentage increase in the premium
8209 rate charged to a covered insured for a new rating period may not exceed the sum of the following:

8210 (i) the percentage change in the new business premium rate measured from the first day
8211 of the prior rating period to the first day of the new rating period. In the case where a covered
8212 carrier is not issuing any new policies the covered carrier shall use the percentage change in the
8213 base premium rate, provided that such change does not exceed, on a percentage basis, the change
8214 in the new business premium rate for the most similar health benefit plan into which the covered
8215 carrier is actively enrolling new covered insureds; and
8216 (ii) any adjustment due to change in coverage or change in the case characteristics of the
8217 covered insured as determined from the carrier's rate manual for the class of business.
8218 (g) The commissioner may grant a one-year extension of the July 1, 1996, deadline
8219 specified in Subsection (1)(f) if the commissioner determines that an extension is needed to avoid
8220 significant disruption of the health insurance market subject to this chapter or to insure the
8221 financial stability of carriers in the market.
8222 (h) (i) Covered carriers shall apply rating factors, including case characteristics,
8223 consistently with respect to all covered insureds in a class of business. Rating factors shall produce
8224 premiums for identical groups which differ only by the amounts attributable to plan design and do
8225 not reflect differences due to the nature of the groups assumed to select particular health benefit
8226 plans.
8227 (ii) A covered carrier shall treat all health benefit plans issued or renewed in the same
8228 calendar month as having the same rating period.
8229 (i) For the purposes of this subsection, a health benefit plan that utilizes a restricted
8230 network provision shall not be considered similar coverage to a health benefit plan that does not
8231 utilize such a network, provided that utilization of the restricted network provision results in
8232 substantial difference in claims costs.
8233 (j) The covered carrier shall not, without prior approval of the commissioner, use case
8234 characteristics other than age, gender, industry, geographic area, family composition, and group
8235 size.
8236 (k) The commissioner may establish regulations in accordance with Title 63, Chapter 46a,
8237 Utah Administrative Rulemaking Act, to implement the provisions of this chapter and to assure
8238 that rating practices used by covered carriers are consistent with the purposes of this chapter,
8239 including regulations that:
8240 (i) assure that differences in rates charged for health benefit plans by covered carriers are

8241 reasonable and reflect objective differences in plan design (not including differences due to the
8242 nature of the groups assumed to select particular health benefit plans);
8243 (ii) prescribe the manner in which case characteristics may be used by covered carriers;
8244 (iii) require insurers, as a condition of transacting business with regard to health care
8245 insurance [~~disability~~] policies after January 1, 1995, to reissue a health care insurance [~~disability~~]
8246 policy to any policyholder whose health care insurance [~~disability~~] policy has, after January 1,
8247 1994, been terminated by the insurer for reasons other than those listed in Subsections
8248 31A-30-107(1)(a) through (1)(e) or not renewed by the insurer after January 1, 1994. The
8249 commissioner may prescribe terms for the reissue of coverage that the commissioner determines
8250 are reasonable and necessary to provide continuity of coverage to insured individuals;
8251 (iv) implement the individual enrollment cap under Section 31A-30-110, including
8252 specifying the contents for certification, auditing standards, underwriting criteria for uninsurable
8253 classification, and limitations on high risk enrollees under Section 31A-30-111; and
8254 (v) establish the individual enrollment cap under Subsection 31A-30-110(1).
8255 (l) Before implementing regulations for underwriting criteria for uninsurable classification,
8256 the commissioner shall contract with an independent consulting organization to develop
8257 industry-wide underwriting criteria for uninsurability based on an individual's expected claims
8258 under open enrollment coverage exceeding 200% of that expected for a standard insurable
8259 individual with the same case characteristics.
8260 (m) The commissioner shall revise rules issued for Sections 31A-22-602 and 31A-22-605
8261 regarding individual [~~disability~~] accident and health policy rates to allow rating in accordance with
8262 this section.
8263 (2) A covered carrier shall not transfer a covered insured involuntarily into or out of a class
8264 of business. A covered carrier shall not offer to transfer a covered insured into or out of a class
8265 of business unless such offer is made to transfer all covered insureds in the class of business
8266 without regard to case characteristics, claim experience, health status, or duration of coverage since
8267 issue.
8268 (3) Upon offering for sale any health benefit plan to a small employer, or individual, the
8269 covered carrier shall, as part of its solicitation and sales materials, disclose or make available all
8270 of the following:
8271 (a) the extent to which premium rates for a specified covered insured are established or

8272 adjusted in part based on the actual or expected variation in claims costs or actual or expected
8273 variation in health status of covered individuals;
8274 (b) provisions concerning the covered carrier's right to change premium rates and the
8275 factors other than claim experience which affect changes in premium rates;
8276 (c) provisions relating to renewability of policies and contracts; and
8277 (d) provisions relating to any preexisting condition provision.
8278 (4) (a) Each covered carrier shall maintain at its principal place of business a complete and
8279 detailed description of its rating practices and renewal underwriting practices, including
8280 information and documentation that demonstrate that its rating methods and practices are based
8281 upon commonly accepted actuarial assumptions and are in accordance with sound actuarial
8282 principles.
8283 (b) Each covered carrier shall file with the commissioner, on or before March 15 of each
8284 year, in a form, manner, and containing such information as prescribed by the commissioner, an
8285 actuarial certification certifying that the covered carrier is in compliance with this chapter and that
8286 the rating methods of the covered carrier are actuarially sound. A copy of that certification shall
8287 be retained by the covered carrier at its principal place of business.
8288 (c) A covered carrier shall make the information and documentation described in this
8289 subsection available to the commissioner upon request.
8290 (d) Records submitted to the commissioner under the provisions of this section shall be
8291 maintained by the commissioner as protected records under Title 63, Chapter 2, Government
8292 Records Access and Management Act.
8293 Section 188. Section **31A-30-106.5** is amended to read:
8294 **31A-30-106.5. Conversion policy -- Premiums -- Rating restrictions.**
8295 (1) All provisions of Section 31A-30-106, except Subsection 31A-30-106(1)(b), apply to
8296 conversion policies.
8297 (2) Conversion policy premium rates may not exceed by more than 35% the index rate for
8298 individuals with similar case characteristics for any class of business in which the policy form has
8299 been approved.
8300 (3) An insurer may not consider pregnancy of a covered insured in determining its
8301 conversion policy premium rates.
8302 Section 189. Section **31A-30-107** is amended to read:

8303 **31A-30-107. Renewal -- Limitations -- Exclusions.**

8304 (1) A health benefit plan subject to this chapter is renewable with respect to all covered
8305 individuals at the option of the covered insured except in any of the following cases:

8306 (a) nonpayment of the required premiums;

8307 (b) fraud or misrepresentation of:

8308 (i) the employer; or

8309 (ii) with respect to coverage of individual insureds, the insureds or their representatives;

8310 (c) noncompliance with the covered carrier's minimum participation requirements;

8311 (d) noncompliance with the covered carrier's employer contribution requirements;

8312 (e) repeated misuse of a provider network provision; or

8313 (f) an election by the covered carrier to nonrenew all of its health benefit plans issued to
8314 covered insureds in this state, in which case the covered carrier shall:

8315 (i) provide advanced notice of its decision under this Subsection (1) to the commissioner
8316 in each state in which it is licensed; [~~and~~]

8317 (ii) provide notice of the decision not to renew coverage to all affected covered insureds
8318 and to the commissioner in each state in which an affected insured individual is known to reside[~~.~~];
8319 and

8320 (iii) provide a plan of orderly withdrawal as required by Section 31A-4-115.

8321 (2) Notice under Subsection (1) shall be provided:

8322 (a) to affected covered insureds at least 180 days prior to nonrenewal of any health benefit
8323 plans by the covered carrier; and

8324 (b) to the commissioner at least three working days prior to the notice to the affected
8325 covered insureds.

8326 (3) A covered carrier that elects not to renew a health benefit plan under Subsection (1)(f)
8327 is prohibited from writing new business subject to this chapter in this state for a period of five
8328 years from the date of notice to the commissioner.

8329 (4) When a covered carrier is doing business subject to this chapter in one service area of
8330 this state, Subsections (1) through (3) apply only to the covered carrier's operations in that service
8331 area.

8332 (5) Health benefit plans covering covered insureds shall comply with Subsections (5)(a)
8333 and (b).

8334 (a) (i) A health benefit plan may not deny, exclude, or limit benefits for a covered
8335 individual for losses incurred more than 12 months, or 18 months in the case of a late enrollee, as
8336 defined in P.L. 104-191, 110 Stat. 1940, Sec. 101, following the effective date of the individual's
8337 coverage due to a preexisting condition.
8338 (ii) A health benefit plan may not define a preexisting condition more restrictively than:
8339 (A) a condition for which medical advice, diagnosis, care, or treatment was recommended
8340 or received during the six months immediately preceding the earlier of:
8341 (I) the enrollment date; or
8342 (II) the effective date of coverage; or
8343 (B) for an individual insurance policy, a pregnancy existing on the effective date of
8344 coverage.
8345 (iii) An individual insurer shall offer a health benefit plan in compliance with Subsections
8346 (5)(a)(i) and (ii), and may, when the insurer and the insured mutually agree in writing to a
8347 condition-specific exclusion rider, offer to issue an individual policy that excludes a specific
8348 physical condition consistent with Subsections (5)(a)(iv) and (v).
8349 (iv) The commissioner shall establish, in rule, a list of nonlife threatening [~~and~~
8350 ~~nondegenerative~~] physical conditions that may be the subject of a condition-specific exclusion
8351 rider.
8352 (v) A condition-specific exclusion rider shall be limited to the excluded condition and may
8353 not extend to any secondary medical condition that may or may not be directly related to the
8354 excluded condition.
8355 (b) (i) A covered carrier shall waive any time period applicable to a preexisting condition
8356 exclusion or limitation period with respect to particular services in a health benefit plan for the
8357 period of time the individual was previously covered by public or private health insurance or by
8358 any other health benefit arrangement that provided benefits with respect to such services, provided
8359 that:
8360 (A) the previous coverage was continuous to a date not more than 63 <u>full</u> days prior to the
8361 effective date of the new coverage; and
8362 (B) the insured provides notification of previous coverage to the covered carrier within 36
8363 months of the coverage effective date if the insurer has previously requested such notification.
8364 (ii) The period of continuous coverage under Subsection (5)(b)(i)(A) may not include any

8365 waiting period for the effective date of the new coverage applied by the employer or the carrier.
8366 This Subsection (5)(b)(ii) does not preclude application of any waiting period applicable to all new
8367 enrollees under the plan.
8368 (iii) Credit for previous coverage as provided under Subsection (5)(b)(i)(A) need not be
8369 given for any condition which was previously excluded under a condition-specific exclusion rider.
8370 A new preexisting waiting period may be applied to any condition that was excluded by a rider
8371 under the terms of previous individual coverage.
8372 Section 190. Section **31A-32a-102** is amended to read:
8373 **31A-32a-102. Definitions.**
8374 As used in this chapter:
8375 (1) "Account administrator" means any of the following:
8376 (a) a depository institution as defined in Section 7-1-103;
8377 (b) a trust company as defined in Section 7-1-103;
8378 (c) an insurance company authorized to do business in this state under this title;
8379 (d) a third party administrator licensed under Section 31A-25-203; and
8380 (e) an employer if the employer has a self-insured health plan under ERISA.
8381 (2) "Account holder" means the resident individual who establishes a medical care savings
8382 account or for whose benefit a medical care savings account is established.
8383 (3) "Deductible" means the total deductible for an employee and all the dependents of that
8384 employee for a calendar year.
8385 (4) "Dependent" means the same as "dependent" under Section 31A-30-103.
8386 (5) "Eligible medical expense" means an expense paid by the taxpayer for:
8387 (a) medical care described in Section 213(d), Internal Revenue Code;
8388 (b) the purchase of a health coverage policy, certificate, or contract, including a qualified
8389 higher deductible health plan; or
8390 (c) premiums on long-term care insurance policies as defined in Section [~~31A-22-1402~~]
8391 31A-1-301.
8392 (6) "Employee" means the individual for whose benefit or for the benefit of whose
8393 dependents a medical care savings account is established. Employee includes a self-employed
8394 individual.
8395 (7) "ERISA" means the Employee Retirement Income Security Act of 1974, Public Law

8396 93-406, 88 Stat. 829.
8397 (8) "Higher deductible" means a deductible of not less than $1,000.
8398 (9) "Medical care savings account" or "account" means a trust account established at a
8399 depository institution in this state pursuant to a medical care savings account program to pay the
8400 eligible medical expenses of:
8401 (a) an employee or account holder; and
8402 (b) the dependents of the employee or account holder.
8403 (10) "Medical care savings account program" or "program" means one of the following
8404 programs:
8405 (a) a program established by an employer in which the employer:
8406 (i) purchases a qualified higher deductible health plan for the benefit of an employee and
8407 the employee's dependents; and
8408 (ii) contributes on behalf of an employee into a medical care savings account; or
8409 (b) a program established by an account holder in which the account holder:
8410 (i) purchases a qualified higher deductible health plan for the benefit of the account holder
8411 and the account holder's dependents; and
8412 (ii) contributes an amount to the medical care savings account.
8413 (11) "Qualified higher deductible health plan" means a health coverage policy, certificate,
8414 or contract that:
8415 (a) provides for payments for covered benefits that exceed the higher deductible; and
8416 (b) is purchased by:
8417 (i) an employer for the benefit of an employee for whom the employer makes deposits into
8418 a medical care savings account; or
8419 (ii) an account holder.
8420 Section 191. Section **31A-33-103.5** is amended to read:
8421 **31A-33-103.5. Powers of Fund -- Limitations.**
8422 (1) The fund may form or acquire subsidiaries or enter into a joint enterprise:
8423 (a) in accordance with Section 31A-33-107; and
8424 (b) except as limited by this section and applicable insurance rules and statutes.
8425 (2) Subject to applicable insurance rules and statutes, the fund may only offer:
8426 (a) workers' compensation insurance in Utah;

8427 (b) workers' compensation insurance in a state other than Utah to the extent necessary to:
8428 (i) accomplish its purpose under Subsection 31A-33-102(1)(b); and
8429 (ii) provide workers' compensation or occupational disease insurance coverage to Utah
8430 employers and their employees engaged in interstate commerce; and
8431 (c) workers' compensation products and services in Utah or other states.
8432 (3) Subject to applicable insurance rules and statutes, a subsidiary of the fund may:
8433 (a) offer workers' compensation insurance coverage only:
8434 (i) in a state other than Utah; and
8435 (ii) (A) to insure the following against liability for compensation based on job-related
8436 accidental injuries and occupational diseases[;]:
8437 (I) an employer, as defined in Section 34A-2-103, that has a majority of its employees, as
8438 defined in Section 34A-2-104, hired or regularly employed in Utah;
8439 (II) an employer, as defined in Section 34A-2-103, whose principal administrative office
8440 is located in Utah; or
8441 (III) a subsidiary or affiliate of an employer described in Subsection (3)(a)(ii)(A)(I) or (II);
8442 or
8443 (B) for a state fund organization that is not an admitted insurer in the other state:
8444 (I) on a fee for service basis; and
8445 (II) without bearing any insurance risk; and
8446 (b) offer workers' compensation products and services in Utah and other states.
8447 (4) The fund shall write workers' compensation insurance in accordance with Section
8448 31A-22-1001.
8449 (5) (a) The fund may enter into a joint enterprise that offers workers' compensation
8450 insurance and other coverage only in the state, provided:
8451 (i) the joint enterprise offers only property or liability insurance in addition to workers'
8452 compensation insurance;
8453 (ii) the fund may not bear any insurance risk associated with the insurance coverage other
8454 than risk associated with workers' compensation insurance; and
8455 (iii) the offer of other insurance shall be part of an insurance program that includes
8456 workers' compensation insurance coverage that is provided by the fund.
8457 (b) The fund or a subsidiary of the fund may not offer, or enter into a joint enterprise that

8458 offers, or otherwise participate in the offering of accident and health [or disability] insurance.
8459 Section 192. Section **31A-33-113** is amended to read:
8460 **31A-33-113. Cancellation of policies.**
8461 The Workers' Compensation Fund may cancel a policy [prior to the conclusion of the
8462 policy period only:] as provided in Section 31A-22-1002.
8463 [(1) (a) by agreeing to the cancellation with the policyholder; and]
8464 [(b) sending notice of the cancellation to the Labor Commission;]
8465 [(2) for nonpayment of premium, after 30 days' notice to:]
8466 [(a) the Labor Commission; and]
8467 [(b) the policyholder; or]
8468 [(3) for failure on the part of the policyholder to comply with the contractual provisions
8469 of the policy, after 30 days' notice to:]
8470 [(a) the Labor Commission; and]
8471 [(b) the policyholder.]
8472 Section 193. Section **34A-2-103** is amended to read:
8473 **34A-2-103. Employers enumerated and defined -- Regularly employed -- Statutory**
8474 **employers.**
8475 (1) (a) The state, and each county, city, town, and school district in the state are considered
8476 employers under this chapter and Chapter 3, Utah Occupational Disease Act.
8477 (b) For the purposes of the exclusive remedy in this chapter and Chapter 3, Utah
8478 Occupational Disease Act prescribed in Sections 34A-2-105 and 34A-3-102, the state is considered
8479 to be a single employer and includes any office, department, agency, authority, commission, board,
8480 institution, hospital, college, university, or other instrumentality of the state.
8481 (2) Except as provided in Subsection (4), each person, including each public utility and
8482 each independent contractor, who regularly employs one or more workers or operatives in the same
8483 business, or in or about the same establishment, under any contract of hire, express or implied, oral
8484 or written, is considered an employer under this chapter and Chapter 3, Utah Occupational Disease
8485 Act. As used in this Subsection (2):
8486 (a) "Independent contractor" means any person engaged in the performance of any work
8487 for another who, while so engaged, is:
8488 (i) independent of the employer in all that pertains to the execution of the work;

8489 (ii) not subject to the routine rule or control of the employer;
8490 (iii) engaged only in the performance of a definite job or piece of work; and
8491 (iv) subordinate to the employer only in effecting a result in accordance with the
8492 employer's design.
8493 (b) "Regularly" includes all employments in the usual course of the trade, business,
8494 profession, or occupation of the employer, whether continuous throughout the year or for only a
8495 portion of the year.
8496 (3) (a) The client company in an employee leasing arrangement under Title 58, Chapter
8497 59, Professional Employer Organization Licensing Act, is considered the employer of leased
8498 employees and shall secure workers' compensation benefits for them by complying with
8499 Subsection 34A-2-201(1) or (2) and commission rules.
8500 (b) Insurance carriers may underwrite workers' compensation secured in accordance with
8501 Subsection (3)(a) showing the leasing company as the named insured and each client company as
8502 an additional insured by means of individual endorsements.
8503 (c) Endorsements shall be filed with the division as directed by commission rule.
8504 (d) The division shall promptly inform the Division of Occupation and Professional
8505 Licensing within the Department of Commerce if the division has reason to believe that an
8506 employee leasing company is not in compliance with Subsection 34A-2-201(1) or (2) and
8507 commission rules.
8508 (4) A domestic employer who does not employ one employee or more than one employee
8509 at least 40 hours per week is not considered an employer under this chapter and Chapter 3, Utah
8510 Occupational Disease Act.
8511 (5) (a) As used in this Subsection (5):
8512 (i) (A) "agricultural employer" means a person who employs agricultural labor as defined
8513 in Subsections 35A-4-206(1) and (2) and does not include employment as provided in Subsection
8514 35A-4-206(3); and
8515 (B) notwithstanding Subsection (5)(a)(i)(A), only for purposes of determining who is a
8516 member of the employer's immediate family under Subsection (5)(a)(ii), if the agricultural
8517 employer is a corporation, partnership, or other business entity, "agricultural employer" means an
8518 officer, director, or partner of the business entity;
8519 (ii) "employer's immediate family" means:

8520 (A) an agricultural employer's:
8521 (I) spouse;
8522 (II) grandparent;
8523 (III) parent;
8524 (IV) sibling;
8525 (V) child;
8526 (VI) grandchild;
8527 (VII) nephew; or
8528 (VIII) niece;
8529 (B) a spouse of any person provided in Subsection [~~(4)~~] (5)(a)(ii)(A)(II) through (VIII);
8530 or
8531 (C) an individual who is similar to those listed in Subsections [~~(4)~~] (5)(a)(ii)(A) or (B) as
8532 defined by rules of the commission; and
8533 (iii) "non-immediate family" means a person who is not a member of the employer's
8534 immediate family.
8535 (b) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an
8536 agricultural employer is not considered an employer of a member of the employer's immediate
8537 family.
8538 (c) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an
8539 agricultural employer is not considered an employer of a non-immediate family employee if:
8540 (i) for the previous calendar year the agricultural employer's total annual payroll for all
8541 non-immediate family employees was less than $8,000; or
8542 (ii) (A) for the previous calendar year the agricultural employer's total annual payroll for
8543 all non-immediate family employees was equal to or greater than $8,000 but less than $50,000; and
8544 (B) the agricultural employer maintains insurance that covers job-related injuries of the
8545 employer's non-immediate family employees in at least the following amounts:
8546 (I) $300,000 liability insurance, as defined in Section 31A-1-301; and
8547 (II) $5,000 for [~~medical, hospital, and surgical~~] health care benefits similar to benefits
8548 under health care insurance as [~~described~~] defined in [~~Subsection~~] Section 31A-1-301[~~(50)(a)(ii)~~].
8549 (d) For purposes of this chapter and Chapter 3, Utah Occupational Disease Act, an
8550 agricultural employer is considered an employer of a non-immediate family employee if:

8551 (i) for the previous calendar year the agricultural employer's total annual payroll for all
8552 non-immediate family employees is equal to or greater than $50,000; or
8553 (ii) (A) for the previous year the agricultural employer's total payroll for non-immediate
8554 family employees was equal to or exceeds $8,000 but is less than $50,000; and
8555 (B) the agricultural employer fails to maintain the insurance required under Subsection
8556 (5)(c)(ii).
8557 (6) An employer of agricultural laborers or domestic servants who is not considered an
8558 employer under this chapter and Chapter 3, Utah Occupational Disease Act, may come under this
8559 chapter and Chapter 3, Utah Occupational Disease Act, by complying with:
8560 (a) this chapter and Chapter 3, Utah Occupational Disease Act; and
8561 (b) the rules of the commission.
8562 (7) (a) If any person who is an employer procures any work to be done wholly or in part
8563 for the employer by a contractor over whose work the employer retains supervision or control, and
8564 this work is a part or process in the trade or business of the employer, the contractor, all persons
8565 employed by the contractor, all subcontractors under the contractor, and all persons employed by
8566 any of these subcontractors, are considered employees of the original employer for the purposes
8567 of this chapter and Chapter 3, Utah Occupational Disease Act.
8568 (b) Any person who is engaged in constructing, improving, repairing, or remodelling a
8569 residence that the person owns or is in the process of acquiring as the person's personal residence
8570 may not be considered an employee or employer solely by operation of Subsection (7)(a).
8571 (c) A partner in a partnership or an owner of a sole proprietorship may not be considered
8572 an employee under Subsection (7)(a) if the employer who procures work to be done by the
8573 partnership or sole proprietorship obtains and relies on either:
8574 (i) a valid certification of the partnership's or sole proprietorship's compliance with Section
8575 34A-2-201 indicating that the partnership or sole proprietorship secured the payment of workers'
8576 compensation benefits pursuant to Section 34A-2-201; or
8577 (ii) if a partnership or sole proprietorship with no employees other than a partner of the
8578 partnership or owner of the sole proprietorship, a workers' compensation policy issued by an
8579 insurer pursuant to Subsection 31A-21-104(8) stating that:
8580 (A) the partnership or sole proprietorship is customarily engaged in an independently
8581 established trade, occupation, profession, or business; and

8582 (B) the partner or owner personally waives the partner's or owner's entitlement to the
8583 benefits of this chapter and Chapter 3, Utah Occupational Disease Act, in the operation of the
8584 partnership or sole proprietorship.
8585 (d) A director or officer of a corporation may not be considered an employee under
8586 Subsection (7)(a) if the director or officer is excluded from coverage under Subsection
8587 34A-2-104(4).
8588 (e) A contractor or subcontractor is not an employee of the employer under Subsection
8589 (7)(a), if the employer who procures work to be done by the contractor or subcontractor obtains
8590 and relies on either:
8591 (i) a valid certification of the contractor's or subcontractor's compliance with Section
8592 34A-2-201; or
8593 (ii) if a partnership, corporation, or sole proprietorship with no employees other than a
8594 partner of the partnership, officer of the corporation, or owner of the sole proprietorship, a workers'
8595 compensation policy issued by an insurer pursuant to Subsection 31A-21-104(8) stating that:
8596 (A) the partnership, corporation, or sole proprietorship is customarily engaged in an
8597 independently established trade, occupation, profession, or business; and
8598 (B) the partner, corporate officer, or owner personally waives the partner's, corporate
8599 officer's, or owner's entitlement to the benefits of this chapter and Chapter 3, Utah Occupational
8600 Disease Act, in the operation of the partnership's, corporation's, or sole proprietorship's enterprise
8601 under a contract of hire for services.
8602 Section 194. Section **58-67-501** is amended to read:
8603 **58-67-501. Unlawful conduct.**
8604 (1) "Unlawful conduct" includes, in addition to the definition in Section 58-1-501:
8605 (a) buying, selling, or fraudulently obtaining, any medical diploma, license, certificate, or
8606 registration;
8607 (b) aiding or abetting the buying, selling, or fraudulently obtaining of any medical diploma,
8608 license, certificate, or registration;
8609 (c) substantially interfering with a licensee's lawful and competent practice of medicine
8610 in accordance with this chapter by:
8611 (i) any person or entity that manages, owns, operates, or conducts a business having a
8612 direct or indirect financial interest in the licensee's professional practice; or

8613 (ii) anyone other than another physician licensed under this title, who is engaged in direct
8614 clinical care or consultation with the licensee in accordance with the standards and ethics of the
8615 profession of medicine; or
8616 (d) entering into a contract that limits a licensee's ability to advise the licensee's patients
8617 fully about treatment options or other issues that affect the health care of the licensee's patients.
8618 (2) "Unlawful conduct" does not include:
8619 (a) establishing, administering, or enforcing the provisions of a policy of [~~disability~~]
8620 accident and health insurance by an insurer doing business in this state in accordance with Title
8621 31A, Insurance Code;
8622 (b) adopting, implementing, or enforcing utilization management standards related to
8623 payment for a licensee's services, provided that:
8624 (i) utilization management standards adopted, implemented, and enforced by the payer
8625 have been approved by a physician or by a committee that contains one or more physicians; and
8626 (ii) the utilization management standards does not preclude a licensee from exercising
8627 independent professional judgment on behalf of the licensee's patients in a manner that is
8628 independent of payment considerations;
8629 (c) developing and implementing clinical practice standards that are intended to reduce
8630 morbidity and mortality or developing and implementing other medical or surgical practice
8631 standards related to the standardization of effective health care practices, provided that:
8632 (i) the practice standards and recommendations have been approved by a physician or by
8633 a committee that contains one or more physicians; and
8634 (ii) the practice standards do not preclude a licensee from exercising independent
8635 professional judgment on behalf of the licensee's patients in a manner that is independent of
8636 payment considerations;
8637 (d) requesting or recommending that a patient obtain a second opinion from a licensee;
8638 (e) conducting peer review, quality evaluation, quality improvement, risk management,
8639 or similar activities designed to identify and address practice deficiencies with health care
8640 providers, health care facilities, or the delivery of health care;
8641 (f) providing employment supervision or adopting employment requirements that do not
8642 interfere with the licensee's ability to exercise independent professional judgment on behalf of the
8643 licensee's patients, provided that employment requirements that may not be considered to interfere

8644 with an employed licensee's exercise of independent professional judgment include:
8645 (i) an employment requirement that restricts the licensee's access to patients with whom
8646 the licensee's employer does not have a contractual relationship, either directly or through contracts
8647 with one or more third-party payers; or
8648 (ii) providing compensation incentives that are not related to the treatment of any
8649 particular patient;
8650 (g) providing benefit coverage information, giving advice, or expressing opinions to a
8651 patient or to a family member of a patient to assist the patient or family member in making a
8652 decision about health care that has been recommended by a licensee; or
8653 (h) any otherwise lawful conduct that does not substantially interfere with the licensee's
8654 ability to exercise independent professional judgment on behalf of the licensee's patients and that
8655 does not constitute the practice of medicine as defined in this chapter.
8656 Section 195. Section **58-68-501** is amended to read:
8657 **58-68-501. Unlawful conduct.**
8658 (1) "Unlawful conduct" includes, in addition to the definition in Section 58-1-501:
8659 (a) buying, selling, or fraudulently obtaining any osteopathic medical diploma, license,
8660 certificate, or registration; and
8661 (b) aiding or abetting the buying, selling, or fraudulently obtaining of any osteopathic
8662 medical diploma, license, certificate, or registration;
8663 (c) substantially interfering with a licensee's lawful and competent practice of medicine
8664 in accordance with this chapter by:
8665 (i) any person or entity that manages, owns, operates, or conducts a business having a
8666 direct or indirect financial interest in the licensee's professional practice; or
8667 (ii) anyone other than another physician licensed under this title, who is engaged in direct
8668 clinical care or consultation with the licensee in accordance with the standards and ethics of the
8669 profession of medicine; or
8670 (d) entering into a contract that limits a licensee's ability to advise the licensee's patients
8671 fully about treatment options or other issues that affect the health care of the licensee's patients.
8672 (2) "Unlawful conduct" does not include:
8673 (a) establishing, administering, or enforcing the provisions of a policy of [~~disability~~]
8674 accident and health insurance by an insurer doing business in this state in accordance with Title

8675 31A, Insurance Code;
8676 (b) adopting, implementing, or enforcing utilization management standards related to
8677 payment for a licensee's services, provided that:
8678 (i) utilization management standards adopted, implemented, and enforced by the payer
8679 have been approved by a physician or by a committee that contains one or more physicians; and
8680 (ii) the utilization management standards does not preclude a licensee from exercising
8681 independent professional judgment on behalf of the licensee's patients in a manner that is
8682 independent of payment considerations;
8683 (c) developing and implementing clinical practice standards that are intended to reduce
8684 morbidity and mortality or developing and implementing other medical or surgical practice
8685 standards related to the standardization of effective health care practices, provided that:
8686 (i) the practice standards and recommendations have been approved by a physician or by
8687 a committee that contains one or more physicians; and
8688 (ii) the practice standards do not preclude a licensee from exercising independent
8689 professional judgment on behalf of the licensee's patients in a manner that is independent of
8690 payment considerations;
8691 (d) requesting or recommending that a patient obtain a second opinion from a licensee;
8692 (e) conducting peer review, quality evaluation, quality improvement, risk management,
8693 or similar activities designed to identify and address practice deficiencies with health care
8694 providers, health care facilities, or the delivery of health care;
8695 (f) providing employment supervision or adopting employment requirements that do not
8696 interfere with the licensee's ability to exercise independent professional judgment on behalf of the
8697 licensee's patients, provided that employment requirements that may not be considered to interfere
8698 with an employed licensee's exercise of independent professional judgment include:
8699 (i) an employment requirement that restricts the licensee's access to patients with whom
8700 the licensee's employer does not have a contractual relationship, either directly or through contracts
8701 with one or more third-party payers; or
8702 (ii) providing compensation incentives that are not related to the treatment of any
8703 particular patient;
8704 (g) providing benefit coverage information, giving advice, or expressing opinions to a
8705 patient or to a family member of a patient to assist the patient or family member in making a

8706 decision about health care that has been recommended by a licensee; or
8707 (h) any otherwise lawful conduct that does not substantially interfere with the licensee's
8708 ability to exercise independent professional judgment on behalf of the licensee's patients and that
8709 does not constitute the practice of medicine as defined in this chapter.
8710 Section 196. Section **59-10-114** is amended to read:
8711 **59-10-114. Additions to and subtractions from federal taxable income of an**
8712 **individual.**
8713 (1) There shall be added to federal taxable income of a resident or nonresident individual:
8714 (a) the amount of any income tax imposed by this or any predecessor Utah individual
8715 income tax law and the amount of any income tax imposed by the laws of another state, the District
8716 of Columbia, or a possession of the United States, to the extent deducted from federal adjusted
8717 gross income, as defined by Section 62, Internal Revenue Code, in determining federal taxable
8718 income;
8719 (b) a lump sum distribution allowable as a deduction under Section 402(d)(3), Internal
8720 Revenue Code, to the extent deductible under Section 62(a)(8), Internal Revenue Code, in
8721 determining federal adjusted gross income;
8722 (c) 25% of the personal exemptions, as defined and calculated in the Internal Revenue
8723 Code;
8724 (d) a withdrawal from a medical care savings account and any penalty imposed in the
8725 taxable year if:
8726 (i) the taxpayer did not deduct or include the amounts on his federal tax return pursuant
8727 to Section 220, Internal Revenue Code; and
8728 (ii) the withdrawal is subject to Subsections 31A-32a-105(1) and (2); and
8729 (e) the amount refunded to a participant under Title 53B, Chapter 8a, Higher Education
8730 Savings Incentive Program, in the year in which the amount is refunded.
8731 (2) There shall be subtracted from federal taxable income of a resident or nonresident
8732 individual:
8733 (a) the interest or dividends on obligations or securities of the United States and its
8734 possessions or of any authority, commission, or instrumentality of the United States, to the extent
8735 includable in gross income for federal income tax purposes but exempt from state income taxes
8736 under the laws of the United States, but the amount subtracted under this subsection shall be

8737 reduced by any interest on indebtedness incurred or continued to purchase or carry the obligations
8738 or securities described in this subsection, and by any expenses incurred in the production of
8739 interest or dividend income described in this subsection to the extent that such expenses, including
8740 amortizable bond premiums, are deductible in determining federal taxable income;
8741 (b) 1/2 of the net amount of any income tax paid or payable to the United States after all
8742 allowable credits, as reported on the United States individual income tax return of the taxpayer for
8743 the same taxable year;
8744 (c) the amount of adoption expenses which, for purposes of this subsection, means any
8745 actual medical and hospital expenses of the mother of the adopted child which are incident to the
8746 child's birth and any welfare agency, child placement service, legal, and other fees or costs relating
8747 to the adoption;
8748 (d) amounts received by taxpayers under age 65 as retirement income which, for purposes
8749 of this section, means pensions and annuities, paid from an annuity contract purchased by an
8750 employer under a plan which meets the requirements of Section 404(a)(2), Internal Revenue Code,
8751 or purchased by an employee under a plan which meets the requirements of Section 408, Internal
8752 Revenue Code, or paid by the United States, a state, or political subdivision thereof, or the District
8753 of Columbia, to the employee involved or the surviving spouse;
8754 (e) for each taxpayer age 65 or over before the close of the taxable year, a $7,500 personal
8755 retirement exemption;
8756 (f) 75% of the amount of the personal exemption, as defined and calculated in the Internal
8757 Revenue Code, for each dependent child with a disability and adult with a disability who is
8758 claimed as a dependent on a taxpayer's return;
8759 (g) any amount included in federal taxable income that was received pursuant to any
8760 federal law enacted in 1988 to provide reparation payments, as damages for human suffering, to
8761 United States citizens and resident aliens of Japanese ancestry who were interned during World
8762 War II;
8763 (h) subject to the limitations of Subsection (3)(e), amounts a taxpayer pays during the
8764 taxable year for health care insurance, as defined in Title 31A, Chapter 1, General Provisions:
8765 (i) for:
8766 (A) the taxpayer;
8767 (B) the taxpayer's spouse; and

8768 (C) the taxpayer's dependents; and
8769 (ii) to the extent the taxpayer does not deduct the amounts under Section 125, 162, or 213,
8770 Internal Revenue Code, in determining federal taxable income for the taxable year;
8771 (i) except as otherwise provided in this subsection, the amount of a contribution made in
8772 the tax year on behalf of the taxpayer to a medical care savings account and interest earned on a
8773 contribution to a medical care savings account established pursuant to Title 31A, Chapter 32a,
8774 Medical Care Savings Account Act, to the extent the contribution is accepted by the account
8775 administrator as provided in the Medical Care Savings Account Act, and if the taxpayer did not
8776 deduct or include amounts on his federal tax return pursuant to Section 220, Internal Revenue
8777 Code. A contribution deductible under this subsection may not exceed either of the following:
8778 (i) the maximum contribution allowed under the Medical Care Savings Account Act for
8779 the tax year multiplied by two for taxpayers who file a joint return, if neither spouse is covered by
8780 health care insurance as defined in Section 31A-1-301 or self-funded plan that covers the other
8781 spouse, and each spouse has a medical care savings account; or
8782 (ii) the maximum contribution allowed under the Medical Care Savings Account Act for
8783 the tax year for taxpayers:
8784 (A) who do not file a joint return; or
8785 (B) who file a joint return, but do not qualify under Subsection (2)(i)(i); and
8786 (j) the amount included in federal taxable income that was derived from money paid by
8787 the taxpayer to the program fund under Title 53B, Chapter 8a, Higher Education Savings Incentive
8788 Program, not to exceed amounts determined under Subsection 53B-8a-106(1)(d) and investment
8789 income earned on participation agreements under Subsection 53B-8a-106(1) when used for higher
8790 education costs of the beneficiary;
8791 (k) for tax years beginning on or after January 1, 2000, any amounts paid for premiums
8792 on long-term care insurance policies as defined in Section [~~31A-22-1402~~] <u>31A-1-301</u> to the extent
8793 the amounts paid for long-term care insurance were not deducted under Section 213, Internal
8794 Revenue Code, in determining federal taxable income; and
8795 (l) for taxable years beginning on or after January 1, 2000, if the conditions of Subsection
8796 (4)(a) are met, the amount of income derived by a Ute tribal member:
8797 (i) during a time period that the Ute tribal member resides on homesteaded land
8798 diminished from the Uintah and Ouray Reservation; and

8799 (ii) from a source within the Uintah and Ouray Reservation.
8800 (3) (a) For purposes of Subsection (2)(d), the amount of retirement income subtracted for
8801 taxpayers under 65 shall be the lesser of the amount included in federal taxable income, or $4,800,
8802 except that:
8803 (i) for married taxpayers filing joint returns, for each $1 of adjusted gross income earned
8804 over $32,000, the amount of the retirement income exemption that may be subtracted shall be
8805 reduced by 50 cents;
8806 (ii) for married taxpayers filing separate returns, for each $1 of adjusted gross income
8807 earned over $16,000, the amount of the retirement income exemption that may be subtracted shall
8808 be reduced by 50 cents; and
8809 (iii) for individual taxpayers, for each $1 of adjusted gross income earned over $25,000,
8810 the amount of the retirement income exemption that may be subtracted shall be reduced by 50
8811 cents.
8812 (b) For purposes of Subsection (2)(e), the amount of the personal retirement exemption
8813 shall be further reduced according to the following schedule:
8814 (i) for married taxpayers filing joint returns, for each $1 of adjusted gross income earned
8815 over $32,000, the amount of the personal retirement exemption shall be reduced by 50 cents;
8816 (ii) for married taxpayers filing separate returns, for each $1 of adjusted gross income
8817 earned over $16,000, the amount of the personal retirement exemption shall be reduced by 50
8818 cents; and
8819 (iii) for individual taxpayers, for each $1 of adjusted gross income earned over $25,000,
8820 the amount of the personal retirement exemption shall be reduced by 50 cents.
8821 (c) For purposes of Subsections (3)(a) and (b), adjusted gross income shall be calculated
8822 by adding to federal adjusted gross income any interest income not otherwise included in federal
8823 adjusted gross income.
8824 (d) For purposes of determining ownership of items of retirement income common law
8825 doctrine will be applied in all cases even though some items may have originated from service or
8826 investments in a community property state. Amounts received by the spouse of a living retiree
8827 because of the retiree's having been employed in a community property state are not deductible as
8828 retirement income of such spouse.
8829 (e) For purposes of Subsection (2)(h), a subtraction for an amount paid for health care

8830 insurance as defined in Title 31A, Chapter 1, General Provisions, is not allowed:
8831 (i) for an amount that is reimbursed or funded in whole or in part by the federal
8832 government, the state, or an agency or instrumentality of the federal government or the state; and
8833 (ii) for a taxpayer who is eligible to participate in a health plan maintained and funded in
8834 whole or in part by the taxpayer's employer or the taxpayer's spouse's employer.
8835 (4) (a) A subtraction for an amount described in Subsection (2)(l) is allowed only if:
8836 (i) the taxpayer is a Ute tribal member; and
8837 (ii) the governor and the Ute tribe execute and maintain an agreement meeting the
8838 requirements of this Subsection (4).
8839 (b) The agreement described in Subsection (4)(a):
8840 (i) may not:
8841 (A) authorize the state to impose a tax in addition to a tax imposed under this chapter;
8842 (B) provide a subtraction under this section greater than or different from the subtraction
8843 described in Subsection (2)(l); or
8844 (C) affect the power of the state to establish rates of taxation; and
8845 (ii) shall:
8846 (A) provide for the implementation of the subtraction described in Subsection (2)(l);
8847 (B) be in writing;
8848 (C) be signed by:
8849 (I) the governor; and
8850 (II) the chair of the Business Committee of the Ute tribe;
8851 (D) be conditioned on obtaining any approval required by federal law; and
8852 (E) state the effective date of the agreement.
8853 (c) (i) The governor shall report to the commission by no later than February 1 of each year
8854 regarding whether or not an agreement meeting the requirements of this Subsection (4) is in effect.
8855 (ii) If an agreement meeting the requirements of this Subsection (4) is terminated, the
8856 subtraction permitted under Subsection (2)(l) is not allowed for taxable years beginning on or after
8857 the January 1 following the termination of the agreement.
8858 (d) For purposes of Subsection (2)(l) and in accordance with Title 63, Chapter 46a, Utah
8859 Administrative Rulemaking Act, the commission may make rules:
8860 (i) for determining whether income is derived from a source within the Uintah and Ouray

8861 Reservation; and
8862 (ii) that are substantially similar to how federal adjusted gross income derived from Utah
8863 sources is determined under Section 59-10-117.
8864 Section 197. Section **62A-11-326.1** is amended to read:
8865 **62A-11-326.1. Enrollment of child in accident and health insurance plan -- Order**
8866 **-- Notice.**
8867 (1) The office may issue a notice to existing and future employers or unions to enroll a
8868 dependent child in [~~a disability~~] an accident and health insurance plan that is available through
8869 [~~his~~] the dependent child's parent or legal guardian's employer or union, when the following
8870 conditions are satisfied:
8871 (a) the parent or legal guardian is already required to obtain insurance coverage for the
8872 child by a prior court or administrative order; and
8873 (b) the parent or legal guardian has failed to provide written proof to the office that:
8874 (i) the child has been enrolled in [~~a disability~~] an accident and health insurance plan in
8875 accordance with the court or administrative order; or
8876 (ii) the coverage required by the order was not available at group rates through the
8877 employer or union 30 or more days prior to the date of the mailing of the notice to enroll.
8878 (2) The office shall provide concurrent notice to the parent or legal guardian in accordance
8879 with Section 62A-11-304.4 of:
8880 (a) the notice to enroll sent to the employer or union; and
8881 (b) the opportunity to contest the enrollment due to a mistake of fact by filing a written
8882 request for an adjudicative proceeding with the office within 15 days of the notice being sent.
8883 (3) A notice to enroll shall result in the enrollment of the child in the parent's [~~disability~~]
8884 accident and health insurance plan, unless the parent successfully contests the notice based on a
8885 mistake of fact.
8886 (4) A notice to enroll issued under this section may be considered a "qualified medical
8887 support order" for the purposes of enrolling a dependent child in a group [~~disability~~] accident and
8888 health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security
8889 Act of 1974.
8890 Section 198. Section **62A-11-326.2** is amended to read:
8891 **62A-11-326.2. Compliance with order -- Enrollment of dependent child for**

8892 **insurance.**
8893 (1) An employer or union shall comply with a notice to enroll issued by the office under
8894 Section 62A-11-326.1 by enrolling the dependent child that is the subject of the notice in the:
8895 (a) [~~disability~~] accident and health insurance plan in which the parent or legal guardian is
8896 enrolled, if the plan satisfies the prior court or administrative order; or
8897 (b) least expensive plan, assuming equivalent benefits, offered by the employer or union
8898 that complies with the prior court or administrative order which provides coverage [~~which~~] that
8899 is reasonably accessible to the dependent child.
8900 (2) The employer, union, or insurer may not refuse to enroll a dependent child pursuant
8901 to a notice to enroll because a parent or legal guardian has not signed an enrollment application.
8902 (3) Upon enrollment of the dependent child, the employer shall deduct the appropriate
8903 premiums from the parent or legal guardian's wages and remit them directly to the insurer.
8904 (4) The insurer shall provide proof of insurance to the office upon request.
8905 (5) The signature of the custodial parent of the insured dependent is a valid authorization
8906 to the insurer for purposes of processing any insurance reimbursement claim.
8907 Section 199. Section **63-25a-413** is amended to read:
8908 **63-25a-413. Collateral sources.**
8909 (1) Collateral source shall include any source of benefits or advantages for economic loss
8910 otherwise reparable under this chapter which the victim or claimant has received, or which is
8911 readily available to the victim from:
8912 (a) the offender;
8913 (b) the insurance of the offender;
8914 (c) the United States government or any of its agencies, a state or any of its political
8915 subdivisions, or an instrumentality of two or more states, except in the case on nonobligatory
8916 state-funded programs;
8917 (d) social security, Medicare, and Medicaid;
8918 (e) state-required temporary nonoccupational income replacement insurance or disability
8919 income insurance;
8920 (f) workers' compensation;
8921 (g) wage continuation programs of any employer;
8922 (h) proceeds of a contract of insurance payable to the victim for the loss he sustained

8923 because of the criminally injurious conduct;
8924 (i) a contract providing prepaid hospital and other health care services or benefits for
8925 disability; or
8926 (j) veteran's benefits, including veteran's hospitalization benefits.
8927 (2) (a) An order of restitution shall not be considered readily available as a collateral
8928 source.
8929 (b) Receipt of an award of reparations under this chapter shall be considered an assignment
8930 of the victim's rights to restitution from the offender.
8931 (3) The victim shall not discharge a claim against a person or entity without the state's
8932 written permission and shall fully cooperate with the state in pursuing its right of reimbursement,
8933 including providing the state with any evidence in his possession.
8934 (4) The state's right of reimbursement applies regardless of whether the victim has been
8935 fully compensated for his losses.
8936 (5) Notwithstanding the collateral source provisions in [~~Subsections~~] Subsection (1) and
8937 Subsection 63-25a-412(1)(a) [~~and 63-25a-413(1)~~], a victim of a sexual offense who requests
8938 testing of himself may be reimbursed for the costs of the HIV test only as provided in Subsection
8939 76-5-503(4).
8940 Section 200. Section **63-55-231** is amended to read:
8941 **63-55-231. Repeal dates, Title 31A.**
8942 (1) Section 31A-2-208.5, Comparison tables, is repealed July 1, 2005.
8943 (2) Section 31A-2-217, Coordination with other states, is repealed July 1, 2003.
8944 [~~(2)~~] (3) Section 31A-22-315, Motor Vehicle Insurance Reporting, is repealed July 1,
8945 2010.
8946 [~~(3)~~] (4) Section 31A-22-625, Catastrophic Coverage of Mental Health Conditions, is
8947 repealed July 1, 2011.
8948 [~~(4)~~] (5) Title 31A, Chapter 31, Insurance Fraud Act, is repealed July 1, 2007.
8949 Section 201. Section **67-22-1** is amended to read:
8950 **67-22-1. Compensation -- Constitutional offices.**
8951 (1) The Legislature fixes salaries for the constitutional offices as follows:
8952 (a) Governor $96,700
8953 (b) Lieutenant Governor $75,200

8954 (c) Attorney General $81,300
8955 (d) State Auditor $77,600
8956 (e) State Treasurer $75,200
8957 (2) The Legislature fixes benefits for the constitutional offices as follows:
8958 (a) Governor:
8959 (i) a vehicle for official and personal use;
8960 (ii) housing;
8961 (iii) household and security staff;
8962 (iv) household expenses;
8963 (v) retirement benefits as provided in Title 49;
8964 (vi) health insurance;
8965 (vii) dental insurance;
8966 (viii) basic life insurance;
8967 (ix) workers' compensation;
8968 (x) required employer contribution to Social Security;
8969 (xi) long-term disability income insurance; and
8970 (xii) the same additional state paid life insurance available to other noncareer service
8971 employees.
8972 (b) Lieutenant governor, attorney general, state auditor, and state treasurer:
8973 (i) a vehicle for official and personal use;
8974 (ii) the option of participating in a state retirement system established by Title 49, Chapter
8975 2, Public Employees' Retirement Act, or Chapter 3, Public Employees' Noncontributory
8976 Retirement Act, or in a deferred compensation plan administered by the State Retirement Office,
8977 in accordance with the Internal Revenue Code and its accompanying rules and regulations;
8978 (iii) health insurance;
8979 (iv) dental insurance;
8980 (v) basic life insurance;
8981 (vi) workers' compensation;
8982 (vii) required employer contribution to social security;
8983 (viii) long-term disability income insurance; and
8984 (ix) the same additional state paid life insurance available to other noncareer service

8985 employees.

8986 (c) Each constitutional office shall pay the cost of the additional state-paid life insurance
8987 for its constitutional officer from its existing budget.

8988 Section 202. Section **67-22-2** is amended to read:

8989 **67-22-2. Compensation -- Other state officers.**

8990 (1) The governor shall establish salaries for the following state officers within the
8991 following salary ranges fixed by the Legislature:

	State Officer	Salary Range
8992	State Officer	Salary Range
8993	Director, Health Policy Commission	$57,900 - $78,400
8994	Commissioner of Agriculture and Food	$62,100 - $84,100
8995	Commissioner of Insurance	$62,100 - $84,100
8996	Commissioner of the Labor Commission	$62,100 - $84,100
8997	Director, Alcoholic Beverage Control	
8998	Commission	$62,100 - $84,100
8999	Commissioner, Department of	
9000	Financial Institutions	$62,100 - $84,100
9001	Members, Board of Pardons and Parole	$62,100 - $84,100
9002	Executive Director, Department	
9003	of Commerce	$62,100 - $84,100
9004	Executive Director, Commission on	
9005	Criminal and Juvenile Justice	$62,100 - $84,100
9006	Adjutant General	$62,100 - $84,100
9007	Chair, Tax Commission	$67,200 - $90,700
9008	Commissioners, Tax Commission	$67,200 - $90,700
9009	Executive Director, Department of	
9010	Community and Economic	
9011	Development	$67,200 - $90,700
9012	Executive Director, Tax Commission	$67,200 - $90,700
9013	Chair, Public Service Commission	$67,200 - $90,700
9014	Commissioner, Public Service Commission	$67,200 - $90,700
9015	Executive Director, Department	

9016 of Corrections $73,100 - $98,700
9017 Commissioner, Department of Public Safety $73,100 - $98,700
9018 Executive Director, Department of
9019 Natural Resources $73,100 - $98,700
9020 Director, Office of Planning
9021 and Budget $73,100 - $98,700
9022 Executive Director, Department of
9023 Administrative Services $73,100 - $98,700
9024 Executive Director, Department of
9025 Human Resource Management $73,100 - $98,700
9026 Executive Director, Department of
9027 Environmental Quality $73,100 - $98,700
9028 State Olympic Officer $79,600 - $107,500
9029 Executive Director, Department of $79,600 - $107,500
9030 Workforce Services
9031 Executive Director, Department of
9032 Health $79,600 - $107,500
9033 Executive Director, Department
9034 of Human Services $79,600 - $107,500
9035 Executive Director, Department
9036 of Transportation $79,600 - $107,500
9037 Chief Information Officer $79,600 - $107,500
9038 (2) (a) The Legislature fixes benefits for the state offices outlined in Subsection (1) as
9039 follows:
9040 (i) the option of participating in a state retirement system established by Title 49, Utah
9041 State Retirement Act, or in a deferred compensation plan administered by the State Retirement
9042 Office in accordance with the Internal Revenue Code and its accompanying rules and regulations;
9043 (ii) health insurance;
9044 (iii) dental insurance;
9045 (iv) basic life insurance;
9046 (v) unemployment compensation;

9047 (vi) workers' compensation;
9048 (vii) required employer contribution to Social Security;
9049 (viii) long-term disability income insurance;
9050 (ix) the same additional state-paid life insurance available to other noncareer service
9051 employees;
9052 (x) the same severance pay available to other noncareer service employees;
9053 (xi) the same sick leave, converted sick leave, educational allowances, and holidays
9054 granted to Schedule B state employees, and the same annual leave granted to Schedule B state
9055 employees with more than ten years of state service;
9056 (xii) the option to convert accumulated sick leave to cash or insurance benefits as provided
9057 by law or rule upon resignation or retirement according to the same criteria and procedures applied
9058 to Schedule B state employees;
9059 (xiii) the option to purchase additional life insurance at group insurance rates according
9060 to the same criteria and procedures applied to Schedule B state employees; and
9061 (xiv) professional memberships if being a member of the professional organization is a
9062 requirement of the position.
9063 (b) Each department shall pay the cost of additional state-paid life insurance for its
9064 executive director from its existing budget.
9065 (3) The Legislature fixes the following additional benefits:
9066 (a) for the executive director of the State Tax Commission a vehicle for official and
9067 personal use;
9068 (b) for the executive director of the Department of Transportation a vehicle for official and
9069 personal use;
9070 (c) for the executive director of the Department of Natural Resources a vehicle for
9071 commute and official use;
9072 (d) for the Commissioner of Public Safety:
9073 (i) an accidental death insurance policy if POST certified; and
9074 (ii) a public safety vehicle for official and personal use;
9075 (e) for the executive director of the Department of Corrections:
9076 (i) an accidental death insurance policy if POST certified; and
9077 (ii) a public safety vehicle for official and personal use;

9078 (f) for the Adjutant General a vehicle for official and personal use; and
9079 (g) for each member of the Board of Pardons and Parole a vehicle for commute and official
9080 use.
9081 (4) (a) The governor has the discretion to establish a specific salary for each office listed
9082 in Subsection (1), and, within that discretion, may provide salary increases within the range fixed
9083 by the Legislature.
9084 (b) The governor shall apply the same overtime regulations applicable to other FLSA
9085 exempt positions.
9086 (c) The governor may develop standards and criteria for reviewing the performance of the
9087 state officers listed in Subsection (1).
9088 (5) Salaries for other Schedule A employees, as defined in Section 67-19-15, which are
9089 not provided for in this chapter, or in Title 67, Chapter 8, Utah Executive and Judicial Salary Act,
9090 shall be established as provided in Section 67-19-15.
9091 Section 203. Section **78-14-4.5** is amended to read:
9092 **78-14-4.5. Amount of award reduced by amounts of collateral sources available to**
9093 **plaintiff -- No reduction where subrogation right exists -- Collateral sources defined --**
9094 **Procedure to preserve subrogation rights -- Evidence admissible -- Exceptions.**
9095 (1) In all malpractice actions against health care providers as defined in Section 78-14-3
9096 in which damages are awarded to compensate the plaintiff for losses sustained, the court shall
9097 reduce the amount of such award by the total of all amounts paid to the plaintiff from all collateral
9098 sources which are available to him; however, there shall be no reduction for collateral sources for
9099 which a subrogation right exists as provided in this section nor shall there be a reduction for any
9100 collateral payment not included in the award of damages. Upon a finding of liability and an
9101 awarding of damages by the trier of fact, the court shall receive evidence concerning the total
9102 amounts of collateral sources which have been paid to or for the benefit of the plaintiff or are
9103 otherwise available to him. The court shall also take testimony of any amount which has been
9104 paid, contributed, or forfeited by, or on behalf of the plaintiff or members of his immediate family
9105 to secure his right to any collateral source benefit which he is receiving as a result of his injury,
9106 and shall offset any reduction in the award by such amounts. No evidence shall be received and
9107 no reduction made with respect to future collateral source benefits except as specified in
9108 Subsection (4).

9109 (2) For purposes of this section "collateral source" means payments made to or for the
9110 benefit of the plaintiff for:
9111 (a) medical expenses and disability payments payable under the United States Social
9112 Security Act, any federal, state, or local income disability act, or any other public program, except
9113 the federal programs which are required by law to seek subrogation;
9114 (b) any health, sickness, or income [~~disability~~] replacement insurance, automobile accident
9115 insurance that provides health benefits or income [~~disability~~] replacement coverage, and any other
9116 similar insurance benefits, except life insurance benefits available to the plaintiff, whether
9117 purchased by the plaintiff or provided by others;
9118 (c) any contract or agreement of any person, group, organization, partnership, or
9119 corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health
9120 care services, except benefits received as gifts, contributions, or assistance made gratuitously; and
9121 (d) any contractual or voluntary wage continuation plan provided by employers or any
9122 other system intended to provide wages during a period of disability.
9123 (3) To preserve subrogation rights for amounts paid or received prior to settlement or
9124 judgment, a provider of collateral sources shall serve at least 30 days before settlement or trial of
9125 the action a written notice upon each health care provider against whom the malpractice action has
9126 been asserted. The written notice shall state the name and address of the provider of collateral
9127 sources, the amount of collateral sources paid, the names and addresses of all persons who received
9128 payment, and the items and purposes for which payment has been made.
9129 (4) Evidence is admissible of government programs that provide payments or benefits
9130 available in the future to or for the benefit of the plaintiff to the extent available irrespective of the
9131 recipient's ability to pay. Evidence of the likelihood or unlikelihood that such programs, payments,
9132 or benefits will be available in the future is also admissible. The trier of fact may consider such
9133 evidence in determining the amount of damages awarded to a plaintiff for future expenses.
9134 (5) [~~No~~] A provider of collateral sources is not entitled to recover the amounts of such
9135 benefits from a health care provider, the plaintiff, or any other person or entity as reimbursement
9136 for collateral source payments made prior to settlement or judgment, including any payments made
9137 under Title 26, Chapter 19, Medical Benefits Recovery Act, except to the extent that subrogation
9138 rights to amounts paid prior to settlement or judgment are preserved as provided in this section.
9139 All policies of insurance providing benefits affected by this section are construed in accordance

9140 with this section.

9141 Section 204. Section **78-45-7.5** is amended to read:

9142 **78-45-7.5. Determination of gross income -- Imputed income.**

9143 (1) As used in the guidelines, "gross income" includes:

9144 (a) prospective income from any source, including nonearned sources, except under
9145 Subsection (3); and

9146 (b) income from salaries, wages, commissions, royalties, bonuses, rents, gifts from anyone,
9147 prizes, dividends, severance pay, pensions, interest, trust income, alimony from previous
9148 marriages, annuities, capital gains, social security benefits, workers' compensation benefits,
9149 unemployment compensation, income replacement disability insurance benefits, and payments
9150 from "nonmeans-tested" government programs.

9151 (2) Income from earned income sources is limited to the equivalent of one full-time
9152 40-hour job. However, if and only if during the time prior to the original support order, the parent
9153 normally and consistently worked more than 40 hours at his job, the court may consider this extra
9154 time as a pattern in calculating the parent's ability to provide child support.

9155 (3) Specifically excluded from gross income are:

9156 (a) cash assistance provided under Title 35A, Chapter 3, Part 3, Family Employment
9157 Program;

9158 (b) benefits received under a housing subsidy program, the Job Training Partnership Act,
9159 Supplemental Security Income, Social Security Disability Insurance, Medicaid, Food Stamps, or
9160 General Assistance; and

9161 (c) other similar means-tested welfare benefits received by a parent.

9162 (4) (a) Gross income from self-employment or operation of a business shall be calculated
9163 by subtracting necessary expenses required for self-employment or business operation from gross
9164 receipts. The income and expenses from self-employment or operation of a business shall be
9165 reviewed to determine an appropriate level of gross income available to the parent to satisfy a child
9166 support award. Only those expenses necessary to allow the business to operate at a reasonable
9167 level may be deducted from gross receipts.

9168 (b) Gross income determined under this subsection may differ from the amount of business
9169 income determined for tax purposes.

9170 (5) (a) When possible, gross income should first be computed on an annual basis and then

9171 recalculated to determine the average gross monthly income.
9172 (b) Each parent shall provide verification of current income. Each parent shall provide
9173 year-to-date pay stubs or employer statements and complete copies of tax returns from at least the
9174 most recent year unless the court finds the verification is not reasonably available. Verification
9175 of income from records maintained by the Department of Workforce Services may be substituted
9176 for pay stubs, employer statements, and income tax returns.
9177 (c) Historical and current earnings shall be used to determine whether an
9178 underemployment or overemployment situation exists.
9179 (6) Gross income includes income imputed to the parent under Subsection (7).
9180 (7) (a) Income may not be imputed to a parent unless the parent stipulates to the amount
9181 imputed, the party defaults, or, in contested cases, a hearing is held and a finding made that the
9182 parent is voluntarily unemployed or underemployed.
9183 (b) If income is imputed to a parent, the income shall be based upon employment potential
9184 and probable earnings as derived from work history, occupation qualifications, and prevailing
9185 earnings for persons of similar backgrounds in the community, or the median earning for persons
9186 in the same occupation in the same geographical area as found in the statistics maintained by the
9187 Bureau of Labor Statistics.
9188 (c) If a parent has no recent work history or their occupation is unknown, income shall be
9189 imputed at least at the federal minimum wage for a 40-hour work week. To impute a greater
9190 income, the judge in a judicial proceeding or the presiding officer in an administrative proceeding
9191 shall enter specific findings of fact as to the evidentiary basis for the imputation.
9192 (d) Income may not be imputed if any of the following conditions exist:
9193 (i) the reasonable costs of child care for the parents' minor children approach or equal the
9194 amount of income the custodial parent can earn;
9195 (ii) a parent is physically or mentally disabled to the extent he cannot earn minimum wage;
9196 (iii) a parent is engaged in career or occupational training to establish basic job skills; or
9197 (iv) unusual emotional or physical needs of a child require the custodial parent's presence
9198 in the home.
9199 (8) (a) Gross income may not include the earnings of a minor child who is the subject of
9200 a child support award nor benefits to a minor child in the child's own right such as Supplemental
9201 Security Income.

9202 (b) Social Security benefits received by a child due to the earnings of a parent shall be
9203 credited as child support to the parent upon whose earning record it is based, by crediting the
9204 amount against the potential obligation of that parent. Other unearned income of a child may be
9205 considered as income to a parent depending upon the circumstances of each case.
9206 Section 205. **Repealer.**
9207 This act repeals:
9208 Section **31A-8-210, Solvency standards.**
9209 Section **31A-8-212, Solvency standards transition.**
9209a ĥ **Section 206. Coordination clause.**
9209b **IF THIS BILL AND H.B. 109, AMENDMENTS TO THE INSURANCE LAW, BOTH PASS, IT IS THE**
9209c **INTENT OF THE LEGISLATURE THAT THE OFFICE OF LEGISLATIVE RESEARCH AND GENERAL**
9209d **COUNSEL IN PREPARING THE UTAH CODE DATABASE FOR PUBLICATION, SHALL:**
9209e **(1) IN SUBSECTION 31A-28-102(2), CHANGE "UTAH LIFE AND DISABILITY INSURANCE**
9209f **GUARANTY ASSOCIATION" TO "UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION";**
9209g **(2) IN SUBSECTION 31A-28-103(3)(b)(iii), CHANGE "DISABILITY" TO "ACCIDENT AND**
9209h **HEALTH";**
9209i **(3) IN SUBSECTION 31A-28-103(3)(b)(iii)(A) AND (B), CHANGE "BASIC HOSPITAL AND**
9209j **MEDICAL OR MAJOR MEDICAL" TO "HEALTH INSURANCE";**
9209k **(4) IN SUBSECTION 31A-28-105(1), CHANGE "UTAH LIFE AND DISABILITY INSURANCE**
9209l **GUARANTY ASSOCIATION" TO "UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION";**
9209m **(5) IN SUBSECTION 31A-28-105(23)(b), CHANGE "DISABILITY" TO "ACCIDENT AND HEALTH";**
9209n **(6) IN SUBSECTION 31A-28-106(1)(a), CHANGE "UTAH LIFE AND DISABILITY INSURANCE**
9209o **GUARANTY ASSOCIATION" TO "UTAH LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION";**
9209p **(7) IN SUBSECTION 31A-28-108(4)(a)(iii), CHANGE "DISABILITY" TO "ACCIDENT AND**
9209q **HEALTH"; AND**
9209r **(8) IN SUBSECTION 31A-28-109(3)(c)(ii), CHANGE "DISABILITY" TO "ACCIDENT AND**
9209s **HEALTH".** ĥ