HB0560S01 compared with HB0560

~~{Omitted text}~~ shows text that was in HB0560 but was omitted in HB0560S01
inserted text shows text that was not in HB0560 but was inserted into HB0560S01

DISCLAIMER: This document is provided to assist you in your comparison of the two bills. Sometimes this automated comparison will NOT be completely accurate. Therefore, you need to read the actual bills. This automatically generated document could contain inaccuracies caused by: limitations of the compare program; bad input data; or other causes.

Ambulance Amendments

2026 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor:

LONG TITLE

General Description:

This bill enacts provisions relating to ambulance membership organizations.

Highlighted Provisions:

This bill:

- provides that accident and health insurance does not include an ambulance membership contract;
- enacts Title 31A, Chapter 6c, Ambulance Membership Organizations;
- defines terms;
- provides that an ambulance membership organization is exempt from certain chapters of Title 31A, Insurance;
- provides the powers and duties of the commissioner of the Insurance Department (commissioner) in relation to Title 31A, Chapter 6c, Ambulance Membership Organizations;
- provides the licensing requirements for an ambulance membership organization;
- provides the license renewal process for an ambulance membership organization;
- provides that an ambulance membership organization shall submit an annual report to the commissioner;

HB0560

- provides requirements for an ambulance membership organization to maintain reserve funds and a surety bond;
- provides that an ambulance membership organization may charge a fee to a member of the ambulance membership organization;
- provides an ambulance membership organization's required disclosures to the ambulance membership organization's members;
- provides the requirements for an ambulance membership contract;
- prohibits an ambulance membership organization from selling, offering for sale, or providing an ambulance membership contract to an individual enrolled in Medicaid;
- provides the requirements for an individual who purchases an ambulance membership contract and who subsequently enrolls in Medicaid;
- enacts marketing requirements and required disclosures for an ambulance membership organization;
- authorizes the commissioner to revoke or suspend an ambulance membership organization's license;
- provides for penalties related to a violation of Title 31A, Chapter 6c, Ambulance Membership Organizations; and
- makes technical changes.

Money Appropriated in this Bill:

None

Other Special Clauses:

This bill provides a special effective date.

Utah Code Sections Affected:

AMENDS:

31A-1-301 , as last amended by Laws of Utah 2024, Chapter 120

ENACTS:

31A-6c-101 , Utah Code Annotated 1953

31A-6c-102 , Utah Code Annotated 1953

31A-6c-103 , Utah Code Annotated 1953

31A-6c-201 , Utah Code Annotated 1953

31A-6c-202 , Utah Code Annotated 1953

31A-6c-301 , Utah Code Annotated 1953

31A-6c-302 , Utah Code Annotated 1953

31A-6c-303 , Utah Code Annotated 1953

31A-6c-304 , Utah Code Annotated 1953

31A-6c-401 , Utah Code Annotated 1953

31A-6c-402 , Utah Code Annotated 1953

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

(1)

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

(i) a medical condition including:

(A) a medical care expense; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) a fixed indemnity 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:

(i) [-]workers' compensation insurance[.] ; or

(ii) an ambulance membership contract.

(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 (187).

(4) "Adult" means an individual who is 18 years old or older.

(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 77-20-501(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 (98).

(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 a parent organization; and

(ii) whose purpose is to insure risks of the parent organization and 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 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~~] in accordance with 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 26B-3-108;

(ii) the Utah's Children's Health Insurance Program under Section 26B-3-904; 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)

(a) "Direct response solicitation" means an offer for life or accident and health insurance coverage that allows the individual to apply for or enroll in the insurance coverage on the basis of the offer.

(b) "Direct response solicitation" does not include an offer for:

(i) insurance through an employee benefit plan that is exempt from state regulation under federal law; or

(ii) credit life insurance or credit accident and health insurance through a individual's creditor.

(49) "Direct response insurance policy" means an insurance policy solicited and sold without the policyholder having direct contact with a natural person intermediary.

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

(51) "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.

(52) "Disability income insurance" means the same as that term is defined in Subsection (89).

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

(54) "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.

(55)

(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 (55)(b).

(b) "Eligible employee" includes:

(i) an owner, sole proprietor, or partner 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) an independent contractor if the individual is included under a health benefit plan of a small employer.

(c) "Eligible employee" does not include, unless eligible under Subsection (55)(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 (55)(a)(i); or

(iii) a dependent of an employer who does not meet the requirements of Subsection (55)(a)(i).

(56) "Emergency medical condition" means a medical condition that:

(a) manifests itself by acute symptoms, including severe pain; and

(b) would cause a prudent layperson possessing an average knowledge of medicine and health to reasonably expect the absence of immediate medical attention through a hospital emergency department to result in:

(i) placing the layperson's health or the layperson's unborn child's health in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

(57) "Employee" means:

(a) an individual employed by an employer; or

(b) an individual who meets the requirements of Subsection (55)(b).

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

(a) an employee; or

(b) a dependent of an employee.

(59)

(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.

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

(61)

(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.

(62) "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.

(63) "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~~] the insurer's 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.

(64)

(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; or

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

(b) "Escrow" 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.

(65) "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.

(66)

(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.

(67) "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.

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

(69)

(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 (69)(a).

(70) "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.

(71) "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.

(72)

(a) "Fixed indemnity insurance" means accident and health insurance written to provide a fixed amount for a specified event relating to or resulting from an illness or injury.

(b) "Fixed indemnity insurance" includes hospital confinement indemnity insurance.

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

(74)

(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.

(75) "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.

(76) "General lines of authority" include:

(a) the general lines of insurance in Subsection (77);

(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.

(77) "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.

(78) "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.

(79)

(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.

(80) "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.

(81) "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.

(82)

(a) "Health benefit plan" means a policy, contract, certificate, or agreement offered or issued by an insurer to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care, including major medical expense coverage.

(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~~] in accordance with 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) fixed indemnity insurance;

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

(A) Medicare supplement insurance;

(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 health insurance; and

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

(83) "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.

(84)

(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.

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

(86) "Health care sharing ministry" means an entity that:

(a) is a tax-exempt nonprofit entity under the Internal Revenue Code;

(b) limits participants to those who are of a similar faith;

(c) facilitates the sharing of a participant's qualified expenses, as defined by the entity, among other participants by:

(i) matching a participant who has qualified expenses with one or more participants who are able to contribute to paying for the qualified expenses; and

(ii) arranging, directly or indirectly, for each contributing participant's contribution to be used to pay for the qualified expenses;

(d) requires an individual to make one or more minimum payments or contributions as a condition of one or more of the following:

(i) becoming a participant;

(ii) remaining a participant; or

(iii) receiving a contribution to pay qualified expenses; and

(e) in carrying out the functions described in this Subsection (86), makes no assumption of risk or promise to pay any qualified expenses.

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

(88) "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.

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

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

(91) "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.

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

(93) "Individual" means a natural person.

(94) "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.

(95) "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.

(96)

(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.

(97) "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.

(98) "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;

(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 offering 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~~] after 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 (98)(a) through (h) in a manner designed to evade this title.

(99) "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.

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

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

(102)

(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."

(103)

(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 (103)(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.

(104)

(a) "Insurer," "carrier," "insurance carrier," or "insurance company" 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," "carrier," "insurance carrier," or "insurance company" does not include a governmental entity.

(105) "Interinsurance exchange" means the same as that term is defined in Subsection (168).

(106) "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~~] the insurance holding company system's 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.

(107) "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.

(108) "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.

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

(110) "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.

(111)

(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.

(112)

(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.

(113)

(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.

(114)

(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.

(115) "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.

(116) "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.

(117) "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.

(118) "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.

(119) "Limited lines authority" includes the lines of insurance listed in Subsection (118).

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

(121)

(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 (121)(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 insurance;

(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;

(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; or

(xi) limited long-term care as defined in Section 31A-22-2002.

(122) "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.

(123) "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.

(124) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the federal Social Security Act, as then constituted or later amended.

(125)

(a) "Medicare supplement insurance" means health insurance coverage that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of individuals eligible for Medicare.

(b) "Medicare supplement insurance" does not include:

(i) a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act;

(ii) a policy issued under a demonstration project specified in 42 U.S.C. Sec. 1395ss(g)(1);

(iii) a Medicare Advantage plan established under Medicare Part C;

(iv) an outpatient prescription drug plan established under Medicare Part D; or

(v) any health care prepayment plan that provides benefits [~~pursuant to~~] in accordance with an agreement under Section 1833(a)(1)(A) of the Social Security Act.

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

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

(128) "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.

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

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

(131) "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 (131)(b)(iii)(A) through (D); or

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

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

(133) "NAIC" means the National Association of Insurance Commissioners.

(134) "NAIC liquidity stress test framework" means a NAIC publication that includes:

(a) a history of the NAIC's development of regulatory liquidity stress testing;

(b) the scope criteria applicable for a specific data year; and

(c) the liquidity stress test instructions and reporting templates for a specific data year, as adopted by the NAIC and as amended by the NAIC in accordance with NAIC procedures.

(135) "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.

(136) "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.

(137) "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.

(138) "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.

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

(140) "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.

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

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

(143) "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 (143)(a)(i); and

(iii) of the sufficiency of capital resources to support each risk described in Subsection (143)(a)(i); and

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

(144) "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.

(145) "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.

(146) "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.

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

(a) an individual; or

(b) a family.

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

(149) "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 (149)(a) or (b), the calendar year.

(150)

(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.

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

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

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

(154) "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.

(155) "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.

(156)

(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.

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

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

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

(160)

(a) "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.

(161) "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.

(162) "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.

(163)

(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.

(164)

(a) "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 include:

(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.

(165) "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.

(166)

(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.

(167) "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.

(168) "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.

(169) "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."

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

(171) "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.

(172)

(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.

(173) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

(174) "Scope criteria" means the designated exposure bases and minimum magnitudes for a specified data year that are used to establish a preliminary list of insurers considered scoped into the NAIC liquidity stress test framework for that data year.

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

(176)

(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 (176)(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.

(177) "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 (177).

(178)

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

(b) "Self-insurance" includes:

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

(ii) an arrangement under which a person with a managed program of self-insurance and risk management undertakes to indemnify the person's affiliate, subsidiary, director, officer, or employee for liability or risk that arises out of the person's relationship with the affiliate, subsidiary, director, officer, or employee.

(c) "Self-insurance" does not include:

(i) an arrangement under which a number of persons spread their risks among themselves; or

(ii) an arrangement with an independent contractor.

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

(a) by any means;

(b) for money or [~~its~~] the equivalent; and

(c) on behalf of an insurance company.

(180) "Short-term 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.

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

(182)

(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 an owner or a sole proprietor that does not employ at least one employee.

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

(184)

(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~~] the person's affiliates, except for the minimum number of shares the law of the subsidiary's domicile requires to be owned by directors or others.

(185) Subject to Subsection (95)(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.

(186)

(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).

(187) "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~~] the union's 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.

(188) "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.

(189) "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.

(190)

(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.

(191)

(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.

(192) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

(193) "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 described in Subsection (160).

(194) "Voting security" means a security with voting rights, and includes a security convertible into a security with a voting right associated with the security.

(195) "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.

(196) "Workers' compensation insurance" means:

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

(i) a compensable accidental injury; and

(ii) occupational disease disability;

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

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

Section 2. Section **2** is enacted to read:

31A-6c-101. Definitions.

6c. Ambulance Membership Organizations

1. General Provisions

As used in this chapter:

(1) "Ambulance membership contract" means a contract in which one party agrees to reimburse the following expenses for another party in the event of an emergency:

(a) air ambulance charges;

(b) ground ambulance charges;

(c) transportation expenses to return the member to the member's primary residence;

(d) transportation expenses to return a member's companion to the companion's primary residence;

(e) vehicle return expenses; and

(f) other transportation and related services, if:

(i) the commissioner approves the transportation and related services; and

(ii) the transportation and related services are consistent with this chapter.

(2)

(a) "Ambulance membership organization" means a person that offers an ambulance membership contract.

(b) "Ambulance membership organization" does not include a person that offers ambulance services.

(3) "Companion" means an individual who travels with a member.

(4) "Governmental entity" means the governing body of a county or municipality in this state.

(5) "Medicaid program" means the same as that term is defined in Section 26B-3-101.

(6) "Member" means a person who enters into an ambulance membership contract with an ambulance membership organization.

Section 3. Section **3** is enacted to read:

31A-6c-102. Scope of chapter.

(1) An ambulance membership organization may not issue, sell, or offer for sale an ambulance membership contract, unless the ambulance membership organization complies with this chapter.

(2) An ambulance membership organization that complies with this chapter is exempt from:

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

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

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

(d) Chapter 9, Insurance Fraternals;

(e) Chapter 10, Annuities;

(f) Chapter 11, Motor Clubs;

(g) Chapter 12, State Risk Management Fund;

(h) Chapter 14, Foreign Insurers;

(i) Chapter 19a, Utah Rate Regulation Act;

(j) Chapter 25, Third Party Administrators; and

(k) Chapter 28, Guaranty Associations.

Section 4. Section **4** is enacted to read:

31A-6c-103. Powers and duties of the commissioner -- Rulemaking -- Costs.

(1) The commissioner may:

(a) examine or investigate the affairs of an ambulance membership organization to ensure compliance with this chapter;

(b) order an ambulance membership organization or applicant for a license under this chapter to produce material relating to ambulance membership affairs, including any records, books, files, advertising and solicitation materials, and any other information the commissioner deems necessary to ensure compliance with this chapter; and

(c) take statements under oath to determine whether an ambulance membership organization or an applicant for a license under this chapter is in violation of this chapter.

(2) An ambulance membership organization that the commissioner finds has violated a provision of this chapter after an examination or investigation under this section shall pay all costs and fees associated with the examination or investigation.

(3) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules necessary to assist in the enforcement of this chapter.

Section 5. Section **5** is enacted to read:

31A-6c-201. Licensure.

2. Licensing

(1) A person may not perform, offer to perform, or advertise as an ambulance membership organization in this state unless the person is licensed under this chapter.

(2) To obtain or renew a license as an ambulance membership organization, a person shall:

(a) submit an application:

(i) on a form and in a manner the commissioner establishes by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

(ii) that states:

(A) whether the person's previous license under this chapter or for a substantially similar license under the laws of another state has been denied, revoked, suspended, or terminated;

(B) whether the applicant is currently under investigation by law enforcement, a federal entity, or a state entity or is the subject of a pending legal action;

(C) whether the applicant has been found in violation of a statute or regulation in any jurisdiction in the five years before the day on which the applicant submits the application;

(D) that the applicant has established a dedicated toll-free number for the applicant's customers and a website that makes available the name and address of each current ambulance provider with which the applicant has contracted directly or through a provider network;

(E) additional information the commissioner requires by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to determine whether the applicant has adequate expertise and experience to operate an ambulance membership organization; and

(b) pay a licensure fee of $500.

(3) The term of a license issued under this chapter is one year.

Section 6. Section **6** is enacted to read:

31A-6c-202. License renewal -- Reporting requirements.

(1) At least 90 days before the day on which an ambulance membership organization's license expires, the ambulance membership organization seeking renewal of the ambulance membership organization's license shall submit an annual report to the commission in a form the commissioner approves.

(2) The report described in Subsection (1) shall include:

(a) an updated list of the name and address of each ambulance provider of the ambulance membership organization, including:

(i) the extent and nature of any contract or arrangement with the ambulance provider; and

(ii) any possible conflict of interest between the ambulance membership organization and ambulance provider;

(b) the number of members in this state who are enrolled in an ambulance membership contract that the ambulance membership organization offers;

(c) a list of each ambulance membership contract currently active or entered into with a governmental entity that provides membership of the ambulance membership organization to each resident of the governmental entity; and

(d) any other information related to the ambulance membership organization that the commissioner requires to ensure compliance with this chapter.

(3)

(a) The commissioner {~~shall suspend~~ } may not renew an ambulance membership organization's license if the ambulance membership organization fails to file a complete annual report in accordance with Subsection (1).

(b) If the commissioner {~~suspends~~ } does not renew an ambulance membership organization's license in accordance with Subsection (3)(a), the ambulance membership organization may not enroll new members or do business in this state until:

(i) the ambulance membership organization submits a new license application in accordance with Section 31A-6c-201; and

(ii) the commissioner approves the application.

(4) If an ambulance membership organization makes a change to any of the following, the ambulance membership organization shall provide the commissioner a notice of the change at least 30 days before the day on which the ambulance membership organization makes the change:

(a) the ambulance membership organization's name;

(b) the ambulance membership organization's address;

(c) the ambulance membership organization's telephone number;

(d) the ambulance membership organization's address for the principal place of business;

(e) the ambulance membership organization's mailing address; or

(f) the ambulance membership organization's website address.

Section 7. Section **7** is enacted to read:

31A-6c-301. Reserve funds -- Surety bond required.

3. Operational Requirements

(1) An ambulance membership organization licensed under this chapter shall:

(a) establish and maintain a funded reserve account consisting of unencumbered assets of either cash or cash equivalents, equal to at least 20% of the gross earned fee income the ambulance membership organization receives on all active ambulance membership contracts that the ambulance membership organization sells or renews in this state on or after May 6, 2026;

(b) post a surety bond with one or more surety companies that the commissioner approves in an amount of at least $5,000 for every 100 members of the ambulance membership organization who are residents of this state;

(c) maintain additional securities the commissioner requires by rule in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act; and

(d) pay the costs of collection upon a judgment in favor of a member and attorney fees in a successful action brought by member against the ambulance membership organization.

(2) The reserve account described in Subsection (1)(a) shall be:

(a) maintained in a financial institution that the commissioner approves; and

(b) a separate, auditable account for the ambulance membership organization's ambulance membership contracts in force in this state.

Section 8. Section **8** is enacted to read:

31A-6c-302. Charges authorized -- Required disclosures -- Ambulance membership contract requirements.

(1) An ambulance membership organization may assess a one-time application processing fee to the ambulance membership organization's members that may not exceed $25.

(2) If an ambulance membership organization cancels an ambulance membership contract for any reason other than nonpayment of charges by a member, the ambulance membership organization shall issue a pro rata refund of all periodic charges and membership fees to the member.

(3) An ambulance membership organization, or a person that sells an ambulance membership contract for an ambulance membership organization, shall disclose each charge and fee for each ambulance membership contract to each prospective member.

(4) An ambulance membership organization shall provide the terms and conditions of an ambulance membership contract to each prospective member before the day on which the prospective member enters into the ambulance membership contract.

(5) An ambulance membership organization shall file a copy of each ambulance membership contract with the commissioner before the ambulance membership contract goes into effect.

(6) An ambulance membership contract described in Subsection (5) shall:

(a) identify the ambulance membership organization, including the ambulance membership organization's:

(i) physical address;

(ii) website address; and

(iii) toll-free phone number;

(b) conspicuously state:

(i) the total purchase price of the ambulance membership contract, including any membership fees; and

(ii) that the ambulance membership contract is not an insurance contract;

(c) state:

(i) the terms under which the ambulance membership contract is to be paid;

(ii) any cost sharing requirements;

(iii) the services the ambulance membership organization shall provide under the ambulance membership contract, and any limitation, exception, or exclusion;

(iv) any term, restriction, or condition that governs the cancellation of the ambulance membership contract by either the member or the ambulance membership organization;

(v) that if the member cancels the ambulance membership contract within 30 days after the day on which the member purchases the ambulance membership contract, the ambulance membership organization shall refund to the member:

(A) any one-time charge the member pays that exceeds $25; and

(B) each periodic charge and membership fee the member pays; and

(vi) what constitutes acceptable insurance coverage if eligibility for the ambulance membership contract is conditioned on the member's current and continuing health insurance coverage; and

(d) define "medical necessity," if membership coverage of a transport is conditioned on a finding of medical necessity.

Section 9. Section **9** is enacted to read:

31A-6c-303. Ambulance membership restrictions -- Medicaid program.

(1) An ambulance membership organization may not knowingly sell, offer for sale, or provide an ambulance membership contract to an individual who is enrolled in the Medicaid program.

(2)

(a) If an individual who enters into an ambulance membership contract subsequently enrolls in the Medicaid program during the term of the ambulance membership contract, the individual shall notify the ambulance membership organization of the enrollment within 30 days of the day on which the individual enrolls in the Medicaid program.

(b) If the individual notifies the ambulance membership organization in accordance with Subsection (2)(a), the ambulance membership organization shall provide the individual a prorated refund of any consideration the individual pays for the period from the effective date of the Medicaid program enrollment through the day on which the ambulance membership contract expires.

(c) If the individual does not notify the ambulance membership organization in accordance with Subsection (2)(a):

(i) the individual is not entitled to a prorated refund; and

(ii) the ambulance membership organization shall unenroll the individual from the ambulance membership contract within 30 days of the day on which the ambulance membership organization receives notice of the individual's enrollment in the Medicaid program.

Section 10. Section **10** is enacted to read:

31A-6c-304. Marketing requirements -- Required disclosures.

(1) Each advertisement, marketing material, brochure, ambulance membership card, presentation, and any other communication of an ambulance membership organization shall be truthful and not misleading in fact or in implication.

(2) An ambulance membership organization advertising or marketing the ambulance membership organization's ambulance membership contract to residents of this state:

(a) shall file each written advertisement and marketing material to the commissioner for review in compliance with this chapter; and

(b) may not:

(i) use language in the ambulance membership organization's advertisements or marketing that could reasonably mislead a person into believing that the ambulance membership contract is insurance;

(ii) use language in the ambulance membership organization's advertisement, marketing material, brochure, or presentation in relation to the following that could reasonably mislead an individual into believing that the ambulance membership contract is insurance or has been endorsed by the state or a governmental entity:

(A) the ambulance membership organization's licensure or registration with the department or other state department of insurance; or

(B) the ambulance membership organization's relationship to a governmental entity; or

(iii) have a restriction on access to the ambulance membership organization, including a waiting period or notification period.

(3) An ambulance membership organization shall make the following general disclosures in writing, in bold, and in at least 12-point font on the first content page of an advertisement, marketing material, or brochure the ambulance membership organization makes available to prospective members or the public:

(a) the ambulance membership contract is a membership plan and is not insurance coverage; and

(b) the toll-free number and website address where the ambulance membership organization's prospective members may obtain additional information about the services the ambulance membership organization offers.

(4) An ambulance membership organization shall provide the disclosures required by Subsection (3) orally to an individual who makes initial contact with the ambulance membership organization by telephone.

(5) Before a person enters into an ambulance membership contract with an ambulance membership organization, the ambulance membership organization shall mail, give, or, with consent of the person, email to the person a separate document that, in bold and in at least 12-point font, states the following disclosures:

(a) the ambulance membership contract is not insurance coverage;

(b) if eligible and covered under Medicare, the prospective member may consult with a representative of the Medicare program to determine:

(i) the extent of applicable Medicare coverage; and

(ii) what the prospective member's payment obligations would be if the prospective member were transported by ambulance;

(c) a detailed list of each one-time and periodic fee the ambulance membership organization charges or will charge to the prospective member to join the ambulance membership organization and continue membership in the ambulance membership organization;

(d) the counties and areas in this state that the ambulance membership organization serves, including any restrictions to specific service areas;

(e) if, in an emergency, the prospective member is outside of the ambulance membership organization's service area, that the prospective member may be responsible for the entirety of the cost of the ambulance membership organization's services; and

(f) if a member cancels the ambulance membership contract before 30 days after the day on which the member purchases the ambulance membership contract, the ambulance membership organization shall refund to the member:

(i) any one-time charges the member pays that exceed $25; and

(ii) all periodic charges or fees that the member pays.

Section 11. Section **11** is enacted to read:

31A-6c-401. Suspension and revocation.

4. Enforcement

(1) The commissioner may suspend or revoke a license issued under this chapter if the commissioner determines that the ambulance membership organization:

(a) fails to operate in accordance with this chapter;

(b) advertises, merchandises, or attempts to merchandise the ambulance membership organization's services in a manner that misrepresents the ambulance membership organization's services or capacity for service;

(c) engages in deceptive, misleading, or unfair practices;

(d) does not fulfill the ambulance membership organization's obligations as an ambulance membership organization; or

(e) would be hazardous to the ambulance membership organization's members if the commissioner permitted the ambulance membership organization's continued operation.

(2) If the commissioner makes a determination under Subsection (1), the commissioner:

(a) shall send a written notice to the ambulance membership organization that states the grounds for suspending or revoking the ambulance membership organization's license; and

(b) may suspend the authority of the ambulance membership organization to enroll new members for a period of time that may not exceed 90 days for each occurrence, if the commissioner sends the ambulance membership organization a written notice of suspension that describes the conditions the ambulance membership organization shall meet before the commissioner will reinstate the ambulance membership organization's authority to enroll new members.

(3) An ambulance membership organization may request a hearing no later than 30 days after the ambulance membership organization receives a notice under Subsection (2)(a).

(4)

(a) The commissioner may not reinstate a suspended ambulance membership organization's license unless the ambulance membership organization requests the reinstatement.

(b) The commissioner may not grant a request for reinstatement if the commissioner finds by a preponderance of the evidence that the circumstances that resulted in the suspension or revocation still exist or are likely to recur.

(5) The commissioner shall take each action under this section in accordance with Title 63G, Chapter 4, Administrative Procedures Act.

Section 12. Section **12** is enacted to read:

31A-6c-402. Penalties.

A person that violates a provision of this chapter is subject to the penalties described in Section 31A-2-308.

Section 13. **Effective date.**

Effective Date.

This bill takes effect on {~~May 6, 2026~~} January 1, 2027.

2-16-26 12:02 PM