LEGISLATIVE GENERAL COUNSEL
₵ Approved for Filing: A.L. West ₵
₵ 02-08-21 10:19 AM ₵

H.B. 54
1st Sub. (Buff)

Representative James A. Dunnigan proposes the following substitute bill:

INSURANCE REVISIONS

2021 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill amends the Insurance Code.

Highlighted Provisions:

This bill:

- amends references to "blanket insurance policy" for consistency;
- amends the definition of "captive insurance company";
- permits credit to a ceding insurer ceding to a foreign captive insurer under certain conditions;
- provides that inland marine insurance that includes accident and health insurance is subject to Title 31A, Chapter 22, Contracts in Specific Lines;
- removes provisions that the Utah Insurance Commissioner define "conspicuously" in regards to certain forms;
- amend provisions related to mass marketed life or accident and health insurance;
- amends the scope of Title 31A, Chapter 22, Part 6, Accident and Health Insurance;
- allows reinstatement language of individual or franchise accident and health insurance policies to be substantially, rather than verbatim, as provided in statute;
- amends provisions related to the coverage of emergency medical services;
- amends provisions related to notice of discontinuance of a group health benefit

plan;

- amends the minimum nonforfeiture amounts under the standard nonforfeiture law for individual deferred annuities;
- amends reporting provisions related to the study of coverage for in vitro fertilization and genetic testings;
- amends provisions related to the issuance of a group insurance policy for life insurance to an association group;
- amends provisions regarding an association group to whom a group accident and health insurance policy may be issued;
- permits the Utah Insurance Commissioner to adopt rules permitting or including independent review of benefit determinations for long-term care insurance;
- amends the definition of "limited long-term care insurance" under the Limited Long-term Care Insurance Act;
- amends provisions related to the lapse of a license under Title 31A, Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and Reinsurance Intermediaries;
- amends provisions regarding a title insurance producer's business;
- amends provisions related to certain trust obligations for a person authorized to engage in the insurance business;
- amends the definition of "company adjuster";
- amends the coverage and limitations of guaranty association coverage;
- amends the minimum financial requirements for a bail bond agency license;
- amends the requirements for initial licensure and license renewal of a bail bond agency license;
- amends required unimpaired paid-in capital and other capital for capital insurance companies;
- permits a captive insurance company to provide coverage for punitive damages awarded under certain conditions;
- amends provisions allowing a captive insurance company to reinsure risks;
- amends provisions related to a captive insurance company's certificate of dormancy;
- amends the repeal date of the Health Reform Task Force and the task force's

reporting deadlines; and

- makes technical and conforming changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-1-103, as last amended by Laws of Utah 2020, Chapter 32

31A-1-301, as last amended by Laws of Utah 2020, Chapter 32

31A-17-404, as last amended by Laws of Utah 2020, Chapter 32

31A-21-101, as last amended by Laws of Utah 2017, Chapter 363

31A-21-201, as last amended by Laws of Utah 2020, Chapter 32

31A-21-402, as last amended by Laws of Utah 2001, Chapter 116

31A-21-404, as last amended by Laws of Utah 2011, Chapter 62

31A-22-409, as last amended by Laws of Utah 2008, Chapters 345 and 382

31A-22-501, as last amended by Laws of Utah 2019, Chapter 193

31A-22-505, as last amended by Laws of Utah 2020, Chapter 32

31A-22-522, as last amended by Laws of Utah 2002, Chapter 308

31A-22-600, as last amended by Laws of Utah 2001, Chapter 116

31A-22-607, as last amended by Laws of Utah 2011, Chapter 284

31A-22-608, as last amended by Laws of Utah 2001, Chapter 116

31A-22-612, as last amended by Laws of Utah 2018, Chapter 319

31A-22-618.6, as last amended by Laws of Utah 2018, Chapter 319

31A-22-618.7, as last amended by Laws of Utah 2017, Chapter 168 and renumbered and amended by Laws of Utah 2017, Chapter 292

31A-22-618.8, as renumbered and amended by Laws of Utah 2017, Chapter 292

31A-22-627, as last amended by Laws of Utah 2019, Chapter 193

31A-22-654, as enacted by Laws of Utah 2020, Chapter 187

31A-22-701, as last amended by Laws of Utah 2019, Chapter 193

31A-22-716, as last amended by Laws of Utah 2017, Chapter 168

31A-22-717, as last amended by Laws of Utah 2004, Chapter 108
31A-22-1404, as last amended by Laws of Utah 1995, Chapter 344
31A-22-2002, as enacted by Laws of Utah 2020, Chapter 32
31A-23a-113, as last amended by Laws of Utah 2015, Chapter 244
31A-23a-201, as renumbered and amended by Laws of Utah 2003, Chapter 298
31A-23a-406, as last amended by Laws of Utah 2019, Chapter 231
31A-23a-409, as last amended by Laws of Utah 2012, Chapter 253
31A-26-102, as last amended by Laws of Utah 2018, Chapter 319
31A-28-103, as last amended by Laws of Utah 2018, Chapter 391
31A-35-404, as last amended by Laws of Utah 2016, Chapter 234
31A-35-406, as last amended by Laws of Utah 2016, Chapter 234
31A-37-102, as last amended by Laws of Utah 2019, Chapter 193
31A-37-202, as repealed and reenacted by Laws of Utah 2019, Chapter 193
31A-37-204, as last amended by Laws of Utah 2017, Chapter 168
31A-37-303, as last amended by Laws of Utah 2020, Chapter 32
31A-37-701, as last amended by Laws of Utah 2020, Chapter 32
31A-45-501, as renumbered and amended by Laws of Utah 2017, Chapter 292
36-29-106, as last amended by Laws of Utah 2020, Chapter 32
63I-1-236, as last amended by Laws of Utah 2020, Fifth Special Session, Chapter 19

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

Section 1. Section **31A-1-103** is amended to read:

31A-1-103. Scope and applicability of title.

(1) This title does not apply to:

(a) a retainer contract made by an attorney-at-law:

(i) with an individual client; and

(ii) under which fees are based on estimates of the nature and amount of services to be provided to the specific client;

(b) a contract similar to a contract described in Subsection (1)(a) made with a group of clients involved in the same or closely related legal matters;

(c) an arrangement for providing benefits that do not exceed a limited amount of

consultations, advice on simple legal matters, either alone or in combination with referral services, or the promise of fee discounts for handling other legal matters;

(d) limited legal assistance on an informal basis involving neither an express contractual obligation nor reasonable expectations, in the context of an employment, membership, educational, or similar relationship;

(e) legal assistance by employee organizations to their members in matters relating to employment;

(f) death, accident, health, or disability benefits provided to a person by an organization or its affiliate if:

(i) the organization is tax exempt under Section 501(c)(3) of the Internal Revenue Code and has had its principal place of business in Utah for at least five years;

(ii) the person is not an employee of the organization; and

(iii) (A) substantially all the person's time in the organization is spent providing voluntary services:

(I) in furtherance of the organization's purposes;

(II) for a designated period of time; and

(III) for which no compensation, other than expenses, is paid; or

(B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more than 18 months; or

(g) a prepaid contract of limited duration that provides for scheduled maintenance only.

(2) (a) This title restricts otherwise legitimate business activity.

(b) What this title does not prohibit is permitted unless contrary to other provisions of Utah law.

(3) Except as otherwise expressly provided, this title does not apply to:

(a) those activities of an insurer where state jurisdiction is preempted by Section 514 of the federal Employee Retirement Income Security Act of 1974, as amended;

(b) ocean marine insurance;

(c) death, accident, health, or disability benefits provided by an organization if the organization:

(i) has as the organization's principal purpose to achieve charitable, educational, social, or religious objectives rather than to provide death, accident, health, or disability benefits;

(ii) does not incur a legal obligation to pay a specified amount; and

(iii) does not create reasonable expectations of receiving a specified amount on the part of an insured person;

(d) other business specified in rules adopted by the commissioner on a finding that:

(i) the transaction of the business in this state does not require regulation for the protection of the interests of the residents of this state; or

(ii) it would be impracticable to require compliance with this title;

(e) except as provided in Subsection (4), a transaction independently procured through negotiations under Section 31A-15-104;

(f) self-insurance;

(g) reinsurance;

(h) subject to Subsection (5), an employee [~~and~~] or labor union group [~~or~~] insurance policy covering risks in this state or an employee or labor union blanket insurance policy covering risks in this state, if:

(i) the policyholder exists primarily for purposes other than to procure insurance;

(ii) the policyholder:

(A) is not a resident of this state;

(B) is not a domestic corporation; or

(C) does not have the policyholder's principal office in this state;

(iii) no more than 25% of the certificate holders or insureds are residents of this state;

(iv) on request of the commissioner, the insurer files with the department a copy of the policy and a copy of each form or certificate; and

(v) (A) the insurer agrees to pay premium taxes on the Utah portion of the insurer's business, as if the insurer were authorized to do business in this state; and

(B) the insurer provides the commissioner with the security the commissioner considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of Admitted Insurers;

(i) to the extent provided in Subsection (6):

(i) a manufacturer's or seller's warranty; and

(ii) a manufacturer's or seller's service contract;

(j) except to the extent provided in Subsection (7), a public agency insurance mutual;

or

(k) except as provided in Chapter 6b, Guaranteed Asset Protection Waiver Act, a guaranteed asset protection waiver.

(4) A transaction described in Subsection (3)(e) is subject to taxation under Section 31A-3-301.

(5) (a) After a hearing, the commissioner may order an insurer of certain group insurance policies or blanket [~~contracts~~] insurance policies to transfer the Utah portion of the business otherwise exempted under Subsection (3)(h) to an authorized insurer if the contracts have been written by an unauthorized insurer.

(b) If the commissioner finds that the conditions required for the exemption of a group or blanket insurer are not satisfied or that adequate protection to residents of this state is not provided, the commissioner may require:

(i) the insurer to be authorized to do business in this state; or

(ii) that any of the insurer's transactions be subject to this title.

(c) Subsection (3)(h) does not apply to a blanket insurance policy offering accident and health insurance.

(6) (a) As used in Subsection (3)(i) and this Subsection (6):

(i) "manufacturer's or seller's service contract" means a service contract:

(A) made available by:

(I) a manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) made available:

(I) on one or more specific products; or

(II) on products that are components of a system; and

(C) under which the person described in Subsection (6)(a)(i)(A) is liable for services to be provided under the service contract including, if the manufacturer's or seller's service contract designates, providing parts and labor;

(ii) "manufacturer's or seller's warranty" means the guaranty of:

(A) (I) the manufacturer of a product;

(II) a seller of a product; or

(III) an affiliate of a manufacturer or seller of a product;

(B) (I) on one or more specific products; or

(II) on products that are components of a system; and

(C) under which the person described in Subsection (6)(a)(ii)(A) is liable for services to be provided under the warranty, including, if the manufacturer's or seller's warranty designates, providing parts and labor; and

(iii) "service contract" means the same as that term is defined in Section 31A-6a-101.

(b) A manufacturer's or seller's warranty may be designated as:

(i) a warranty;

(ii) a guaranty; or

(iii) a term similar to a term described in Subsection (6)(b)(i) or (ii).

(c) This title does not apply to:

(i) a manufacturer's or seller's warranty;

(ii) a manufacturer's or seller's service contract paid for with consideration that is in addition to the consideration paid for the product itself; and

(iii) a service contract that is not a manufacturer's or seller's warranty or manufacturer's or seller's service contract if:

(A) the service contract is paid for with consideration that is in addition to the consideration paid for the product itself;

(B) the service contract is for the repair or maintenance of goods;

(C) the purchase price of the product is $3,700 or less;

(D) the product is not a motor vehicle; and

(E) the product is not the subject of a home warranty service contract.

(d) This title does not apply to a manufacturer's or seller's warranty or service contract paid for with consideration that is in addition to the consideration paid for the product itself regardless of whether the manufacturer's or seller's warranty or service contract is sold:

(i) at the time of the purchase of the product; or

(ii) at a time other than the time of the purchase of the product.

(7) (a) For purposes of this Subsection (7), "public agency insurance mutual" means an entity formed by two or more political subdivisions or public agencies of the state:

(i) under Title 11, Chapter 13, Interlocal Cooperation Act; and

(ii) for the purpose of providing for the political subdivisions or public agencies:

(A) subject to Subsection (7)(b), insurance coverage; or

(B) risk management.

(b) Notwithstanding Subsection (7)(a)(ii)(A), a public agency insurance mutual may not provide health insurance unless the public agency insurance mutual provides the health insurance using:

(i) a third party administrator licensed under Chapter 25, Third Party Administrators;

(ii) an admitted insurer; or

(iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.

(c) Except for this Subsection (7), a public agency insurance mutual is exempt from this title.

(d) A public agency insurance mutual is considered to be a governmental entity and political subdivision of the state with all of the rights, privileges, and immunities of a governmental entity or political subdivision of the state including all the rights and benefits of Title 63G, Chapter 7, Governmental Immunity Act of Utah.

Section 2. Section **31A-1-301** is amended to read:

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage;

(D) loss of income coverage;

(E) prescription drug coverage;

(F) dental coverage; or

(G) vision coverage.

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

(d) For purposes of a national licensing registry, "accident and health insurance" is the same as "accident and health or sickness insurance."

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

(3) "Administrator" means the same as that term is defined in Subsection [~~(179)~~] (178).

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

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

(6) "Agency" means:

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

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

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

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

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

human life.

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverage as originally offered; or

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

(B) decline to insure the risk; or

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

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

(a) the original articles;

(b) a special law;

(c) a charter;

(d) an amendment;

(e) restated articles;

(f) articles of merger or consolidation;

(g) a trust instrument;

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

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

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

(13) "Binder" means the same as that term is defined in Section 31A-21-102.

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

(a) without individual underwriting or application; and

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

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

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

(a) that is open to the public;

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

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

(17) "Business entity" means:

(a) a corporation;

(b) an association;

(c) a partnership;

(d) a limited liability company;

(e) a limited liability partnership; or

(f) another legal entity.

(18) "Business of insurance" means the same as that term is defined in Subsection (94).

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

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

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

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

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

(21) "Captive insurance company" means:

(a) an insurer:

(i) owned by [~~another~~] a parent organization; and

(ii) whose [~~exclusive~~] purpose is to insure risks of the parent organization and [~~an affiliated company; or~~] other risks as authorized under:

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

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

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

(i) owned by the insureds; and

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

(A) a member organization;

(B) a group member; or

(C) an affiliate of:

(I) a member organization; or

(II) a group member.

(22) "Casualty insurance" means liability insurance.

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

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

(b) a third party.

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

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

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

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

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

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

(i) provides board and lodging;

(ii) provides one or more of the following:

(A) a personal service;

(B) a nursing service;

(C) a medical service; or

(D) any other health-related service; and

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

(A) for the life of the insured; or

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

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

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

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

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

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

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

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

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

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

(33) "Corporate governance annual disclosure" means a report an insurer or insurance group files in accordance with the requirements of Chapter 16b, Corporate Governance Annual Disclosure Act.

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a surplus lines producer;

(III) a limited line producer;

(IV) a consultant;

(V) a managing general agent;

(VI) a reinsurance intermediary;

(VII) a third party administrator; or

(VIII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

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

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

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

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

(iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L. No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No. 109-415.

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

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

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

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

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

(40) "Credit property insurance" means insurance:

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

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

(41) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

(42) (a) "Crop insurance" means insurance providing protection against damage to

crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation, disease, or other yield-reducing conditions or perils that is:

(i) provided by the private insurance market; or

(ii) subsidized by the Federal Crop Insurance Corporation.

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

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

(i) for the customer service representative's:

(A) producer;

(B) surplus lines producer; or

(C) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

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

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(47) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(50) "Disability income insurance" means the same as that term is defined in Subsection (85).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

(ii) a person described in Subsection (53)(b).

(b) "Eligible employee" includes:

(i) an owner who:

(A) works on a full-time basis;

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

(C) employs at least one common employee; and

(ii) if the individual is included under a health benefit plan of a small employer:

(A) a sole proprietor;

(B) a partner in a partnership; or

(C) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (53)(b):

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

(ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i); or

(iii) a dependent of an employer who does not meet the requirements of Subsection (53)(a)(i).

(54) "Employee" means:

(a) an individual employed by an employer; and

(b) an owner who meets the requirements of Subsection (53)(b)(i).

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

(a) an employee; or

(b) a dependent of an employee.

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

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

(A) one or more employers;

(B) one or more labor organizations; or

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

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

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

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

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

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

(58) (a) "Enrollee" means:

(i) a policyholder;

(ii) a certificate holder;

(iii) a subscriber; or

(iv) a covered individual:

(A) who has entered into a contract with an organization for health care; or

(B) on whose behalf an arrangement for health care has been made.

(b) "Enrollee" includes an insured.

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

(a) the first day of coverage; or

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

(60) "Enterprise risk" means an activity, circumstance, event, or series of events involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a material adverse effect upon the financial condition or liquidity of the insurer or its insurance holding company system as a whole, including anything that would cause:

(a) the insurer's risk-based capital to fall into an action or control level as set forth in Sections 31A-17-601 through 31A-17-613; or

(b) the insurer to be in hazardous financial condition set forth in Section 31A-27a-101.

(61) (a) "Escrow" means:

(i) a transaction that effects the sale, transfer, encumbering, or leasing of real property, when a person not a party to the transaction, and neither having nor acquiring an interest in the title, performs, in accordance with the written instructions or terms of the written agreement between the parties to the transaction, any of the following actions:

(A) the explanation, holding, or creation of a document; or

(B) the receipt, deposit, and disbursement of money;

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" does not include:

(i) the following notarial acts performed by a notary within the state:

(A) an acknowledgment;

(B) a copy certification;

(C) jurat; and

(D) an oath or affirmation;

(ii) the receipt or delivery of a document; or

(iii) the receipt of money for delivery to the escrow agent.

(62) "Escrow agent" means an agency title insurance producer meeting the requirements of Sections 31A-4-107, 31A-14-211, and 31A-23a-204, who is acting through an individual title insurance producer licensed with an escrow subline of authority.

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

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

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

(a) a specific physical condition;

(b) a specific medical procedure;

(c) a specific disease or disorder; or

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

(65) "Expense reimbursement insurance" means insurance:

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

(b) written:

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

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

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

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

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

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

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection (67)(a).

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

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application;

(n) an advertisement;

(o) a binder; or

(p) an outline of coverage.

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

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

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

(i) a policy;

(ii) a certificate;

(iii) an application;

(iv) an outline of coverage; or

(v) an endorsement.

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

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

(73) "General lines of authority" include:

(a) the general lines of insurance in Subsection (74);

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

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

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

(iii) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

(74) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

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

(a) (i) to an employee; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through another method.

(76) (a) "Group insurance policy" means a policy covering a group of persons that is

issued:

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

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

(A) the policy; or

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

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

(77) "Group-wide supervisor" means the commissioner or other regulatory official designated as the group-wide supervisor for an internationally active insurance group under Section 31A-16-108.6.

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

(79) (a) "Health benefit plan" means, except as provided in Subsection (79)(b), a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care.

(b) "Health benefit plan" does not include:

(i) coverage only for accident or disability income insurance, or any combination thereof;

(ii) coverage issued as a supplement to liability insurance;

(iii) liability insurance, including general liability insurance and automobile liability insurance;

(iv) workers' compensation or similar insurance;

(v) automobile medical payment insurance;

(vi) credit-only insurance;

(vii) coverage for on-site medical clinics;

(viii) other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits;

(ix) the following benefits if they are provided under a separate policy, certificate, or

contract of insurance or are otherwise not an integral part of the plan:

(A) limited scope dental or vision benefits;

(B) benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(C) other similar limited benefits, specified in federal regulations issued pursuant to Pub. L. No. 104-191;

(x) the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of benefits and any exclusion of benefits under any health plan, and the benefits are paid with respect to an event without regard to whether benefits are provided under any health plan:

(A) coverage only for specified disease or illness; or

(B) hospital indemnity or other fixed indemnity insurance;

(xi) the following if offered as a separate policy, certificate, or contract of insurance:

(A) Medicare supplemental health insurance as defined under the Social Security Act, 42 U.S.C. Sec. 1395ss(g)(1);

(B) coverage supplemental to the coverage provided under United States Code, Title 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or

(C) similar supplemental coverage provided to coverage under a group health insurance plan;

(xii) short-term[~~, limited-duration~~] limited duration health insurance; and

(xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145.

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

(a) a professional service;

(b) a personal service;

(c) a facility;

(d) equipment;

(e) a device;

(f) supplies; or

(g) medicine.

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

(i) a health care benefit; or

(ii) payment of an incurred health care expense.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

(82) "Health care provider" means the same as that term is defined in Section 78B-3-403.

(83) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec. 155.20.

(84) "Health Insurance Portability and Accountability Act" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936, as amended.

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

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

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

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

(89) "Individual" means a natural person.

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

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

(91) "Insolvency" or "insolvent" means that:

(a) an insurer is unable to pay the insurer's obligations as the obligations are due;

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

(c) an insurer's admitted assets are less than the insurer's liabilities.

(92) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

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

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

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

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

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

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

(b) providing a benefit to an employee in the event of a contingency not within the

control of the employee, in which the employee is entitled to the benefit as a right, which benefit may be provided either:

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

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

(c) providing an annuity:

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

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

(d) providing the characteristic services of a motor club as outlined in Subsection (125);

(e) providing another person with insurance;

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) transacting or proposing a life settlement; and

(i) doing, or proposing to do, any business in substance equivalent to Subsections (94)(a) through (h) in a manner designed to evade this title.

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

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

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

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

(96) "Insurance group" means the persons that comprise an insurance holding company system.

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

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

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

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

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

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

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

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

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

(i) a policyholder;

(ii) a subscriber;

(iii) a member; and

(iv) a beneficiary.

(b) The definition in Subsection (99)(a):

(i) applies only to this title;

(ii) does not define the meaning of "insured" as used in an insurance policy or certificate; and

(iii) includes an enrollee.

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

(i) a fraternal benefit society;

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

(iii) a motor club;

(iv) an employee welfare plan;

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

(vi) a health maintenance organization.

(b) "Insurer" does not include a governmental entity.

(101) "Interinsurance exchange" means the same as that term is defined in Subsection (160).

(102) "Internationally active insurance group" means an insurance holding company system:

(a) that includes an insurer registered under Section 31A-16-105;

(b) that has premiums written in at least three countries;

(c) whose percentage of gross premiums written outside the United States is at least 10% of its total gross written premiums; and

(d) that, based on a three-year rolling average, has:

(i) total assets of at least $50,000,000,000; or

(ii) total gross written premiums of at least $10,000,000,000.

(103) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

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

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

(b) employs at least one employee on the first day of the plan year.

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

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

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

(b) through special enrollment.

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

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

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

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

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

(A) medical malpractice insurance;

(B) professional liability insurance; and

(C) workers' compensation insurance;

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

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

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

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

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance;

(ii) residential dwelling liability insurance; and

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

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

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

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

(i) insurance on a human life; and

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

(b) The business of life insurance includes:

(i) granting a death benefit;

(ii) granting an annuity benefit;

(iii) granting an endowment benefit;

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

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

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

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

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

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

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

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

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

(114) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) car rental related insurance;

(f) travel insurance;

(g) crop insurance;

(h) self-service storage insurance;

(i) guaranteed asset protection waiver;

(j) portable electronics insurance; and

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

(115) "Limited lines authority" includes the lines of insurance listed in Subsection (114).

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

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

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

(118) "Managed care organization" means a person:

(a) licensed as a health maintenance organization under Chapter 8, Health Maintenance Organizations and Limited Health Plans; or

(b) (i) licensed under:

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

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

(C) Chapter 14, Foreign Insurers; and

(ii) that requires an enrollee to use, or offers incentives, including financial incentives, for an enrollee to use, network providers.

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

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

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

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

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

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

(125) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) (A) trip reimbursement;

(B) towing services;

(C) emergency road services;

(D) stolen automobile services;

(E) a combination of the services listed in Subsections (125)(b)(iii)(A) through (D); or

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

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

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

(a) that is issued by an insurer; and

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

(128) "Network provider" means a health care provider who has an agreement with a managed care organization to provide health care services to an enrollee with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly from the

managed care organization.

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

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

(a) ships or hulls of ships;

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

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

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

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

(132) "ORSA guidance manual" means the current version of the Own Risk and Solvency Assessment Guidance Manual developed and adopted by the National Association of Insurance Commissioners and as amended from time to time.

(133) "ORSA summary report" means a confidential high-level summary of an insurer or insurance group's own risk and solvency assessment.

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

(135) "Own risk and solvency assessment" means an insurer or insurance group's confidential internal assessment:

(a) (i) of each material and relevant risk associated with the insurer or insurance group;

(ii) of the insurer or insurance group's current business plan to support each risk described in Subsection (135)(a)(i); and

(iii) of the sufficiency of capital resources to support each risk described in Subsection (135)(a)(i); and

(b) that is appropriate to the nature, scale, and complexity of an insurer or insurance group.

(136) "Participating" means a plan of insurance under which the insured is entitled to

receive a dividend representing a share of the surplus of the insurer.

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

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

(b) receives:

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

(ii) another government health benefit.

(138) "Person" includes:

(a) an individual;

(b) a partnership;

(c) a corporation;

(d) an incorporated or unincorporated association;

(e) a joint stock company;

(f) a trust;

(g) a limited liability company;

(h) a reciprocal;

(i) a syndicate; or

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

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

(a) an individual; or

(b) a family.

(140) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec. 1002(16)(B).

(141) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection (141)(a) or (b), the calendar year.

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

(i) purports to be an enforceable contract; and

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

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

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

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

(iii) a corporation licensed under:

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

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

(c) "Policy" does not include:

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

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

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

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

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

(146) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No. 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and

related federal regulations and guidance.

(147) "Preexisting condition," with respect to health care insurance:

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

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

(148) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) an assessment;

(ii) a membership fee;

(iii) a required contribution; or

(iv) monetary consideration.

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

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

(149) "Principal officers" for a corporation means the officers designated under Subsection 31A-5-203(3).

(150) "Proceeding" includes an action or special statutory proceeding.

(151) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of a professional service.

(152) (a) Except as provided in Subsection (152)(b), "property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property:

(i) from all hazards or causes; and

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

(b) "Property insurance" does not include:

(i) inland marine insurance; and

(ii) ocean marine insurance.

(153) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

(154) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

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

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

(i) the commissioner by rule; or

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

(155) (a) "Rate" means:

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

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

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

(156) (a) Except as provided in Subsection (156)(b), "rate service organization" means a person who assists an insurer in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

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

(157) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) a classification;

(c) a rate-related underwriting rule; and

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

(158) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow, or give, directly or indirectly:

(i) a refund of premium or portion of premium;

(ii) a refund of commission or portion of commission;

(iii) a refund of all or a portion of a consultant fee; or

(iv) providing services or other benefits not specified in an insurance or annuity contract.

(b) "Rebate" does not include:

(i) a refund due to termination or changes in coverage;

(ii) a refund due to overcharges made in error by the licensee; or

(iii) savings or wellness benefits as provided in the contract by the licensee.

(159) "Received by the department" means:

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

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

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

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

(i) facsimile;

(ii) email; or

(iii) another electronic method; or

(e) a date specified in:

(i) a statute;

(ii) a rule; or

(iii) an order.

(160) "Reciprocal" or "interinsurance exchange" means an unincorporated association of persons:

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

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

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

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

(162) "Reinsurer" means a person licensed in this state as an insurer with the authority to assume reinsurance.

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

(164) (a) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract.

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

(165) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

(166) "Secondary medical condition" means a complication related to an exclusion from coverage in accident and health insurance.

(167) (a) "Security" means a:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections (167)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) an endowment policy; or

(C) an annuity contract; or

(ii) a burial certificate or burial contract.

(168) "Securityholder" means a specified person who owns a security of a person, including:

(a) common stock;

(b) preferred stock;

(c) debt obligations; and

(d) any other security convertible into or evidencing the right of any of the items listed in this Subsection (168).

(169) (a) "Self-insurance" means an arrangement under which a person provides for spreading its own risks by a systematic plan.

(b) Except as provided in this Subsection (169), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(c) "Self-insurance" includes:

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

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

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

(170) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(171) "Short-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance, but that provides coverage for less than 12 consecutive months for each covered person.~~]

[~~(172)~~] (171) "Short-term[~~, limited-duration~~] limited duration health insurance" means a health benefit product that:

(a) after taking into account any renewals or extensions, has a total duration of no more

than 36 months; and

(b) has an expiration date specified in the contract that is less than 12 months after the original effective date of coverage under the health benefit product.

[~~(173)~~] (172) "Significant break in coverage" means a period of 63 consecutive days during each of which an individual does not have creditable coverage.

[~~(174)~~] (173) (a) "Small employer" means, in connection with a health benefit plan and with respect to a calendar year and to a plan year, an employer who:

(i) (A) employed at least one but not more than 50 eligible employees on business days during the preceding calendar year; or

(B) if the employer did not exist for the entirety of the preceding calendar year, reasonably expects to employ an average of at least one but not more than 50 eligible employees on business days during the current calendar year;

(ii) employs at least one employee on the first day of the plan year; and

(iii) for an employer who has common ownership with one or more other employers, is treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

(b) "Small employer" does not include a sole proprietor that does not employ at least one employee.

[~~(175)~~] (174) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act.

[~~(176)~~] (175) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(177)~~] (176) Subject to Subsection (91)(b), "surety insurance" includes:

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

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(178)~~] (177) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

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

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

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

(c) "Excess surplus" means:

(i) for a life insurer, accident and health insurer, health organization, or property and casualty insurer as defined in Section 31A-17-601, the lesser of:

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

(I) 2.5; and

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

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

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(179)~~] (178) "Third party administrator" or "administrator" means a person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering a:

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

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

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

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

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

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

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

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

(iv) Chapter 9, Insurance Fraternals; or

(v) Chapter 14, Foreign Insurers;

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

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

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

(i) that is:

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

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

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

[~~(180)~~] (179) "Title insurance" means the insuring, guaranteeing, or indemnifying of an owner of real or personal property or the holder of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or

encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(181)~~] (180) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(182)~~] (181) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

(b) "Trustee," when used in reference to an employee welfare fund, means an individual, firm, association, organization, joint stock company, or corporation, whether acting individually or jointly and whether designated by that name or any other, that is charged with or has the overall management of an employee welfare fund.

[~~(183)~~] (182) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(184)~~] (183) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(185)~~] (184) "Vehicle liability insurance" means insurance against liability resulting from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a vehicle comprehensive or vehicle physical damage coverage under Subsection (152).

[~~(186)~~] (185) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

[~~(187)~~] (186) "Waiting period" for a health benefit plan means the period that must pass before coverage for an individual, who is otherwise eligible to enroll under the terms of

the health benefit plan, can become effective.

[~~(188)~~] (187) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 3. Section **31A-17-404** is amended to read:

31A-17-404. Credit allowed a domestic ceding insurer against reserves for reinsurance.

(1) (a) [~~A~~] Subject to Subsections (1)(b) and (c), a domestic ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), (7), (8), or (9) [~~subject to the following:~~].

[~~(a)~~] (b) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume:

(i) in [~~its~~] the assuming insurer's state of domicile; or

(ii) in the case of a United States branch of an alien assuming insurer, in the state through which [~~it~~] the assuming insurer is entered and licensed to transact insurance or reinsurance.

[~~(b)~~] (c) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of Subsection (11) are met.

(2) A domestic ceding insurer is allowed credit for reinsurance ceded:

(a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;

(b) only to the extent that the accounting:

(i) is consistent with the terms of the reinsurance contract; and

(ii) clearly reflects:

(A) the amount and nature of risk transferred; and

(B) liability, including contingent liability, of the ceding insurer;

(c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and

(d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract.

(3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited by the commissioner as a reinsurer in this state.

(b) An insurer is accredited as a reinsurer if the insurer:

(i) files with the commissioner evidence of the insurer's submission to this state's jurisdiction;

(ii) submits to the commissioner's authority to examine the insurer's books and records;

(iii) (A) is licensed to transact insurance or reinsurance in at least one state; or

(B) in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(iv) files annually with the commissioner a copy of the insurer's:

(A) annual statement filed with the insurance department of [~~its~~] the insurer's state of domicile; and

(B) most recent audited financial statement; and

(v) (A) (I) has not had [~~its~~] the insurer's accreditation denied by the commissioner within 90 days after the day on which the insurer submits the information required by this Subsection (4); and

(II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or

(B) (I) has [~~its~~] the insurer's accreditation approved by the commissioner; and

(II) maintains a surplus with regard to policyholders in an amount less than $20,000,000.

(c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing.

(5) (a) A domestic ceding insurer is allowed a credit if:

(i) the reinsurance is ceded to an assuming insurer that is:

(A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

(B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii);

(ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and

(iii) the assuming insurer or United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and

(B) submits to the authority of the commissioner to examine [~~its~~] the insurer's books and records.

(b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

(6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund:

(i) created in accordance with rules made by the commissioner pursuant to Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) in a qualified United States financial institution for the payment of a valid claim of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; and

(C) a successor in interest to the United States ceding insurer.

(b) To enable the commissioner to determine the sufficiency of the trust fund described in Subsection (6)(a), the assuming insurer shall:

(i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and

(ii) (A) submit to examination of its books and records by the commissioner; and

(B) pay the cost of an examination.

(c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the

form of the trust and any amendment to the trust is approved by:

(A) the commissioner of the state where the trust is domiciled; or

(B) the commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust.

(ii) The form of the trust and an amendment to the trust shall be filed with the commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

(iii) The trust instrument shall provide that a contested claim is valid and enforceable upon the final order of a court of competent jurisdiction in the United States.

(iv) The trust shall vest legal title to [~~its~~] the trust's assets in [~~its~~] one or more of the trust's trustees for the benefit of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; or

(C) a successor in interest to the United States ceding insurer.

(v) The trust and the assuming insurer are subject to examination as determined by the commissioner.

(vi) The trust shall remain in effect for as long as the assuming insurer has an outstanding obligation due under a reinsurance agreement subject to the trust.

(vii) No later than February 28 of each year, the trustee of the trust shall:

(A) report to the commissioner in writing the balance of the trust;

(B) list the trust's investments at the end of the preceding calendar year; and

(C) (I) certify the date of termination of the trust, if so planned; or

(II) certify that the trust will not expire before the following December 31.

(d) The following requirements apply to the following categories of assuming insurer:

(i) For a single assuming insurer:

(A) the trust fund shall consist of funds in trust in an amount not less than the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

(B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000, except as provided in Subsection (6)(d)(ii).

(ii) (A) At any time after the assuming insurer has permanently discontinued underwriting new business secured by the trust for at least three full years, the commissioner with principal regulatory oversight of the trust may authorize a reduction in the required

trusteed surplus, but only after a finding, based on an assessment of the risk, that the new required surplus level is adequate for the protection of United States ceding insurers, policyholders, and claimants in light of reasonably foreseeable adverse loss development.

(B) The risk assessment may involve an actuarial review, including an independent analysis of reserves and cash flows, and shall consider all material risk factors, including, when applicable, the lines of business involved, the stability of the incurred loss estimates, and the effect of the surplus requirements on the assuming insurer's liquidity or solvency.

(C) The minimum required trusteed surplus may not be reduced to an amount less than 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers covered by the trust.

(iii) For a group acting as assuming insurer, including incorporated and individual unincorporated underwriters:

(A) for reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to an underwriter of the group;

(B) for reinsurance ceded under a reinsurance agreement with an inception date on or before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the other provisions of this chapter, the trust shall consist of a trusteed account in an amount not less than the respective underwriters' several insurance and reinsurance liabilities attributable to business written in the United States;

(C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group for all years of account;

(D) the incorporated members of the group:

(I) may not be engaged in a business other than underwriting as a member of the group; and

(II) are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner:

(I) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(II) if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group.

(iv) For a group of incorporated underwriters under common administration, the group shall:

(A) have continuously transacted an insurance business outside the United States for at least three years immediately preceding the day on which the group makes application for accreditation;

(B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

(C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group;

(D) in addition to complying with the other provisions of this Subsection (6)(d)(iv), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner:

(I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(II) a financial statement of each underwriter member of the group prepared by an independent public accountant.

(7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that secures [~~its~~] the assuming insurer's obligations in accordance with this Subsection (7):

(a) The insurer shall be certified by the commissioner as a reinsurer in this state.

(b) To be eligible for certification, the assuming insurer shall:

(i) be domiciled and licensed to transact insurance or reinsurance in a qualified

jurisdiction, as determined by the commissioner pursuant to Subsection (7)(d);

(ii) maintain minimum capital and surplus, or its equivalent, in an amount to be determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(iii) maintain financial strength ratings from two or more rating agencies considered acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(iv) agree to:

(A) submit to the jurisdiction of this state;

(B) appoint the commissioner as [~~its~~] the assuming insurer's agent for service of process in this state;

(C) provide security for 100% of the assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers if [~~it~~] the assuming insurer resists enforcement of a final United States judgment;

(D) agree to meet applicable information filing requirements as determined by the commissioner including an application for certification, a renewal and on an ongoing basis; and

(E) any other requirements for certification considered relevant by the commissioner.

(c) An association, including incorporated and individual unincorporated underwriters, may be a certified reinsurer[~~. To be eligible for certification, in addition to satisfying requirements of Subsections (7)(a) and (b)~~], if the association:

(i) satisfies the requirements of Subsections (7)(a) and (b);

[~~(i)~~] (ii) [~~shall satisfy its~~] satisfies the association's minimum capital and surplus requirements through the capital and surplus equivalents, net of liabilities, of the association and [~~its~~] the association's members, which shall include a joint central fund that may be applied to any unsatisfied obligation of the association or any of [~~its~~] the association's members in an amount determined by the commissioner to provide adequate protection;

[~~(ii)~~] (iii) [~~may~~] does not have incorporated members of the association engaged in any business other than underwriting as a member of the association;

[~~(iii)~~] (iv) [~~shall be~~] is subject to the same level of regulation and solvency control of the incorporated members of the association by the association's domiciliary regulator as are the unincorporated members; and

[~~(iv)~~] (v) within 90 days after [~~its~~] the day on which the association's financial statements are due to be filed with the association's domiciliary regulator [~~provide: (A)~~], provides to the commissioner:

(A) an annual certification by the association's domiciliary regulator of the solvency of each underwriter member; or

(B) if a certification described in Subsection (7)(c)(v)(A) is unavailable, financial statements prepared by independent public accountants, of each underwriter member of the association.

(d) (i) The commissioner shall create and publish a list of qualified jurisdictions under which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be considered for certification by the commissioner as a certified reinsurer.

[~~(i)~~] (ii) To determine whether the domiciliary jurisdiction of a non-United States assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

(A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory system of the jurisdiction, both initially and on an ongoing basis;

(B) shall consider the rights, the benefits, and the extent of reciprocal recognition afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the United States;

(C) shall require the qualified jurisdiction to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

(D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has determined that the jurisdiction does not adequately and promptly enforce final United States judgments and arbitration awards.

[~~(ii)~~] (iii) The commissioner may consider additional factors in determining a qualified jurisdiction.

[~~(iii)~~] (iv) A list of qualified jurisdictions shall be published through the National Association of Insurance Commissioners' Committee Process [~~and the~~].

(v) The commissioner shall:

(A) consider [~~this list~~] the National Association of Insurance Commissioners' list of qualified jurisdictions in determining qualified jurisdictions; and

(B) if the commissioner approves a jurisdiction as qualified that does not appear on the

National Association of Insurance [~~Commissioner's~~] Commissioners' list of qualified jurisdictions, provide thoroughly documented justification in accordance with criteria to be developed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

[~~(iv)~~] (vi) United States jurisdictions that meet the requirement for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program shall be recognized as qualified jurisdictions.

[~~(v)~~] (vii) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of revocation.

(e) The commissioner shall:

(i) assign a rating to each certified reinsurer, giving due consideration to the financial strength ratings that have been assigned by rating agencies considered acceptable to the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(ii) publish a list of all certified reinsurers and their ratings.

(f) A certified reinsurer shall secure obligations assumed from United States ceding insurers under this Subsection (7) at a level consistent with [~~its~~] the certified reinsurer's rating, as specified in rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(i) For a domestic ceding insurer to qualify for full financial statement credit for reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a form acceptable to the commissioner and consistent with Section 31A-17-404.1, or in a multibeneficiary trust in accordance with Subsections (5), (6), and (9), except as otherwise provided in this Subsection (7).

(ii) If a certified reinsurer maintains a trust to fully secure [~~its~~] the certified reinsurer's obligations subject to Subsections (5), (6), and (9), and chooses to secure [~~its~~] the certified reinsurer's obligations incurred as a certified reinsurer in the form of a multibeneficiary trust, the certified reinsurer shall maintain separate trust accounts for [~~its~~] the certified reinsurer's obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer with reduced security as permitted by this Subsection (7) or comparable laws of other United

States jurisdictions and for [~~its~~] the certified reinsurer's obligations subject to Subsections (5), (6), and (9).

(iii) It shall be a condition to the grant of certification under this Subsection (7) that the certified reinsurer shall have bound itself:

(A) by the language of the trust and agreement with the commissioner with principal regulatory oversight of the trust account; and

(B) upon termination of the trust account, to fund, out of the remaining surplus of the trust, any deficiency of any other trust account.

(iv) The minimum trusteed surplus requirements provided in Subsections (5), (6), and (9) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer for the purpose of securing obligations incurred under this Subsection (7), except that the trust shall maintain a minimum trusteed surplus of $10,000,000.

(v) With respect to obligations incurred by a certified reinsurer under this Subsection (7), if the security is insufficient, the commissioner:

(A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

(B) may impose further reductions in allowable credit upon finding that there is a material risk that the certified reinsurer's obligations will not be paid in full when due.

(vi) (A) For purposes of this Subsection (7), a certified reinsurer whose certification has been terminated for any reason shall be treated as a certified reinsurer required to secure 100% of [~~its~~] the certified reinsurer's obligations.

[~~(A)~~] (B) As used in this Subsection (7), the term "terminated" refers to revocation, suspension, voluntary surrender, and inactive status.

[~~(B)~~] (C) If the commissioner continues to assign a higher rating as permitted by other provisions of this section, the requirement under this Subsection (7)(f)(vi) does not apply to a certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

(g) If an applicant for certification has been certified as a reinsurer in a National Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

(i) defer to that jurisdiction's certification;

(ii) defer to the rating assigned by that jurisdiction; and

(iii) consider such reinsurer to be a certified reinsurer in this state.

(h) (i) A certified reinsurer that ceases to assume new business in this state may request

to maintain [~~its~~] the certified reinsurer's certification in inactive status in order to continue to qualify for a reduction in security for its in-force business.

(ii) An inactive certified reinsurer shall continue to comply with all applicable requirements of this Subsection (7).

(iii) The commissioner shall assign a rating to a reinsurer that qualifies under this Subsection (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not assuming new business.

(8) (a) As used in this Subsection (8):

(i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that:

(A) is currently in effect or in a period of provisional application; and

(B) addresses the elimination, under specified conditions, of collateral requirements as a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this state or for allowing the ceding insurer to recognize credit for reinsurance.

(ii) "Reciprocal jurisdiction" means a jurisdiction that is:

(A) a non-United States jurisdiction that is subject to an in-force covered agreement with the United States, each within its legal authority, or, in the case of a covered agreement between the United States and European Union, is a member state of the European Union;

(B) a United States jurisdiction that meets the requirements for accreditation under the National Association of Insurance Commissioners' financial standards and accreditation program; or

(C) a qualified jurisdiction, as determined by the commissioner in accordance with Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain additional requirements, consistent with the terms and conditions of in-force covered agreements, as specified by the commissioner in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) (i) Credit [~~shall be~~] is allowed when the reinsurance is ceded to an assuming insurer meeting each of the conditions set forth in this Subsection (8)(b).

(ii) The assuming insurer must have [~~its~~] the assuming insurer's head office in or be domiciled in, as applicable, and be licensed in a reciprocal jurisdiction.

(iii) (A) The assuming insurer [~~must~~] shall have and maintain, on an ongoing basis,

minimum capital and surplus, or its equivalent, calculated according to the methodology of [~~its~~] the assuming insurer's domiciliary jurisdiction, in an amount to be set forth in regulation.

(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, [~~it must~~] the assuming insurer shall have and maintain, on an ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated according to the methodology applicable in [~~its~~] the assuming insurer's domiciliary jurisdiction, and a central fund containing a balance in amounts [~~to be~~] set forth in regulation.

(iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ration, as applicable, which will be set forth in regulation.

(B) If the assuming insurer is an association, including incorporated and individual unincorporated underwriters, [~~it~~] the assuming insurer must have and maintain, on an ongoing basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming insurer has [~~its~~] the assuming insurer's head office or is domiciled, as applicable, and is also licensed.

(v) The assuming insurer must agree and provide adequate assurance to the commissioner, in a form specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:

(A) the assuming insurer must provide prompt written notice and explanation to the commissioner if [~~it~~] the assuming insurer falls below the minimum requirements set forth in [~~Subsections~~] Subsection (8)(c) or (d), or if any regulatory action is taken against [~~it~~] the assuming insurer for serious noncompliance with applicable law;

(B) the assuming insurer must consent in writing to the jurisdiction of the courts of this state and to the appointment of the commissioner as agent for service of process, however the commissioner may require that consent for service of process be provided to the commissioner and included in each reinsurance agreement and nothing in this provision shall limit, or in any way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute resolution mechanisms, except to the extent such agreements are unenforceable under applicable insolvency or delinquency laws;

(C) the assuming insurer must consent in writing to pay all final judgments, wherever enforcement is sought, obtained by a ceding insurer or [~~its~~] the ceding insurer's legal successor, that have been declared enforceable in the jurisdiction where the judgment was obtained;

(D) each reinsurance agreement must include a provision requiring the assuming insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists enforcement of a final judgment that is enforceable under the law of the jurisdiction in which [~~it~~] the final judgement was obtained or a properly enforceable arbitration award, whether obtained by the ceding insurer or by [~~its~~] the ceding insurer's legal successor on behalf of [~~its~~] the ceding insurer's resolution estate; and

(E) the assuming insurer must confirm that [~~it~~] the assuming insurer is not presently participating in any solvent scheme of arrangement which involved this state's ceding insurers, and agree to notify the ceding insurer and the commissioner and to provide security:

(I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and

(II) in a form consistent with the provisions of Subsections (7) and (10) and as specified by the commissioner in regulation.

(vi) The assuming insurer or [~~its~~] the assuming insurer's legal successor must provide, if requested by the commissioner, on behalf of [~~itself~~] the assuming insurer and any legal predecessors, certain documentation to the commissioner, as specified by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(vii) The assuming insurer must maintain a practice of prompt payment of claims under reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(viii) The assuming insurer's supervisory authority must confirm to the commissioner on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements set forth in Subsections (8)(c) and (d).

(ix) Nothing in this provision precludes an assuming insurer from providing the commissioner with information on a voluntary basis.

(c) (i) The commissioner shall timely create and publish a list of reciprocal jurisdictions.

(ii) (A) A list of reciprocal jurisdictions is published through the National Association of Insurance Commissioners' Committee Process.

(B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal jurisdictions in accordance with the criteria developed under rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner [~~shall~~] may not remove from the list a reciprocal jurisdiction.

(B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance ceded to an assuming insurer [~~which has its~~] whose home office or [~~is domiciled~~] domicile is in that jurisdiction [~~shall be~~] is allowed, if otherwise allowed under this chapter.

(d) (i) The commissioner shall timely create and publish a list of assuming insurers that have satisfied the conditions set forth in this subsection and to which cessions shall be granted credit in accordance with this Subsection (8).

(ii) The commissioner may add an assuming insurer to such list if a National Association of Insurance Commissioners accredited jurisdiction has added such assuming insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer submits the information to the commissioner as required under this Subsection (8) and complies with any additional requirements that the commissioner may impose by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the extent that they conflict with an applicable covered agreement.

(e) (i) If the commissioner determines that an assuming insurer no longer meets one or more of the requirements under this Subsection (8), the commissioner may revoke or suspend the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement issued, amended, or renewed after the [~~effective date of the suspension~~] day on which the suspension is effective qualifies for credit except to the extent that the assuming insurer's obligations under the contract are secured in accordance with Subsection (10).

(B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be granted after the [~~effective date of the revocation~~] day on which the revocation is effective with respect to any reinsurance agreements entered into by the assuming insurer, including reinsurance agreements entered into [~~prior to the date of~~] before the day on which the revocation is effective, except to the extent that the assuming insurer's obligations under the contract are secured in a form acceptable to the commissioner and consistent with the provisions of Subsection (10).

(f) If subject to a legal process of rehabilitation, liquidation, or conservation, as applicable, the ceding insurer, or [~~its~~] the ceding insurer's representative, may seek and, if determined appropriate by the court in which the proceedings are pending, may obtain an order requiring that the assuming insurer post security for all outstanding ceded liabilities.

(g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a reinsurance agreement to agree on requirements for security or other terms in that reinsurance agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

(h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements entered into, amended, or renewed on or after the effective date of the statute adding this Subsection (8), and only with respect to losses incurred and reserves reported on or after the later of:

(A) the [~~date~~] day on which the assuming insurer has met all eligibility requirements pursuant to Subsection (8)(b); and

[~~(B) the effective date of the new reinsurance agreement, amendment or renewal.~~]

(B) the day on which the new reinsurance agreement, amendment, or renewal is effective.

(ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the reinsurance qualifies for credit under any other applicable provision of this chapter.

(iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or reduce the security provided under any reinsurance agreement except as permitted by the terms of the agreement.

(iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to any reinsurance agreement to renegotiate the agreement.

(9) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.

(10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7), or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting forth:

(i) the valuation of assets or reserve credits;

(ii) the amount and forms of security supporting reinsurance arrangements; and

(iii) the circumstances pursuant to which credit will be reduced or eliminated.

(c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with the assuming insurer as security for the payment of obligations thereunder, if the security is:

(A) held in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(B) in the case of a trust, held in a qualified United States financial institution.

(ii) The security described in this Subsection (10)(c) may be in the form of:

(A) cash;

(B) securities listed by the Securities Valuation Office of the National Association of Insurance Commissioners, including those deemed exempt from filing as defined by the Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted assets;

(C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a qualified United States financial institution effective no later than December 31 of the year for which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or before the filing date of its annual statement;

(D) letters of credit meeting applicable standards of issuer acceptability as of the dates of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's

subsequent failure to meet applicable standards of issuer acceptability, continue to be acceptable as security until their expiration, extension, renewal, modification or amendment, whichever first occurs; or

(E) any other form of security acceptable to the commissioner.

(11) Reinsurance credit [~~may not be~~] is not allowed a domestic ceding insurer unless the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

(a) (i) being an admitted insurer; and

(ii) submitting to jurisdiction under Section 31A-2-309;

(b) having irrevocably appointed the commissioner as the domestic ceding insurer's agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or

(c) agreeing in the reinsurance contract:

(i) that if the assuming insurer fails to perform [~~its~~] the assuming insurer's obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of an appellate court in the event of an appeal; and

(ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company.

(12) Submitting to the jurisdiction of Utah courts under Subsection (11) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes.

(13) (a) If an assuming insurer does not meet the requirements of Subsection (3), (4), (5), or (8), the credit permitted by Subsection (6) or (7) may not be allowed unless the assuming insurer agrees in the trust instrument to the [~~following conditions.~~] conditions described in Subsections (13)(b) through (e).

[~~(a)~~] (b) (i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection (13)[~~(a)~~](b)(ii) occurs the trustee shall comply with:

(A) an order of the commissioner with regulatory oversight over the trust; or

(B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) This Subsection (13)[~~(a)~~](b) applies if:

(A) the trust fund is inadequate because the trust contains an amount less than the amount required by Subsection (6)(d); or

(B) the grantor of the trust is:

(I) declared insolvent; or

(II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile.

[~~(b)~~] (c) The assets of a trust fund described in Subsection [~~(13)(a)~~] (13)(b) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company.

[~~(c)~~] (d) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument.

[~~(d)~~] (e) A grantor shall waive any right otherwise available to [~~it~~] the grantor under United States law that is inconsistent with this Subsection (13).

(14) (a) If an accredited or certified reinsurer ceases to meet the requirements for accreditation or certification, the commissioner may suspend or revoke the reinsurer's accreditation or certification.

[~~(a)~~] (b) The commissioner shall give the reinsurer notice and opportunity for hearing.

[~~(b)~~] (c) The suspension or revocation may not take effect until after the [~~commissioner's~~] day on which the commissioner issues an order after a hearing, unless:

(i) the reinsurer waives [~~its~~] the reinsurer's right to hearing;

(ii) the commissioner's order is based on:

(A) regulatory action by the reinsurer's domiciliary jurisdiction; or

(B) the voluntary surrender or termination of the reinsurer's eligibility to transact insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state under Subsection (7)(g); or

(iii) the commissioner's finding that an emergency requires immediate action and a court of competent jurisdiction has not stayed the commissioner's action.

[~~(c)~~] (d) While a reinsurer's accreditation or certification is suspended, no reinsurance contract issued or renewed after the effective date of the suspension qualifies for credit except to the extent that the reinsurer's obligations under the contract are secured in accordance with Section 31A-17-404.1.

[~~(d)~~] (e) If a reinsurer's accreditation or certification is revoked, no credit for reinsurance may be granted after the effective date of the revocation except to the extent that the reinsurer's obligations under the contract are secured in accordance with Subsection (7)(f) or Section 31A-17-404.1.

(15) (a) A ceding insurer shall take steps to manage [~~its~~] the ceding insurer's reinsurance recoverables proportionate to [~~its~~] the ceding insurer's own book of business.

(b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after the day on which reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers:

(A) exceeds 50% of the domestic ceding insurer's last reported surplus to policyholders; or

(B) after it is determined that reinsurance recoverables from any single assuming insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding insurer's last reported surplus to policyholders.

(ii) The notification required by Subsection (15)(b)(i) shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(c) A ceding insurer shall take steps to diversify [~~its~~] the ceding insurer's reinsurance program.

(d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after [~~ceding or being likely to cede~~] the day on which the ceding insurer cedes or is likely to cede more than 20% of the ceding insurer's gross written premium in the prior calendar year to any:

(A) single assuming insurer; or

(B) group of affiliated assuming insurers.

(ii) The notification shall demonstrate that the exposure is safely managed by the domestic ceding insurer.

(16) A ceding insurer licensed under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 7, Nonprofit Health Service Insurance Corporations, Chapter 8, Health Maintenance Organizations and Limited Health Plans, Chapter 9, Insurance Fraternals, or Chapter 14, Foreign Insurers is not allowed credit if the reinsurance is ceded to an assuming domestic or foreign captive insurer, unless the assuming domestic or foreign captive insurer complies with:

(a) Chapter 4, Insurers in General;

(b) Chapter 16, Insurance Holding Companies;

(c) Chapter 16a, Risk Management and Own Risk and Solvency Assessment Act;

(d) Chapter 17, Determination of Financial Condition; and

(e) Chapter 18, Investments.

Section 4. Section **31A-21-101** is amended to read:

31A-21-101. Scope of Chapters 21 and 22.

(1) Except as provided in Subsections (2) through (6), this chapter and Chapter 22, Contracts in Specific Lines, apply to all insurance policies, applications, and certificates:

(a) delivered or issued for delivery in this state;

(b) on property ordinarily located in this state;

(c) on persons residing in this state when the policy is issued; or

(d) on business operations in this state.

(2) This chapter and Chapter 22, Contracts in Specific Lines, do not apply to:

(a) an exemption provided in Section 31A-1-103;

(b) an insurance policy procured under Sections 31A-15-103 and 31A-15-104;

(c) an insurance policy on business operations in this state:

(i) if:

(A) the contract is negotiated primarily outside this state; and

(B) the operations in this state are incidental or subordinate to operations outside this state; and

(ii) except that insurance required by a Utah statute shall conform to the statutory requirements; or

(d) other exemptions provided in this title.

(3) (a) Sections 31A-21-102, 31A-21-103, 31A-21-104, Subsections 31A-21-107(1) and (3), and Sections 31A-21-306, 31A-21-308, 31A-21-312, and 31A-21-314 apply to ocean marine and inland marine insurance.

(b) Section 31A-21-201 applies to inland marine insurance that is written according to manual rules or rating plans.

(c) Inland marine insurance that includes accident and health insurance is subject to Chapter 22, Contracts in Specific Lines.

(4) A group insurance policy or a blanket insurance policy is subject to this chapter and Chapter 22, Contracts in Specific Lines, except:

(a) a group [~~or blanket~~] insurance policy outside the scope of this title under Subsection 31A-1-103(3)(h);

(b) a blanket insurance policy outside the scope of this title under Subsection 31A-1-103(3)(h); and

[~~(b)~~] (c) other exemptions provided under Subsection (5).

(5) The commissioner may by rule exempt any class of insurance contract or class of insurer from any or all of the provisions of this chapter and Chapter 22, Contracts in Specific Lines, if the interests of the Utah insureds, creditors, or the public would not be harmed by the exemption.

(6) Workers' compensation insurance is subject to this chapter and Chapter 22, Contracts in Specific Lines.

(7) Unless clearly inapplicable, any provision of this chapter or Chapter 22, Contracts in Specific Lines, applicable to either a policy or a contract is applicable to both.

Section 5. Section **31A-21-201** is amended to read:

31A-21-201. Filing of forms.

(1) (a) Except as exempted under Subsections 31A-21-101(2) through (6), a form may not be used, sold, or offered for sale until the form is filed with the commissioner.

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

(i) the form;

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

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

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

(3) (a) The commissioner may prohibit the use of a form at any time upon a finding that:

(i) the form:

(A) is inequitable;

(B) is unfairly discriminatory;

(C) is misleading;

(D) is deceptive;

(E) is obscure;

(F) is unfair;

(G) encourages misrepresentation; or

(H) is not in the public interest;

(ii) the form provides benefits or contains another provision that endangers the solidity of the insurer;

(iii) except for a life or accident and health insurance policy form, the form is an insurance policy or application for an insurance policy, that fails to conspicuously[~~, as defined by rule,~~] provide:

(A) the exact name of the insurer; and

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy;

(iv) except an application required by Section 31A-22-635, the form is a life or accident and health insurance policy form that fails to conspicuously[~~, as defined by rule,~~] provide:

(A) the exact name of the insurer;

(B) the state of domicile of the insurer filing the insurance policy or application for the insurance policy; and

(C) for a life insurance policy only, the address of the administrative office of the insurer filing the form;

(v) the form violates a statute or a rule adopted by the commissioner; or

(vi) the form is otherwise contrary to law.

(b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may order that, on or before a date not less than 15 days after the day on which the commissioner issues the order, the use of the form be discontinued.

(ii) Once use of a form is prohibited, the form may not be used until appropriate changes are filed with and reviewed by the commissioner.

(iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the commissioner may require the insurer to disclose contract deficiencies to the existing policyholders.

(c) If the commissioner prohibits use of a form under this Subsection (3), the prohibition shall:

(i) be in writing;

(ii) constitute an order; and

(iii) state the reasons for the prohibition.

(4) (a) If, after a hearing, the commissioner determines that it is in the public interest, the commissioner may require by rule or order that a form be subject to the commissioner's approval before [~~its use~~] an insurer uses the form.

(b) The rule or order described in Subsection (4)(a) shall prescribe the filing procedures for a form if the procedures are different from the procedures stated in this section.

(c) The type of form that under Subsection (4)(a) the commissioner may require approval of before use includes:

(i) a form for a particular class of insurance;

(ii) a form for a specific line of insurance;

(iii) a specific type of form; or

(iv) a form for a specific market segment.

(5) (a) An insurer shall maintain a complete and accurate record of the following for the time period described in Subsection (5)(b):

(i) a form:

(A) filed under this section for use; or

(B) that is in use; and

(ii) a document filed under this section with a form described in Subsection (5)(a)(i).

(b) The insurer shall maintain a record required under Subsection (5)(a) for the balance of the current year, plus five years from:

(i) the last day on which the form is used; or

(ii) the last day an insurance policy that is issued using the form is in effect.

Section 6. Section **31A-21-402** is amended to read:

31A-21-402. Definitions.

As used in this part:

(1) (a) "Direct response solicitation" means any offer [~~by~~] an insurer makes to persons in this state, either directly or through a third party, to effect life or accident and health insurance coverage which enables the individual to apply or enroll for the insurance on the basis of the offer.

(b) "Direct response solicitation" does not include:

(i) solicitations for insurance through an employee benefit plan exempt from state regulation under preemptive federal law[~~, nor does it include~~]; or

(ii) solicitations through [~~the~~] an individual's creditor with respect to credit life or credit accident and health insurance.

(2) "Mass marketed life or accident and health insurance" means the insurance under any individual, franchise, group, or blanket insurance policy of life or accident and health insurance [~~which~~]:

(a) that is offered by means of direct response solicitation through:

(i) a sponsoring organization; or [~~through~~]

(ii) the mails or other mass communications media; and

(b) under which the person insured pays all or substantially all of the cost of [~~his~~] the person's insurance.

Section 7. Section **31A-21-404** is amended to read:

31A-21-404. Out-of-state insurers.

[~~Any~~] Notwithstanding Subsection 31A-1-103(3)(h), an insurer extending mass marketed life or accident and health insurance under a group insurance policy issued outside of this state to residents of this state or a blanket insurance policy issued outside of this state to residents of this state shall, with respect to the mass marketed life or accident and health

insurance policy:

(1) comply with:

(a) Sections 31A-23a-402, 31A-23a-402.5, and 31A-23a-403; and

(b) Chapter 26, Part 3, Claim Practices; and

(2) upon the commissioner's request, deliver to the commissioner a copy of:

(a) any mass marketed life or accident and health insurance policy[~~, certificates issued under these policies, and~~];

(b) a certificate issued under a mass marketed life or accident and health insurance policy;

(c) an application for a mass marketed life or accident and health insurance policy;

(d) an enrollment form for a mass marketed life or accident and health insurance policy; and

(e) advertising material used in this state in connection with [~~the~~] a mass marketed life or accident and health insurance policy.

Section 8. Section **31A-22-409** is amended to read:

31A-22-409. Standard Nonforfeiture Law for Individual Deferred Annuities.

(1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(2) This section does not apply to:

(a) reinsurance;

(b) a group annuity purchased under a retirement plan or plan of deferred compensation:

(i) established or maintained by:

(A) an employer, including a partnership or sole proprietorship;

(B) an employee organization; or

(C) both an employer and an employee organization; and

(ii) other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code;

(c) a premium deposit fund;

(d) a variable annuity;

(e) an investment annuity;

(f) an immediate annuity;

(g) a deferred annuity contract after annuity payments have commenced;

(h) a reversionary annuity; or

(i) a contract that is delivered outside this state through an agent or other representative of the company issuing the contract.

(3) (a) If a policy is issued after this section takes effect as set forth in Subsection (15), a contract of annuity, except as stated in Subsection (2), may not be delivered or issued for delivery in this state unless the contract of annuity contains in substance:

(i) the provisions described in Subsection (3)(b); or

(ii) provisions corresponding to the provisions described in Subsection (3)(b) that in the opinion of the commissioner are at least as favorable to the contractholder, governing cessation of payment of consideration under the contract.

(b) Subsection (3)(a)(i) requires the following provisions:

(i) the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such a value as specified in Subsections (7), (8), (9), (10), and (12):

(A) upon cessation of payment of consideration under a contract; or

(B) upon a written request of the contract owner;

(ii) if a contract provides for a lump-sum settlement at maturity, or at any other time, upon surrender of the contract at or before the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections (7), (8), (10), and (12);

(iii) a statement of the mortality table, if any, and interest rates used in calculating any of the following that are guaranteed under the contract:

(A) minimum paid-up annuity benefit;

(B) cash surrender benefit; or

(C) death benefit;

(iv) sufficient information to determine the amounts of the benefits described in Subsection (3)(b)(iii);

(v) a statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by a statute of the state in which the contract is delivered; and

(vi) an explanation of the manner in which a benefit described in Subsection (3)(b)(v) is altered by the existence of any:

(A) additional amounts credited by the company to the contract;

(B) indebtedness to the company on the contract; or

(C) prior withdrawals from or partial surrender of the contract.

(c) Notwithstanding the requirements of this Subsection (3), a deferred annuity contract may provide that if no consideration is received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid before the period would be less than $20 monthly:

(i) the company may at the company's option terminate the contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table specified in the contract, if any, and the interest rate specified in the contract for determining the paid-up annuity benefit; and

(ii) the payment described in Subsection (3)(c)(i), relieves the company of any further obligation under the contract.

(d) A company may reserve the right to defer the payment of cash surrender benefit for a period not to exceed six months after demand for the payment of the cash surrender benefit with surrender of the contract.

(4) For a policy issued before June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (4).

(a) (i) With respect to a contract providing for flexible considerations, the minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at a rate of interest of 3% per annum of percentages of the net considerations paid [~~prior to~~] before such time:

(A) decreased by the sum of:

(I) any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum; and

(II) the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(B) increased by any existing additional amounts credited by the company to the contract.

(ii) For purposes of this Subsection (4)(a), the net consideration for a given contract year used to define the minimum nonforfeiture amount shall be:

(A) an amount not less than zero; and

(B) equal to the corresponding gross considerations credited to the contract during that contract year less:

(I) an annual contract charge of $30; and

(II) a collection charge of $1.25 per consideration credited to the contract during that contract year.

(iii) The percentages of net considerations shall be:

(A) 65% of the net consideration for the first contract year; and

(B) 87-1/2% of the net considerations for the second and later contract years.

(iv) Notwithstanding Subsection (4)(a)(iii), the percentage shall be 65% of the portion of the total net consideration for any renewal contract year that exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%.

(b) (i) Except as provided in Subsections (4)(b)(ii) and (iii), with respect to a contract providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:

(A) calculated on the assumption that considerations are paid annually in advance; and

(B) defined as for contracts with flexible considerations that are paid annually.

(ii) The portion of the net consideration for the first contract year to be accumulated shall be equal to an amount that is the sum of:

(A) 65% of the net consideration for the first contract year; and

(B) 22-1/2% of the excess of the net consideration for the first contract year over the lesser of the net considerations for:

(I) the second contract year; and

(II) the third contract year.

(iii) The annual contract charge shall be the lesser of $30 or 10% of the gross annual consideration.

(c) With respect to a contract providing for a single consideration payment, minimum

nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:

(i) the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90%; and

(ii) the net consideration shall be the gross consideration less a contract charge of $75.

(5) (a) For a policy issued on or after June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (5).

[~~(a)~~] (b) The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at rates of interest as indicated in Subsection (5)[~~(b)~~](c), of 87-1/2% of the gross considerations paid before such time decreased by the sum of:

(i) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection (5)[~~(b)~~](c);

(ii) an annual contract charge of $50, accumulated at rates of interest as indicated in Subsection (5)[~~(b)~~](c);

(iii) any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection (5)[~~(b)~~](c); and

(iv) the amount of any indebtedness to the company on the contract, including interest due and accrued.

[~~(b)~~] (c) (i) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of:

(A) 3% per annum; [~~and~~] or

(B) the five-year Constant Maturity Treasury Rate reported by the Federal Reserve, rounded to the nearest 1/20th of 1%, as of a date or average over a period no longer than 15 months [~~prior to~~] before the contract issue date or redetermination date under Subsection (5)[~~(b)~~](c)(iii):

(I) reduced by 125 basis points; and

(II) where the resulting interest rate is not less than 100 basis points, 1% for a policy issued on or after June 1, 2006, and before June 1, 2021, or where the resulting interest rate is not less than 15 basis points, 0.15% for a policy issued on or after June 1, 2021.

(ii) The interest rate shall apply for an initial period and may be redetermined for additional periods.

(iii) (A) If the interest rate will be reset, the contract shall state:

(I) the initial period;

(II) the redetermination date;

(III) the redetermination basis; and

(IV) the redetermination period.

(B) The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

[~~(c)~~] (d) (i) During the period or term that a contract provides substantive participation in an equity indexed benefit, the reduction described in Subsection (5)[~~(b)~~](c)(i)(B)(I) may be increased by up to an additional 100 basis points to reflect the value of the equity index benefit.

(ii) The present value of the additional reduction at the contract issue date and at each redetermination date may not exceed the market value of the benefit.

(iii) (A) The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit.

(B) If the demonstration required under Subsection (5)[~~(c)~~](d)(iii)(A) is not made to the satisfaction of the commissioner, the commissioner may disallow or limit the additional reduction.

(6) Notwithstanding Subsection (4), for a policy issued on or after June 1, 2004 and before June 1, 2006, at the election of a company, on a contract form-by-contract form basis, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract may be based upon minimum nonforfeiture amounts as established in Subsection (5).

(7) (a) A paid-up annuity benefit available under a contract shall be such that the contract's present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date.

(b) The present value described in Subsection (7)(a) shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(8) (a) For a contract that provides cash surrender benefits, the cash surrender benefits

available before maturity may not be less than the present value as of the date of surrender of that portion of the cash surrender value that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender:

(i) decreased by the amount appropriate to reflect any prior withdrawals from or partial surrender of the contract;

(ii) decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(iii) increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of this Subsection (8), the present value is to be calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value.

(c) In no event shall a cash surrender benefit be less than the minimum nonforfeiture amount at that time.

(d) The death benefit under a contract described in Subsection (8)(a) shall be at least equal to the cash surrender benefit.

(9) (a) For a contract that does not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time [~~prior to~~] before maturity may not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of Subsection (9)(a), the present value for the period [~~prior to~~] before the maturity date is to be calculated on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value.

(c) For a contract that does not provide a death benefit before commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.

(d) In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(10) (a) For the purpose of determining the benefits calculated under Subsections (8) and (9), the maturity date shall be considered to be:

(i) in the case of an annuity contract issued on or before May 5, 2002, under which an election may be made to have an annuity payment commence at an optional maturity date, the latest date for which an election is permitted by the contract, except that it may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years [~~of age~~] old; or

(B) the tenth anniversary of the contract; or

(ii) in the case of an annuity contract issued on or after May 6, 2002, the latest date permitted by the contract, except that [~~it~~] the maturity date may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years [~~of age~~] old; or

(B) the tenth anniversary of the contract.

(b) In the case of an annuity contract issued on or after May 6, 2002:

(i) for a contract that provides cash surrender benefits, the cash surrender value on or past the maturity date shall be equal to the amount used to determine the annuity benefit payments; and

(ii) a surrender charge may not be imposed on or past maturity.

(11) A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the commencement of any annuity payments shall include a statement in a prominent place in the contract that these benefits are not provided.

(12) A paid-up annuity, cash surrender, or death benefit available at any time, other than on the contract anniversary under a contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(13) (a) For a contract that provides, within the same contract by rider or supplemental contract provisions, both annuity benefits and life insurance benefits that are in excess of the

greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall:

(i) be equal to the sum of:

(A) the minimum nonforfeiture benefits for the annuity portion; and

(B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and

(ii) computed as if each portion were a separate contract.

(b) (i) Notwithstanding Subsections (7), (8), (9), (10), and (12), additional benefits payable, as described in Subsection (13)(b)(ii), and consideration for the additional benefits payable, shall be disregarded in ascertaining, if required by this section:

(A) the minimum nonforfeiture amounts;

(B) paid-up annuity;

(C) cash surrender; and

(D) death benefits.

(ii) For purposes of this Subsection (13), an additional benefit is a benefit payable:

(A) in the event of total and permanent disability;

(B) as reversionary annuity or deferred reversionary annuity benefits; or

(C) as other policy benefits additional to life insurance, endowment, and annuity benefits.

(iii) The inclusion of the additional benefits described in this Subsection (13) may not be required in any paid-up benefits, unless the additional benefits separately would require:

(A) minimum nonforfeiture amounts;

(B) paid-up annuity;

(C) cash surrender; and

(D) death benefits.

(14) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules necessary to implement this section, including:

(a) ensuring that any additional reduction under Subsection (5)[~~(c)~~](d) is consistent with the requirements imposed by Subsection (5)[~~(c)~~](d); and

(b) providing for adjustments in addition to the adjustments allowed under Subsection (5)[~~(c)~~](d) to the calculation of minimum nonforfeiture amounts for:

(i) a contract that provides substantive participation in an equity index benefit; and

(ii) a contract for which the commissioner determines adjustments are justified.

(15) (a) After this section takes effect, a company may file with the commissioner a written notice of [~~its~~] the company's election to comply with this section after a specified date before July 1, 1988.

(b) This section applies to annuity contracts of a company issued on or after the date the company specifies in the notice.

(c) If a company makes no election under Subsection (15)(a), the operative date of this section for such company is July 1, 1988.

Section 9. Section **31A-22-501** is amended to read:

31A-22-501. Eligible groups.

A group insurance policy of life insurance or a blanket insurance policy of life insurance may not be delivered in Utah unless the insured group:

(1) falls within at least one of the classifications under Sections 31A-22-501.1 through 31A-22-509; and

(2) is formed and maintained in good faith for purposes other than obtaining insurance.

Section 10. Section **31A-22-505** is amended to read:

31A-22-505. Association groups.

[~~(1) A policy is subject to the requirements of this section if the policy is issued as policyholder to an association or to the trustees of a fund established, created, or maintained for the benefit of members of one or more associations:~~]

[~~(a) with a minimum membership of 100 persons;~~]

[~~(b) with a constitution and bylaws;~~]

[~~(c) having a shared substantial common purpose that:~~]

[~~(i) is the same profession, trade, occupation, or similar; or~~]

[~~(ii) is by some common economic or representation of interest or genuine organizational relationship unrelated to the provision of benefits; and~~]

[~~(d) that has been in active existence for at least two years.~~]

(1) An insurer may issue a group insurance policy for life insurance to an association group if:

(a) the commissioner authorizes the association group;

(b) the benefits of the group insurance policy are reasonable in relation to the

premiums charged for the policy; and

(c) the association group:

(i) purchases insurance on a group basis on behalf of the association group's members;

(ii) is formed and maintained for a shared substantially common purpose that:

(A) is not related to obtaining insurance; and

(B) is the same profession, trade, or occupation or has some common economic, representation of interest, or genuine organizational relationship;

(iii) has at least 100 members;

(iv) has been actively in existence for at least five years;

(v) has a constitution and bylaws that require:

(A) the association to hold regular meetings not less than annually to further the purpose of the association's members; and

(B) members of the association to have voting privileges and representation on any governing board or committee;

(vi) does not condition membership in the association group on any health status-related factor;

(vii) makes insurance offered through the association group available exclusively to a member of the association; and

(viii) only offers insurance through the association group in connection with a member of the association group.

(2) [~~The policy~~] A group insurance policy for life insurance that an insurer issues to an association group may insure members and employees of the association, employees of the members, one or more of the preceding entities, or all of any classes of these named entities for the benefit of persons other than the employees' employer, or any officials, representatives, trustees, or agents of the employer or association.

(3) (a) The [~~premiums~~] following shall [~~be paid by~~] pay the premium under a group insurance policy for life insurance that an insurer issues to an association group:

(i) the policyholder from funds contributed by the [~~associations~~] association;

(ii) employer members, from funds contributed by the covered persons; or

(iii) from any combination of Subsections (3)(a)(i) and (ii).

(b) Except as provided under Section 31A-22-512, a policy on which no part of the

premium is contributed by the covered persons, specifically for their insurance, is required to insure all eligible persons.

(4) (a) An association group that meets the requirements described under Subsection (1) shall disclose the following to each insured member:

(i) each cost related to joining and maintaining membership in the association;

(ii) that membership fees or dues are in addition to the policy premium;

(iii) that the association group holds the master group insurance policy;

(iv) that the association group and insurer determine the amount of the premium charged and the terms and conditions of coverage under the group insurance policy; and

(v) that the association group policyholder and insurer may change the premium and terms and conditions of coverage under the insurance policy:

(A) through agreement; and

(B) without the consent of the individual certificate holder.

(b) If an insurer collects membership fees or dues on behalf of an association, the insurer shall disclose to each member of the association that the insurer is billing and collecting membership fees and dues on behalf of the association.

Section 11. Section **31A-22-522** is amended to read:

31A-22-522. Required provision for notice of termination.

(1) [~~A policy for~~] A group insurance policy for life insurance coverage or a blanket insurance policy for life insurance coverage [~~issued or renewed after July 1, 2001,~~] shall include a provision that obligates the policyholder to notify each employee or group member:

(a) in writing;

(b) 30 days before the [~~date~~] day on which the coverage [~~is terminated~~] terminates; and

(c) (i) that the group insurance policy for life insurance coverage or blanket insurance policy for life insurance coverage is being terminated; and

(ii) the rights the employee or group member has to convert coverage upon termination.

(2) For a [~~policy for~~] group insurance policy for life insurance coverage or a blanket insurance policy for life insurance coverage described in Subsection (1), an insurer shall:

(a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's monthly notice to the policyholder of premium payments due; and

(b) provide a sample notice to the policyholder at least once a year.

Section 12. Section **31A-22-600** is amended to read:

31A-22-600. Scope of Part 6.

(1) Except where a provision's application is otherwise specifically limited, this part applies to all:

(a) accident and health insurance contracts, including credit accident and health;

(b) franchise;

(c) group contracts; and

(d) [~~a~~] life insurance and annuity [~~policy, but only if~~] policies that directly or through a rider provide:

[~~(i) it includes supplemental benefits and riders including accelerated benefits; and~~]

(i) accident and health insurance benefits; or

(ii) accelerated benefits where the receipt of benefits is contingent on morbidity requirements.

(2) Nothing in this part applies to or affects:

(a) workers' compensation insurance;

(b) reinsurance; or

(c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance.

(3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy:

(a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of:

(i) terminal illness;

(ii) medical conditions requiring extraordinary medical intervention; or

(iii) permanent institutional confinement; and

(b) that provides the option of a lump-sum payment for those benefits.

Section 13. Section **31A-22-607** is amended to read:

31A-22-607. Grace period.

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

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

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

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

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

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

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

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

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

(b) A group insurance policy for accident and health insurance or a blanket insurance policy for accident and health insurance [~~policy~~] is in force during a grace period.

(c) If an insurer does not receive payment before the day on which a grace period expires, the group insurance policy for accident and health insurance or blanket insurance policy for accident and health insurance [~~policy is terminated~~] terminates as of the last day [~~of~~] on which the grace period is in effect.

(d) A group insurance policy for accident and health insurance or a blanket insurance policy for accident and health insurance [~~policy~~] may provide for payment of a pro rata premium for the period the [~~group or blanket accident and health insurance~~] policy is in effect during a grace period under this Subsection (2).

(3) If an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection 31A-21-303(4)(b).

(4) (a) An insurer shall send a written renewal notice to the policyholder:

(i) no sooner than 90 days before, and no later than 14 days before, the day on which an accident and health insurance policy renews; or

(ii) if the renewal notice includes a change in premium, at least 45 days before the day on which an accident and health insurance policy renews.

(b) The renewal notice described in Subsection (4)(a) shall clearly state:

(i) the renewal amount;

(ii) how the policyholder may pay the renewal premium, including the day on which the renewal premium is due; and

(iii) that failure of the policyholder to pay the renewal premium extinguishes the policyholder's right to renew.

(5) The extinguishment of a policyholder's right to renew for nonpayment of premium is effective no sooner than 10 days after the day on which the policyholder receives written notice that the policyholder has failed to pay the premium when due.

Section 14. Section **31A-22-608** is amended to read:

31A-22-608. Reinstatement of individual or franchise accident and health insurance policies.

(1) Every individual or franchise accident and health insurance policy shall contain a provision which reads substantially as follows:

"REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated

policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

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

Section 15. Section **31A-22-612** is amended to read:

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

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

(2) Every policy [~~which~~] that contains [~~this~~] the type of provision described in Subsection (1) shall provide that:

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

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

(i) provide the coverage [~~being issued which~~] that is most nearly similar to the terminated coverage[~~. Probationary or waiting periods in the policy are considered~~]; and

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

(3) (a) When [~~the~~] an insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly

provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid.

(b) The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided.

(c) If [~~the~~] a spouse applies and tenders the first monthly premium to the insurer within 30 days after [~~receiving~~] the day on which the spouse receives the notice provided by this Subsection (3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.

(4) This section does not apply to:

(a) a blanket insurance policy providing accident and health insurance [~~policies offered on a group blanket basis~~]; or

(b) a health benefit plan.

Section 16. Section **31A-22-618.6** is amended to read:

31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit plans.

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

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

(a) for noncompliance with the insurer's employer contribution requirements;

(b) if there is no longer any enrollee under the group health plan who lives, resides, or works in:

(i) the service area of the insurer; or

(ii) the area for which the insurer is authorized to do business;

(c) for coverage made available in the small or large employer market only through an association, if:

(i) the employer's membership in the association ceases; and

(ii) the coverage is terminated uniformly without regard to any health status-related

factor relating to any covered individual; or

(d) for noncompliance with the insurer's minimum employee participation requirements, except as provided in Subsection (3).

(3) If a small employer no longer employs at least one eligible employee, a carrier may not discontinue or not renew the health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least one eligible employee.

(4) (a) A small employer that, after purchasing a health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the small group market.

(b) A large employer that, after purchasing a health benefit plan in the large group market, employs on average fewer than 51 eligible employees on each business day in a calendar year may continue to renew the health benefit plan purchased in the large group market.

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

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

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

(c) the plan sponsor:

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

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

(d) the insurer:

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

(ii) [~~(A)~~] provides notice of the discontinuation in writing to each plan sponsor, employee, [~~or~~] and dependent of [~~a plan sponsor or~~] an employee, at least 90 days before the [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues;

[~~(B)~~] (iii) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the [~~date~~] day on which the notice is sent to [~~the~~] each affected

plan [~~sponsors, employees, and dependents of the plan sponsors or employees~~] sponsor, employee, and dependent of an employee;

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

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

(e) the insurer:

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

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets; [~~and~~]

(ii) [~~(A)~~] provides notice of the discontinuation in writing to each plan sponsor, employee, [~~or~~] and dependent of [~~a plan sponsor or~~] an employee at least 180 days before the [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues;

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

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

[~~(D)~~] (v) provides a plan of orderly withdrawal as required by Section 31A-4-115.

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

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

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee [~~that~~] whose coverage is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the [~~date of discontinuance~~] day on which the employee's coverage discontinues; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage [~~is discontinued~~] discontinues under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll [~~when coverage is discontinued~~] as described in Subsection (6)(b).

(d) An eligible [~~employee~~] employee's coverage may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) An insurer may modify a health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans with that product.

Section 17. Section **31A-22-618.7** is amended to read:

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

(1) (a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all enrollees or dependents; and

(ii) at the option of the enrollee.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

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

(a) if:

(i) there is no longer an enrollee under the individual health benefit plan who lives, resides, or works in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

(ii) coverage is terminated uniformly without regard to any health status-related factor relating to any covered enrollee; or

(b) for coverage made available through an association, if:

(i) the enrollee's membership in the association ceases; and

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

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

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

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

(c) the enrollee:

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

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

(d) the insurer:

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

(ii) (A) provides notice of the discontinuation in writing to each enrollee provided

coverage at least 90 days before the [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues;

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

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

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

(e) the insurer:

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

(ii) (A) provides notice of the discontinuation in writing to each enrollee provided coverage at least 180 days before the [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues;

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

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

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

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

(a) at the time of coverage renewal; and

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

Section 18. Section **31A-22-618.8** is amended to read:

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

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health

benefit plan under Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) is prohibited from writing new business:

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

(b) for a period of five years beginning on the [~~date of discontinuation of~~] day on which the last coverage that is discontinued.

(2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-22-618.6 and 31A-22-618.7 apply only to the insurer's operations in that service area.

(3) The commissioner may, by rule or order, define the scope of service area.

Section 19. Section **31A-22-627** is amended to read:

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

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

(a) shall provide[~~, at a minimum,~~] coverage of emergency services [~~as required in 29 C.F.R. Sec. 2590.715-2719A~~]; and

(b) may not:

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

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

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

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

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

(3) For purposes of this section:

(a) "Emergency medical condition" means a medical condition manifesting itself by

acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, who possesses an average knowledge of medicine and health, would reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:

(i) placing the insured's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

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

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

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

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

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

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

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

(b) impose the following fines:

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

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

Section 20. Section **31A-22-654** is amended to read:

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

(1) As used in this section:

(a) "Qualified condition" means the same as that term is defined in Section 49-20-420.

(b) "Qualified insurer" means an insurer that provides a health benefit plan [~~described~~] as defined in Section [~~31A-22-600~~] 31A-1-301 to more than 25,000 enrollees in the state as of December 31 of the preceding reporting year.

(c) "Qualified enrollee" means an enrollee of a qualified insurer who:

(i) has been diagnosed by a physician as having a genetic trait associated with a

qualified condition; and

(ii) intends to get pregnant with a partner who is diagnosed by a physician as having a genetic trait associated with the same qualified condition as the enrollee.

(2) (a) A qualified insurer shall submit the information described in this Subsection (2) to the department [~~with the qualified insurer's rate filings required under Section 31A-2-201.1~~] for a plan year beginning:

(i) on or after January 1, 2022, but before December 31, 2022; and

(ii) on or after January 1, 2025, but before December 31, 2025.

(b) A qualified insurer shall study whether providing the coverage for the services described in Subsections (3)(a) and (b) for qualified enrollees will result in cost savings for the qualified insurer.

(c) (i) If a qualified insurer determines that providing the coverage described in Subsection (3) for qualified enrollees will result in cost savings for the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b), and:

(A) describe how the qualified insurer intends to provide the coverage described in Subsection (3); or

(B) submit an explanation of why the insurer will not provide the coverage described in Subsection (3).

(ii) If a qualified insurer determines that providing the coverage described in Subsection (3) will not result in cost savings to the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b).

(d) A qualified insurer shall provide the information required under this Subsection (2) to the department no later than:

(i) January 1, 2022, for a plan year beginning on or after January 1, 2022, but before December 31, 2022; and

(ii) January 1, 2025, for a plan year beginning on or after January 1, 2025, but before December 31, 2025.

(3) A qualified insurer shall consider coverage for:

(a) in vitro fertilization services for a qualified enrollee; and

(b) genetic testing of a qualified enrollee who received in vitro fertilization services

under Subsection (3)(a).

(4) The department shall report the information received under Subsection (2) to the Health and Human Services Interim Committee on or before:

(a) for information submitted under Subsection (2)(a)(i), November 1, 2022; and

(b) for information submitted under Subsection (2)(a)(ii), November 1, 2025.

Section 21. Section **31A-22-701** is amended to read:

31A-22-701. Groups eligible for group or blanket insurance.

[~~(1) As used in this section, "association group" means a lawfully formed association of individuals or business entities that:~~]

[~~(a) purchases insurance on a group basis on behalf of members; and~~]

[~~(b) is formed and maintained in good faith for purposes other than obtaining insurance.~~]

[~~(2)~~] (1) A group [~~accident and health~~] insurance policy for accident and health insurance may be issued to:

(a) a group:

(i) to which a group life insurance policy may be issued under Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-505, 31A-22-506, or 31A-22-507; and

(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;

[~~(b) an association group authorized by the commissioner that:~~]

[~~(i) has been actively in existence for at least five years;~~]

[~~(ii) has a constitution and bylaws;~~]

[~~(iii) has a shared or common purpose that is not primarily a business or customer relationship;~~]

[~~(iv) is formed and maintained in good faith for purposes other than obtaining insurance;~~]

[~~(v) does not condition membership in the association group on any health status-related factor relating to an individual, including an employee of an employer or a dependent of an employee;~~]

[~~(vi) makes accident and health insurance coverage offered through the association group available to all members regardless of any health status-related factor relating to the~~

~~members or individuals eligible for coverage through a member;~~]

[~~(vii) does not make accident and health insurance coverage offered through the association group available other than in connection with a member of the association group; and~~]

[~~(viii) is actuarially sound; or~~]

[~~(c)~~] (b) a group specifically authorized by the commissioner, upon a finding that:

(i) authorization is not contrary to the public interest;

(ii) the group is actuarially sound;

(iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;

(iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups;

(v) the group would not present hazards of adverse selection;

(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and

(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance[~~.~~]; or

(c) a postsecondary educational institution covering students, upon a finding that:

(i) the policy provides standards for financial soundness;

(ii) the policy protects the students covered;

(iii) the policy provides for the establishment of a financially viable alternative to traditional health care plans;

(iv) authorization is not contrary to the public interest;

(v) the policy would not present hazards of adverse selection; and

(vi) the premiums for the policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided.

[~~(3)~~] (2) A blanket insurance policy offering accident and health insurance [~~policy~~]:

(a) covers a defined class of persons;

(b) may not be offered or underwritten on an individual basis;

(c) shall cover only a group that is:

(i) actuarially sound; and

(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and

(d) may be issued only to:

(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;

(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;

(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;

(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;

(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;

(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(vii) a newspaper or other publisher, as policyholder, covering its carriers;

(viii) a labor union, as a policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;

(ix) an association that has a constitution and bylaws covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; or

(x) any other class of risks that, in the judgment of the commissioner, may be properly

eligible for a blanket insurance policy offering accident and health insurance.

[~~(4)~~] (3) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) a class of risks; or

(c) both Subsections [~~(4)~~](3)(a) and (b).

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

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

(1) [~~A policy for~~] A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health [~~coverage issued or renewed after July 1, 1990,~~] insurance shall include a provision that obligates the policyholder:

(a) to give [~~30 days prior~~] written notice of termination to each employee or group member 30 days before the day on which the policy terminates; and

(b) to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination.

(2) (a) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1).

(b) Insurers shall provide a sample notice to the policyholder at least once a year.

Section 23. Section **31A-22-717** is amended to read:

31A-22-717. Provisions pertaining to service members and their families affected by mobilization into the armed forces.

For [~~any~~] a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health [~~coverage~~] insurance, an insurer:

(1) may not refuse to reinstate an insured or [~~his~~] the insured's family whose coverage lapsed due to the insured's mobilization into the United States armed forces provided application is made within 180 days [~~of release~~] after the day on which the insured is released from active duty;

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

(3) may not increase the insured's premium in excess of what [~~it~~] the premium would have been increased to in the normal course of time had the insured not been mobilized into the

United States armed forces.

Section 24. Section **31A-22-1404** is amended to read:

31A-22-1404. Rulemaking authority.

The commissioner may adopt rules that may permit or include:

(1) the increase of benefits over time;

(2) standards for full and fair disclosure of the manner, content, and required disclosures for the sale of long-term care insurance policies;

(3) terms of renewability;

(4) initial and subsequent conditions of eligibility;

(5) nonduplication of coverage provisions;

(6) coverage of dependents;

(7) termination of coverage;

(8) continuation or conversion;

(9) probationary periods;

(10) limitations, exceptions, and reductions of coverage;

(11) preexisting conditions;

(12) elimination and waiting periods;

(13) requirements for replacement;

(14) recurrent conditions;

(15) definition of terms;

(16) loss ratio requirements;

(17) post claim underwriting;

(18) waiver of premium;

(19) independent review of benefit determinations;

[~~(19)~~] (20) inflation protection benefits; and

[~~(20)~~] (21) premium rate filing and review.

Section 25. Section **31A-22-2002** is amended to read:

31A-22-2002. Definitions.

As used in this part:

(1) "Applicant" means:

(a) when referring to an individual limited long-term care insurance policy, the person

who seeks to contract for benefits; and

(b) when referring to a group limited long-term care insurance policy, the proposed certificate holder.

(2) "Elimination period" means the length of time between meeting the eligibility for benefit payment and receiving benefit payments from an insurer.

(3) "Group limited long-term care insurance" means a limited long-term care insurance policy that is delivered or issued for delivery:

(a) in this state; and

(b) to an eligible group, as described under Subsection 31A-22-701(2).

(4) (a) "Limited long-term care insurance" means an insurance[~~: (i)~~] policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage:

[~~(A)~~] (i) for less than 12 consecutive months for each covered person;

[~~(B)~~] (ii) on an expense-incurred, indemnity, prepaid or other basis; and

[~~(C)~~] (iii) for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting other than an acute care unit of a hospital[~~; or~~].

[~~(ii)~~] (b) "Limited long-term care insurance" includes a policy or rider described in Subsection (4)(a) that provides for payment of benefits based on cognitive impairment or the loss of functional capacity.

[~~(b)~~] (c) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide:

(i) basic Medicare supplement coverage;

(ii) basic hospital expense coverage;

(iii) basic medical-surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accidental only coverage;

(viii) specified disease or specified accident coverage; or

(ix) limited benefit health coverage.

(5) "Preexisting condition" means a condition for which medical advice or treatment is

recommended:

(a) by, or received from, a provider of health care services; and

(b) within six months before the day on which the coverage of an insured person becomes effective.

(6) "Waiting period" means the time an insured waits before some or all of the insured's coverage becomes effective.

Section 26. Section **31A-23a-113** is amended to read:

31A-23a-113. License lapse and voluntary surrender.

(1) (a) A license issued under this chapter, including a line of authority, shall lapse if the licensee fails to:

(i) pay when due a fee under Section 31A-3-103;

(ii) complete continuing education requirements under Section 31A-23a-202 before submitting the license renewal application;

(iii) submit a completed renewal application as required by Section 31A-23a-104;

(iv) submit additional documentation required to complete the licensing process as related to a specific license type or line of authority; or

(v) maintain an active license in a licensee's home state if the licensee is a nonresident licensee.

(b) A license that lapses shall expire effective at midnight on the day on which the license expires.

[~~(b)~~] (c) (i) A licensee whose license lapses may request reinstatement of the license and line of authority no more than one year after the day on which the license lapses.

(ii) A licensee whose license lapses due to the following may request an action described in Subsection (1)[~~(b)~~](c)(iii):

(A) military service;

(B) voluntary service for a period of time designated by the person for whom the licensee provides voluntary service; or

(C) some other extenuating circumstances, [~~such as~~] including long-term medical disability.

(iii) A licensee described in Subsection (1)[~~(b)~~](c)(ii) may request:

(A) reinstatement of the license and line of authority no later than one year after the

day on which the license lapses; and

(B) waiver of any of the following imposed for failure to comply with renewal procedures:

(I) an examination requirement;

(II) reinstatement fees set under Section 31A-3-103;

(III) continuing education requirements; or

(IV) other sanction imposed for failure to comply with renewal procedures.

(2) If a license or line of authority issued under this chapter is voluntarily surrendered, the license or line of authority may be reinstated:

(a) during the license period in which the license or line of authority is voluntarily surrendered; and

(b) no later than one year after the day on which the license or line of authority is voluntarily surrendered.

Section 27. Section **31A-23a-201** is amended to read:

31A-23a-201. Exceptions to producer licensing.

(1) The commissioner may not require a license as an insurance producer of:

(a) an officer, director, or employee of an insurer or of an insurance producer if:

(i) the officer, director, or employee does not receive any commission on a policy written or sold to insure risks residing, located, or to be performed in this state; and

(ii) (A) the officer's, director's, or employee's activities are:

(I) executive, administrative, managerial, clerical, or a combination of these activities; and

(II) only indirectly related to the sale, solicitation, or negotiation of insurance;

(B) the officer's, director's, or employee's function relates to:

(I) underwriting;

(II) loss control;

(III) inspection; or

(IV) the processing, adjusting, investigating or settling of a claim on a contract of insurance; or

(C) (I) the officer, director, or employee is acting in the capacity of a special agent or agency supervisor assisting an insurance producer;

(II) the officer's, director's, or employee's activities are limited to providing technical advice and assistance to a licensed insurance producer; and

(III) the officer's, director's, or employee's activities do not include the sale, solicitation, or negotiation of insurance;

(b) a person who:

(i) is paid no commission for the services described in Subsection (1)(b)(ii); and

(ii) secures and furnishes information for the purpose of:

(A) group life insurance;

(B) group property and casualty insurance;

(C) group annuities;

(D) a group insurance policy for accident and health insurance or a blanket insurance policy for accident and health insurance;

(E) enrolling individuals under plans;

(F) issuing certificates under plans; or

(G) otherwise assisting in administering plans;

(c) a person who:

(i) is paid no commission for the services described in Subsection (1)(c)(ii); and

(ii) performs administrative services related to mass marketed property and casualty insurance;

(d) (i) any of the following if the conditions of Subsection (1)(d)(ii) are met:

(A) an employer or association; or

(B) an officer, director, employee, or trustee of an employee trust plan;

(ii) a person listed in Subsection (1)(d)(i):

(A) to the extent that the employer, officer, employee, director, or trustee is engaged in the administration or operation of a program of employee benefits for:

(I) the employer's or association's own employees; or

(II) the employees of a subsidiary or affiliate of an employer or association;

(B) the program involves the use of insurance issued by an insurer; and

(C) the employer, association, officer, director, employee, or trustee is not in any manner compensated, directly or indirectly, by the company issuing the contract;

(e) an employee of an insurer or organization employed by an insurer who:

(i) is engaging in:

(A) the inspection, rating, or classification of risks; or

(B) the supervision of the training of insurance producers; and

(ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;

(f) a person whose activities in this state are limited to advertising:

(i) without the intent to solicit insurance in this state;

(ii) through communications in mass media including:

(A) a printed publication; or

(B) a form of electronic mass media;

(iii) that is distributed to residents outside of the state; and

(iv) if the person does not sell, solicit, or negotiate insurance that would insure risks residing, located, or to be performed in this state;

(g) a person who:

(i) is not a resident of this state;

(ii) sells, solicits, or negotiates a contract of insurance:

(A) for commercial property and casualty risks to an insured with risks located in more than one state insured under that contract; and

(B) insures risks located in a state in which the person is licensed as provided in Subsection (1)(g)(iii); and

(iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in the state where the insured maintains its principal place of business; or

(h) if the employee does not sell, solicit, or receive a commission for a contract of insurance, a salaried full-time employee who counsels or advises the employee's employer relating to the insurance interests of:

(i) the employer; or

(ii) a subsidiary or business affiliate of the employer.

(2) The commissioner may by rule exempt a class of persons from the license requirement of Subsection 31A-23a-103(1) if:

(a) the functions performed by the class of persons does not require:

(i) special competence;

(ii) special trustworthiness; or

(iii) regulatory surveillance made possible by licensing; or

(b) other existing safeguards make regulation unnecessary.

Section 28. Section **31A-23a-406** is amended to read:

31A-23a-406. Title insurance producer's business.

(1) An individual title insurance producer or agency title insurance producer may do escrow involving real property transactions if all of the following exist:

(a) the individual title insurance producer or agency title insurance producer is licensed with:

(i) the title line of authority; and

(ii) the escrow subline of authority;

(b) the individual title insurance producer or agency title insurance producer is appointed by a title insurer authorized to do business in the state;

(c) except as provided in Subsection (3), the individual title insurance producer or agency title insurance producer issues one or more of the following as part of the transaction:

(i) an owner's policy of title insurance;

(ii) a lender's policy of title insurance; or

(iii) if the transaction does not involve a transfer of ownership, an endorsement to an owner's or a lender's policy of title insurance;

(d) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow[~~: (i)~~] is deposited:

[~~(A)~~] (i) in a federally insured [~~financial~~] depository institution, as defined in Section 7-1-103, that:

(A) has an office in this state, if the individual title insurance producer or agency title insurance producer depositing the money is a resident licensee; and

(B) is authorized by the depository institution's primary regulator to engage in trust business, as defined in Section 7-5-1, in this state; and

[~~(B)~~] (ii) in a trust account that is separate from all other trust account money that is not related to real estate transactions;

[~~(ii)~~] (e) money deposited with the individual title insurance producer or agency title insurance producer in connection with any escrow is the property of the one or more persons entitled to the money under the provisions of the escrow; and

[~~(iii)~~] (f) money deposited with the individual title insurance producer or agency title insurance producer in connection with an escrow is segregated escrow by escrow in the records of the individual title insurance producer or agency title insurance producer;

[~~(c)~~] (g) earnings on money held in escrow may be paid out of the escrow account to any person in accordance with the conditions of the escrow;

[~~(f)~~] (h) the escrow does not require the individual title insurance producer or agency title insurance producer to hold:

(i) construction money; or

(ii) money held for exchange under Section 1031, Internal Revenue Code; and

[~~(g)~~] (i) the individual title insurance producer or agency title insurance producer shall maintain a physical office in Utah staffed by a person with an escrow subline of authority who processes the escrow.

(2) Notwithstanding Subsection (1), an individual title insurance producer or agency title insurance producer may engage in the escrow business if:

(a) the escrow involves:

(i) a mobile home;

(ii) a grazing right;

(iii) a water right; or

(iv) other personal property authorized by the commissioner; and

(b) the individual title insurance producer or agency title insurance producer complies with this section except for Subsection (1)(c).

(3) (a) Subsection (1)(c) does not apply if the transaction is for the transfer of real property from the School and Institutional Trust Lands Administration.

(b) This subsection does not prohibit an individual title insurance producer or agency title insurance producer from issuing a policy described in Subsection (1)(c) as part of a transaction described in Subsection (3)(a).

(4) Money held in escrow:

(a) is not subject to any debts of the individual title insurance producer or agency title insurance producer;

(b) may only be used to fulfill the terms of the individual escrow under which the money is accepted; and

(c) may not be used until the conditions of the escrow are met.

(5) Assets or property other than escrow money received by an individual title insurance producer or agency title insurance producer in accordance with an escrow shall be maintained in a manner that will:

(a) reasonably preserve and protect the asset or property from loss, theft, or damages; and

(b) otherwise comply with the general duties and responsibilities of a fiduciary or bailee.

(6) (a) A check from the trust account described in Subsection (1)(d) may not be drawn, executed, or dated, or money otherwise disbursed unless the segregated escrow account from which money is to be disbursed contains a sufficient credit balance consisting of collected and cleared money at the time the check is drawn, executed, or dated, or money is otherwise disbursed.

(b) As used in this Subsection (6), money is considered to be "collected and cleared," and may be disbursed as follows:

(i) cash may be disbursed on the same day the cash is deposited;

(ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

(iii) the proceeds of one or more of the following financial instruments may be disbursed on the same day the financial instruments are deposited if received from a single party to the real estate transaction and if the aggregate of the financial instruments for the real estate transaction is less than $10,000:

(A) a cashier's check, certified check, or official check that is drawn on an existing account at a federally insured financial institution;

(B) a check drawn on the trust account of a principal broker or associate broker licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual title insurance producer or agency title insurance producer has reasonable and prudent grounds to believe sufficient money will be available from the trust account on which the check is drawn at the time of disbursement of proceeds from the individual title insurance producer or agency title insurance producer's escrow account;

(C) a personal check not to exceed $500 per closing; or

(D) a check drawn on the escrow account of another individual title insurance producer

or agency title insurance producer, if the individual title insurance producer or agency title insurance producer in the escrow transaction has reasonable and prudent grounds to believe that sufficient money will be available for withdrawal from the account upon which the check is drawn at the time of disbursement of money from the escrow account of the individual title insurance producer or agency title insurance producer in the escrow transaction.

(c) A check or deposit not described in Subsection (6)(b) may be disbursed:

(i) within the time limits provided under the Expedited Funds Availability Act, 12 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

(ii) upon notification from the financial institution to which the money has been deposited that final settlement has occurred on the deposited financial instrument.

(7) An individual title insurance producer or agency title insurance producer shall maintain a record of a receipt or disbursement of escrow money.

(8) An individual title insurance producer or agency title insurance producer shall comply with:

(a) Section 31A-23a-409;

(b) Title 46, Chapter 1, Notaries Public Reform Act; and

(c) any rules adopted by the Title and Escrow Commission, subject to Section 31A-2-404, that govern escrows.

(9) If an individual title insurance producer or agency title insurance producer conducts a search for real estate located in the state, the individual title insurance producer or agency title insurance producer shall conduct a reasonable search of the public records.

Section 29. Section **31A-23a-409** is amended to read:

31A-23a-409. Trust obligation for money collected.

(1) (a) Subject to Subsection (7), a licensee is a trustee for money that is paid to, received by, or collected by a licensee for forwarding to insurers or to insureds.

(b) (i) Except as provided in Subsection (1)(b)(ii), a licensee may not commingle trust funds with:

(A) the licensee's own money; or

(B) money held in any other capacity.

(ii) This Subsection (1)(b) does not apply to:

(A) amounts necessary to pay bank charges; and

(B) money paid by insureds and belonging in part to the licensee as a fee or commission.

(c) Except as provided under Subsection (4), a licensee owes to insureds and insurers the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds through the licensee.

(d) (i) Unless money is sent to the appropriate payee by the close of the next business day after their receipt, the licensee shall deposit them in an account authorized under Subsection (2).

(ii) Money deposited under this Subsection (1)(d) shall remain in an account authorized under Subsection (2) until sent to the appropriate payee.

(2) Money required to be deposited under Subsection (1) shall be deposited:

(a) in a federally insured trust account in a depository institution, as defined in Section 7-1-103, which:

(i) has an office in this state, if the licensee depositing the money is a resident licensee;

(ii) has federal deposit insurance; and

(iii) is authorized by its primary regulator to engage in the trust business, as defined by Section 7-5-1, in this state; or

(b) in some other account, [~~approved by~~] that:

(i) the commissioner approves by rule or order[~~, providing~~]; and

(ii) provides safety comparable to [~~federally insured trust accounts~~] an account described in Subsection (2)(a).

(3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the amount of the federal insurance on the accounts.

(4) A trust account into which money is deposited may be interest bearing. The interest accrued on the account may be paid to the licensee, so long as the licensee otherwise complies with this section and with the contract with the insurer.

(5) A depository institution or other organization holding trust funds under this section may not offset or impound trust account funds against debts and obligations incurred by the licensee.

(6) A licensee who, not being lawfully entitled to do so, diverts or appropriates any portion of the money held under Subsection (1) to the licensee's own use, is guilty of theft

under Title 76, Chapter 6, Part 4, Theft. Section 76-6-412 applies in determining the classification of the offense. Sanctions under Section 31A-2-308 also apply.

(7) A nonresident licensee:

(a) shall comply with Subsection (1)(a) by complying with the trust account requirements of the nonresident licensee's home state; and

(b) is not required to comply with the other provisions of this section.

Section 30. Section **31A-26-102** is amended to read:

31A-26-102. Definitions.

As used in this chapter, unless expressly provided otherwise:

(1) "Company adjuster" means a person employed by an insurer[~~, or an entity under common control or ownership with the insurer,~~] who negotiates or settles claims on behalf of the [~~employer~~] insurer or an affiliated insurer.

(2) "Designated home state" means the state or territory of the United States or the District of Columbia:

(a) in which an insurance adjuster does not maintain the adjuster's principal:

(i) place of residence; or

(ii) place of business;

(b) if the resident state, territory, or District of Columbia of the adjuster does not license adjusters for the line of authority sought, the adjuster has qualified for the license as if the person were a resident in the state, territory, or District of Columbia described in Subsection (2)(a), including an applicable:

(i) examination requirement;

(ii) fingerprint background check requirement; and

(iii) continuing education requirement; and

(c) that the adjuster has designated [~~the state, territory, or District of Columbia~~] as the insurance adjuster's designated home state.

(3) "Home state" means:

(a) a state or territory of the United States or the District of Columbia in which an insurance adjuster:

(i) maintains the adjuster's principal:

(A) place of residence; or

(B) place of business; and

(ii) is licensed to act as a resident adjuster; or

(b) if the resident state, territory, or the District of Columbia described in Subsection (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District of Columbia:

(i) in which the adjuster is licensed;

(ii) in which the adjuster is in good standing; and

(iii) that the adjuster has designated as the adjuster's designated home state.

(4) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of one or more insurers.

(5) "Insurance adjusting" or "adjusting" means directing or conducting the investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

(6) (a) "Organization" means a person other than a natural person[~~, and~~].

(b) "Organization" includes a sole proprietorship by which a natural person does business under an assumed name.

(7) "Portable electronics insurance" [~~is as~~] means the same as that term is defined in Section 31A-22-1802.

(8) "Public adjuster" means a person required to be licensed under Section 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants under insurance policies.

Section 31. Section **31A-28-103** is amended to read:

31A-28-103. Coverage and limitations.

(1) This part provides coverage for a policy or contract specified in Subsections (6) and (7) to a person who is:

(a) except for a nonresident certificate holder under a group policy or contract, a beneficiary, assignee, or payee of a person covered by Subsection (1)(b), including a health care provider rendering services covered under an accident and health insurance policy or certificate, regardless of where that person resides; or

(b) an owner of or a certificate holder or enrollee under a policy or contract, other than

an unallocated annuity contract or structured settlement annuity, if the owner, enrollee, or certificate holder is:

(i) a resident of Utah; or

(ii) not a resident of Utah, but only if:

(A) the member insurer that issued the policy or contract is domiciled in this state;

(B) the state in which the person resides has an association similar to the association created by this part; and

(C) the person is not eligible for coverage by an association in any other state because the insurer was not licensed in the other states at the time specified in the other states' guaranty association's laws.

(2) For an unallocated annuity contract specified in Subsections (6) and (7):

(a) Subsection (1) does not apply; and

(b) except as provided in Subsections (4) and (5), this part provides coverage for the unallocated annuity contract specified in Subsection (2) to a person who is:

(i) the owner of the unallocated annuity contract if the contract is issued to or in connection with a specific benefit plan whose plan sponsor has its principal place of business in this state; or

(ii) an owner of an unallocated annuity contract issued to or in connection with a government lottery if the owner is a resident.

(3) For a structured settlement annuity specified in Subsections (6) and (7):

(a) Subsection (1) does not apply; and

(b) except as provided in Subsections (4) and (5), this part provides coverage for the structured settlement annuity specified in Subsections (6) and (7) to a person who is a payee under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the payee:

(i) is a resident, regardless of where the contract owner resides;

(ii) is not a resident, but only if one or more of the contract owners of the structured settlement annuity is a resident, and the payee, beneficiary, or contract owner is not eligible for coverage by the association of the state in which the payee or contract owner resides; or

(iii) is not a resident, but only if:

(A) no contract owner of the structured settlement annuity is a resident;

(B) the insurer that issued the structured settlement annuity is domiciled in this state;

(C) the state in which the contract owner resides has an association similar to the association created by this part; and

(D) the payee, beneficiary, or the contract owner is not eligible for coverage by the association of the state in which the payee or contract owner resides.

(4) This part may not provide coverage for a policy or contract specified in Subsections (6) and (7) to a person who:

(a) is a payee or beneficiary of a contract owner resident of this state, if the payee or beneficiary is afforded any coverage by the association of another state;

(b) is covered under Subsection (2), if any coverage is provided to the person by the association of another state; or

(c) acquires rights to receive payments through a structured settlement factoring transaction, regardless of whether the transaction occurred before or after 26 U.S.C. Sec. 5891(c)(3)(A) became effective.

(5) (a) This part provides coverage for a policy or contract specified in Subsections (6) and (7) to a person who is a resident of this state and, in special circumstances, to a nonresident.

(b) To avoid duplicate coverage, if a person who would otherwise receive coverage under this part is provided coverage under the laws of any other state, the person may not be provided coverage under this part.

(c) In determining the application of this Subsection (5) when a person could be covered by the association of more than one state, whether as an owner, payee, enrollee, beneficiary, or assignee, this part shall be construed in conjunction with other state laws to result in coverage by only one association.

(6) (a) Except as limited by this part, this part provides coverage to a person specified in Subsections (1) through (5) for:

(i) a direct nongroup life insurance, direct accident and health insurance, or direct annuity policy or contract;

(ii) a supplemental contract to a policy or contract described in Subsection (6)(a)(i);

(iii) a certificate under a direct group policy or contract; and

(iv) an unallocated annuity contract issued by a member insurer.

(b) For purposes of Subsection (6)(a), an annuity contract and a certificate under a group annuity contract includes:

(i) a guaranteed investment contract;

(ii) a deposit administration contract;

(iii) an unallocated funding agreement;

(iv) an allocated funding agreement;

(v) a structured settlement annuity;

(vi) an annuity issued to or in connection with a government lottery; and

(vii) an immediate or deferred annuity contract.

(7) This part does not provide coverage for:

(a) a portion of a policy or contract:

(i) not guaranteed by the member insurer; or

(ii) under which the risk is borne by the policy or contract owner;

(b) a policy or contract of reinsurance, unless:

(i) an assumption certificate is issued before the coverage date;

(ii) the assumption certificate required by Subsection (7)(b)(i) is in effect pursuant to the reinsurance policy or contract; and

(iii) the reinsurance contract is approved by the appropriate regulatory authorities;

(c) except as provided in Subsection (11)(e), a portion of a policy or contract to the extent that the rate of interest on which the policy or contract is based, or the interest rate, crediting rate, or similar factor determined by use of an index or other external reference stated in the policy or contract employed in calculating returns or changes in value exceeds:

(i) a rate of interest determined by subtracting two percentage points from Moody's Corporate Bond Yield Average averaged:

(A) over the period of four years before the coverage date with respect to the policy or contract; or

(B) for the corresponding lesser period if the policy or contract was issued less than four years before the association became obligated; or

(ii) a rate of interest determined by subtracting three percentage points from Moody's Corporate Bond Yield Average as most recently available as determined on or after the earlier of:

(A) the day on which the member insurer becomes an impaired insurer; or

(B) the day on which the member insurer becomes an insolvent insurer;

(d) a portion of a policy or contract issued to a plan or program of an employer, association, or other person to provide life, accident and health, or annuity benefits to its employees, members, or others, to the extent that the plan or program is self-funded or uninsured, including benefits payable by an employer, association, or other person under:

(i) a multiple employer welfare arrangement, as that term is defined in 29 U.S.C. Sec. 1002;

(ii) a minimum premium group insurance plan;

(iii) a stop-loss group insurance plan; or

(iv) an administrative services only contract;

(e) a portion of a policy or contract to the extent that it provides:

(i) a dividend;

(ii) an experience rating credit;

(iii) voting rights; or

(iv) payment of a fee or allowance to any person, including the policy or contract owner, in connection with the service to or administration of the policy or contract;

(f) an unallocated annuity contract issued to or in connection with a benefit plan protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with respect to the benefit plan;

(g) a portion of an unallocated annuity contract that is not issued to or in connection with:

(i) a specific benefit plan of:

(A) employees;

(B) a union; or

(C) an association of natural persons; or

(ii) a government lottery;

(h) a portion of a policy or contract to the extent that the assessment required by Section 31A-28-109 that applies to the policy or contract is preempted by federal or state law;

(i) an obligation that does not arise under the express written terms of the policy or

contract issued by a member insurer to the enrollee, certificate holder, contract owner, or policy owner, including:

(i) a claim based on marketing materials;

(ii) a claim based on a side letter, rider, or other document that is issued by the member insurer without meeting applicable policy or contract form filing or approval requirements;

(iii) a misrepresentation regarding a policy or contract benefit;

(iv) an extra-contractual claim;

(v) a claim for penalties; or

(vi) a claim for consequential or incidental damages;

(j) a contract that establishes the member insurer's obligations to provide a book value accounting guaranty for defined contribution benefit plan participants by reference to a portfolio of assets that is owned by a person that is:

(i) (A) the benefit plan; or

(B) the benefit plan's trustee; and

(ii) not an affiliate of the member insurer;

(k) a portion of a policy or contract to the extent it provides for interest or other changes in value:

(i) to be determined by the use of an index or other external reference stated in the policy or contract; and

(ii) as of the date the member insurer becomes an impaired or insolvent insurer, whichever occurs earlier:

(A) that have not been credited to the policy or contract; or

(B) as to which the policy or contract owner's rights are subject to forfeiture;

(l) a policy or contract providing hospital, medical, prescription drug, or other health care benefit pursuant to:

(i) Part C or D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.; [~~or~~]

(ii) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq.; or

(iii) Title XXI of the Social Security Act, 42 U.S.C. Sec. 1397aa et seq.; or

(m) a structured settlement annuity benefit to which a payee or beneficiary has transferred the payee or beneficiary's rights in a structured settlement factoring transaction, regardless of whether the transaction occurred before or after 26 U.S.C. Sec. 5891(c)(3)(A)

became effective.

(8) The benefits for which the association may become liable may not exceed the lesser of:

(a) the contractual obligations for which the member insurer is liable or would have been liable if it were not an impaired or insolvent insurer;

(b) with respect to one life, regardless of the number of policies or contracts:

(i) for a life insurance policy:

(A) if the insured died before the coverage date, $500,000 of the death benefit;

(B) if the insurer received a valid request for cash surrender before the coverage date but has not paid the cash surrender value before the coverage date, $200,000 of cash surrender benefits; or

(C) if neither Subsection (8)(b)(i)(A) nor (B) applies, the covered portion of each benefit provided under the policy;

(ii) for an annuity contract, the covered portion of each benefit provided under the contract; and

(iii) for an accident and health insurance policy or contract:

(A) classified as a health benefit plan, $500,000; or

(B) not classified as a health benefit plan, the covered portion of each benefit provided under the policy;

(c) for an individual participating in a governmental retirement plan established under Section 401, 403(b), or 457, Internal Revenue Code, covered by an unallocated annuity contract, or a beneficiary of that individual if the individual is deceased, $250,000 in present value of annuity benefits, in the aggregate, including:

(i) net cash surrender; and

(ii) net cash withdrawal values; or

(d) for a payee of a structured settlement annuity or a beneficiary of the payee if the payee is deceased, the limits set forth in Subsection (8)(b).

(9) Notwithstanding Subsection (8), the association may not be obligated to cover more than:

(a) an aggregate of $500,000 in benefits for any one life under:

(i) Subsection (8)(b)(i)(A);

(ii) Subsection (8)(b)(i)(B);

(iii) Subsection (8)(b)(ii); and

(iv) Subsection (8)(b)(iii)(B);

(b) $5,000,000 in benefits for one owner of multiple nongroup policies of life insurance:

(i) whether the policy or contract owner is an individual, firm, corporation, or other person;

(ii) whether the persons insured are officers, managers, employees, or other persons; and

(iii) regardless of the number of policies and contracts held by the owner; and

(c) $5,000,000 in benefits, regardless of the number of contracts held by the contract owner or plan sponsor, for:

(i) one contract owner provided coverage under Subsection (2)(b)(ii); or

(ii) one plan sponsor whose plans own, directly or in trust, one or more unallocated annuity contracts not included in Subsection (8)(b)(ii).

(10) (a) Notwithstanding Subsection (9)(c) and except as provided in Subsection (10)(b), the association shall provide coverage if one or more unallocated annuity contracts are:

(i) covered contracts under this part;

(ii) owned by a trust or other entity for the benefit of two or more plan sponsors; and

(iii) the largest interest in the trust or entity owning the contract or contracts is held by a plan sponsor whose principal place of business is in the state.

(b) The association may not be obligated to cover more than $5,000,000 in benefits with respect to the unallocated contracts described in Subsection (10)(a).

(11) (a) The limitations set forth in Subsections (8) and (9) are limitations on the benefits for which the association is obligated before taking into account:

(i) the association's subrogation and assignment rights; or

(ii) the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer attributable to covered policies.

(b) The costs of the association's obligations under this part may be met by the use of assets:

(i) attributable to covered policies, as described in Subsection 31A-28-114(3)(c); or

(ii) reimbursed to the association pursuant to the association's subrogation and assignment rights.

(c) Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which the long-term care rider relates.

(d) In performing [~~its~~] the association's obligations to provide coverage under Section 31A-28-108, the association may not be required to guarantee, assume, reinsure, reissue, perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed a contractual obligation of the insolvent or impaired insurer under a covered policy or contract that does not materially affect the economic values or economic benefits of the covered policy or contract.

(e) The exclusion from coverage described in Subsection (7)(c) does not apply to any portion of a policy or contract, including a rider, that provides long-term care or any other accident and health insurance benefit.

Section 32. Section **31A-35-404** is amended to read:

31A-35-404. Minimum financial requirements for bail bond agency license.

(1) (a) A bail bond agency that pledges the assets of a letter of credit from a Utah depository institution in connection with a judicial proceeding shall maintain an irrevocable letter of credit with a minimum face value of $300,000 assigned to the state from a Utah depository institution.

(b) Notwithstanding Subsection (1)(a), a bail bond agency described in Subsection (1)(a) that is licensed under this chapter [~~as of~~] on or before December 31, 1999, shall maintain an irrevocable letter of credit with a minimum face value of $250,000 assigned to the state from a Utah depository institution.

(2) (a) A bail bond agency that pledges personal or real property, or both, as security for a bail bond in connection with a judicial proceeding shall maintain[~~: (i) (A)~~] a verified financial statement for the current year:

[~~(I)~~] (i) reviewed by a certified public accountant; and

[~~(II)~~] (ii) showing a minimum net worth of [~~at least~~]:

(A) $300,000, at least $100,000 of which is in liquid assets; or

(B) if the bail bond agency is licensed under this chapter on or before December 31, 1999, $250,000, at least $50,000 of which is in liquid assets.

[~~(B) notwithstanding Subsection (2)(a)(i), if the bail bond agency is licensed under this chapter as of December 31, 1999, a current financial statement:~~]

[~~(I) reviewed by a certified public accountant; and~~]

[~~(II) showing a net worth of at least $250,000, at least $50,000 of which is in liquid assets;~~]

[~~(ii) a copy of the applicant's federal and state income tax returns for the preceding two years, but only for an original application; and~~]

[~~(iii) for each parcel of real property owned by the applicant and included in net worth calculations:~~]

[~~(A) a title letter or report, or a current abstract of title from the office of the county recorder; and~~]

[~~(B) (I) a certified appraisal made not more than six months prior to licensure for each parcel and a title report that is current as of the date of licensure, if the bail bond agency is in its first year of licensure and has pledged real property owned by the applicant; or~~]

[~~(II) a certified appraisal report or a current tax notice and a title letter or report, or a current abstract of title from the county recorder if the bail bond agency is in its second or subsequent year of licensure and has pledged real property owned by the applicant.~~]

(b) For purposes of this Subsection (2), only real or personal property located in Utah may be included in the net worth of the bail bond agency.

(3) A bail bond agency shall maintain a qualifying power of attorney issued by a surety insurer if:

(a) the bail bond agency is the agent of the surety insurer; and

(b) the surety insurer:

(i) sells bail bonds;

(ii) is in good standing in its state of domicile; and

(iii) is granted a certificate to write bail bonds in Utah.

(4) The commissioner may revoke the license of a bail bond agency that fails to maintain the minimum financial requirements required under this section.

(5) The commissioner may set by rule the limits on the aggregate amounts of bail bonds issued by a bail bond agency.

Section 33. Section **31A-35-406** is amended to read:

31A-35-406. Initial licensing, license renewal, and license reinstatement.

(1) An applicant for an initial bail bond agency license shall:

(a) complete and submit to the department an application;

(b) submit to the department, as applicable, a copy of the applicant's:

(i) irrevocable letter of credit, as required under Subsection 31A-35-404(1);

(ii) verified financial statement, as required under Subsection 31A-35-404(2); or

(iii) qualifying power of attorney, as required under Subsection 31A-35-404(3); and

(c) pay the department the applicable renewal fee established in accordance with Section 31A-3-103.

[~~(1)~~] (2) (a) A license under this chapter expires annually effective at midnight on August 14.

(b) To renew [~~its~~] a bail bond agency license issued under this chapter, on or before July 15, [~~a~~] the bail bond agency shall:

(i) complete and submit to the department a renewal application [~~to the department;~~] that includes certification that:

[~~(ii) require that a principal of the agency attends at least one board meeting each year; and~~]

(A) a principal of the agency attended or participated by telephone in at least one entire board meeting during the 12-month period before July 15; and

(B) as of May 1, the agency complies with aggregate bond limits established by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(ii) submit to the department, as applicable, a copy of the applicant's:

(A) irrevocable letter of credit, as required under Subsection 31A-35-404(1);

(B) verified financial statement, as required under Subsection 31A-35-404(2); or

(C) qualifying power of attorney, as required under Subsection 31A-35-404(3); and

(iii) pay the department the applicable renewal fee established in accordance with Section 31A-3-103.

[~~(b)~~] (c) A bail bond agency shall renew [~~its~~] the bail bond agency's license under this chapter annually as established by department rule, regardless of when the license is issued.

[~~(2)~~] (3) (a) A bail bond agency may apply for reinstatement of an expired bail bond agency license within one year [~~following the expiration of the license under Subsection (1)~~

~~by:~~] after the day on which the license expires by complying with the renewal requirements described in Subsection (2).

[~~(a) submitting the renewal application required by Subsection (1); and~~]

[~~(b) paying a license reinstatement fee established in accordance with Section 31A-3-103.~~]

[~~(3)~~] (b) If a bail bond agency license has been expired for more than one year, the person applying for reinstatement of the bail bond agency license shall[~~:~~] comply with the initial licensing requirements described in Subsection (1).

[~~(a) submit a new application form to the commissioner; and~~]

[~~(b) pay the application fee established in accordance with Section 31A-3-103.~~]

(4) If a bail bond agency license is suspended, the applicant may not submit an application for a bail bond agency license until after [~~the end of~~] the day on which the period of suspension ends.

(5) [~~A~~] The department shall deposit a fee collected under this section [~~shall be deposited~~] in the restricted account created in Section 31A-35-407.

Section 34. Section **31A-37-102** is amended to read:

31A-37-102. Definitions.

As used in this chapter:

(1) (a) "Affiliated company" means a business entity that because of common ownership, control, operation, or management is in the same corporate or limited liability company system as:

(i) a parent;

(ii) an industrial insured; or

(iii) a member organization.

(b) [~~Notwithstanding Subsection (1)(a), the commissioner may issue~~] "Affiliated company" does not include a business entity for which the commissioner issues an order finding that [~~a~~] the business entity is not an affiliated company.

(2) "Alien captive insurance company" means an insurer:

(a) formed to write insurance business for a parent or affiliate of the insurer; and

(b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes statutory or regulatory standards:

(i) on a business entity transacting the business of insurance in the alien or foreign jurisdiction; and

(ii) in a form acceptable to the commissioner.

(3) "Applicant captive insurance company" means an entity that has submitted an application for a certificate of authority for a captive insurance company, unless the application has been denied or withdrawn.

(4) "Association" means a legal association of two or more persons that has been in continuous existence for at least one year if:

(a) the association or its member organizations:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an association captive insurance company incorporated as a stock insurer; or

(ii) have complete voting control over an association captive insurance company incorporated as a mutual insurer;

(b) the association's member organizations collectively constitute all of the subscribers of an association captive insurance company formed as a reciprocal insurer; or

(c) the association or [~~its~~] the association's member organizations have complete voting control over an association captive insurance company formed as a limited liability company.

(5) "Association captive insurance company" means a business entity that insures risks of:

(a) a member organization of the association;

(b) an affiliate of a member organization of the association; and

(c) the association.

(6) "Branch business" means an insurance business transacted by a branch captive insurance company in this state.

(7) "Branch captive insurance company" means an alien captive insurance company that has a certificate of authority from the commissioner to transact the business of insurance in this state through a captive insurance company that is domiciled outside of this state.

(8) "Branch operation" means a business operation of a branch captive insurance company in this state.

(9) (a) "Captive insurance company" means the same as that term is defined in Section 31A-1-301.

(b) "Captive insurance company" includes any of the following formed or holding a certificate of authority under this chapter:

[~~(a)~~] (i) a branch captive insurance company;

[~~(b)~~] (ii) a pure captive insurance company;

[~~(c)~~] (iii) an association captive insurance company;

[~~(d)~~] (iv) a sponsored captive insurance company;

[~~(e)~~] (v) an industrial insured captive insurance company, including an industrial insured captive insurance company formed as a risk retention group captive in this state pursuant to the provisions of the Federal Liability Risk Retention Act of 1986;

[~~(f)~~] (vi) a special purpose captive insurance company; or

[~~(g)~~] (vii) a special purpose financial captive insurance company.

(10) "Commissioner" means Utah's Insurance Commissioner or the commissioner's designee.

(11) "Common ownership and control" means that two or more captive insurance companies are owned or controlled by the same person or group of persons as follows:

(a) in the case of a captive insurance company that is a stock corporation, the direct or indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;

(b) in the case of a captive insurance company that is a mutual corporation, the direct or indirect ownership of 80% or more of the surplus and the voting power of the mutual corporation;

(c) in the case of a captive insurance company that is a limited liability company, the direct or indirect ownership by the same member or members of 80% or more of the membership interests in the limited liability company; or

(d) in the case of a sponsored captive insurance company, a protected cell is a separate captive insurance company owned and controlled by the protected cell's participant, only if:

(i) the participant is the only participant with respect to the protected cell; and

(ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored captive insurance company through common ownership and control.

(12) "Consolidated debt to total capital ratio" means the ratio of Subsection (12)(a) to (b).

(a) This Subsection (12)(a) is an amount equal to the sum of all debts and hybrid

capital instruments including:

(i) all borrowings from depository institutions;

(ii) all senior debt;

(iii) all subordinated debts;

(iv) all trust preferred shares; and

(v) all other hybrid capital instruments that are not included in the determination of consolidated GAAP net worth issued and outstanding.

(b) This Subsection (12)(b) is an amount equal to the sum of:

(i) total capital consisting of all debts and hybrid capital instruments as described in Subsection (12)(a); and

(ii) shareholders' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(13) "Consolidated GAAP net worth" means the consolidated shareholders' or members' equity determined in accordance with generally accepted accounting principles for reporting to the United States Securities and Exchange Commission.

(14) "Controlled unaffiliated business" means a business entity:

(a) (i) in the case of a pure captive insurance company, that is not in the corporate or limited liability company system of a parent or the parent's affiliate; or

(ii) in the case of an industrial insured captive insurance company, that is not in the corporate or limited liability company system of an industrial insured or an affiliated company of the industrial insured;

(b) (i) in the case of a pure captive insurance company, that has a contractual relationship with a parent or affiliate; or

(ii) in the case of an industrial insured captive insurance company, that has a contractual relationship with an industrial insured or an affiliated company of the industrial insured; and

(c) whose risks that are or will be insured by a pure captive insurance company, an industrial insured captive insurance company, or both, are managed in accordance with Subsection 31A-37-106(1)(j) by:

(i) (A) a pure captive insurance company; or

(B) an industrial insured captive insurance company; or

(ii) a parent or affiliate of:

(A) a pure captive insurance company; or

(B) an industrial insured captive insurance company.

(15) "Criminal act" means an act for which a person receives a verdict or finding of guilt after a criminal trial or a plea of guilty or nolo contendere to a criminal charge.

[~~(15)~~] (16) "Establisher" means a person who establishes a business entity or a trust.

[~~(16)~~] (17) "Governing body" means the persons who hold the ultimate authority to direct and manage the affairs of an entity.

[~~(17)~~] (18) "Industrial insured" means an insured:

(a) that produces insurance:

(i) by the services of a full-time employee acting as a risk manager or insurance manager; or

(ii) using the services of a regularly and continuously qualified insurance consultant;

(b) whose aggregate annual premiums for insurance on all risks total at least $25,000; and

(c) that has at least 25 full-time employees.

[~~(18)~~] (19) "Industrial insured captive insurance company" means a business entity that:

(a) insures risks of the industrial insureds that comprise the industrial insured group; and

(b) may insure the risks of:

(i) an affiliated company of an industrial insured; or

(ii) a controlled unaffiliated business of:

(A) an industrial insured; or

(B) an affiliated company of an industrial insured.

[~~(19)~~] (20) "Industrial insured group" means:

(a) a group of industrial insureds that collectively:

(i) own, control, or hold with power to vote all of the outstanding voting securities of an industrial insured captive insurance company incorporated or organized as a limited liability company as a stock insurer; or

(ii) have complete voting control over an industrial insured captive insurance company

incorporated or organized as a limited liability company as a mutual insurer;

(b) a group that is:

(i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901 et seq., as amended, as a corporation or other limited liability association; and

(ii) taxable under this title as a:

(A) stock corporation; or

(B) mutual insurer; or

(c) a group that has complete voting control over an industrial captive insurance company formed as a limited liability company.

[~~(20)~~] (21) "Member organization" means a person that belongs to an association.

[~~(21)~~] (22) "Parent" means a person that directly or indirectly owns, controls, or holds with power to vote more than 50% of the outstanding securities of an organization.

[~~(22)~~] (23) "Participant" means an entity that is insured by a sponsored captive insurance company:

(a) if the losses of the participant are limited through a participant contract to the assets of a protected cell; and

(b) (i) the entity is permitted to be a participant under Section 31A-37-403; or

(ii) the entity is an affiliate of an entity permitted to be a participant under Section 31A-37-403.

[~~(23)~~] (24) "Participant contract" means a contract by which a sponsored captive insurance company:

(a) insures the risks of a participant; and

(b) limits the losses of the participant to the assets of a protected cell.

[~~(24)~~] (25) "Protected cell" means a separate account established and maintained by a sponsored captive insurance company for one participant.

[~~(25)~~] (26) "Pure captive insurance company" means a business entity that insures risks of a parent or affiliate of the business entity.

[~~(26)~~] (27) "Special purpose financial captive insurance company" [~~is as~~] means the same as that term is defined in Section 31A-37a-102.

[~~(27)~~] (28) "Sponsor" means an entity that:

(a) meets the requirements of Section 31A-37-402; and

(b) is approved by the commissioner to:

(i) provide all or part of the capital and surplus required by applicable law in an amount of not less than $350,000, which amount the commissioner may increase by order if the commissioner considers it necessary; and

(ii) organize and operate a sponsored captive insurance company.

[~~(28)~~] (29) "Sponsored captive insurance company" means a captive insurance company:

(a) in which the minimum capital and surplus required by applicable law is provided by one or more sponsors;

(b) that is formed or holding a certificate of authority under this chapter;

(c) that insures the risks of a separate participant through the contract; and

(d) that segregates each participant's liability through one or more protected cells.

[~~(29)~~] (30) "Treasury rates" means the United States Treasury strip asked yield as published in the Wall Street Journal as of a balance sheet date.

Section 35. Section **31A-37-202** is amended to read:

31A-37-202. Permissive areas of insurance.

(1) Except as provided in Subsections (2) and (3), a captive insurance company may not directly insure a risk other than the risk of the captive insurance company's parent or affiliated company.

(2) In addition to the risks described in Subsection (1), an association captive insurance company may insure the risk of:

(a) a member organization of the association captive insurance company's association; or

(b) an affiliate of a member organization of the association captive insurance company's association.

(3) The following may insure a risk of a controlled unaffiliated business:

(a) an industrial insured captive insurance company;

(b) a protected cell;

(c) a pure captive insurance company; or

(d) a sponsored captive insurance company.

(4) To the extent allowed by a captive insurance company's organizational charter, a

captive insurance company may provide any type of insurance described in this title, except:

(a) workers' compensation insurance;

(b) personal motor vehicle insurance;

(c) homeowners' insurance; and

(d) any component of the types of insurance described in Subsections (4)(a) through (c).

(5) A captive insurance company may not provide coverage for:

(a) a wager or gaming risk;

(b) loss of an election; or

(c) the penal consequences of a crime[~~; or~~].

[~~(d) punitive damages.~~]

(6) Unless the punitive damages award arises out of a criminal act of an insured, a captive insurance company may provide coverage for punitive damages awarded, including through adjudication or compromise, against the captive insurance company's:

(a) parent;

(b) affiliated company; or

(c) controlled unaffiliated business.

[~~(6)~~] (7) Notwithstanding Subsection (4), if approved by the commissioner, a captive insurance company may insure as a reimbursement a limited layer or deductible of workers' compensation coverage.

Section 36. Section **31A-37-204** is amended to read:

31A-37-204. Paid-in capital -- Other capital.

(1) (a) The commissioner may not issue a certificate of authority to a company described in Subsection (1)(c) unless the company possesses and thereafter maintains unimpaired paid-in capital and unimpaired paid-in surplus of:

(i) in the case of a pure captive insurance company, not less than $250,000;

(ii) in the case of an association captive insurance company, not less than $750,000;

(iii) in the case of an industrial insured captive insurance company incorporated as a stock insurer, not less than $700,000;

(iv) in the case of a sponsored captive insurance company, not less than [~~$1,000,000~~] $500,000, of which a minimum of [~~$350,000~~] $200,000 is provided by the sponsor; or

(v) in the case of a special purpose captive insurance company, an amount determined by the commissioner after giving due consideration to the company's business plan, feasibility study, and pro-formas, including the nature of the risks to be insured.

(b) The paid-in capital and surplus required under this Subsection (1) may be in the form of:

(i) (A) cash; or

(B) cash equivalent;

(ii) an irrevocable letter of credit:

(A) issued by:

(I) a bank chartered by this state; or

(II) a member bank of the Federal Reserve System; and

(B) approved by the commissioner;

(iii) marketable securities as determined by Subsection (5); or

(iv) some other thing of value approved by the commissioner, for a period not to exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant to an approved plan of liquidation and reorganization of another captive insurance company or alien captive insurance company in another jurisdiction.

(c) This Subsection (1) applies to:

(i) a pure captive insurance company;

(ii) a sponsored captive insurance company;

(iii) a special purpose captive insurance company;

(iv) an association captive insurance company; or

(v) an industrial insured captive insurance company.

(2) (a) The commissioner may, under Section 31A-37-106, prescribe additional capital based on the type, volume, and nature of insurance business transacted.

(b) The capital prescribed by the commissioner under this Subsection (2) may be in the form of:

(i) cash;

(ii) an irrevocable letter of credit issued by:

(A) a bank chartered by this state; or

(B) a member bank of the Federal Reserve System; or

(iii) marketable securities as determined by Subsection (5).

(3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as security for the payment of liabilities attributable to branch operations, shall, through its branch operations, establish and maintain a trust fund:

(i) funded by an irrevocable letter of credit or other acceptable asset; and

(ii) in the United States for the benefit of:

(A) United States policyholders; and

(B) United States ceding insurers under:

(I) insurance policies issued; or

(II) reinsurance contracts issued or assumed.

(b) The amount of the security required under this Subsection (3) shall be no less than:

(i) the capital and surplus required by this chapter; and

(ii) the reserves on the insurance policies or reinsurance contracts, including:

(A) reserves for losses;

(B) allocated loss adjustment expenses;

(C) incurred but not reported losses; and

(D) unearned premiums with regard to business written through branch operations.

(c) Notwithstanding the other provisions of this Subsection (3):

(i) the commissioner may permit a branch captive insurance company that is required to post security for loss reserves on branch business by its reinsurer to reduce the funds in the trust account required by this section by the same amount as the security posted if the security remains posted with the reinsurer; and

(ii) a branch captive insurance company that is the result of the licensure of an alien captive insurance company that is not formed in an alien jurisdiction is not subject to the requirements of this Subsection (3).

(4) (a) A captive insurance company may not pay the following without the prior approval of the commissioner:

(i) a dividend out of capital or surplus in excess of the limits under Section 16-10a-640; or

(ii) a distribution with respect to capital or surplus in excess of the limits under Section 16-10a-640.

(b) The commissioner shall condition approval of an ongoing plan for the payment of dividends or other distributions on the retention, at the time of each payment, of capital or surplus in excess of:

(i) amounts specified by the commissioner under Section 31A-37-106; or

(ii) determined in accordance with formulas approved by the commissioner under Section 31A-37-106.

(5) For purposes of this section, marketable securities means:

(a) a bond or other evidence of indebtedness of a governmental unit in the United States or Canada or any instrumentality of the United States or Canada; or

(b) securities:

(i) traded on one or more of the following exchanges in the United States:

(A) New York;

(B) American; or

(C) NASDAQ;

(ii) when no particular security, or a substantially related security, applied toward the required minimum capital and surplus requirement of Subsection (1) represents more than 50% of the minimum capital and surplus requirement; and

(iii) when no group of up to four particular securities, consolidating substantially related securities, applied toward the required minimum capital and surplus requirement of Subsection (1) represents more than 90% of the minimum capital and surplus requirement.

(6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive insurance company, the commissioner may reject the application of specific assets or amounts of specific assets to satisfying the requirement of Subsection (1).

Section 37. Section **31A-37-303** is amended to read:

31A-37-303. Reinsurance.

(1) (a) A captive insurance company may cede risks to any insurance company approved by the commissioner.

(b) [~~A~~] Except as provided in Subsection (1)(c), a captive insurance company may provide reinsurance[~~, as authorized in this title,~~] on risks ceded by any other insurer with prior approval of the commissioner.

(c) A captive insurance company may not provide reinsurance on a punitive damages

risk ceded by an insurer, unless the punitive damages risk is the risk of the captive insurance company's:

(i) parent;

(ii) affiliated company; or

(iii) controlled unaffiliated business.

(2) (a) A captive insurance company may take credit for reserves on risks or portions of risks ceded to reinsurers if the captive insurance company complies with:

(i) Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4; or [~~if the captive insurance company complies with~~]

(ii) other requirements as the commissioner may establish by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a)(ii), a captive insurance company may not take credit for:

(i) reserves on risks ceded to a reinsurer; or

(ii) portions of risks ceded to a reinsurer.

Section 38. Section **31A-37-701** is amended to read:

31A-37-701. Certificate of dormancy.

(1) In accordance with the provisions of this section, a captive insurance company, other than a risk retention group, may apply, without fee, to the commissioner for a certificate of dormancy.

(2) (a) A captive insurance company, other than a risk retention group, is eligible for a certificate of dormancy if the captive insurance company:

(i) has ceased transacting the business of insurance, including the issuance of insurance policies; and

(ii) has no remaining insurance liabilities or obligations associated with insurance business transactions or insurance policies.

(b) For purposes of Subsection (2)(a)(ii), the commissioner may disregard liabilities or obligations for which the captive insurance company has withheld sufficient funds or that are otherwise sufficiently secured.

(3) Except as provided in Subsection [~~(5)~~] (4), a captive insurance company that holds

a certificate of dormancy is subject to all requirements of this chapter.

(4) A captive insurance company that holds a certificate of dormancy:

(a) shall possess and maintain unimpaired paid-in capital and unimpaired paid-in surplus of:

(i) in the case of a pure captive insurance company or a special purpose captive insurance company, not less than $25,000;

(ii) in the case of an association captive insurance company, not less than $75,000; or

(iii) in the case of a sponsored captive insurance company, not less than [~~$100,000~~] $50,000, of which the sponsor provides at least [~~$35,000 is provided by the sponsor~~] $20,000; and

(b) is not required to:

(i) subject to Subsection (5), submit an annual audit or statement of actuarial opinion;

(ii) maintain an active agreement with an independent auditor or actuary; or

(iii) hold an annual meeting of the captive insurance company in the state.

(5) The commissioner may require a captive insurance company that holds a certificate of dormancy to submit an annual audit if the commissioner determines that there are concerns regarding the captive insurance company's solvency or liquidity.

(6) To maintain a certificate of dormancy and in lieu of a certificate of authority renewal fee, no later than July 1 of each year, a captive insurance company shall pay an annual dormancy renewal fee that is equal to 50% of the captive insurance's company's certificate of authority renewal fee.

(7) A captive insurance company may consecutively renew a certificate of dormancy no more than five times.

Section 39. Section **31A-45-501** is amended to read:

31A-45-501. Access to health care providers.

(1) As used in this section:

(a) "Class of health care provider" means a health care provider or a health care facility regulated by the state within the same professional, trade, occupational, or certification category established under Title 58, Occupations and Professions, or within the same facility licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(b) "Covered health care services" or "covered services" means health care services for which an enrollee is entitled to receive under the terms of a [~~health maintenance~~] managed care organization contract.

(c) "Credentialed staff member" means a health care provider with active staff privileges at an independent hospital or federally qualified health center.

(d) "Federally qualified health center" means as defined in the Social Security Act, 42 U.S.C. Sec. 1395x.

(e) "Independent hospital" means a general acute hospital or a critical access hospital that:

(i) is either:

(A) located 20 miles or more from any other general acute hospital or critical access hospital; or

(B) licensed as of January 1, 2004;

(ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act; [~~and~~]

(iii) is controlled by a board of directors of which 51% or more reside in the county where the hospital is located; and[~~:~~]

(iv) (A) the hospital's board of directors is ultimately responsible for the policy and financial decisions of the hospital; or

(B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part, by an entity that owns or controls a health maintenance organization if the hospital is a contracting facility of the organization.

(f) "Noncontracting provider" means an independent hospital, federally qualified health center, or credentialed staff member that has not contracted with a managed care organization to provide health care services to enrollees of the managed care organization.

(2) Except for a managed care organization that is under the common ownership or control of an entity with a hospital located within 10 paved road miles of an independent hospital, a managed care organization shall pay for covered health care services rendered to an enrollee by an independent hospital, a credentialed staff member at an independent hospital, or a credentialed staff member at his local practice location if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the independent hospital; or

(ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the independent hospital than a contracting hospital;

(b) the independent hospital is located prior to December 31, 2000 in a county with a population density of less than 100 people per square mile, or the independent hospital is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract.

(3) A managed care organization shall pay for covered health care services rendered to an enrollee at a federally qualified health center if:

(a) the enrollee:

(i) lives or resides within 30 paved road miles of the federally qualified health center; or

(ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the federally qualified health center than a contracting provider;

(b) the federally qualified health center is located in a county with a population density of less than 30 people per square mile; and

(c) the enrollee has complied with the prior authorization and utilization review requirements otherwise required by the managed care organization contract.

(4) (a) A managed care organization shall reimburse a noncontracting provider or the enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as [~~it~~] the managed care organization pays to contracting providers under a noncapitated arrangement for comparable services.

(b) A managed care organization shall reimburse a federally qualified health center or the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by the managed care organization under a noncapitated arrangement for comparable services to a contracting provider in the same class of health care providers as the provider who rendered the service.

(5) (a) A noncontracting independent hospital may not balance bill a patient when the [~~health maintenance~~] managed care organization reimburses a noncontracting independent hospital or an enrollee in accordance with Subsection (4)(a).

(b) A noncontracting federally qualified health center may not balance bill a patient when the federally qualified health center or the enrollee receives reimbursement in accordance with Subsection (4)(b).

(6) A noncontracting provider may only refer an enrollee to another noncontracting provider so as to obligate the enrollee's managed care organization to pay for the resulting services if:

(a) the noncontracting provider making the referral or the enrollee has received prior authorization from the organization for the referral; or

(b) the practice location of the noncontracting provider to whom the referral is made:

(i) is located in a county with a population density of less than 25 people per square mile; and

(ii) is within 30 paved road miles of:

(A) the place where the enrollee lives or resides; or

(B) the independent hospital or federally qualified health center at which the enrollee may receive covered services pursuant to Subsection (2) or (3).

(7) Notwithstanding this section, a managed care organization may contract directly with an independent hospital, federally qualified health center, or credentialed staff member.

(8) (a) A managed care organization that violates any provision of this section is subject to sanctions as determined by the commissioner in accordance with Section 31A-2-308.

(b) Violations of this section include:

(i) failing to provide the notice required by Subsection (8)(d) by placing the notice in any managed care organization's provider list that is supplied to enrollees, including any website maintained by the managed care organization;

(ii) failing to provide notice of an enrollee's rights under this section when:

(A) an enrollee makes personal contact with the managed care organization by telephone, electronic transaction, or in person; and

(B) the enrollee inquires about the enrollee's rights to access an independent hospital or federally qualified health center; and

(iii) refusing to reprocess or reconsider a claim, initially denied by the managed care organization, when the provisions of this section apply to the claim.

(c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of

Commissioner:

(i) adopt rules as necessary to implement this section;

(ii) identify in rule:

(A) the counties with a population density of less than 100 people per square mile;

(B) independent hospitals as defined in Subsection (1)(e); and

(C) federally qualified health centers as defined in Subsection (1)(d).

(d) (i) A managed care organization shall:

(A) use the information developed by the commissioner under Subsection (8)(c) to identify the rural counties, independent hospitals, and federally qualified health centers that are located in the managed care organization's service area; and

(B) include the providers identified under Subsection (8)(d)(i)(A) in the notice required in Subsection (8)(d)(ii).

(ii) The managed care organization shall provide the following notice, in bold type, to enrollees as specified under Subsection (8)(b)(i), and shall keep the notice current:

"You may be entitled to coverage for health care services from the following noncontracted providers if you live or reside within 30 paved road miles of the listed providers, or if you live or reside in closer proximity to the listed providers than to your contracted providers:

This list may change periodically, please check on our website or call for verification. Please be advised that if you choose a noncontracted provider you will be responsible for any charges not covered by your health insurance plan.

If you have questions concerning your rights to see a provider on this list you may contact your managed care organization at _____. If the managed care organization does not resolve your problem, you may contact the Office of Consumer Health Assistance in the Insurance Department, toll free."

(e) A person whose interests are affected by an alleged violation of this section may contact the Office of Consumer Health Assistance and request assistance, or file a complaint as provided in Section 31A-2-216.

Section 40. Section **36-29-106** is amended to read:

36-29-106. Health Reform Task Force.

(1) There is created the Health Reform Task Force consisting of the following 11

members:

(a) four members of the Senate appointed by the president of the Senate, no more than three of whom are from the same political party; and

(b) seven members of the House of Representatives appointed by the speaker of the House of Representatives, no more than five of whom are from the same political party.

(2) (a) The president of the Senate shall designate a member of the Senate appointed under Subsection (1)(a) as a cochair of the task force.

(b) The speaker of the House of Representatives shall designate a member of the House of Representatives appointed under Subsection (1)(b) as a cochair of the task force.

(3) Salaries and expenses of the members of the task force shall be paid in accordance with Section 36-2-2 and Legislative Joint Rules, Title 5, Chapter 3, Legislator Compensation.

(4) The Office of Legislative Research and General Counsel shall provide staff support to the task force.

(5) The task force shall review and make recommendations on health system reform, including the following issues:

(a) the need for state statutory and regulatory changes in response to federal actions affecting health care;

(b) Medicaid and reforms to the Medicaid program;

(c) options for increasing state flexibility, including the use of federal waivers;

(d) the state's health insurance marketplace;

(e) health insurance code modifications;

(f) insurance network adequacy standards and balance billing; and

(g) rising health care costs.

(6) A final report, including any proposed legislation, shall be presented to the Business and Labor Interim Committee and Health and Human Services Interim Committee before November 30, [~~2019~~] 2021, and November 30, [~~2020~~] 2022.

Section 41. Section **63I-1-236** is amended to read:

63I-1-236. Repeal dates, Title 36.

(1) Title 36, Chapter 17, Legislative Process Committee, is repealed January 1, 2023.

(2) Section 36-12-20 is repealed June 30, 2023.

(3) Title 36, Chapter 28, Veterans and Military Affairs Commission, is repealed

January 1, 2025.

[~~(4) Section 36-29-105 is repealed on December 31, 2020.~~]

[~~(5)~~] (4) Section 36-29-106 is repealed June 1, [~~2021~~] 2023.

[~~(6)~~] (5) Title 36, Chapter 31, Martha Hughes Cannon Capitol Statue Oversight Committee, is repealed January 1, 2022.