# Chapter 22
# Contracts in Specific Lines

## Part 1
## Contracts of Suretyship

**31A-22-101 Scope of part.**

This Part 1, Contracts of Suretyship, applies to those suretyship obligations that are subject to Chapter 21, Insurance Contracts in General, and this chapter under Section 31A-21-101.

Amended by Chapter 90, 2004 General Session

**31A-22-102 Bonds need not be under seal.**

Under this code, no suretyship obligation is required to be under seal.

Enacted by Chapter 242, 1985 General Session

**31A-22-103 Validity of surety bonds.**

(1) An undertaking to stand as surety which is issued by an insurer authorized to do a surety business in this state is complete compliance with any qualification requirement in Utah law respecting surety bonds. This undertaking is acceptable to any state official or court-appointed fiduciary authorized to receive or empowered to require the undertaking. A copy of a surety's certificate of authority, certified by the commissioner, is prima facie evidence that a surety was authorized to do business in this state on the date of the certificate.

(2) No instrument executed by an insurer authorized to do a surety business is ineffective because of the insurer's failure to attach a copy of its certificate of authority to do business in this state. However, a public official or court-appointed fiduciary may, by prior written request, require that a copy of the insurer's certificate of authority, certified by the commissioner, be delivered. The insurer's failure to deliver a certified copy of the surety's certificate of authority within 10 days of receipt of the request is adequate grounds for refusing to accept the suretyship instrument. Failure to request a copy of the certificate of authority prior to accepting the surety instrument is a waiver of the right to request the certificate.

(3) After executing an obligation of suretyship, no insurer may deny its corporate power to execute that type of instrument or to incur that type of liability in any proceeding against the insurer upon that instrument.

Amended by Chapter 204, 1986 General Session

**31A-22-104 Indemnity agreements and security for benefit of surety.**

(1) Any insurer authorized to do a surety business may contract with any person, including a principal debtor under a suretyship obligation, for indemnity or security to protect the surety against losses. No indemnity agreement or provision of security by the principal debtor releases from or changes the liability of the principal debtor or of the sureties from the terms established in the bond. No surety may be indemnified through funds held by the principal debtor in a fiduciary capacity.

(2) Security may be in any of the following forms:

(a) deposits of money or other property of the principal debtor which can be held by a responsible financial institution authorized by law to do that type of business, in a manner that prevents withdrawal or alienation of the money or other property without the written consent of the sureties or an order of a court of competent jurisdiction made after notice is given to the sureties and a hearing is held as directed by the court; or

(b) security interests in real or personal property perfected under the laws of Utah.

(3) This section does not affect a surety's common-law right to reimbursement, subrogation, or exoneration.

Amended by Chapter 218, 1987 General Session

**31A-22-105 Common control of fiduciary funds permissible.**

Any fiduciary from whom a bond, undertaking, or other obligation is required may agree and arrange with the fiduciary's sureties for the deposit for safekeeping of any and all assets for which the fiduciary is responsible with a depository institution authorized by law to hold the assets, in a manner which prevents the withdrawal or alienation of any part of the property without the written consent of the sureties, or an order of the court made after notice is given to the sureties and a hearing is held as directed by the court. This deposit agreement does not release or change the fiduciary responsibility of the principal, or the liability of the principal or sureties as established under the bond.

Amended by Chapter 302, 2025 General Session

**31A-22-106 Petition of fiduciary's surety to be relieved from liability.**

Any surety securing others against losses caused by breach of duty by a fiduciary, herein called "principal," may petition the court where the surety's obligation is filed or which has jurisdiction over the principal, for an order relieving the surety from further liability for the acts or omissions of the principal. This order may be issued only after the court is satisfied that the principal has accounted to the petitioner and has obtained a new surety. The surety relieved from liability shall refund any unearned part of the premium paid which the surety held as consideration for its promise to be surety. To relieve a surety from liability, the court may order the principal to account, to obtain a new surety, or to refrain from acting except to preserve property held in a fiduciary capacity.

Enacted by Chapter 242, 1985 General Session

**31A-22-107 Bond premium allowable expense of fiduciary.**

Any fiduciary required by law, or the court in providing a surety to secure the fiduciary's performance, may include as part of the expense of executing the fiduciary responsibility a reasonable premium paid to a surety for becoming the fiduciary's surety. However, the court may not allow an expense allowance greater than the larger of 1% of the surety's maximum obligation or $25.

Enacted by Chapter 242, 1985 General Session

## Part 2
## Liability Insurance in General

**31A-22-201 Required provisions of liability insurance policies.**

Every liability insurance policy shall provide that the bankruptcy or insolvency of the insured may not diminish any liability of the insurer to third parties, and that if execution against the insured is returned unsatisfied, an action may be maintained against the insurer to the extent that the liability is covered by the policy.

Enacted by Chapter 242, 1985 General Session

**31A-22-202 Protection of third-party claimants.**

(1) An insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any person, or for damage to the property of any person, may not be retroactively abrogated to the detriment of any third-party claimant by any agreement between the insurer and insured after the occurrence of any injury, death, or damage for which the insured may be liable. This attempted abrogation is void.
(2) A motor vehicle liability policy may be rescinded or cancelled as to an insured for fraud, material misrepresentation, or any reason allowable under the law.
(3) A motor vehicle liability policy may not be rescinded for fraud or material misrepresentation, as to minimum liability coverage limits under Section 31A-22-304, to the detriment of a third party for a loss otherwise covered by the policy.

Amended by Chapter 138, 2016 General Session

**31A-22-203 Notice and proof of loss.**

Section 31A-21-312 applies to the notice required under liability policies. Subsection 31A-21-312(1) may not be construed to extend the normal provisions of any claims-made coverage that required notice of an occurrence or claim prior to the expiration of the policy for coverage to be in force.

Amended by Chapter 10, 1988 Special Session 2
Amended by Chapter 10, 1988 Special Session 2

**31A-22-204 Restriction on limitation of coverage.**

No insurer may limit coverage under a policy insuring against legal liability to claims that are first made against the insured while the policy is in force, unless the policy contains on the cover page, a conspicuous statement that the coverage of the policy is limited in that way.

Enacted by Chapter 242, 1985 General Session

**31A-22-205 Applicability of restatement of law.**

(1) A restatement of the law of liability insurance is not the law or public policy of this state if the statement of law is inconsistent or in conflict with:
  (a) the Constitution of the United States;
  (b) the Utah Constitution;
  (c) a state statute;
  (d) state case law; or
  (e) state-adopted common law.

(2) Nothing in this section precludes a court from referencing or considering a restatement or other legal treatise.

Enacted by Chapter 32, 2020 General Session

## Part 3
## Motor Vehicle Insurance

**31A-22-301 Definitions.**

As used in this part:

(1)
(a) "Motor vehicle" means the same as that term is defined in Section 41-6a-102.
(b) For purposes of this chapter, "motor vehicle" includes a street-legal all-terrain vehicle.
(2) "Motor vehicle business" means a motor vehicle sales agency, repair shop, service station, storage garage, or public parking place.
(3) "Motor vehicle liability policy" means a policy which satisfies the requirements of Sections 31A-22-303 and 31A-22-304.
(4) "Motorboat" means the same as that term is defined in Section 73-18c-102.
(5) "Occupying" means being in or on a motor vehicle as a passenger or operator, or being engaged in the immediate acts of entering, boarding, or alighting from a motor vehicle.
(6) "Operator" means the same as that term is defined in Subsection 41-12a-103(7).
(7) "Owner" means the same as that term is defined in Subsection 41-12a-103(8).
(8) "Pedestrian" means any natural person not occupying a motor vehicle.
(9) "Street-legal all-terrain vehicle" means the same as that term is defined in Section 41-6a-102.

Amended by Chapter 236, 2024 General Session

**31A-22-302 Required components of motor vehicle insurance policies -- Exceptions.**

(1) Every policy of insurance or combination of policies purchased to satisfy the owner's or operator's security requirement of Section 41-12a-301 shall include:
(a) motor vehicle liability coverage under Sections 31A-22-303 and 31A-22-304;
(b) uninsured motorist coverage under Section 31A-22-305, unless affirmatively waived under Subsection 31A-22-305(5);
(c) underinsured motorist coverage under Section 31A-22-305.3, unless affirmatively waived under Subsection 31A-22-305.3(3); and
(d) except as provided in Subsection (2) and subject to Subsection (4), personal injury protection under Sections 31A-22-306 through 31A-22-309.
(2) A policy of insurance or combination of policies, purchased to satisfy the owner's or operator's security requirement of Section 41-12a-301 for a motorcycle, off-highway vehicle, street-legal all-terrain vehicle, trailer, or semitrailer is not required to have personal injury protection under Sections 31A-22-306 through 31A-22-309.
(3) A card issued by an insurance company as evidence of owner's or operator's security under Section 41-12a-302 may not display the owner's or operator's address on the card.
(4)
(a) First party medical coverages may be offered or included in policies issued to motorcycle, off-highway vehicle, street-legal all-terrain vehicle, trailer, and semitrailer owners or operators.

(b) Owners and operators of motorcycles, off-highway vehicles, street-legal all-terrain vehicles, trailers, and semitrailers are not covered by personal injury protection coverages in connection with injuries incurred while operating any of these vehicles.

(5) First party medical coverage expenses shall be governed by the relative value study provisions under Subsections 31A-22-307(2) and (3).

Amended by Chapter 382, 2026 General Session

**31A-22-302.5 Named driver exclusions.**

(1) A policy of personal lines insurance or combination of personal lines policies purchased to satisfy the owner's or operator's security requirement under Section 41-12a-301 may specifically exclude from coverage:

(a) a person who is a resident of the named insured's household, including a person who usually makes the person's home in the same household but temporarily lives elsewhere; or

(b) a person who usually or customarily operates the motor vehicle.

(2) The named driver exclusion under Subsection (1) is effective only if:

(a) at the time of the proposed exclusion, each person excluded from coverage satisfies the owner's or operator's security requirement under Section 41-12a-301, independently of the named insured's proof of owner's or operator's security;

(b) any named insured and the person excluded from coverage each provide written consent to the exclusion; and

(c) the insurer includes the name of each person excluded from coverage in the evidence of insurance provided to an additional insured or loss payee.

(3) The provisions of Subsection (2)(a) do not apply to the named driver exclusion of the person excluded from coverage if the person's driver license has been denied, suspended, or revoked.

(4) The named driver exclusion shall remain effective until removed by the insurer.

(5) If the driver license of a person excluded from coverage under Subsection (1) has been denied, suspended, revoked, or disqualified and the person excluded from coverage subsequently operates a motor vehicle, the exclusion shall:

(a) exclude all liability coverage and all physical damage coverage without regard to the comparative fault of the excluded driver;

(b) proportionately reduce any benefits otherwise payable to the person excluded from coverage and to any named insured for benefits payable under uninsured motorist coverage, underinsured motorist coverage, personal injury protection coverage, and first party medical coverage to the extent the person excluded from coverage was comparatively at fault; and

(c) if the person excluded from coverage is 50% or more at fault in causing the accident, bar both the excluded driver and any named insured from recovering any benefits under any coverage listed under Subsection (5)(b).

(6) The named driver exclusion under Subsection (1) does not apply when the person excluded from coverage is:

(a) a non-driving passenger in a motor vehicle; or

(b) a pedestrian.

Amended by Chapter 425, 2011 General Session

**31A-22-303 Motor vehicle liability coverage.**

(1)

(a) In addition to complying with the requirements of Chapter 21, Insurance Contracts in General, and Part 2, Liability Insurance in General, a policy of motor vehicle liability coverage under Subsection 31A-22-302(1)(a) shall:

(i) name the motor vehicle owner or operator in whose name the policy was purchased, state that named insured's address, the coverage afforded, the premium charged, the policy period, and the limits of liability;

(ii)

(A) if it is an owner's policy, designate by appropriate reference all the motor vehicles on which coverage is granted, insure the person named in the policy, insure any other person using any named motor vehicle with the express or implied permission of the named insured, and, except as provided in Section 31A-22-302.5, insure any person included in Subsection (1)(a)(iii) against loss from the liability imposed by law for damages arising out of the ownership, maintenance, or use of these motor vehicles within the United States and Canada, subject to limits exclusive of interest and costs, for each motor vehicle, in amounts not less than the minimum limits specified under Section 31A-22-304; or

(B) if it is an operator's policy, insure the person named as insured against loss from the liability imposed upon him by law for damages arising out of the insured's use of any motor vehicle not owned by him, within the same territorial limits and with the same limits of liability as in an owner's policy under Subsection (1)(a)(ii)(A);

(iii) except as provided in Section 31A-22-302.5, insure persons related to the named insured by blood, marriage, adoption, or guardianship who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere, to the same extent as the named insured;

(iv) where a claim is brought by the named insured or a person described in Subsection (1)(a)(iii), the available coverage of the policy may not be reduced or stepped-down because:

(A) a permissive user driving a covered motor vehicle is at fault in causing an accident; or

(B) the named insured or any of the persons described in Subsection (1)(a)(iii) driving a covered motor vehicle is at fault in causing an accident; and

(v) cover damages or injury resulting from a covered driver of a motor vehicle who is stricken by an unforeseeable paralysis, seizure, or other unconscious condition and who is not reasonably aware that paralysis, seizure, or other unconscious condition is about to occur to the extent that a person of ordinary prudence would not attempt to continue driving.

(b) The driver's liability under Subsection (1)(a)(v) is limited to the insurance coverage.

(c)

(i) "Guardianship" under Subsection (1)(a)(iii) includes the relationship between a foster parent and a minor who is in the legal custody of the Division of Child and Family Services if:

(A) the minor resides in a foster home, as defined in Section 62A-2-101, with a foster parent who is the named insured; and

(B) the foster parent has signed to be jointly and severally liable for compensatory damages caused by the minor's operation of a motor vehicle in accordance with Section 53-3-211.

(ii) "Guardianship" as defined under this Subsection (1)(c) ceases to exist when a minor described in Subsection (1)(c)(i)(A) is no longer a resident of the named insured's household.

(2)

(a) A policy containing motor vehicle liability coverage under Subsection 31A-22-302(1)(a) may:

(i) provide for the prorating of the insurance under that policy with other valid and collectible insurance;

(ii) grant any lawful coverage in addition to the required motor vehicle liability coverage;

(iii) if the policy is issued to a person other than a motor vehicle business, limit the coverage afforded to a motor vehicle business or its officers, agents, or employees to the minimum limits under Section 31A-22-304, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent; and

(iv) if issued to a motor vehicle business, restrict coverage afforded to anyone other than the motor vehicle business or its officers, agents, or employees to the minimum limits under Section 31A-22-304, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent.

(b)

(i) The liability insurance coverage of a permissive user of a motor vehicle owned by a motor vehicle business shall be primary coverage.

(ii) The liability insurance coverage of a motor vehicle business shall be secondary to the liability insurance coverage of a permissive user as specified under Subsection (2)(b)(i).

(3) Motor vehicle liability coverage need not insure any liability:

(a) under any workers' compensation law under Title 34A, Utah Labor Code;

(b) resulting from bodily injury to or death of an employee of the named insured, other than a domestic employee, while engaged in the employment of the insured, or while engaged in the operation, maintenance, or repair of a designated vehicle; or

(c) resulting from damage to property owned by, rented to, bailed to, or transported by the insured.

(4) An insurance carrier providing motor vehicle liability coverage has the right to settle any claim covered by the policy, and if the settlement is made in good faith, the amount of the settlement is deductible from the limits of liability specified under Section 31A-22-304.

(5) A policy containing motor vehicle liability coverage imposes on the insurer the duty to defend, in good faith, any person insured under the policy against any claim or suit seeking damages which would be payable under the policy.

(6)

(a) If a policy containing motor vehicle liability coverage provides an insurer with the defense of lack of cooperation on the part of the insured, that defense is not effective against a third person making a claim against the insurer, unless there was collusion between the third person and the insured.

(b) If the defense of lack of cooperation is not effective against the claimant, after payment, the insurer is subrogated to the injured person's claim against the insured to the extent of the payment and is entitled to reimbursement by the insured after the injured third person has been made whole with respect to the claim against the insured.

(7)

(a) A policy of motor vehicle coverage may limit coverage to the policy minimum limits under Section 31A-22-304 if the policy or a specifically reduced premium was extended to the insured upon express written declaration executed by the insured that the insured motor vehicle would not be operated by a person described in Subsection (7)(c) operating in a manner described in Subsection (7)(b)(i).

(b)

(i) A policy of motor vehicle liability coverage may limit coverage as described in Subsection (7)(a) if the insured motor vehicle is operated by an individual described in Subsection (7)(c) if the individual described in Subsection (7)(c) is guilty of:

(A) driving under the influence as described in Section 41-6a-502;

(B) impaired driving as described in Section 41-6a-502.5; or
(C) operating a vehicle with a measurable controlled substance in the individual's body as described in Section 41-6a-517.
(ii) An individual's refusal to submit to a chemical test as described in Sections 41-6a-520 and 41-6a-520.1 is admissible evidence, but not conclusive, that the individual is guilty of an offense described in Subsection (7)(b)(i).
(c) A reduction in coverage as described in Subsection (7)(a) applies to the following individuals:
(i) the insured;
(ii) the spouse of the insured; or
(iii) if the individual has a separate policy as a secondary source of coverage, and:
(A) the individual is over the age of 21 and resides in the household of the insured; or
(B) the individual is a permissible user of the motor vehicle.
(d) A reduction in coverage as described in Subsection (7)(a) does not apply to an individual under the age of 21 who is a relative of the insured and a resident of the insured's household.
(8)
(a) When a claim is brought exclusively by a named insured or a person described in Subsection (1)(a)(iii) and asserted exclusively against a named insured or an individual described in Subsection (1)(a)(iii), the claimant may elect to resolve the claim:
(i) by submitting the claim to binding arbitration; or
(ii) through litigation.
(b) Once the claimant has elected to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of both parties and the defendant's liability insurer.
(c)
(i) Unless otherwise agreed on in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a panel of three arbitrators.
(ii) Unless otherwise agreed on in writing by the parties, each party shall select an arbitrator. The arbitrators selected by the parties shall select a third arbitrator.
(d) Unless otherwise agreed on in writing by the parties, each party will pay the fees and costs of the arbitrator that party selects. Both parties shall share equally the fees and costs of the third arbitrator.
(e) Except as otherwise provided in this section, an arbitration procedure conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act, unless otherwise agreed on in writing by the parties.
(f)
(i) Discovery shall be conducted in accordance with Rules 26b through 36, Utah Rules of Civil Procedure.
(ii) All issues of discovery shall be resolved by the arbitration panel.
(g) A written decision of two of the three arbitrators shall constitute a final decision of the arbitration panel.
(h) Prior to the rendering of the arbitration award:
(i) the existence of a liability insurance policy may be disclosed to the arbitration panel; and
(ii) the amount of all applicable liability insurance policy limits may not be disclosed to the arbitration panel.
(i) The amount of the arbitration award may not exceed the liability limits of all the defendant's applicable liability insurance policies, including applicable liability umbrella policies. If the initial arbitration award exceeds the liability limits of all applicable liability insurance policies,

the arbitration award shall be reduced to an amount equal to the liability limits of all applicable liability insurance policies.

(j) The arbitration award is the final resolution of all claims between the parties unless the award was procured by corruption, fraud, or other undue means.

(k) If the arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitration panel may award reasonable fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(l) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(9) An at-fault driver or an insurer issuing a policy of insurance under this part that is covering an at-fault driver may not reduce compensation to an injured party based on the injured party not being covered by a policy of insurance that provides personal injury protection coverage under Sections 31A-22-306 through 31A-22-309.

Amended by Chapter 415, 2023 General Session

**31A-22-304 Motor vehicle liability policy minimum limits.**

(1) A policy issued or renewed on or before December 31, 2024, containing motor vehicle liability coverage may not limit the insurer's liability under that coverage below the following:

(a)

(i) $25,000 because of liability for bodily injury to or death of one person, arising out of the use of a motor vehicle in any one accident;

(ii) subject to the limit for one person in Subsection (1)(a)(i), in the amount of $65,000 because of liability for bodily injury to or death of two or more persons arising out of the use of a motor vehicle in any one accident; and

(iii) in the amount of $15,000 because of liability for injury to, or destruction of, property of others arising out of the use of a motor vehicle in any one accident; or

(b) $80,000 in any one accident whether arising from bodily injury to or the death of others, or from destruction of, or damage to, the property of others.

(2) Subject to Subsection (3), a policy issued or renewed on or after January 1, 2025, containing motor vehicle liability coverage may not limit the insurer's liability under that coverage below the following:

(a)

(i) $30,000 because of liability for bodily injury to or death of one person, arising out of the use of a motor vehicle in any one accident;

(ii) subject to the limit for one person in Subsection (2)(a)(i), in the amount of $65,000 because of liability for bodily injury to or death of two or more persons arising out of the use of a motor vehicle in any one accident; and

(iii) in the amount of $25,000 because of liability for injury to, or destruction of, property of others arising out of the use of a motor vehicle in any one accident; or

(b) $90,000 in any one accident whether arising from bodily injury to or the death of others, or from destruction of, or damage to, the property of others.

(3) Notwithstanding Subsection (2), for a policy for a self-insured, private rental fleet, the policy containing motor vehicle liability coverage may not limit the insurer's liability under that coverage below the following:

(a)

(i) $25,000 because of liability for bodily injury to or death of one person, arising out of the use of a motor vehicle in any one accident;

(ii) subject to the limit for one person in Subsection (3)(a)(i), in the amount of $65,000 because of liability for bodily injury to or death of two or more persons arising out of the use of a motor vehicle in any one accident; and

(iii) in the amount of $15,000 because of liability for injury to, or destruction of, property of others arising out of the use of a motor vehicle in any one accident; or

(b) $80,000 in any one accident whether arising from bodily injury to or the death of others, or from destruction of, or damage to, the property of others.

Amended by Chapter 51, 2023 General Session

**31A-22-305 Uninsured motorist coverage.**

(1) As used in this section, "covered persons" includes:

(a) the named insured;

(b) for a claim arising on or after May 13, 2014, the named insured's dependent minor children;

(c) persons related to the named insured by blood, marriage, adoption, or guardianship, who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere;

(d) any person occupying or using a motor vehicle:

(i) referred to in the policy; or

(ii) owned by a self-insured; and

(e) any person who is entitled to recover damages against the owner or operator of the uninsured or underinsured motor vehicle because of bodily injury to or death of persons under Subsection (1)(a), (b), (c), or (d).

(2) As used in this section, "uninsured motor vehicle" includes:

(a)

(i) a motor vehicle, the operation, maintenance, or use of which is not covered under a liability policy at the time of an injury-causing occurrence; or

(ii)

(A) a motor vehicle covered with lower liability limits than required by Section 31A-22-304; and

(B) the motor vehicle described in Subsection (2)(a)(ii)(A) is uninsured to the extent of the deficiency;

(b) an unidentified motor vehicle that left the scene of an accident proximately caused by the motor vehicle operator;

(c) a motor vehicle covered by a liability policy, but coverage for an accident is disputed by the liability insurer for more than 60 days or continues to be disputed for more than 60 days; or

(d)

(i) an insured motor vehicle if, before or after the accident, the liability insurer of the motor vehicle is declared insolvent by a court of competent jurisdiction; and

(ii) the motor vehicle described in Subsection (2)(d)(i) is uninsured only to the extent that the claim against the insolvent insurer is not paid by a guaranty association or fund.

(3) Uninsured motorist coverage under Subsection 31A-22-302(1)(b) provides coverage for covered persons who are legally entitled to recover damages from owners or operators of uninsured motor vehicles because of bodily injury, sickness, disease, or death.

(4)

(a) For new policies written on or after January 1, 2001, the limits of uninsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named

insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that uninsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has no liability insurance; and

(v) discloses the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(b) Any selection or rejection under this Subsection (4) continues for that issuer of the liability coverage until the insured requests, in writing, a change of uninsured motorist coverage from that liability insurer.

(c)

(i) Subsections (4)(a) and (b) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (4)(a) and (b) clarifies the application of law and does not enlarge, eliminate, or destroy vested rights.

(d) For purposes of this Subsection (4), "new policy" means:

(i) any policy that is issued which does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(e)

(i) As used in this Subsection (4)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (4)(d).

(iii) If an additional motor vehicle is added to a personal lines policy where uninsured motorist coverage has been rejected, or where uninsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days that:

(A) in the same manner as described in Subsection (4)(a)(iv), explains the purpose of uninsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (4)(d)(ii) does not constitute a new policy.

(g)

(i) Subsection (4)(d) applies retroactively to any claim arising on or after January 1, 2001, for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of this Subsection (4):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies the application of law.

(h) A self-insured, including a governmental entity, may elect to provide uninsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (4)(a) and (5)(a) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an uninsured motorist claim.

(i) Uninsured motorist coverage may not be sold with limits that are less than the minimum bodily injury limits for motor vehicle liability policies under Section 31A-22-304.

(j) The acknowledgment under Subsection (4)(a) continues for that issuer of the uninsured motorist coverage until the named insured requests, in writing, different uninsured motorist coverage from the insurer.

(k)

(i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of uninsured motorist coverage in the same manner as described in Subsection (4)(a)(iv); and

(B) a disclosure of the additional premiums required to purchase uninsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under Subsection (4)(k)(i) shall be sent to all named insureds that carry uninsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum uninsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(l) For purposes of this Subsection (4), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(5)

(a)

(i) Except as provided in Subsection (5)(b), the named insured may reject uninsured motorist coverage by an express writing to the insurer that provides liability coverage under Subsection 31A-22-302(1)(a).

(ii) This rejection shall be on a form provided by the insurer that includes a reasonable explanation of the purpose of uninsured motorist coverage.

(iii) This rejection continues for that issuer of the liability coverage until the insured in writing requests uninsured motorist coverage from that liability insurer.

(b)

(i) All persons, including governmental entities, that are engaged in the business of, or that accept payment for, transporting natural persons by motor vehicle, and all school districts that provide transportation services for their students, shall provide coverage for all motor vehicles used for that purpose, by purchase of a policy of insurance or by self-insurance, uninsured motorist coverage of at least $25,000 per person and $500,000 per accident.

(ii) This coverage is secondary to any other insurance covering an injured covered person.

(c) Uninsured motorist coverage:

(i) in order to avoid double recovery, does not cover any benefit under Title 34A, Chapter 2, Workers' Compensation Act, or Title 34A, Chapter 3, Utah Occupational Disease Act, provided by the workers' compensation insurance carrier, uninsured employer, the Uninsured Employers' Fund created in Section 34A-2-704, or the Employers' Reinsurance Fund created in Section 34A-2-702, except that:

(A) the covered person is credited an amount described in Subsection 34A-2-106(5); and

(B) the benefits described in this Subsection (5)(c)(i) do not need to be paid before an uninsured motorist claim may be pursued and resolved;

(ii) may not be subrogated by the workers' compensation insurance carrier, uninsured employer, the Uninsured Employers' Fund created in Section 34A-2-704, or the Employers' Reinsurance Fund created in Section 34A-2-702;

(iii) may not be reduced by any benefits provided by the workers' compensation insurance carrier, uninsured employer, the Uninsured Employers' Fund created in Section 34A-2-704, or the Employers' Reinsurance Fund created in Section 34A-2-702;

(iv) notwithstanding Subsection 31A-1-103(3)(f), may be reduced by health insurance subrogation only after the covered person has been made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (5)(c)(v), may be recovered:

(A) for a person under 18 years old who is injured within the scope of Subsection (5)(c)(v) but limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(d) As used in this Subsection (5), "motor vehicle" means the same as that term is defined in Section 41-1a-102.

(6) When a covered person alleges that an uninsured motor vehicle under Subsection (2)(b) proximately caused an accident without touching the covered person or the motor vehicle occupied by the covered person, the covered person shall show the existence of the uninsured motor vehicle by clear and convincing evidence consisting of more than the covered person's testimony.

(7)

(a) The limit of liability for uninsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(b)

(i) Subsection (7)(a) applies to all persons except a covered person as defined under Subsection (8)(b).

(ii) A covered person as defined under Subsection (8)(b)(ii) is entitled to the highest limits of uninsured motorist coverage afforded for any one motor vehicle that the covered person is the named insured or an insured family member.

(iii) This coverage shall be in addition to the coverage on the motor vehicle the covered person is occupying.

(iv) Neither the primary nor the secondary coverage may be set off against the other.

(c) Coverage on a motor vehicle occupied at the time of an accident shall be primary coverage, and the coverage elected by a person described under Subsections (1)(a) through (c) shall be secondary coverage.

(8)

(a) Uninsured motorist coverage under this section applies to bodily injury, sickness, disease, or death of covered persons while occupying or using a motor vehicle only if the motor vehicle is described in the policy under which a claim is made, or if the motor vehicle is a newly acquired or replacement motor vehicle covered under the terms of the policy. Except as provided in Subsection (7) or this Subsection (8), a covered person injured in a motor vehicle described in a policy that includes uninsured motorist benefits may not elect to collect uninsured motorist coverage benefits from any other motor vehicle insurance policy under which the person is a covered person.

(b) Each of the following persons may also recover uninsured motorist benefits under any one other policy in which they are described as a "covered person" as defined in Subsection (1):

(i) a covered person injured as a pedestrian by an uninsured motor vehicle; and

(ii) except as provided in Subsection (8)(c), a covered person injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(A) to the covered person;

(B) to the covered person's spouse; or

(C) to the covered person's resident parent or resident sibling.

(c)

(i) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(A) a dependent minor of parents who reside in separate households; and

(B) injured while occupying or using a motor vehicle that is not owned, leased, or furnished:

(I) to the covered person;

(II) to the covered person's resident parent; or

(III) to the covered person's resident sibling.

(ii) Each parent's policy under this Subsection (8)(c) is liable only for the percentage of the damages that the limit of liability of each parent's policy of uninsured motorist coverage bears to the total of both parents' uninsured coverage applicable to the accident.

(d) A covered person's recovery under any available policies may not exceed the full amount of damages.

(e) A covered person in Subsection (8)(b) is not barred against making subsequent elections if recovery is unavailable under previous elections.

(f)

(i) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(ii) Except to the extent permitted by Subsection (7) and this Subsection (8), interpolicy stacking is prohibited for uninsured motorist coverage.

(9)

(a) When a claim is brought by a named insured or a person described in Subsection (1) and is asserted against the covered person's uninsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which uninsured benefits are claimed, the election provided in Subsection (9)(a) is available to the claimant only, except that if the policy

under which insured benefits are claimed provides that either an insured or the insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to arbitrate shall stay the litigation of the claim under Subsection (9)(a)(ii).

(c) Once the claimant has elected to commence litigation under Subsection (9)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the uninsured motorist carrier.

(d) For purposes of the statute of limitations applicable to a claim described in Subsection (9)(a), if the claimant does not elect to resolve the claim through litigation, the claim is considered filed when the claimant submits the claim to binding arbitration in accordance with this Subsection (9).

(e)

(i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (9)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (9)(e)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (9)(e)(ii), the parties shall select a panel of three arbitrators.

(f) If the parties select a panel of three arbitrators under Subsection (9)(e)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (9)(f)(i) shall select one additional arbitrator to be included in the panel.

(g) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (9)(e)(i); or

(ii) if an arbitration panel is selected under Subsection (9)(e)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (9)(f)(ii).

(h) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(i)

(i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (10)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (10)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

(j) All issues of discovery shall be resolved by the arbitrator or the arbitration panel.

(k) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(l)

(i) Except as provided in Subsection (10), the amount of an arbitration award may not exceed the uninsured motorist policy limits of all applicable uninsured motorist policies, including applicable uninsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the uninsured motorist policy limits of all applicable uninsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined uninsured motorist policy limits of all applicable uninsured motorist policies.

(m) The arbitrator or arbitration panel may not decide the issues of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) any allegations or claims asserting consequential damages or bad faith liability.

(n) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(o) If the arbitrator or arbitration panel finds that the action was not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the claim in good faith.

(p) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (9)(m) between the parties unless:

(i) the award was procured by corruption, fraud, or other undue means; and

(ii) within 20 days after service of the arbitration award, a party:

(A) files a complaint requesting a trial de novo in a court with jurisdiction under Title 78A, Judiciary and Judicial Administration; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (9)(p)(ii)(A).

(q)

(i) Upon filing a complaint for a trial de novo under Subsection (9)(p), the claim shall proceed through litigation in accordance with the Utah Rules of Civil Procedure and Utah Rules of Evidence.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, a party may request a jury trial with a complaint requesting a trial de novo under Subsection (9)(p)(ii)(A).

(r)

(i) If the claimant, as the moving party in a trial de novo requested under Subsection (9)(p), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the uninsured motorist carrier, as the moving party in a trial de novo requested under Subsection (9)(p), does not obtain a verdict that is at least 20% less than the arbitration award, the uninsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (9)(r)(iv), the costs under this Subsection (9)(r) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (9)(r) may not exceed $2,500 unless Subsection (10)(h)(iii) applies.

(s) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (9)(r), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(t) Upon a motion of the nonmoving party, the court may award reasonable attorney fees to the nonmoving party if the court determines that the moving party requested a trial de novo to

harass, cause unreasonable delay, needlessly increase the cost of litigation, or abuse the judicial process.

(u) Nothing in this section is intended to limit any claim under any other portion of an applicable insurance policy.

(v) If there are multiple uninsured motorist policies, as set forth in Subsection (8), the claimant may elect to arbitrate in one hearing the claims against all the uninsured motorist carriers.

(10)

(a) Within 30 days after a covered person elects to submit a claim for uninsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the uninsured motorist carrier:

(i) a written demand for payment of uninsured motorist coverage benefits, setting forth:

(A) subject to Subsection (10)(l), the specific monetary amount of the demand, including a computation of the covered person's claimed past medical expenses, claimed past lost wages, and the other claimed past economic damages; and

(B) the factual and legal basis and any supporting documentation for the demand;

(ii) a written statement under oath disclosing:

(A)

(I) the names and last known addresses of all health care providers who have rendered health care services to the covered person that are material to the claims for which uninsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (10)(a)(ii)(A)(I);

(B)

(I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and

(II) the names and last known addresses of the health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which uninsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;

(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for uninsured motorist benefits up to the time the election for arbitration or litigation has been exercised;

(D) other documents to reasonably support the claims being asserted; and

(E) all state and federal statutory lienholders including a statement as to whether the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance

Program benefits under Title 26B, Chapter 3, Part 9, Utah Children's Health Insurance Program, or if the claim is subject to any other state or federal statutory liens; and

(iii) signed authorizations to allow the uninsured motorist carrier to only obtain records and billings from the individuals or entities disclosed under Subsections (10)(a)(ii)(A)(I), (B)(I), and (C).

(b)

(i) If the uninsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (10)(a)(ii) is reasonably necessary, the uninsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the uninsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the uninsured motorist carrier may request the arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (10)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c)

(i) An uninsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of uninsured motorist benefits under Subsection (10)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (10)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (10)(a)(i);

(B) except as provided in Subsection (10)(c)(i)(C), tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26B, Chapter 3, Part 9, Utah Children's Health Insurance Program, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the uninsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the uninsured motorist carrier under Subsection (10)(c)(i) is the total amount of the uninsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an uninsured motorist carrier as provided for in Subsection (10)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (10)(c)(i) as payment in full of all uninsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (10)(c)(i) as partial payment of all uninsured motorist claims; and

(B) continue to litigate or arbitrate the remaining claim in accordance with the election made under Subsections (9)(a) through (c).

(e) If a covered person elects to accept the amount tendered under Subsection (10)(c)(i) as partial payment of all uninsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the uninsured motorist carrier under Subsection (10)(c)(i).

(f) In an arbitration proceeding on the remaining uninsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (10)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of uninsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the average of the covered person's initial written demand for payment provided for in Subsection (10)(a)(i) and the uninsured motorist carrier's initial written response provided for in Subsection (10)(c)(i), the uninsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award exceeds the policy limits of the subject uninsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h)

(i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii)

(A) Objection to the affidavit of costs shall specify with particularity the costs to which the uninsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (10)(g)(ii) may not exceed $5,000.

(i)

(i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for uninsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (10)(a).

(ii) If the information under Subsection (10)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (10)(g).

(j) This Subsection (10) does not limit any other cause of action that arose or may arise against the uninsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (10) only apply to motor vehicle accidents that occur on or after March 30, 2010.

(l)

(i)

(A) The written demand requirement in Subsection (10)(a)(i)(A) does not affect the covered person's requirement to provide a computation of any other economic damages claimed,

and the one or more respondents shall have a reasonable time after the receipt of the computation of any other economic damages claimed to conduct fact and expert discovery as to any additional damages claimed.

(B) The changes made by Laws of Utah 2014, Chapter 290, Section 10, and Chapter 300, Section 10, to this Subsection (10)(l) and Subsection (10)(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(ii) The changes made by Laws of Utah 2014, Chapter 290, Section 10, and Chapter 300, Section 10, to Subsections (10)(a)(ii)(A)(II) and (B)(II) apply to any claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(11)

(a) A person shall commence an action on a written policy or contract for uninsured motorist coverage within four years after the inception of loss.

(b) Subsection (11)(a) shall apply to all claims that have not been time barred by Subsection 31A-21-313(1)(a) as of May 14, 2019.

Amended by Chapter 310, 2026 General Session

**31A-22-305.3 Underinsured motorist coverage.**

(1) As used in this section:

(a) "Covered person" means the same as that term is defined in Section 31A-22-305.

(b)

(i) "Underinsured motor vehicle" includes a motor vehicle, the operation, maintenance, or use of which is covered under a liability policy at the time of an injury-causing occurrence, but which has insufficient liability coverage to compensate fully the injured party for all special and general damages.

(ii) The term "underinsured motor vehicle" does not include:

(A) a motor vehicle that is covered under the liability coverage of the same policy that also contains the underinsured motorist coverage;

(B) an uninsured motor vehicle as defined in Subsection 31A-22-305(2); or

(C) a motor vehicle owned or leased by:

(I) a named insured;

(II) a named insured's spouse; or

(III) a dependent of a named insured.

(2)

(a) Underinsured motorist coverage under Subsection 31A-22-302(1)(c) provides coverage for a covered person who is legally entitled to recover damages from an owner or operator of an underinsured motor vehicle because of bodily injury, sickness, disease, or death.

(b) A covered person occupying or using a motor vehicle owned, leased, or furnished to the covered person, the covered person's spouse, or covered person's resident relative may recover underinsured benefits only if the motor vehicle is:

(i) described in the policy under which a claim is made; or

(ii) a newly acquired or replacement motor vehicle covered under the terms of the policy.

(3)

(a) For purposes of this Subsection (3), "new policy" means:

(i) any policy that is issued that does not include a renewal or reinstatement of an existing policy; or

(ii) a change to an existing policy that results in:

(A) a named insured being added to or deleted from the policy; or

(B) a change in the limits of the named insured's motor vehicle liability coverage.

(b) For new policies written on or after January 1, 2001, the limits of underinsured motorist coverage shall be equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy, unless a named insured rejects or purchases coverage in a lesser amount by signing an acknowledgment form that:

(i) is filed with the department;

(ii) is provided by the insurer;

(iii) waives the higher coverage;

(iv) need only state in this or similar language that "underinsured motorist coverage provides benefits or protection to you and other covered persons for bodily injury resulting from an accident caused by the fault of another party where the other party has insufficient liability insurance"; and

(v) discloses the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(c) Any selection or rejection under Subsection (3)(b) continues for that issuer of the liability coverage until the insured requests, in writing, a change of underinsured motorist coverage from that liability insurer.

(d)

(i) Subsections (3)(b) and (c) apply retroactively to any claim arising on or after January 1, 2001, for which, as of May 14, 2013, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsections (3)(b) and (c) clarifies the application of law and does not enlarge, eliminate, or destroy vested rights.

(e)

(i) As used in this Subsection (3)(e), "additional motor vehicle" means a change that increases the total number of vehicles insured by the policy, and does not include replacement, substitute, or temporary vehicles.

(ii) The adding of an additional motor vehicle to an existing personal lines or commercial lines policy does not constitute a new policy for purposes of Subsection (3)(a).

(iii) If an additional motor vehicle is added to a personal lines policy where underinsured motorist coverage has been rejected, or where underinsured motorist limits are lower than the named insured's motor vehicle liability limits, the insurer shall provide a notice to a named insured within 30 days that:

(A) in the same manner described in Subsection (3)(b)(iv), explains the purpose of underinsured motorist coverage; and

(B) encourages the named insured to contact the insurance company or insurance producer for quotes as to the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(f) A change in policy number resulting from any policy change not identified under Subsection (3)(a)(ii) does not constitute a new policy.

(g)

(i) Subsection (3)(a) applies retroactively to any claim arising on or after January 1, 2001 for which, as of May 1, 2012, an insured has not made a written demand for arbitration or filed a complaint in a court of competent jurisdiction.

(ii) The Legislature finds that the retroactive application of Subsection (3)(a):

(A) does not enlarge, eliminate, or destroy vested rights; and

(B) clarifies legislative intent.

(h) A self-insured, including a governmental entity, may elect to provide underinsured motorist coverage in an amount that is less than its maximum self-insured retention under Subsections (3)(b) and (l) by issuing a declaratory memorandum or policy statement from the chief financial officer or chief risk officer that declares the:

(i) self-insured entity's coverage level; and

(ii) process for filing an underinsured motorist claim.

(i) Underinsured motorist coverage may not be sold with limits that are less than:

(i) $10,000 for one person in any one accident; and

(ii) at least $20,000 for two or more persons in any one accident.

(j) An acknowledgment under Subsection (3)(b) continues for that issuer of the underinsured motorist coverage until the named insured, in writing, requests different underinsured motorist coverage from the insurer.

(k)

(i) The named insured's underinsured motorist coverage, as described in Subsection (2), is secondary to the liability coverage of an owner or operator of an underinsured motor vehicle, as described in Subsection (1).

(ii) Underinsured motorist coverage may not be set off against the liability coverage of the owner or operator of an underinsured motor vehicle, but shall be added to, combined with, or stacked upon the liability coverage of the owner or operator of the underinsured motor vehicle to determine the limit of coverage available to the injured person.

(l)

(i) In conjunction with the first two renewal notices sent after January 1, 2001, for policies existing on that date, the insurer shall disclose in the same medium as the premium renewal notice, an explanation of:

(A) the purpose of underinsured motorist coverage in the same manner as described in Subsection (3)(b)(iv); and

(B) a disclosure of the additional premiums required to purchase underinsured motorist coverage with limits equal to the lesser of the limits of the named insured's motor vehicle liability coverage or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(ii) The disclosure required under this Subsection (3)(l) shall be sent to all named insureds that carry underinsured motorist coverage limits in an amount less than the named insured's motor vehicle liability policy limits or the maximum underinsured motorist coverage limits available by the insurer under the named insured's motor vehicle policy.

(m) For purposes of this Subsection (3), a notice or disclosure sent to a named insured in a household constitutes notice or disclosure to all insureds within the household.

(4)

(a)

(i) Except as provided in this Subsection (4), a covered person injured in a motor vehicle described in a policy that includes underinsured motorist benefits may not elect to collect underinsured motorist coverage benefits from another motor vehicle insurance policy.

(ii) The limit of liability for underinsured motorist coverage for two or more motor vehicles may not be added together, combined, or stacked to determine the limit of insurance coverage available to an injured person for any one accident.

(iii) Subsection (4)(a)(ii) applies to all persons except a covered person described under Subsections (4)(b)(i) and (ii).

(b)

(i) A covered person injured as a pedestrian by an underinsured motor vehicle may recover underinsured motorist benefits under any one other policy in which they are described as a covered person.

(ii) Except as provided in Subsection (4)(b)(iii), a covered person injured while occupying, using, or maintaining a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's spouse, or the covered person's resident parent or resident sibling, may also recover benefits under any one other policy under which the covered person is also a covered person.

(iii)

(A) A covered person may recover benefits from no more than two additional policies, one additional policy from each parent's household if the covered person is:

(I) a dependent minor of parents who reside in separate households; and

(II) injured while occupying or using a motor vehicle that is not owned, leased, or furnished to the covered person, the covered person's resident parent, or the covered person's resident sibling.

(B) Each parent's policy under this Subsection (4)(b)(iii) is liable only for the percentage of the damages that the limit of liability of each parent's policy of underinsured motorist coverage bears to the total of both parents' underinsured coverage applicable to the accident.

(iv) A covered person's recovery under any available policies may not exceed the full amount of damages.

(v) Underinsured coverage on a motor vehicle occupied at the time of an accident is primary coverage, and the coverage elected by a person described under Subsections 31A-22-305(1)(a), (b), and (c) is secondary coverage.

(vi) The primary and the secondary coverage may not be set off against the other.

(vii) A covered person as described under Subsection (4)(b)(i) or is entitled to the highest limits of underinsured motorist coverage under only one additional policy per household applicable to that covered person as a named insured, spouse, or relative.

(viii) A covered injured person is not barred against making subsequent elections if recovery is unavailable under previous elections.

(ix)

(A) As used in this section, "interpolicy stacking" means recovering benefits for a single incident of loss under more than one insurance policy.

(B) Except to the extent permitted by this Subsection (4), interpolicy stacking is prohibited for underinsured motorist coverage.

(c) Underinsured motorist coverage:

(i) in order to avoid double recovery, does not cover any benefit under Title 34A, Chapter 2, Workers' Compensation Act, or Title 34A, Chapter 3, Utah Occupational Disease Act, provided by the workers' compensation insurance carrier, uninsured employer, the Uninsured Employers' Fund created in Section 34A-2-704, or the Employers' Reinsurance Fund created in Section 34A-2-702, except that:

(A) the covered person is credited an amount described in Subsection 34A-2-106(5); and

(B) the benefits described in this Subsection (4)(c)(i) do not need to be paid before an underinsured motorist claim may be pursued and resolved;

(ii) may not be subrogated by a workers' compensation insurance carrier, uninsured employer, the Uninsured Employers' Fund created in Section 34A-2-704, or the Employers' Reinsurance Fund created in Section 34A-2-702;

(iii) may not be reduced by benefits provided by the workers' compensation insurance carrier, uninsured employer, the Uninsured Employers' Fund created in Section 34A-2-704, or the Employers' Reinsurance Fund created in Section 34A-2-702;

(iv) notwithstanding Subsection 31A-1-103(3)(f), may be reduced by health insurance subrogation only after the covered person is made whole;

(v) may not be collected for bodily injury or death sustained by a person:

(A) while committing a violation of Section 41-1a-1314;

(B) who, as a passenger in a vehicle, has knowledge that the vehicle is being operated in violation of Section 41-1a-1314; or

(C) while committing a felony; and

(vi) notwithstanding Subsection (4)(c)(v), may be recovered:

(A) for a person younger than 18 years old who is injured within the scope of Subsection (4)(c)(v), but is limited to medical and funeral expenses; or

(B) by a law enforcement officer as defined in Section 53-13-103, who is injured within the course and scope of the law enforcement officer's duties.

(5)

(a) Notwithstanding Section 31A-21-313, an action on a written policy or contract for underinsured motorist coverage shall be commenced within four years after the inception of loss.

(b) The inception of the loss under Subsection 31A-21-313(1) for underinsured motorist claims occurs upon the date of the settlement check representing the last liability policy payment.

(6) An underinsured motorist insurer does not have a right of reimbursement against a person liable for the damages resulting from an injury-causing occurrence if the person's liability insurer has tendered the policy limit and the limits have been accepted by the claimant.

(7) Except as otherwise provided in this section, a covered person may seek, subject to the terms and conditions of the policy, additional coverage under any policy:

(a) that provides coverage for damages resulting from motor vehicle accidents; and

(b) that is not required to conform to Section 31A-22-302.

(8)

(a) When a claim is brought by a named insured or a person described in Subsection 31A-22-305(1) and is asserted against the covered person's underinsured motorist carrier, the claimant may elect to resolve the claim:

(i) by submitting the claim to binding arbitration; or

(ii) through litigation.

(b) Unless otherwise provided in the policy under which underinsured benefits are claimed, the election provided in Subsection (8)(a) is available to the claimant only, except that if the policy under which insured benefits are claimed provides that either an insured or the insurer may elect arbitration, the insured or the insurer may elect arbitration and that election to arbitrate shall stay the litigation of the claim under Subsection (8)(a)(ii).

(c) Once a claimant elects to commence litigation under Subsection (8)(a)(ii), the claimant may not elect to resolve the claim through binding arbitration under this section without the written consent of the underinsured motorist coverage carrier.

(d) For purposes of the statute of limitations applicable to a claim described in Subsection (8)(a), if the claimant does not elect to resolve the claim through litigation, the claim is considered filed when the claimant submits the claim to binding arbitration in accordance with this Subsection (8).

(e)

(i) Unless otherwise agreed to in writing by the parties, a claim that is submitted to binding arbitration under Subsection (8)(a)(i) shall be resolved by a single arbitrator.

(ii) All parties shall agree on the single arbitrator selected under Subsection (8)(e)(i).

(iii) If the parties are unable to agree on a single arbitrator as required under Subsection (8)(e)(ii), the parties shall select a panel of three arbitrators.

(f) If the parties select a panel of three arbitrators under Subsection (8)(e)(iii):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (8)(f)(i) shall select one additional arbitrator to be included in the panel.

(g) Unless otherwise agreed to in writing:

(i) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(e)(i); or

(ii) if an arbitration panel is selected under Subsection (8)(e)(iii):

(A) each party shall pay the fees and costs of the arbitrator selected by that party; and

(B) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (8)(f)(ii).

(h) Except as otherwise provided in this section or unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section is governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(i)

(i) The arbitration shall be conducted in accordance with Rules 26(a)(4) through (f), 27 through 37, 54, and 68 of the Utah Rules of Civil Procedure, once the requirements of Subsections (9)(a) through (c) are satisfied.

(ii) The specified tier as defined by Rule 26(c)(3) of the Utah Rules of Civil Procedure shall be determined based on the claimant's specific monetary amount in the written demand for payment of uninsured motorist coverage benefits as required in Subsection (9)(a)(i)(A).

(iii) Rules 26.1 and 26.2 of the Utah Rules of Civil Procedure do not apply to arbitration claims under this part.

(j) An issue of discovery shall be resolved by the arbitrator or the arbitration panel.

(k) A written decision by a single arbitrator or by a majority of the arbitration panel constitutes a final decision.

(l)

(i) Except as provided in Subsection (9), the amount of an arbitration award may not exceed the underinsured motorist policy limits of all applicable underinsured motorist policies, including applicable underinsured motorist umbrella policies.

(ii) If the initial arbitration award exceeds the underinsured motorist policy limits of all applicable underinsured motorist policies, the arbitration award shall be reduced to an amount equal to the combined underinsured motorist policy limits of all applicable underinsured motorist policies.

(m) The arbitrator or arbitration panel may not decide an issue of coverage or extra-contractual damages, including:

(i) whether the claimant is a covered person;

(ii) whether the policy extends coverage to the loss; or

(iii) an allegation or claim asserting consequential damages or bad faith liability.

(n) The arbitrator or arbitration panel may not conduct arbitration on a class-wide or class-representative basis.

(o) If the arbitrator or arbitration panel finds that the arbitration is not brought, pursued, or defended in good faith, the arbitrator or arbitration panel may award reasonable attorney fees and costs against the party that failed to bring, pursue, or defend the arbitration in good faith.

(p) An arbitration award issued under this section shall be the final resolution of all claims not excluded by Subsection (8)(m) between the parties unless:

(i) the award is procured by corruption, fraud, or other undue means; or

(ii) either party, within 20 days after service of the arbitration award:

(A) files a complaint requesting a trial de novo in the a court with jurisdiction under Title 78A, Judiciary and Judicial Administration; and

(B) serves the nonmoving party with a copy of the complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).

(q)

(i) Upon filing a complaint for a trial de novo under Subsection (8)(p), a claim shall proceed through litigation in accordance with the Utah Rules of Civil Procedure and Utah Rules of Evidence.

(ii) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a complaint requesting a trial de novo under Subsection (8)(p)(ii)(A).

(r)

(i) If the claimant, as the moving party in a trial de novo requested under Subsection (8)(p), does not obtain a verdict that is at least $5,000 and is at least 20% greater than the arbitration award, the claimant is responsible for all of the nonmoving party's costs.

(ii) If the underinsured motorist carrier, as the moving party in a trial de novo requested under Subsection (8)(p), does not obtain a verdict that is at least 20% less than the arbitration award, the underinsured motorist carrier is responsible for all of the nonmoving party's costs.

(iii) Except as provided in Subsection (8)(r)(iv), the costs under this Subsection (8)(r) shall include:

(A) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure; and

(B) the costs of expert witnesses and depositions.

(iv) An award of costs under this Subsection (8)(r) may not exceed $2,500 unless Subsection (9)(h)(iii) applies.

(s) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsection (8)(r), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(i) was not fully disclosed in writing prior to the arbitration proceeding; or

(ii) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(t) Upon a motion of the nonmoving party, the court may award reasonable attorney fees to the nonmoving party if the court determines that the moving party requested a trial de novo to harass, cause unreasonable delay, needlessly increase the cost of litigation, or abuse the judicial process.

(u) Nothing in this section is intended to limit a claim under another portion of an applicable insurance policy.

(v) If there are multiple underinsured motorist policies, as set forth in Subsection (4), the claimant may elect to arbitrate in one hearing the claims against all the underinsured motorist carriers.

(9)

(a) Within 30 days after a covered person elects to submit a claim for underinsured motorist benefits to binding arbitration or files litigation, the covered person shall provide to the underinsured motorist carrier:
(i) a written demand for payment of underinsured motorist coverage benefits, setting forth:
(A) subject to Subsection (9)(l), the specific monetary amount of the demand, including a computation of the covered person's claimed past medical expenses, claimed past lost wages, and all other claimed past economic damages; and
(B) the factual and legal basis and any supporting documentation for the demand;
(ii) a written statement under oath disclosing:
(A)
(I) the names and last known addresses of all health care providers who have rendered health care services to the covered person that are material to the claims for which the underinsured motorist benefits are sought for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and
(II) the names and last known addresses of the health care providers who have rendered health care services to the covered person, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised that have not been disclosed under Subsection (9)(a)(ii)(A)(I);
(B)
(I) the names and last known addresses of all health insurers or other entities to whom the covered person has submitted claims for health care services or benefits material to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised; and
(II) the names and last known addresses of the health insurers or other entities to whom the covered person has submitted claims for health care services or benefits, which the covered person claims are immaterial to the claims for which underinsured motorist benefits are sought, for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation have not been disclosed;
(C) if lost wages, diminished earning capacity, or similar damages are claimed, all employers of the covered person for a period of five years preceding the date of the event giving rise to the claim for underinsured motorist benefits up to the time the election for arbitration or litigation has been exercised;
(D) other documents to reasonably support the claims being asserted; and
(E) all state and federal statutory lienholders including a statement as to whether the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26B, Chapter 3, Part 9, Utah Children's Health Insurance Program, or if the claim is subject to any other state or federal statutory liens; and
(iii) signed authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities disclosed under Subsections (9)(a)(ii)(A)(I), (B)(I), and (C).
(b)

(i) If the underinsured motorist carrier determines that the disclosure of undisclosed health care providers or health care insurers under Subsection (9)(a)(ii) is reasonably necessary, the underinsured motorist carrier may:

(A) make a request for the disclosure of the identity of the health care providers or health care insurers; and

(B) make a request for authorizations to allow the underinsured motorist carrier to only obtain records and billings from the individuals or entities not disclosed.

(ii) If the covered person does not provide the requested information within 10 days:

(A) the covered person shall disclose, in writing, the legal or factual basis for the failure to disclose the health care providers or health care insurers; and

(B) either the covered person or the underinsured motorist carrier may request the arbitrator or arbitration panel to resolve the issue of whether the identities or records are to be provided if the covered person has elected arbitration.

(iii) The time periods imposed by Subsection (9)(c)(i) are tolled pending resolution of the dispute concerning the disclosure and production of records of the health care providers or health care insurers.

(c)

(i) An underinsured motorist carrier that receives an election for arbitration or a notice of filing litigation and the demand for payment of underinsured motorist benefits under Subsection (9)(a)(i) shall have a reasonable time, not to exceed 60 days from the date of the demand and receipt of the items specified in Subsections (9)(a)(i) through (iii), to:

(A) provide a written response to the written demand for payment provided for in Subsection (9)(a)(i);

(B) except as provided in Subsection (9)(c)(i)(C), tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person; and

(C) if the covered person is a recipient of Medicare or Medicaid benefits or Utah Children's Health Insurance Program benefits under Title 26B, Chapter 3, Part 9, Utah Children's Health Insurance Program, or if the claim is subject to any other state or federal statutory liens, tender the amount, if any, of the underinsured motorist carrier's determination of the amount owed to the covered person less:

(I) if the amount of the state or federal statutory lien is established, the amount of the lien; or

(II) if the amount of the state or federal statutory lien is not established, two times the amount of the medical expenses subject to the state or federal statutory lien until such time as the amount of the state or federal statutory lien is established.

(ii) If the amount tendered by the underinsured motorist carrier under Subsection (9)(c)(i) is the total amount of the underinsured motorist policy limits, the tendered amount shall be accepted by the covered person.

(d) A covered person who receives a written response from an underinsured motorist carrier as provided for in Subsection (9)(c)(i), may:

(i) elect to accept the amount tendered in Subsection (9)(c)(i) as payment in full of all underinsured motorist claims; or

(ii) elect to:

(A) accept the amount tendered in Subsection (9)(c)(i) as partial payment of all underinsured motorist claims; and

(B) continue to litigate or arbitrate the remaining claim in accordance with the election made under Subsections (8)(a) through (c).

(e) If a covered person elects to accept the amount tendered under Subsection (9)(c)(i) as partial payment of all underinsured motorist claims, the final award obtained through arbitration, litigation, or later settlement shall be reduced by any payment made by the underinsured motorist carrier under Subsection (9)(c)(i).

(f) In an arbitration proceeding on the remaining underinsured claims:

(i) the parties may not disclose to the arbitrator or arbitration panel the amount paid under Subsection (9)(c)(i) until after the arbitration award has been rendered; and

(ii) the parties may not disclose the amount of the limits of underinsured motorist benefits provided by the policy.

(g) If the final award obtained through arbitration or litigation is greater than the average of the covered person's initial written demand for payment provided for in Subsection (9)(a)(i) and the underinsured motorist carrier's initial written response provided for in Subsection (9)(c)(i), the underinsured motorist carrier shall pay:

(i) the final award obtained through arbitration or litigation, except that if the award exceeds the policy limits of the subject underinsured motorist policy by more than $15,000, the amount shall be reduced to an amount equal to the policy limits plus $15,000; and

(ii) any of the following applicable costs:

(A) any costs as set forth in Rule 54(d), Utah Rules of Civil Procedure;

(B) the arbitrator or arbitration panel's fee; and

(C) the reasonable costs of expert witnesses and depositions used in the presentation of evidence during arbitration or litigation.

(h)

(i) The covered person shall provide an affidavit of costs within five days of an arbitration award.

(ii)

(A) Objection to the affidavit of costs shall specify with particularity the costs to which the underinsured motorist carrier objects.

(B) The objection shall be resolved by the arbitrator or arbitration panel.

(iii) The award of costs by the arbitrator or arbitration panel under Subsection (9)(g)(ii) may not exceed $5,000.

(i)

(i) A covered person shall disclose all material information, other than rebuttal evidence, within 30 days after a covered person elects to submit a claim for underinsured motorist coverage benefits to binding arbitration or files litigation as specified in Subsection (9)(a).

(ii) If the information under Subsection (9)(i)(i) is not disclosed, the covered person may not recover costs or any amounts in excess of the policy under Subsection (9)(g).

(j) This Subsection (9) does not limit any other cause of action that arose or may arise against the underinsured motorist carrier from the same dispute.

(k) The provisions of this Subsection (9) only apply to motor vehicle accidents that occur on or after March 30, 2010.

(l)

(i) The written demand requirement in Subsection (9)(a)(i)(A) does not affect the covered person's requirement to provide a computation of any other economic damages claimed, and the one or more respondents shall have a reasonable time after the receipt of the computation of any other economic damages claimed to conduct fact and expert discovery as to any additional damages claimed. The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter 300, Section 11, to this Subsection (9)(l) and Subsection (9)

(a)(i)(A) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

(ii) The changes made by Laws of Utah 2014, Chapter 290, Section 11, and Chapter 300, Section 11, under Subsections (9)(a)(ii)(A)(II) and (B)(II) apply to a claim submitted to binding arbitration or through litigation on or after May 13, 2014.

Amended by Chapter 310, 2026 General Session

**31A-22-305.5 Uninsured motorist property damage coverage -- Coverage limitations.**

(1)

(a) At the request of the named insured, every motor vehicle liability policy of insurance under Sections 31A-22-303 and 31A-22-304 or combination of policies purchased to satisfy the owner's or operator's security requirement of Section 41-12a-301 which policy does not provide insurance for collision damage shall provide uninsured motorist property damage coverage for property damage to the motor vehicle described in the policy.

(b) The uninsured motorist property damage coverage provided under Subsection (1)(a) shall be for the benefit of covered persons, as defined under Section 31A-22-305, who are legally entitled to recover damages:

(i) from the owner or operator of an uninsured motor vehicle, as defined under Subsections 31A-22-305(2)(a), (c), and (d); and

(ii) arising out of the operation, maintenance, or use of an uninsured motor vehicle.

(2)

(a) Except as provided under Subsection (5), the coverage provided under this section shall include payment for loss or damage to the motor vehicle described in the policy, not to exceed the motor vehicle's actual cash value or $3,500, whichever is less.

(b) Property damage does not include compensation for loss of use of the motor vehicle.

(3) The coverage provided under this section shall be payable only if:

(a) the occurrence causing the property damage involves actual physical contact between the covered motor vehicle and an uninsured motor vehicle;

(b) the owner, operator, or license plate number of the uninsured motor vehicle is identified; and

(c) the insured or someone on his behalf reports the occurrence within 10 days to the insurer or his agent.

(4) Except as provided under Subsection (5), the coverage provided under this section shall be subject to a $250 deductible and shall be excess to any other insurance covering property damage to the motor vehicle described in the policy.

(5) The insurer providing coverage under this section may, at appropriate premium rates, make available additional:

(a) coverage above the limits provided under Subsection (2); and

(b) deductibles for the coverage under Subsection (5)(a) above the limits provided under Subsection (4).

(6) A rating surcharge may not be applied to any policy of motor vehicle insurance issued in this state as a result of payment of a claim made under this section.

Amended by Chapter 37, 2005 General Session

**31A-22-306 Personal injury protection.**

Personal injury protection under Subsection 31A-22-302(2) provides the coverages and benefits described under Section 31A-22-307 to persons described under Section 31A-22-308, but is subject to the limitations, exclusions, and conditions set forth in Section 31A-22-309.

Amended by Chapter 204, 1986 General Session

**31A-22-307 Personal injury protection coverages and benefits.**

(1) Personal injury protection coverages and benefits include:

(a) up to the minimum amount required coverage of not less than $3,000 per person, the reasonable value of all expenses for necessary:

(i) medical services;

(ii) surgical services;

(iii) X-ray services;

(iv) dental services;

(v) rehabilitation services, including prosthetic devices;

(vi) ambulance services;

(vii) hospital services; and

(viii) nursing services;

(b)

(i) the lesser of $250 per week or 85% of any loss of gross income and loss of earning capacity per person from inability to work, for a maximum of 52 consecutive weeks after the loss, except that this benefit need not be paid for the first three days of disability, unless the disability continues for longer than two consecutive weeks after the date of injury; and

(ii) a special damage allowance not exceeding $20 per day for a maximum of 365 days, for services actually rendered or expenses reasonably incurred for services that, but for the injury, the injured person would have performed for the injured person's household, except that this benefit need not be paid for the first three days after the date of injury unless the person's inability to perform these services continues for more than two consecutive weeks;

(c) funeral, burial, or cremation benefits not to exceed a total of $1,500 per person; and

(d) compensation on account of death of a person, payable to the person's heirs, in the total of $3,000.

(2)

(a)

(i) To determine the reasonable value of the medical expenses provided for in Subsection (1) and under Subsection 31A-22-309(1)(a)(vi), the commissioner shall conduct a relative value study of services and accommodations for the diagnosis, care, recovery, or rehabilitation of an injured person in the most populous county in the state to assign a unit value and determine the 75th percentile charge for each type of service and accommodation.

(ii) The relative value study shall be updated every other year.

(iii) In conducting the relative value study, the department may consult or contract with appropriate public and private medical and health agencies or other technical experts.

(iv) The costs and expenses incurred in conducting, maintaining, and administering the relative value study shall be funded by the tax created under Section 59-9-105.

(v) Upon completion of the relative value study, the department shall prepare and publish a relative value study which sets forth the unit value and the 75th percentile charge assigned to each type of service and accommodation.

(b)

(i) The reasonable value of any service or accommodation is determined by applying the unit value and the 75th percentile charge assigned to the service or accommodation under the relative value study.

(ii) If a service or accommodation is not assigned a unit value or the 75th percentile charge under the relative value study, the value of the service or accommodation shall equal the reasonable cost of the same or similar service or accommodation in the most populous county of this state.

(c) This Subsection (2) does not preclude the department from adopting a schedule already established or a schedule prepared by persons outside the department, if it meets the requirements of this Subsection (2).

(d) Every insurer shall report to the commissioner any pattern of overcharging, excessive treatment, or other improper actions by a health provider within 30 days after the day on which the insurer has knowledge of the pattern.

(e)

(i) In disputed cases, a court on its own motion or on the motion of either party, may designate an impartial medical panel of not more than three licensed physicians to examine the claimant and testify on the issue of the reasonable value of the claimant's medical services or expenses.

(ii) An impartial medical panel designated under Subsection (2)(e)(i) shall consist of a majority of health care professionals within the same license classification and specialty as the provider of the claimant's medical services or expenses.

(3) Medical expenses as provided for in Subsection (1)(a) and in Subsection 31A-22-309(1)(a)(vi) include expenses for any nonmedical remedial care and treatment rendered in accordance with a recognized religious method of healing.

(4) The insured may waive for the named insured and the named insured's spouse only the loss of gross income benefits of Subsection (1)(b)(i) if the insured states in writing that:

(a) within 31 days of applying for coverage, neither the insured nor the insured's spouse received any earned income from regular employment; and

(b) for at least 180 days from the date of the writing and during the period of insurance, neither the insured nor the insured's spouse will receive earned income from regular employment.

(5) This section does not:

(a) prohibit the issuance of a policy of insurance providing coverages greater than the minimum coverage required under this chapter; or

(b) require the segregation of those minimum coverages from other coverages in the same policy.

(6) Deductibles are not permitted with respect to the insurance coverages required under this section.

(7)

(a) A person shall bring an action on a written policy or contract for personal injury protection coverage within four years after the inception of loss.

(b) This Subsection (7) applies to a claim that is not time barred by Subsection 31A-21-313(1)(a) as of May 3, 2023.

Amended by Chapter 185, 2023 General Session

**31A-22-308 Persons covered by personal injury protection.**

The following may receive benefits under personal injury protection coverage:

(1) the named insured, when injured in an accident involving any motor vehicle, regardless of whether the accident occurs in this state, the United States, its territories or possessions, or Canada, except where the injury is the result of the use or operation of the named insured's own motor vehicle not actually insured under the policy;
(2) persons related to the insured by blood, marriage, adoption, or guardianship who are residents of the insured's household, including those who usually make their home in the same household but temporarily live elsewhere under the circumstances described in Subsection (1), except where the person is injured as a result of the use or operation of the person's own motor vehicle not insured under the policy; and
(3) any other natural person whose injuries arise out of an automobile accident occurring:
  (a) while the person occupies a motor vehicle described in the policy with the express or implied consent of the named insured; or
  (b) if the person is a pedestrian who is injured in an accident occurring in Utah involving the described motor vehicle.

Amended by Chapter 302, 2025 General Session

**31A-22-309 Limitations, exclusions, and conditions to personal injury protection.**
(1)
  (a) A person who has or is required to have direct benefit coverage under a policy that includes personal injury protection may not maintain a cause of action for general damages arising out of personal injuries alleged to have been caused by an automobile accident, except where the person sustains one or more of the following:
    (i) death;
    (ii) dismemberment;
    (iii) permanent disability or permanent impairment based upon objective findings;
    (iv) permanent disfigurement;
    (v) a bone fracture; or
    (vi) medical expenses to a person in excess of $3,000.
  (b) Subsection (1)(a) does not apply to a person making an uninsured motorist claim.
(2)
  (a) An insurer issuing personal injury protection coverage under this part may only exclude from this coverage benefits:
    (i) for an injury the insured sustains while occupying another motor vehicle owned by or furnished for the regular use of the insured or a resident family member of the insured and not insured under the policy;
    (ii) for an injury a person sustains while operating the insured motor vehicle without the express or implied consent of the insured or while not in lawful possession of the insured motor vehicle;
    (iii) to an injured person, if the person's conduct contributed to the person's injury:
      (A) by intentionally causing injury to the person; or
      (B) while committing a felony;
    (iv) for an injury a person sustains arising out of the use of a motor vehicle while located for use as a residence or premises;
    (v) for an injury due to war, whether declared, civil war, insurrection, rebellion, or revolution, or to an act or a condition incident to a war, civil war, insurrection, rebellion, or revolution; or
    (vi) for an injury resulting from the radioactive, toxic, explosive, or other hazardous properties of nuclear materials.

(b) This Subsection (2) does not limit the exclusions that may be contained in other types of coverage.

(3) The benefits payable to an injured person under Section 31A-22-307 are reduced by:

(a) any benefits that the injured person receives or is entitled to receive as a result of an accident covered in this code under any workers' compensation or similar statutory plan; and

(b) any amounts that the injured person receives or is entitled to receive from the United States or any of the United States' agencies because that person is on active duty in the military service.

(4) When a person injured is also an insured party under any other policy, including those policies complying with this part, primary coverage is given by the policy insuring the motor vehicle in use during the accident.

(5)

(a) Payment of the benefits provided for in Section 31A-22-307 shall be made on a monthly basis as expenses are incurred.

(b) Benefits for any period are overdue if the insurer does not pay the benefits within 30 days after the day on which the insurer receives reasonable proof of the fact and amount of expenses incurred during the period.

(c) If reasonable proof is not supplied as to the entire claim, the amount supported by reasonable proof is overdue if not paid within 30 days after the insurer receives that proof.

(d) Any part or all of the remainder of the claim that is later supported by reasonable proof is also overdue if not paid within 30 days after the day on which the insurer receives the proof.

(e) If the insurer fails to pay the expenses when due, these expenses shall bear interest at the rate of 1-1/2% per month after the due date.

(f)

(i) The person entitled to the benefits may bring an action in contract to recover the expenses plus the applicable interest.

(ii) If the insurer is required by the action to pay any overdue benefits and interest, the insurer is also required to pay a reasonable attorney's fee to the claimant.

(6)

(a) Except as provided in Subsection (6)(b), a policy that provides personal injury protection coverage is subject to the following:

(i) that where the insured under the policy is or would be held legally liable for the personal injuries sustained by any person to whom benefits required under personal injury protection have been paid by another insurer, the insurer of the person who would be held legally liable shall reimburse the other insurer for the payment, but not in excess of the amount of damages recoverable; and

(ii) that the issue of liability for that reimbursement and the reimbursement's amount shall be decided by mandatory, binding arbitration between the insurers.

(b) There shall be no right of reimbursement between insurers under Subsection (6)(a) if the insurer of the person who would be held legally liable for the personal injuries sustained has tendered the insurer's policy limit.

(c)

(i) If the insurer of the person who would be held legally liable for the personal injuries sustained reimburses a no-fault insurer before settling a third party liability claim with an injured person and subsequently determines that some or all of the reimbursed amount is needed to settle a third party claim, the insurer of the person who would be held legally liable for the personal injuries sustained shall provide written notice to the no-fault insurer that some or all of the reimbursed amount is needed to settle a third party liability claim.

(ii) The written notice described under Subsection (6)(c)(i) shall:
(A) identify the amount of the reimbursement that is needed to settle a third party liability claim;
(B) provide notice to the no-fault insurer that the no-fault insurer has 15 days to return the amount described in Subsection (6)(c)(ii)(A); and
(C) identify the third party liability insurer that the returned amount shall be paid to.
(iii) A no-fault insurer that receives a notice under this Subsection (6)(c) shall return the portion of the reimbursement identified under Subsection (6)(c)(ii) to the third party liability insurer identified under Subsection (6)(c)(ii)(C) within 15 business days after the day on which the no-fault insurer receives a notice under this Subsection (6)(c).

Amended by Chapter 45, 2026 General Session

**31A-22-310 Assigned risk plan.**

(1) After consultation with insurers authorized to issue policies containing the provisions specified under Section 31A-22-302, the insurance commissioner shall approve a reasonable plan for the equitable apportionment among the insurers of applicants for those policies who are in good faith entitled to, but are unable to procure, these policies through ordinary methods.
(2) Upon the commissioner's approval of a plan under this section, all insurers issuing policies described under Section 31A-22-302 shall subscribe to and participate in the commissioner's approved plan.
(3) Any applicant for a policy under the commissioner's plan, any person insured under the plan, and any insurer affected by the commissioner's plan may appeal to the insurance commissioner from any ruling or decision of the manager or committee designated to operate the plan.
(4) Section 31A-2-306 applies to the commissioner's decision on this appeal.

Amended by Chapter 161, 1987 General Session

**31A-22-311 Definitions.**

As used in Sections 31A-22-312 and 31A-22-314:
(1) "Authorized driver" means the person to whom the vehicle is rented and includes:
(a) the spouse of the person renting the vehicle if the spouse is a licensed driver satisfying the rental company's minimum age requirement;
(b) the employer or coworker of the person renting the vehicle if the employer or coworker is engaged in business activity with the renter and if the employer or coworker are licensed drivers satisfying the rental company's minimum age requirement;
(c) any person who operates the vehicle during an emergency situation;
(d) any person who operates the vehicle while parking the vehicle at a commercial establishment; or
(e) any person expressly listed by the rental company on the rental agreement as an authorized driver.
(2) "Damage" means any damage or loss to the rented vehicle resulting from a collision, including loss of use and any costs and expenses incident to the damage or loss.
(3) "Rental agreement" means any written agreement stating the terms and conditions governing the use of a private passenger motor vehicle provided by a rental company.
(4) "Rental company" means any person or organization in the business of providing private passenger motor vehicles to the public.

(5) "Renter" means any person or organization obtaining the use of a private passenger motor vehicle from a rental company under the terms of a rental agreement.

Amended by Chapter 302, 2025 General Session

**31A-22-312 Liability for collision damage -- No security required -- No waiver -- Section inapplicable to rental companies disclosing charges.**

(1) No rental company may, in rental agreements of 30 continuous days or less, hold any authorized driver liable for any damage except when:
  (a) the damage is caused intentionally by an authorized driver or as a result of the authorized driver's willful and wanton misconduct;
  (b) the damage arises out of the authorized driver's operation of the vehicle while illegally intoxicated or under the influence of any illegal drug as defined or determined under the law of the state where the damage occurred;
  (c) the damage is caused while the authorized driver is engaged in any speed contest;
  (d) the rental transaction is based on information supplied by the renter with the intent to defraud the rental company;
  (e) the damage arises out of the use of the vehicle while committing or otherwise engaged in a criminal act in which the use of the motor vehicle is substantially related to the nature of the criminal activity;
  (f) the damage arises out of the use of the motor vehicle to carry persons or property for hire; or
  (g) the damage arises out of the use of the motor vehicle outside of the United States or Canada unless the use is specifically authorized by the rental agreement.
(2) No security or deposit for damage in any form may be required or requested by the rental company during the rental period, or pending the resolution of any dispute.
(3) No waiver may be offered to provide coverage for any of the exceptions listed in this section.
(4) This section does not apply to any rental company:
  (a) whose advertising in this state clearly discloses all charges and costs incidental to the basic daily rental rate; and
  (b) that provides written notice to renters clearly printed on the rental agreement and prominently displayed at its place of business, that the renter's own motor vehicle insurance or the renter's credit card agreement may cover any damage or loss to the rental vehicle.

Amended by Chapter 302, 2025 General Session

**31A-22-314 Mandatory coverage.**

(1) As used in this section, "owner's or operator's security" has the same meaning as defined in Section 41-12a-103.
(2)
  (a) A rental company shall maintain owner's or operator's security meeting the requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act.
  (b) Owner's or operator's security maintained by a rental company under Subsection (2)(a) applies only when there is no other valid or collectible insurance or other form of security meeting the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act.
  (c) If other valid or collectible insurance or other form of security satisfies the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, on a loss involving a rental vehicle, a rental company's obligation under Title

41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, is satisfied.

(d) When no other valid or collectible insurance or other form of security exists meeting the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, a rental company shall provide security meeting the minimum requirements of Title 41, Chapter 12a, Financial Responsibility of Motor Vehicle Owners and Operators Act, for losses involving a rental vehicle.

(3) Nothing in this section shall be construed to expand or reduce the liability of a rental company or to impair a rental company's right to indemnity, contribution, or both.

Amended by Chapter 391, 2007 General Session

**31A-22-315 Motor vehicle insurance reporting -- Penalty.**

(1)

(a) As used in this section, "commercial motor vehicle insurance coverage" means an insurance policy that:

(i) includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage; and

(ii) is defined by the department.

(b) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules defining commercial motor vehicle insurance coverage.

(2)

(a) Except as provided in Subsections (2)(b) and (c), each insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part shall before the seventh and twenty-first day of each calendar month provide to the Department of Public Safety's designated agent selected in accordance with Title 41, Chapter 12a, Part 8, Uninsured Motorist Identification Database Program, a record of each motor vehicle or motorboat insurance policy in effect for vehicles registered or garaged in Utah as of the previous submission that was issued by the insurer.

(b) Each insurer that issues commercial motor vehicle insurance coverage shall before the seventh day of each calendar month provide to the Department of Public Safety's designated agent selected in accordance with Title 41, Chapter 12a, Part 8, Uninsured Motorist Identification Database Program, a record of each commercial motor vehicle insurance policy in effect for vehicles registered or garaged in Utah as of the previous month that was issued by the insurer.

(c) An insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part is not required to provide a record of a motor vehicle insurance policy in effect for a vehicle to the Department of Public Safety's designated agent under Subsection (2)(a) or (b) if the policy covers a vehicle that is registered under Section 41-1a-221, 41-1a-222, or 41-1a-301.

(d) This Subsection (2) does not preclude more frequent reporting.

(3)

(a) A record provided by an insurer under Subsection (2)(a) shall include:

(i) the name, date of birth, and driver license number, if the insured provides a driver license number to the insurer, of each insured owner or operator, and the address of the named insured;

(ii) the make, year, and vehicle identification number of each insured vehicle; and
(iii) the policy number, effective date, and expiration date of each policy.
(b) A record provided by an insurer under Subsection (2)(b) shall include:
(i) the named insured;
(ii) the policy number, effective date, and expiration date of each policy; and
(iii) the following information, if available:
(A) the name, date of birth, and driver license number of each insured owner or operator, and the address of the named insured; and
(B) the make, year, and vehicle identification number of each insured vehicle.
(4) Each insurer shall provide this information by an electronic means or by another form the Department of Public Safety's designated agent agrees to accept.
(5)
(a) The commissioner may, following procedures set forth in Title 63G, Chapter 4, Administrative Procedures Act, assess a fine against an insurer of up to $250 for each day the insurer fails to comply with this section.
(b) If an insurer shows that the failure to comply with this section was inadvertent, accidental, or the result of excusable neglect, the commissioner shall excuse the fine.

Amended by Chapter 236, 2024 General Session

**31A-22-315.5 Motor vehicle insurance verification -- Penalty.**
(1)
(a) Except as provided in Subsection (1)(b), and in addition to the reporting requirements under Section 31A-22-315, each insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part shall, upon request, provide to the Department of Public Safety's designated agent selected in accordance with Title 41, Chapter 12a, Part 8, Uninsured Motorist Identification Database Program, verification of whether or not a motor vehicle insurance policy is in effect for a specified vehicle.
(b) An insurer that issues a policy that includes motor vehicle liability coverage, uninsured motorist coverage, underinsured motorist coverage, or personal injury coverage under this part is not required to provide verification of a motor vehicle insurance policy in effect for a vehicle to the Department of Public Safety's designated agent under Subsection (1)(a) if:
(i) the policy covers a vehicle that is registered under Section 41-1a-221, 41-1a-222, or 41-1a-301;
(ii) the policy covers a commercial motor vehicle; or
(iii) the insurer issues insurance for less than 500 motor vehicles.
(2) Each insurer shall provide the verification required under Subsection (1) using an electronic service established by the insurers, through the Internet, world wide web, or a similar proprietary or common carrier electronic system that:
(a) is compliant with:
(i) the specifications and standards of the Insurance Industry Committee on Motor Vehicle Administration; and
(ii) other applicable industry standards;
(b) is available 24 hours a day, seven days a week, subject to reasonable allowances for:
(i) scheduled maintenance; or
(ii) temporary system failures; and
(c) includes appropriate security measures, consistent with industry standards, to:

(i) secure its data against unauthorized access; and
(ii) maintain a record of all information requests.
(3)
(a) The commissioner may, following procedures set forth in Title 63G, Chapter 4, Administrative Procedures Act, assess a fine against an insurer of up to $250 for each day the insurer fails to comply with this section.
(b) The commissioner shall excuse the fine if an insurer shows that the failure to comply with this section was:
(i) inadvertent;
(ii) accidental; or
(iii) the result of excusable neglect.

Enacted by Chapter 243, 2012 General Session

**31A-22-316 Title.**

Sections 31A-22-316 through 31A-22-319 are known as the "Aftermarket Crash Parts Act."

Renumbered and Amended by Chapter 8, 1995 General Session

**31A-22-317 Definitions.**

As used in Sections 31A-22-316 through 31A-22-319:
(1) "Aftermarket crash part" means a replacement for any of the nonmechanical sheet metal or plastic parts that generally constitute the exterior of a motor vehicle, including inner and outer panels.
(2) "Installer" means an individual who replaces or repairs the parts of a motor vehicle.
(3) "Insurer" means an insurance company and any person authorized to represent the insurer with respect to a claim.
(4) "Nonoriginal equipment manufacturer" or "non-OEM" means a manufacturer of replacement parts for a different manufacturer's equipment.
(5) "Non-OEM aftermarket crash part" means an aftermarket crash part not made for or by the manufacturer of the motor vehicle.
(6) "OEM aftermarket crash part" means an aftermarket crash part made for or by the manufacturer of the motor vehicle.
(7) "Repair facility" means any motor vehicle dealer, garage, body shop, or other commercial entity that repairs or replaces those parts that generally constitute the exterior of a motor vehicle.

Amended by Chapter 106, 2026 General Session

**31A-22-318 Identification.**

(1) Any aftermarket crash part supplied by a nonoriginal equipment manufacturer for use in a motor vehicle in this state shall have the logo or name of the nonoriginal equipment manufacturer affixed or inscribed on the aftermarket crash part.
(2) The nonoriginal equipment manufacturer's logo or name shall be visible after installation whenever practicable.

Renumbered and Amended by Chapter 8, 1995 General Session

**31A-22-319 Prohibition on insurer requiring certain parts -- Disclosure.**

(1) Unless an insurer gives an insured notice in writing an insurer may not specify the use of non-OEM aftermarket crash parts in the repair of an insured's motor vehicle.
(2)
(a) For a policy issued on or after October 1, 2026, the insurer shall provide to the insured, at the time of issuance and renewal, a written notice stating that the insurer may authorize or specify the use of aftermarket crash parts in the event of a covered loss.
(b) An insurer may provide the notice described in Subsection (2)(a) electronically in accordance with applicable law.
(c) The notice described in Subsection (2)(a):
(i) is informational only and does not create, expand, or alter coverage or obligations under the policy; and
(ii) shall include the following disclosure in at least 10-point font: "In the event of a covered loss, the insurer may authorize or specify the use of aftermarket crash parts supplied by a source other than the manufacturer of your vehicle. Parts used in the repair of your vehicle by a manufacturer other than the original manufacturer are required to be at least equivalent in kind and quality in terms of fit, quality, and performance to the original parts they are replacing."
(3) When an insurer authorizes or specifies the use of a non-OEM aftermarket crash part, the written estimate shall:
(a) clearly identify each non-OEM aftermarket crash part; and
(b) contain the following disclosure in at least 10-point font, that appears on or is attached to the insured's copy of the estimate: "This estimate has been prepared based on the authorization of your insurer and the use of aftermarket crash parts not made by the original manufacturer of your motor vehicle. Parts used in the repair of your vehicle that are made by a manufacturer other than the original manufacturer are required to be at least equivalent in kind and quality in terms of fit, quality, and performance. Warranties applicable to these replacement parts are provided by the manufacturer or distributor of these parts rather than the manufacturer of your vehicle."
(4) Nothing in this section:
(a) creates an express or implied warranty by the insurer beyond the terms of the policy of insurance;
(b) requires an insurer to provide coverage for OEM aftermarket crash parts unless the coverage is expressly provided in the policy; or
(c) prohibits the voluntary use of OEM aftermarket crash parts.
(5) Notwithstanding Sections 31A-2-101 and 31A-2-201, the department and the commissioner are not required to administer or otherwise enforce Subsection (3).

Amended by Chapter 106, 2026 General Session

**31A-22-320 Use of credit information.**
(1) For purposes of this section:
(a) "Credit information" means:
(i) a consumer report;
(ii) a credit score;
(iii) any information obtained by the insurer from a consumer report;
(iv) any part of a consumer report; or
(v) any part of a credit score.
(b)

(i) Except as provided in Subsection (1)(b)(ii), "consumer report" is as defined in 15 U.S.C. 1681a.
(ii) "Consumer report" does not include:
(A) a motor vehicle record obtained from a state or an agency of a state; or
(B) any information regarding an applicant's or insured's insurance claim history.
(c)
(i) "Credit score" means a numerical value or a categorization that is:
(A) derived from information in a consumer report;
(B) derived from a statistical tool or modeling system; and
(C) developed to predict the likelihood of:
(I) future insurance claims behavior; or
(II) credit behavior.
(ii) "Credit score" includes:
(A) a risk predictor; or
(B) a risk score.
(iii) A numerical value or a categorization described in Subsection (1)(c)(i) is a credit score if it is developed to predict the behavior described in Subsection (1)(c)(i)(C) regardless of whether it is developed to predict other factors in addition to predicting the behavior described in Subsection (1)(c)(i)(C).
(d) "Motor vehicle related insurance policy" means:
(i) a motor vehicle liability policy;
(ii) a policy that contains uninsured motorist coverage;
(iii) a policy that contains underinsured motorist coverage;
(iv) a policy that contains property damage coverage under this part; or
(v) a policy that contains personal injury coverage under this part.
(2) An insurer that issues a motor vehicle related insurance policy:
(a) except as provided in Subsection (2)(b), may not use credit information for the purpose of determining for the motor vehicle related insurance policy:
(i) renewal;
(ii) nonrenewal;
(iii) termination;
(iv) eligibility;
(v) underwriting; or
(vi) rating; and
(b) notwithstanding Subsection (2)(a), may use credit information for the purpose of:
(i) if risk related factors other than credit information are considered, determining initial underwriting; or
(ii) providing to an insured:
(A) a reduction in rates paid by the insured for the motor vehicle related insurance policy; or
(B) any other discount similar to the reduction in rates described in Subsection (2)(b)(ii)(A).
(3) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules necessary to enforce this section.

Amended by Chapter 382, 2008 General Session

**31A-22-321 Use of arbitration in third party motor vehicle accident cases.**

(1) A person injured as a result of a motor vehicle accident may elect to submit all third party bodily injury claims to arbitration by filing a notice of the submission of the claim to binding arbitration in a court with jurisdiction under Title 78A, Judiciary and Judicial Administration, if:
(a) the claimant or the claimant's representative has:
(i) previously and timely filed a complaint in a court that includes a third party bodily injury claim; and
(ii) filed a notice to submit the claim to arbitration within 14 days after the complaint has been answered; and
(b) the notice required under Subsection (1)(a)(ii) is filed while the action under Subsection (1)(a)(i) is still pending.
(2)
(a) If a party submits a bodily injury claim to arbitration under Subsection (1), the party submitting the claim or the party's representative is limited to an arbitration award that does not exceed $75,000 or the defendant's per person limits of third party bodily insurance, whichever is less, in addition to any available personal injury protection benefits and any claim for property damage.
(b) A claim for reimbursement of personal injury protection benefits is to be resolved between insurers as provided for in Subsection 31A-22-309(6)(a)(ii).
(c) A claim for property damage may not be made in an arbitration proceeding under Subsection (1) unless agreed upon by the parties in writing.
(d) A party who elects to proceed against a defendant under this section:
(i) waives the right to obtain a judgment against the personal assets of the defendant; and
(ii) is limited to recovery only against available limits of insurance , plus a maximum $15,000 in excess of policy limits, and available costs if appealed.
(e)
(i) This section does not prevent a party from pursuing an underinsured motorist claim as set out in Section 31A-22-305.3.
(ii) An underinsured motorist claim described in Subsection (2)(e)(i) is not limited to the defendant's per person limits of third party bodily insurance coverage or the $75,000 limit.
(iii) There shall be no right of subrogation on the part of the underinsured motorist carrier for a claim submitted to arbitration under this section.
(3) A claim for punitive damages may not be made in an arbitration proceeding under Subsection (1) or any subsequent proceeding, even if the claim is later resolved through a trial de novo under Subsection (11).
(4)
(a) A person who has elected arbitration under this section may rescind the person's election if the rescission is made within:
(i) 90 days after the election to arbitrate; and
(ii) no less than 30 days before any scheduled arbitration hearing.
(b) A person seeking to rescind an election to arbitrate under this Subsection (4) shall:
(i) file a notice of the rescission of the election to arbitrate with the court in which the matter was filed; and
(ii) send copies of the notice of the rescission of the election to arbitrate to all counsel of record to the action.
(c) All discovery completed in anticipation of the arbitration hearing shall be available for use by the parties as allowed by the Utah Rules of Civil Procedure and Utah Rules of Evidence.

(d) A party who has elected to arbitrate under this section and then rescinded the election to arbitrate under this Subsection (4) may not elect to arbitrate the claim under this section again.

(5)

(a) Unless otherwise agreed to by the parties or by order of the court, an arbitration process elected under this section is subject to Rule 26, Utah Rules of Civil Procedure.

(b) Unless otherwise agreed to by the parties or ordered by the court, discovery shall be completed within 150 days after the date arbitration is elected under this section or the date the answer is filed, whichever is longer.

(6)

(a) Unless otherwise agreed to in writing by the parties, a claim that is submitted to arbitration under this section shall be resolved by a single arbitrator.

(b) Unless otherwise agreed to by the parties or ordered by the court, all parties shall agree on the single arbitrator selected under Subsection (6)(a) within 90 days of the answer of the defendant.

(c) If the parties are unable to agree on a single arbitrator as required under Subsection (6)(b), the parties shall select a panel of three arbitrators.

(d) If the parties select a panel of three arbitrators under Subsection (6)(c):

(i) each side shall select one arbitrator; and

(ii) the arbitrators appointed under Subsection (6)(d)(i) shall select one additional arbitrator to be included in the panel.

(7) Unless otherwise agreed to in writing:

(a) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (6)(a); and

(b) if an arbitration panel is selected under Subsection (6)(d):

(i) each party shall pay the fees and costs of the arbitrator selected by that party's side; and

(ii) each party shall pay an equal share of the fees and costs of the arbitrator selected under Subsection (6)(d)(ii).

(8) Except as otherwise provided in this section and unless otherwise agreed to in writing by the parties, an arbitration proceeding conducted under this section shall be governed by Title 78B, Chapter 11, Utah Uniform Arbitration Act.

(9)

(a) Subject to the provisions of this section, the Utah Rules of Civil Procedure and Utah Rules of Evidence apply to the arbitration proceeding.

(b) The Utah Rules of Civil Procedure and Utah Rules of Evidence shall be applied liberally with the intent of concluding the claim in a timely and cost-efficient manner.

(c) Discovery shall be conducted in accordance with Rules 26 through 37 of the Utah Rules of Civil Procedure and shall be subject to the jurisdiction of the court in which the matter is filed.

(d) Dispositive motions shall be filed, heard, and decided by the court prior to the arbitration proceeding in accordance with the court's scheduling order.

(10) A written decision by a single arbitrator or by a majority of the arbitration panel shall constitute a final decision.

(11) An arbitration award issued under this section shall be the final resolution of all bodily injury claims between the parties and may be reduced to judgment by the court upon motion and notice unless:

(a) either party, within 20 days after service of the arbitration award:

(i) files a notice requesting a trial de novo in the court; and

(ii) serves the nonmoving party with a copy of the notice requesting a trial de novo under Subsection (11)(a)(i); or

(b) the arbitration award has been satisfied.

(12)

(a) Upon filing a notice requesting a trial de novo under Subsection (11):

(i) unless otherwise stipulated to by the parties or ordered by the court, an additional 120 days shall be allowed for further discovery;

(ii) the additional discovery time under Subsection (12)(a)(i) shall run from the notice of appeal; and

(iii) the claim shall proceed through litigation in accordance with the Utah Rules of Civil Procedure and Utah Rules of Evidence.

(b) In accordance with Rule 38, Utah Rules of Civil Procedure, either party may request a jury trial with a request for trial de novo filed under Subsection (11)(a)(i).

(13)

(a) If the plaintiff, as the moving party in a trial de novo requested under Subsection (11), does not obtain a verdict that is at least $5,000 and is at least 30% greater than the damages awarded in arbitration, excluding the items listed in Subsection (19), the plaintiff is responsible for all of the nonmoving party's costs.

(b) The costs described in Subsection (13)(a) include:

(i) any costs set forth in Rule 54(d), Utah Rules of Civil Procedure;

(ii) the costs of expert witnesses and depositions;

(iii) the arbitration costs paid by the prevailing party under Subsection (7);

(iv) prejudgment interest described in Section 78B-5-824; and

(v) postjudgment interest described in Section 15-1-4.

(14)

(a) If a defendant, as the moving party in a trial de novo requested under Subsection (11), does not obtain a verdict that is at least 30% less than the damages awarded in arbitration, excluding the items described in Subsection (19), the defendant is responsible for all of the nonmoving party's costs.

(b) The costs described in Subsection (14)(a) include:

(i) costs described in Rule 54(d), Utah Rules of Civil Procedure;

(ii) the costs of expert witnesses and depositions;

(iii) the arbitration costs paid by the prevailing party under Subsection (7);

(iv) prejudgment interest described in Section 78B-5-824; and

(v) postjudgment interest described in Section 15-1-4.

(15) For purposes of determining whether a party's verdict is greater or less than the arbitration award under Subsections (13) and (14), a court may not consider any recovery or other relief granted on a claim for damages if the claim for damages:

(a) was not fully disclosed in writing prior to the arbitration proceeding; or

(b) was not disclosed in response to discovery contrary to the Utah Rules of Civil Procedure.

(16) Upon a motion of the nonmoving party, the court may award reasonable attorney fees to the nonmoving party if the court determines that the moving party requested a trial de novo to harass, cause unreasonable delay, needlessly increase the cost of litigation, or abuse the judicial process.

(17) Nothing in this section is intended to affect or prevent any first party claim from later being brought under any first party insurance policy under which the injured person is a covered person.

(18)

(a) If a defendant requests a trial de novo under Subsection (11), the total damages award at trial may not exceed $15,000 above any available per person limits of insurance coverage, not including the costs described in Subsection (14)(b).
(b) If a plaintiff requests a trial de novo under Subsection (11), the verdict at trial may not exceed $75,000, or the per person limits of insurance coverage, whichever is less.
(19) All arbitration awards issued under this section shall include:
(a) the costs described in Rule 54(d), Utah Rules of Civil Procedure;
(b) the arbitration costs paid by the prevailing party under Subsection (7);
(c) prejudgment interest described in Section 78B-5-824; and
(d) postjudgment interest described in Section 15-1-4.
(20) If a party requests a trial de novo under Subsection (11), the party shall file a copy of the notice requesting a trial de novo with the commissioner notifying the commissioner of the party's request for a trial de novo under Subsection (11).

Amended by Chapter 310, 2026 General Session

**31A-22-322 Improper administration of cancelled auto insurance coverage.**
(1) Upon cancellation by an insured of auto insurance coverage, the insurer shall discontinue any automatic payments and withdrawals related to the cancelled policy before the later of:
(a) 15 days after the request for cancellation; or
(b) 15 days after the effective date of the cancellation.
(2) After cancellation by an insured of auto insurance coverage, the insurer may not reinstate the cancelled policy without the express consent of the insured.
(3) After cancellation by an insured of auto insurance coverage, the insurer shall refund any funds collected by the insurer to which the insurer is not entitled, calculated according to the terms of the insurance policy, before the later of:
(a) 30 days after the request for cancellation; or
(b) 30 days after the effective date of the cancellation.
(4) The commissioner may order an insurer who violates this section to forfeit to the state not more than $2,500 for each violation.

Enacted by Chapter 125, 2016 General Session

**31A-22-323 Policy-limit demands, correspondence, and disclosure requirements -- Third-party liability claims.**
(1)
(a) In a third-party liability claim arising under this part in which a claimant or claimant's legal counsel sends a demand letter to a liability insurance carrier demanding the insured's liability policy limits in exchange for a release of claims, such a demand letter shall:
(i) include reasonably sufficient information to allow a reasonable liability insurance carrier to evaluate the claim, including a description of the incident, injuries, liability basis, and damages, copies of the medical records and bills supporting claimed medical damages, and information supporting any other elements of claimed economic damages; and
(ii) provide the liability insurance carrier with no less than 30 days to accept or reject the policy-limit demand.
(b) A claimant is not required to provide expert reports or attorney work product as part of the demand letter described in Subsection (1)(a).
(2)

(a) If the liability insurance carrier that receives a claimant's demand letter described in Subsection (1) declines to tender the insured's liability policy limits following the receipt of the demand letter, and the claimant intends to file a cause of action against the insured, and the claimant or claimant's legal counsel elects to correspond directly with an unrepresented insured, the correspondence with the insured shall:

(i) be in writing, with a copy of the correspondence delivered to the applicable liability insurance carrier;

(ii) include:

(A) a reference to this statutory section;

(B) a plain-language explanation of the claimant's claims against the insured;

(C) a description of the claimant's related injuries;

(D) a copy of the demand letter described in Subsection (1) that was sent to the liability insurance carrier; and

(E) if applicable, a copy of the liability insurance carrier's written response to the demand letter described in Subsection (1);

(iii) comply with the Rules of Professional Conduct established by the Utah Supreme Court, including an indication that the interests of the claimant and the claimant's legal counsel are adverse to the insured; and

(iv) indicate the legal action the claimant and claimant's legal counsel intend to pursue against the insured.

(b) Unless necessary to preserve the claimant's legal rights, a claimant or the claimant's legal counsel may not file a cause of action against the insured until 45 days after that date on which the insured has received the correspondence described in Subsection (2)(a).

(c) If a claimant intends to pursue damages in the legal action described in Subsection (2)(a) that exceed the applicable liability insurance policy limit, the correspondence described in Subsection (2)(a):

(i) shall identify the insured's right:

(A) to review the entirety of the claimant's demand letter, claimed medical records and expenses, and other supporting documentation with the claimant's liability insurance carrier; and

(B) to discuss the insured's rights and responsibilities with respect to any excess verdict, judgment, settlement, or award with the insured's liability insurance carrier, as well as with independent legal counsel; and

(ii) if the correspondence references or suggests the possibility of placing a judgment lien against personal property of the insured following any judgment, shall include a plain-language explanation of the process for obtaining a judgment lien.

(3)

(a) Within 30 days after the date on which the liability insurance carrier receives a copy of the correspondence described in Subsection (2), the liability insurance carrier shall provide the insured with a written disclosure stating whether the liability insurance carrier agrees:

(i) to defend the insured against the claim; and

(ii) to indemnify the insured for any verdict, judgment, settlement, or award arising from the claim, including whether:

(A) the indemnification is limited to the applicable policy limits; or

(B) the indemnification will extend to a verdict, judgment, settlement, or award in excess of the applicable policy limit.

(b) If the liability insurance carrier's decision to indemnify the insured is limited to the applicable policy limits, the disclosure in Subsection (3)(a) shall:

(i) provide a reasonable explanation as to the basis of the decision; and
(ii) notify the insured of the insured's right to seek independent legal counsel regarding the insured's rights and responsibilities with respect to the decision whether to indemnify the insured.

(4)
(a) A disclosure made under Subsection (3):
(i) does not expand, reduce, or modify coverage under the insurance policy; and
(ii) is intended solely to provide clarity to the insured regarding the liability insurance carrier's position.
(b)
(i) Compliance with the procedural provisions of this section does not preclude a finding that the liability insurance carrier breached the liability insurance carrier's duty of good faith if the liability insurance carrier's substantive decisions regarding settlement, defense, or indemnification were unreasonable under the circumstances.
(ii) The reasonableness of a liability insurance carrier's conduct with regard to the decision to defend and indemnify the insured as described in Subsection (3) shall be evaluated based on all relevant circumstances existing at the time decisions were made.

(5) Nothing in this section alters, limits, or waives:
(a) a liability insurance carrier's duty to act in good faith and deal fairly with the liability insurance carrier's insured;
(b) any rights or remedies available to an insured arising from a liability insurance carrier's failure to accept a reasonable settlement offer within applicable policy limits; or
(c) any defenses, claims, or causes of action available under common law or statute to any party.

(6)
(a) A claimant's failure to comply with Subsection (1) or (2) does not bar the claimant from filing suit against the insured or pursuing any remedies available at law, but may be considered by a court in evaluating whether a settlement demand was reasonable for purposes of determining whether a liability insurance carrier breached the liability insurance carrier's duty of good faith.
(b) A liability insurance carrier's failure to comply with the disclosure requirements of Subsection (3) does not create an independent cause of action, but may be considered as evidence of bad faith in any subsequent action by the insured against the liability insurance carrier.
(c) Nothing in this section may be construed to create additional procedural prerequisites to an insured's right to pursue a bad faith claim against the liability insurance carrier.
(d) This section supplements and does not replace existing common law and statutory duties and remedies relating to a liability insurance carrier's duty of good faith and fair dealing with the liability insurance carrier's insured.
(e) Nothing in this section creates a private cause of action.

Enacted by Chapter 85, 2026 General Session

***Effective 5/5/2027***

**31A-22-324 Insurer obligations -- Recovery operations -- Arbitration.**

(1) As used in this section:
(a) "Commercial vehicle" means the same as that term is defined in Section 72-9-102.
(b) "Motor carrier" means the same as that term is defined in Section 72-9-102.
(c) "Motor vehicle" means the same as that term is defined in Section 41-1a-102.

(d) "Non-consent police generated tow" means the towing of a vehicle, vessel, or outboard motor made at the request of a peace officer, a person acting on behalf of a law enforcement agency, or a highway authority under:
(i) Section 41-1a-1101;
(ii) Section 41-6a-210;
(iii) Section 41-6a-527;
(iv) Section 41-6a-1405;
(v) Section 41-6a-1406;
(vi) Section 41-6a-1408;
(vii) Section 73-18-20.1; or
(viii) another provision of law.
(e) "Power unit" means a motor vehicle that is a commercial vehicle.
(f) "Recovery operation" means the same as that term is defined in Section 72-1-102.
(g) "Recovery operator" means a tow truck motor carrier that performs a recovery operation.
(h) "Tow truck motor carrier" means the same as that term is defined in Section 72-9-102.
(2) A motor carrier shall pay the costs associated with a recovery operation from the motor vehicle insurance policy issued for the power unit.
(3) A commercial liability insurer that provides an endorsement described in Subsection (7)(a) that insures a vehicle or cargo recovered as part of a recovery operation shall pay the recovery operator directly for all reasonable and necessary services involved in the recovery operation.
(4)
(a) A commercial liability insurer that provides an endorsement described in Subsection (7)(a) that insures a vehicle recovered as part of a recovery operation shall, within 60 days after the day on which the insurer receives an invoice with documentation of the services performed for the recovery operation:
(i) pay the recovery operator the full amount invoiced by the recovery operator; or
(ii) pay the lesser of:
(A) 75% of the total of the invoiced amount; or
(B) $40,000.
(b) An insurer may dispute the amount invoiced by a recovery operator as described in Subsection (4)(a) within 60 days after the day on which the insurer receives an invoice from the recovery operator.
(5) Before commencing arbitration as described in Subsection (6), the insurer and the recovery operator shall attempt to resolve a dispute through mediation.
(6)
(a) A dispute regarding the reasonableness or necessity of an unpaid amount shall be resolved by binding arbitration.
(b) Arbitration under this Subsection (6) shall:
(i) be conducted in accordance with Title 78B, Chapter 11, Utah Uniform Arbitration Act;
(ii) be limited to a determination of the reasonableness and necessity of the disputed amount; and
(iii) be initiated by a written demand for arbitration served on the opposing party.
(c) If arbitration is initiated, the insurer shall post a bond or other security, in a form acceptable to the arbitrator, in an amount that is equal to the difference of the total invoiced amount and the amount paid by the insurer under Subsection (4)(a).
(d) Upon receipt of proof of the bond or other security described in Subsection (6)(c), the recovery operator shall immediately release the recovered vehicle and any associated cargo to the insurer or the insurer's authorized agent.

(e) The arbitrator shall issue a written decision and award determining the amount, if any, payable from the bond or other security.
(f) An arbitration award issued under this Subsection (6) is:
(i) final and binding; and
(ii) subject to judicial review as provided in Title 78B, Chapter 11, Utah Uniform Arbitration Act.
(g) If the arbitrator determines that all or a portion of the disputed charges are not reasonable or not necessary, the insurer is not liable for the amount the arbitrator determines not reasonable or not necessary, and the arbitrator shall order the release of any remaining bond or other security to the insurer.
(h) If the total amount posted by the insurer as described in Subsection (6)(c) exceeds the final amount that an arbitrator determines to be reasonable and necessary as described in Subsection (6)(e), the recovery operator shall return to the insurer the difference of the amount paid by the insurer and the final amount decided by the arbitrator.
(i) Nothing in this Subsection (6) authorizes a recovery operator to withhold release of a recovered vehicle or cargo after compliance with Subsection (6)(c).
(7)
(a) In addition to any other coverage required by this title, a motor carrier operating in this state shall obtain a motor vehicle liability insurance policy for a power unit that includes a separate coverage endorsement providing coverage for costs associated with a recovery operation.
(b) The endorsement requirement described in Subsection (7)(a) applies to commercial vehicles covered by:
(i) a liability-only insurance policy; or
(ii) a full coverage insurance policy, if the policy does not include at least $40,000 of coverage for a recovery operation.
(c) The recovery coverage described in Subsection (7)(a) applies only to a recovery operation that is a non-consent police generated tow.
(d) The minimum coverage limit for recovery coverage required under this Subsection (7) is $40,000 per recovery operation.
(e) An insurer may offer, and a motor carrier may purchase, recovery coverage in excess of the minimum amount required under Subsection (7)(d).
(8) If a recovery operator charges more than the maximum rates established by the Department of Transportation by rule as described in Section 72-9-603 for recovery services:
(a) a requirement for an insurer to pay a bill described in this section is void; and
(b) a bond requirement that applies to the recovery operator is void.

Enacted by Chapter 189, 2026 General Session

## Part 4
## Life Insurance and Annuities

**31A-22-400 Scope of part.**

This Part 4, Life Insurance and Annuities, applies to all life insurance policies and contracts, including:
(1) an annuity contract;
(2) a credit life contract;
(3) a franchise contract;

(4) a group contract; and
(5) a blanket contract.

Amended by Chapter 90, 2004 General Session

**31A-22-401 Prohibited life insurance policy provisions.**

No life insurance company may issue or deliver any life insurance policy subject to this chapter under Section 31A-21-101 which contains any provision:

(1) forfeiting the policy for failure to repay any loan on the policy or to pay interest on the loan while the total indebtedness on the policy is less than its loan value, and in ascertaining the indebtedness due upon policy loans, the interest, if not paid when due, may be added to the principal of those loans and may bear interest at the same rate as the principal;
(2) claiming that the policy was issued or became effective more than one year before the original application for the insurance is executed, if the insured would then be rated at an age more than one year younger than the insured's age at the date of the insured's application, unless the aggregate amount of the annual premiums for the whole term of the back-dated period is paid in cash;
(3) allowing assessments or calls to be made upon policyholders; or
(4) allowing an insurer to cancel or terminate a policy for a reason other than:
  (a) nonpayment of a premium when due; or
  (b) as allowed pursuant to Subsection 31A-21-105(2).

Amended by Chapter 302, 2025 General Session

**31A-22-402 Grace period -- Notification.**

(1)
  (a) Every life insurance policy other than a group policy shall contain a provision entitling the policyholder to a grace period within which the payment of any premium may be made after the first payment of any premium.
  (b) During the grace period described in Subsection (1)(a), the policy continues in full force.
(2) The grace period required by Subsection (1) may not be less than:
  (a) 31 days; or
  (b) four weeks for policies whose premiums are payable more frequently than monthly.
(3) The insurer may impose an interest charge during the grace period not in excess of the interest rate:
  (a) set by the policy for policy loans; or
  (b) in the absence of a provision described in Subsection (3)(a), a rate set by the commissioner by rule.
(4) If a claim arises under the policy during the grace period, an insurer may deduct from the policy proceeds:
  (a) the amount of any premium due or overdue;
  (b) interest at the rate provided in this section; and
  (c) any deferred installment of the annual premium.
(5)
  (a) At least 30 days before the day on which the insurer terminates coverage, the insurer shall send written notice of termination of coverage to:
    (i) the policyholder's last-known address; and
    (ii) a third party designated in accordance with Section 31A-22-430.

(b) An insurer shall obtain and, upon request, demonstrate proof of delivery for a notice the insurer sends under Subsection (5)(a).
(c) Proof of delivery described in Subsection (5)(b) may include a certified mail receipt or, for electronic delivery, a read receipt.

Amended by Chapter 221, 2021 General Session

**31A-22-403 Incontestability.**
(1) This section does not apply to group policies.
(2)
(a) Except as provided in Subsection (3), a life insurance policy is incontestable after the policy has been in force for a period of two years from the policy's date of issue:
(i) during the lifetime of the insured; or
(ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.
(b) A life insurance policy shall state that the life insurance policy is incontestable after the time period described in Subsection (2)(a).
(3)
(a) A life insurance policy described in Subsection (2) may be contested for nonpayment of premiums.
(b) A life insurance policy described in Subsection (2) may be contested as to:
(i) provisions relating to accident and health benefits allowed under Section 31A-22-609; and
(ii) additional benefits in the event of death by accident.
(c) If a life insurance policy described in Subsection (2) allows the insured, after the policy's issuance and for an additional premium, to obtain a death benefit that is larger than when the policy was originally issued, the payment of the additional increment of benefit is contestable:
(i) until two years after the incremental increase of benefits; and
(ii) based only on a ground that may arise in connection with the incremental increase.
(4)
(a) A reinstated life insurance policy may be contested:
(i) for two years following reinstatement on the same basis as at original issuance; and
(ii) only as to matters arising in connection with the reinstatement.
(b) Any grounds for contest available at original issuance continue to be available for contest until the policy has been in force for a total of two years:
(i) during the lifetime of the insured; and
(ii) for a survivorship life insurance policy, during the lifetime of the surviving insured.
(5)
(a) The limitations on incontestability under this section:
(i) preclude only a contest of the validity of the policy; and
(ii) do not preclude the good faith assertion at any time of defenses based upon provisions in the policy that exclude or qualify coverage, whether or not those qualifications or exclusions are specifically excepted in the policy's incontestability clause.
(b) A provision on which the contestable period would normally run may not be reformulated as a coverage exclusion or restriction to take advantage of this Subsection (5).
(6) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules to implement this section.

Amended by Chapter 382, 2008 General Session

**31A-22-404 Suicide.**

(1)
(a) Suicide is not a defense to a claim under a life insurance policy that is in force for two years from the date of issuance of the later of:
(i) the policy; or
(ii) the certificate.
(b) Subsection (1)(a) applies whether:
(i) the insured's death by suicide is voluntary or involuntary; or
(ii) the insured is sane or insane.
(c) If a suicide occurs within the two-year period described in Subsection (1)(a), the insurer shall pay to the beneficiary an amount not less than the premium paid less the following:
(i) a dividend paid;
(ii) an indebtedness; and
(iii) a partial withdrawal.

(2)
(a) If after a life insurance policy is in effect the policy allows the policyholder to purchase a death benefit that is larger than when the policy was originally effective for an additional premium, the payment of the additional increment of benefit may be limited in the event of a suicide within a two-year period beginning on the day on which the increment increase takes effect.
(b) If a suicide occurs within the two-year period described in Subsection (2)(a), the insurer shall pay to the beneficiary an amount not less than the additional premium paid for the additional increment of benefit.

(3) For a survivorship life insurance policy, this section applies when within two years from the day on which the survivorship life insurance policy is issued:
(a) the death of all insureds results from suicide; or
(b) the death of the surviving insured results from suicide.

(4) This section does not apply to:
(a) a policy insuring against death by accident only; or
(b) an accident or double indemnity provision of an insurance policy.

Amended by Chapter 349, 2009 General Session

**31A-22-405 Misstated age or gender.**

(1) Subject to Subsection (2), if the age or gender of the person whose life is at risk is misstated in an application for a policy of life insurance, and the error is not adjusted during the person's lifetime, the amount payable under the policy is what the premium paid would have purchased if the age or gender had been stated correctly.

(2) If the person whose life is at risk was, at the time the insurance was applied for, beyond the maximum age limit designated by the insurer, the insurer shall refund at least the amount of the premiums collected under the policy.

Amended by Chapter 308, 2002 General Session

**31A-22-406 Table of installments.**

Any life insurance policy which provides that the proceeds may be payable in installments, which are determinable at the issue of the policy, shall provide in the policy a table showing the amounts and intervals of the guaranteed installments.

Enacted by Chapter 242, 1985 General Session

**31A-22-407 Reinstatement.**

(1)
(a) Except as provided under Subsection (2), an individual life insurance policy shall be reinstated upon written application made within three years, or within two years in the case of an individual life insurance policy with a face amount under $5,000, from the date of premium default.
(b) An applicant described in Subsection (1)(a) shall
(i) produce evidence of insurability satisfactory to the insurer;
(ii) pay all premiums in arrears; and
(iii) pay or reinstate any other indebtedness to the insurer upon the policy, all with interest:
(A) compounded annually, at a rate not exceeding the rate set by the policy for policy loans compounded annually; or
(B) if no rate is set in the policy, the commissioner shall adopt a rule that sets the rate the same as under Section 31A-22-402.

(2) Subsection (1) does not apply if any of these conditions exist:
(a) the policy has been surrendered for its cash surrender value;
(b) the policy's cash surrender value has been exhausted; or
(c) the paid-up term insurance, if any, has expired.

Amended by Chapter 175, 2025 General Session

**31A-22-408 Standard Nonforfeiture Law for Life Insurance.**

(1)
(a) This section is known as the "Standard Nonforfeiture Law for Life Insurance."
(b) This section does not apply to group life insurance.
(c) As used in this section, "operative date of the valuation manual" means the same as that term is described in Subsection 31A-17-514(2).

(2) In the case of policies issued on or after July 1, 1961, no policy of life insurance, except as stated in Subsection (8), may be delivered or issued for delivery in this state unless it contains in substance the following provisions, or corresponding provisions which in the opinion of the commissioner are at least as favorable to the defaulting or surrendering policyholder as are the minimum requirements specified in this section, and are essentially in compliance with Subsection (8):
(a) That, in the event of default in any premium payment, after premiums have been paid for at least one full year the company will grant, upon proper request not later than 60 days after the due date of the premium in default, a paid-up nonforfeiture benefit on a plan stipulated in the policy, effective as of such due date, of such amount as is specified in this section. In lieu of that stipulated paid-up nonforfeiture benefit, the company may substitute, upon proper request not later than 60 days after the due date of the premium in default, an actuarially equivalent alternative paid-up nonforfeiture benefit which provides a greater amount or longer period of death benefits or, if applicable, a greater amount or earlier payment of endowment benefits.
(b) That, upon surrender of the policy within 60 days after the due date of any premium payment in default after premiums have been paid for at least three full years in the case of ordinary insurance or five full years in the case of industrial insurance, the company will pay, in lieu of

any paid-up nonforfeiture benefit, a cash surrender value of such amount as is specified in this section.

(c) That a specified paid-up nonforfeiture benefit shall become effective as specified in the policy unless the person entitled to make such election elects another available option not later than 60 days after the due date of the premium in default.

(d) That, if the policy shall have been paid by the completion of all premium payments or if it is continued under any paid-up nonforfeiture benefit which became effective on or after the third policy anniversary in the case of ordinary insurance or the fifth policy anniversary in the case of industrial insurance, the company will pay upon surrender of the policy within 30 days after any policy anniversary, a cash surrender value in the amount specified in this section.

(e) In the case of policies which cause, on a basis guaranteed in the policy, unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than a change to a new policy, a statement of the mortality table, interest rate, and method used in calculating cash surrender values and the paid-up nonforfeiture benefits available under the policy. In the case of other policies, a statement of the mortality table and interest rate used in calculating the cash surrender values and the paid-up nonforfeiture benefit, if any, available under the policy on each policy anniversary either during the first 20 policy years or during the term of the policy, whichever is shorter, such values and benefits to be calculated upon the assumption that there are no dividends or paid-up additions credited to the policy and that there is no indebtedness to the company on the policy.

(f) A statement that the cash surrender values and the paid-up nonforfeiture benefits available under the policy are not less than the minimum values and benefits required by or pursuant to the insurance law of the state in which the policy is delivered; an explanation of the manner in which the cash surrender values and the paid-up nonforfeiture benefits are altered by the existence of any paid-up additions credited to the policy or any indebtedness to the company on the policy; if a detailed statement of the method of computation of the values and benefits shown in the policy is not stated in the policy, a statement that such method of computation has been filed with the insurance supervisory official of the state in which the policy is delivered; and a statement of the method to be used in calculating the cash surrender value and paid-up nonforfeiture benefit available under the policy on any policy anniversary beyond the last anniversary for which such values and benefits are consecutively shown in the policy.

(g) Any of the foregoing provisions or portions thereof not applicable by reason of the plan of insurance may, to the extent inapplicable, be omitted from the policy.

(h) The company shall reserve the right to defer the payment of any cash surrender value for a period of six months after demand therefor with surrender of the policy with the consent of the commissioner; provided, however, that the policy shall remain in full force and effect until the insurer has made the payment.

(3)

(a) Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary, whether or not required by Subsection (2), shall be an amount not less than the excess, if any, of the present value, on such anniversary, of the future guaranteed benefits which would have been provided for by the policy, including any existing paid-up additions, if there had been no default, over the sum of:

(i) the then present value of the adjusted premiums as defined in Subsections (5) and (6), corresponding to premiums which would have fallen due on and after such anniversary; and

(ii) the amount of any indebtedness to the company on the policy.

(b) Provided, however, that for any policy issued on or after the operative date of Subsection (6)(d) as defined in Subsection (6)(d), which provides supplemental life insurance or annuity benefits at the option of the insured and for an identifiable additional premium by rider or supplemental policy provision, the cash surrender value referred to in Subsection (3)(a) shall be an amount not less than the sum of the cash surrender value as defined in Subsection (3)(a) for an otherwise similar policy issued at the same age without such rider or supplemental policy provision and the cash surrender value as defined in Subsection (3)(a) for a policy which provides only the benefits otherwise provided by such rider or supplemental policy provision.

(c) Provided, further, that for any family policy issued on or after the operative date of Subsection (6)(d) as defined in Subsection (6)(d), which defines a primary insured and provides term insurance on the life of the spouse of the primary insured expiring before the spouse's age 71, the cash surrender value referred to in Subsection (3)(a) shall be an amount not less than the sum of the cash surrender value as defined in Subsection (3)(a) for an otherwise similar policy issued at the same age without such term insurance on the life of the spouse and the cash surrender value as defined in Subsection (3)(a) for a policy which provides only the benefits otherwise provided by such term insurance on the life of the spouse.

(d) Any cash surrender value available within 30 days after any policy anniversary under any policy paid-up by completion of all premium payments or any policy continued under any paid-up nonforfeiture benefit, whether or not required by Subsection (2) shall be an amount not less than the present value, on such anniversary, of the future guaranteed benefits provided for by the policy, including any existing paid-up additions, decreased by any indebtedness to the company on the policy.

(4) Any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment due on any policy anniversary shall be such that its present value as of such anniversary shall be at least equal to the cash surrender value then provided for by the policy or, if none is provided for, that cash surrender value which would have been required by this section in the absence of the condition that premiums shall have been paid for at least a specified period.

(5)

(a)

(i) This Subsection (5) does not apply to policies issued on or after the operative date of Subsection (6)(d) as defined in Subsection (6)(d).

(ii) Except as provided in Subsection (5)(c), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding any extra premiums charged because of impairments or special hazards, that the present value, at the date of issue of the policy, of all such adjusted premiums shall be equal to the sum of:

(A) the then present value of the future guaranteed benefits provided for by the policy;

(B) 2% of the amount of insurance, if the insurance be uniform in amount, or of the equivalent uniform amount if the amount of insurance varies with duration of the policy;

(C) 40% of the adjusted premium for the first policy year; and

(D) 25% of either the adjusted premium for the first policy year or the adjusted premium for a whole life policy of the same uniform or equivalent uniform amount with uniform premiums for the whole of life issued at the same age for the same amount of insurance, whichever is less.

(iii) Provided, however, that in applying the percentages specified in Subsections (5)(a)(ii)(C) and (D), no adjusted premium shall be considered to exceed 4% of the amount of insurance

or uniform amount equivalent thereto. The date of issue of a policy for the purpose of this Subsection (5) shall be the date as of which the rated age of the insured is determined.

(b) In the case of a policy providing an amount of insurance varying with duration of the policy, the equivalent uniform amount thereof for the purpose of this Subsection (5) shall be considered to be the uniform amount of insurance provided by an otherwise similar policy, containing the same endowment benefit or benefits, if any, issued at the same age and for the same term, the amount of which does not vary with duration and the benefits under which have the same present value at the date of issue as the benefits under the policy; provided, however, that in the case of a policy providing a varying amount of insurance issued on the life of a child under age 10, the equivalent uniform amount may be computed as though the amount of insurance provided by the policy before the attainment of age 10 were the amount provided by such policy at age 10.

(c)

(i) The adjusted premiums for any policy providing term insurance benefits by rider or supplemental policy provision shall be equal to the sum of:

(A) the adjusted premiums for an otherwise similar policy issued at the same age without such term insurance benefits; and

(B) during the period for which premiums for such term insurance benefits are payable, the adjusted premiums for such term insurance.

(ii) The foregoing items (A) and (B) of Subsection (5)(c)(i) being calculated separately and as specified in Subsections (5)(a) and (b) except that, for the purposes of (B), (C), and (D) of Subsection (5)(a)(ii), the amount of insurance or equivalent uniform amount of insurance used in calculation of the adjusted premiums referred to in (B) of Subsection (5)(a)(ii) shall be equal to the excess of the corresponding amount determined for the entire policy over the amount used in the calculation of the adjusted premiums in (A) of Subsection (5)(c)(i).

(d) Except as otherwise provided in Subsection (6), all adjusted premiums and present values referred to in this section shall for all policies of ordinary insurance be calculated on the basis of the Commissioner's 1941 Standard Ordinary Mortality Table, provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than three years younger than the actual age of the insured and such calculations for all policies of industrial insurance shall be made on the basis of the 1941 Standard Industrial Mortality Table. All calculations shall be made on the basis of the rate of interest, not exceeding 3-1/2% per annum, specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than 130% of the rates of mortality according to such applicable table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(6)

(a) This Subsection (6)(a) does not apply to ordinary policies issued on or after the operative date of Subsection (6)(d) as defined in Subsection (6)(d). In the case of ordinary policies issued on or after the operative date of Subsection (6)(a) as defined in Subsection (6)(b), all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioner's 1958 Standard Ordinary Mortality Table and the rate of interest as specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that such rate of interest may not exceed 3-1/2% per annum for policies issued before June

1, 1973, 4% per annum for policies issued on or after May 31, 1973, and before April 2, 1980, and the rate of interest may not exceed 5-1/2% per annum for policies issued after April 2, 1980, except that for any single premium whole life or endowment insurance policy a rate of interest not exceeding 6-1/2% per annum may be used, and provided that for any category of ordinary insurance issued on female risks, adjusted premiums and present values may be calculated according to an age not more than six years younger than the actual age of the insured. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioner's 1958 Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(b) Any company may file with the commissioner a written notice of its election to comply with the provisions of Subsection (6)(a) after a specified date before January 1, 1966. After filing such notice, then upon such specified date, which is the operative date of Subsection (6)(a) for such company, this Subsection (6)(a) shall become operative with respect to the ordinary policies thereafter issued by such company. If a company makes no such election, the operative date of Subsection (6)(a) for such company is January 1, 1966.

(c)

(i) This Subsection (6)(c) does not apply to industrial policies issued after the operative date of Subsection (6)(d) as defined in Subsection (6)(d). In the case of industrial policies issued on or after the operative date of this Subsection (6)(c) as defined in this Subsection (6)(c), all adjusted premiums and present values referred to in this section shall be calculated on the basis of the Commissioner's 1961 Standard Industrial Mortality Table and the rate of interest specified in the policy for calculating cash surrender values and paid-up nonforfeiture benefits, provided that such rate of interest may not exceed 3-1/2% per annum for policies issued before June 1, 1973, 4% per annum for policies issued after May 31, 1973, and before April 2, 1980, and 5-1/2% per annum for policies issued after April 2, 1980, except that for any single premium whole life or endowment insurance policy issued after April 2, 1980, a rate of interest not exceeding 6-1/2% per annum may be used. Provided, however, that in calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may be not more than those shown in the Commissioner's 1961 Industrial Extended Term Insurance Table. Provided, further, that for insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on such other table of mortality as may be specified by the company and approved by the commissioner.

(ii) Any company may file with the commissioner a written notice of its election to comply with the provisions of this Subsection (6)(c) after a specified date before January 1, 1968. After filing such notice, then upon that specified date, which is the operative date of this Subsection (6)(c) for such company, this Subsection (6)(c) shall become operative with respect to the industrial policies thereafter issued by such company. If a company makes no such election, the operative date of this Subsection (6)(c) for such company shall be January 1, 1968.

(d)

(i) This Subsection (6)(d) applies to all policies issued on or after the operative date of this Subsection (6)(d) as defined in this Subsection (6)(d). Except as provided in Subsection

(6)(d)(vii), the adjusted premiums for any policy shall be calculated on an annual basis and shall be such uniform percentage of the respective premiums specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments or special hazards and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the date of issue of policy, of all adjusted premiums shall be equal to the sum of:

(A) the then present value of the future guaranteed benefits provided for by the policy;

(B) 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

(C) 125% of the nonforfeiture net level premium as defined in Subsection (6)(d)(iii), except that in applying the percentage specified in this Subsection (6)(d)(i)(C), no nonforfeiture net level premium shall be considered to exceed 4% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years.

(ii) The date of issue of a policy for the purpose of this Subsection (6)(d) shall be the date as of which the rated age of the insured is determined.

(iii) The nonforfeiture net level premium shall be equal to the present value, at the date of issue of the policy, of the guaranteed benefits provided for by the policy divided by the present value, at the date of issue of the policy, of an annuity of one per annum payable on the date of issue of the policy and on each anniversary of such policy on which a premium falls due.

(iv) In the case of policies which cause on a basis guaranteed in the policy unscheduled changes in benefits or premiums, or which provide an option for changes in benefits or premiums other than change to a new policy, the adjusted premiums and present values shall initially be calculated on the assumption that future benefits and premiums do not change from those stipulated at the date of issue of the policy. At the time of any such change in the benefits or premiums the future adjusted premiums, nonforfeiture net level premiums, and present values shall be recalculated on the assumption that future benefits and premiums do not change from those stipulated by the policy immediately after the change.

(v) Except as otherwise provided in Subsection (6)(d)(viii), the recalculated future adjusted premiums for any such policy shall be such uniform percentage of the respective future premiums specified in the policy for each policy year, excluding amounts specified in the policy for each policy year, excluding amounts payable as extra premiums to cover impairments and special hazards, and also excluding any uniform annual contract charge or policy fee specified in the policy in a statement of the method to be used in calculating the cash surrender values and paid-up nonforfeiture benefits, that the present value, at the time of change to the newly defined benefits or premiums, of all such future adjusted premiums shall be equal to the excess of:

(A) the sum of:

(I) the then present value of the then future guaranteed benefits provided for by the policy; and

(II) the additional expense allowance, if any; over

(B) the then cash surrender value, if any, or present value of any paid-up nonforfeiture benefit under the policy.

(vi) The additional expense allowance, at the time of the change to the newly defined benefits or premiums, shall be the sum of:

(A) 1% of the excess, if positive, of the average amount of insurance at the beginning of each of the first 10 policy years subsequent to the change over the average amount of insurance before the change at the beginning of each of the first 10 policy years subsequent to the time of the most recent previous change, or, if there has been no previous change, the date of issue of the policy; and

(B) 125% of the increase, if positive, in the nonforfeiture net level premium.

(vii) The recalculated nonforfeiture net level premium shall be equal to:

(A) the sum of:

(I) the nonforfeiture net level premium applicable before the change times the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of the change on which a premium would have fallen due had the change not occurred; and

(II) the present value of the increase in future guaranteed benefits provided for by the policy; divided by

(B) the present value of an annuity of one per annum payable on each anniversary of the policy on or subsequent to the date of change on which a premium falls due.

(viii) Notwithstanding any other provision of this Subsection (6)(d) to the contrary, in the case of a policy issued on a substandard basis which provides reduced graded amounts of insurance so that, in each policy year, such policy has the same tabular mortality cost as an otherwise similar policy issued on the standard basis which provides higher uniform amounts of insurance, adjusted premiums and present values for such substandard policy may be calculated as if it were issued to provide such higher uniform amounts of insurance on the standard basis.

(ix) Any adjusted premiums and present values referred to in this section shall:

(A) for policies of ordinary insurance be calculated on the basis of:

(I) the Commissioner's 1980 Standard Ordinary Mortality Table; or

(II) at the election of the company for any one or more specified plans of life insurance, the Commissioner's 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors;

(B) for all policies of industrial insurance be calculated on the basis of the Commissioner's 1961 Standard Industrial Mortality Table; and

(C) for all policies issued in a particular calendar year be calculated on the basis of a rate of interest not exceeding the nonforfeiture interest rate as defined in Subsection (6)(d)(xi), for policies issued in that calendar year.

(x) Notwithstanding Subsection (6)(d)(ix):

(A) At the option of the company, calculations for all policies issued in a particular calendar year may be made on the basis of a rate of interest not exceeding the nonforfeiture interest rate, as defined in Subsection (6)(d)(xi), for policies issued in the immediately preceding calendar year.

(B) Under any paid-up nonforfeiture benefit, including any paid-up dividend additions, any cash surrender value available, whether or not required by Subsection (2), shall be calculated on the basis of the mortality table and rate of interest used in determining the amount of such paid-up nonforfeiture benefit and paid-up dividend additions, if any.

(C) A company may calculate the amount of any guaranteed paid-up nonforfeiture benefit, including paid-up additions under the policy, on the basis of an interest rate no lower than that specified in the policy for calculating cash surrender values.

(D) In calculating the present value of any paid-up term insurance with accompanying pure endowment, if any, offered as a nonforfeiture benefit, the rates of mortality assumed may

be not more than those shown in the Commissioner's 1980 Extended Term Insurance Table for policies of ordinary insurance and not more than the Commissioner's 1961 Industrial Extended Term Insurance Table for policies of industrial insurance.

(E) For insurance issued on a substandard basis, the calculation of any such adjusted premiums and present values may be based on appropriate modifications of the aforementioned tables.

(F) For a policy issued before the operative date of the valuation manual, a Commissioner's Standard Ordinary Mortality Tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rules adopted by the commissioner for use in determining the minimum nonforfeiture standard, may be substituted for the Commissioner's 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioner's 1980 Extended Term Insurance Table. For a policy issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioner's Standard Mortality Table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioner's 1980 Standard Ordinary Mortality Table with or without Ten-Year Select Mortality Factors or for the Commissioner's 1980 Extended Term Insurance Table. If the commissioner approves by rule any Commissioner's Standard Ordinary Mortality Table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(G) For a policy issued before the operative date of the valuation manual, any Commissioner's Standard Industrial Mortality Tables, adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rules adopted by the commissioner for use in determining the minimum nonforfeiture standard may be substituted for the Commissioner's 1961 Industrial Extended Term Insurance Table. For a policy issued on or after the operative date of the valuation manual, the valuation manual shall provide the Commissioner's Standard Mortality Table for use in determining the minimum nonforfeiture standard that may be substituted for the Commissioner's 1961 Standard Industrial Mortality Table or the Commissioner's 1961 Industrial Extended Term Insurance Table. If the commissioner approves by rule any Commissioner's Standard Industrial Mortality Table adopted by the National Association of Insurance Commissioners for use in determining the minimum nonforfeiture standard for policies issued on or after the operative date of the valuation manual, then that minimum nonforfeiture standard supersedes the minimum nonforfeiture standard provided by the valuation manual.

(xi) The nonforfeiture interest rate is defined in this Subsection (6)(d)(xi):

(A) for a policy issued before the operative date of the valuation manual, the nonforteiture interest rate per annum for any policy issued in a particular calendar year shall be equal to 125% of the calendar year statutory valuation interest rate for such policy as defined in the Standard Valuation Law, rounded to the nearest one-fourth of 1%, except that the nonforfeiture interest rate may not be less than 4%; and

(B) for a policy issued on and after the operative date of the valuation manual, the nonforfeiture interest rate per annum for any policy issued in a particular calendar year shall be provided by the valuation manual.

(xii) Notwithstanding any other provision in this title to the contrary, any refiling of nonforfeiture values or their methods of computation for any previously approved policy form which

involves only a change in the interest rate or mortality table used to compute nonforfeiture values does not require refiling of any other provisions of that policy form.

(xiii) After the effective date of this Subsection (6)(d), any company may, at any time before January 1, 1989, file with the commissioner a written notice of its election to comply with the provisions of this subsection with regard to any number of plans of insurance after a specified date before January 1, 1989, which specified date shall be the operative date of this Subsection (6)(d) for the plan or plans, but if a company elects to make the provisions of this subsection operative before January 1, 1989, for fewer than all plans, the company shall comply with rules adopted by the commissioner. There is no limit to the number of times this election may be made. If the company makes no such election, the operative date of this subsection for such company shall be January 1, 1989.

(7) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on the estimates of future experience, or in the case of any plan of life insurance which is of such nature that minimum values cannot be determined by the methods described in Subsection (2), (3), (4), (5), (6)(a), (6)(b), (6)(c), or (6)(d), then:

(a) the insurer shall demonstrate to the satisfaction of the commissioner that the benefits provided under the plan are substantially as favorable to policyholders and insureds as the minimum benefits otherwise required by Subsection (2), (3), (4), (5), (6)(a), (6)(b), (6)(c), or (6)(d);

(b) the plan of life insurance shall satisfy the commissioner that the benefits and the pattern of premiums of that plan are not such as to mislead prospective policyholders or insureds; and

(c) the cash surrender values and paid-up nonforfeiture benefits provided by the plan may not be less than the minimum values and benefits required for the plan computed by a method consistent with the principles of this Standard Nonforfeiture Law for Life Insurance, as determined by rules adopted by the commissioner.

(8)

(a)

(i) Any cash surrender value and any paid-up nonforfeiture benefit, available under the policy in the event of default in a premium payment due at any time other than on the policy anniversary, shall be calculated with allowance for the lapse of time and the payment of fractional premiums beyond the last preceding policy anniversary.

(ii) All values referred to in Subsections (3), (4), (5), and (6) may be calculated upon the assumption that any death benefit is payable at the end of the policy year of death.

(iii) The net value of any paid-up additions, other than paid-up term additions, may not be less than the amounts used to provide such additions.

(b) Notwithstanding the provisions of Subsection (3), additional benefits specified in Subsection (8)(c) and premiums for all such additional benefits shall be disregarded in ascertaining cash surrender values and nonforfeiture benefits required by this section, and no such additional benefits shall be required to be included in any paid-up nonforfeiture benefits.

(c) Additional benefits referred to in Subsection (8)(b) include benefits payable:

(i) in the event of death or dismemberment by accident or accidental means;

(ii) in the event of total and permanent disability;

(iii) as reversionary annuity or deferred reversionary annuity benefits;

(iv) as term insurance benefits provided by a rider or supplemental policy provision to which, if issued as a separate policy, this section would not apply;

(v) as term insurance on the life of a child or on the lives of children provided in a policy on the life of a parent of the child, if such term insurance expires before the child's age is 26, if

uniform in amount after the child's age is one, and has not become paid-up by reason of the death of a parent of the child; and

(vi) as other policy benefits additional to life insurance endowment benefits.

(9)

(a) This Subsection (9), in addition to all other applicable subsections of this section, applies to all policies issued on or after January 1, 1985. Any cash surrender value available under the policy in the event of default in a premium payment due on any policy anniversary shall be in an amount which does not differ by more than 2/10 of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years, from the sum of:

(i) the greater of zero and the basic cash value specified in Subsection (9)(b); and

(ii) the present value of any existing paid-up additions less the amount of any indebtedness to the company under the policy.

(b) The basic cash value shall be equal to the present value, on such anniversary of the future guaranteed benefits which would have been provided for by the policy, excluding any existing paid-up additions and before deduction of any indebtedness to the company, if there had been no default, less the then present value of the nonforfeiture factors, as defined in Subsection (9)(c), corresponding to premiums which would have fallen due on and after such anniversary. Provided, however, that the effects on the basic cash value of supplemental life insurance or annuity benefits or of family coverage, as described in Subsection (3) or (5), whichever is applicable, shall be the same as are the effects specified in Subsection (3) or (5), whichever is applicable, on the cash surrender values defined in that subsection.

(c) The nonforfeiture factor for each policy year shall be an amount equal to a percentage of the adjusted premium for the policy year, as defined in Subsection (5) or (6)(d), whichever is applicable. Except as is required by the next succeeding sentence of this paragraph, such percentage:

(i) shall be the same percentage for each policy year between the second policy anniversary and the later of:

(A) the fifth policy anniversary; and

(B) the first policy anniversary at which there is available under the policy a cash surrender value in an amount, before including any paid-up additions and before deducting any indebtedness, of at least 2/10 of 1% of either the amount of insurance, if the insurance be uniform in amount, or the average amount of insurance at the beginning of each of the first 10 policy years; and

(ii) shall be such that no percentage after the later of the two policy anniversaries specified in Subsection (9)(a) may apply to fewer than five consecutive policy years.

(d) Provided, that no basic cash value may be less than the value which would be obtained if the adjusted premiums for the policy, as defined in Subsection (5) or Subsection (6)(d), whichever is applicable, were substituted for the nonforfeiture factors in the calculation of the basic value.

(e) All adjusted premiums and present values referred to in this Subsection (9) shall for a particular policy be calculated on the same mortality and interest bases as are used in demonstrating the policy's compliance with the other subsections of this nonforfeiture law. The cash surrender values referred to in this Subsection (9) shall include any endowment benefits provided for by the policy.

(f) Any cash surrender value available other than in the event of default in a premium payment due on a policy anniversary, and the amount of any paid-up nonforfeiture benefit available under the policy in the event of default in a premium payment shall be determined in manners

consistent with the manners specified for determining the analogous minimum amounts in Subsections (2), (3), (4), (5), (6), and (8). The amounts of any cash surrender values and of any paid-up nonforfeiture benefits granted in connection with additional benefits such as those listed as Subsection (8)(c) shall conform with the principles of this Subsection (9).

(10)

(a) This section does not apply to any of the following:

(i) reinsurance;

(ii) group insurance;

(iii) pure endowment;

(iv) an annuity or reversionary annuity contract;

(v) a term policy of uniform amount, which provides no guaranteed nonforfeiture or endowment benefits, or renewal thereof, of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(vi) a term policy of decreasing amount, which provides no guaranteed nonforfeiture or endowment benefits, on which each adjusted premium, calculated as specified in Subsections (5) and (6), is less than the adjusted premium so calculated, on a term policy of uniform amount, or renewal thereof, which provides no guaranteed nonforfeiture or endowment benefits, issued at the same age and for the same initial amount of insurance, and for a term of 20 years or less expiring before age 71, for which uniform premiums are payable during the entire term of the policy;

(vii) a policy, which provides no guaranteed nonforfeiture or endowment benefits, for which no cash surrender value, if any, or present value of any paid-up nonforfeiture benefit, at the beginning of any policy year, calculated as specified in Subsections (3), (4), (5), and (6) exceeds 2-1/2% of the amount of insurance at the beginning of the same policy year; or

(viii) a policy which shall be delivered outside this state through an agent or other representative of the company issuing the policy.

(b) For purposes of determining the applicability of this section, the age of expiry for a joint term insurance policy shall be the age of expiry of the oldest life.

(11) The commissioner may adopt rules interpreting, describing, and clarifying the application of this nonforfeiture law to any form of life insurance for which the interpretation, description, or clarification is considered necessary by the commissioner, including unusual and new forms of life insurance.

Amended by Chapter 163, 2016 General Session

**31A-22-409 Standard Nonforfeiture Law for Individual Deferred Annuities.**

(1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred Annuities."

(2) This section does not apply to:

(a) reinsurance;

(b) a group annuity purchased under a retirement plan or plan of deferred compensation:

(i) established or maintained by:

(A) an employer, including a partnership or sole proprietorship;

(B) an employee organization; or

(C) both an employer and an employee organization; and

(ii) other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code;

(c) a premium deposit fund;

(d) a variable annuity;

(e) an investment annuity;
(f) an immediate annuity;
(g) a deferred annuity contract after annuity payments have commenced;
(h) a reversionary annuity; or
(i) a contract that is delivered outside this state through an agent or other representative of the company issuing the contract.

(3)
(a) If a policy is issued after this section takes effect as set forth in Subsection (15), a contract of annuity, except as stated in Subsection (2), may not be delivered or issued for delivery in this state unless the contract of annuity contains in substance:
(i) the provisions described in Subsection (3)(b); or
(ii) provisions corresponding to the provisions described in Subsection (3)(b) that in the opinion of the commissioner are at least as favorable to the contractholder, governing cessation of payment of consideration under the contract.
(b) Subsection (3)(a)(i) requires the following provisions:
(i) the company shall grant a paid-up annuity benefit on a plan stipulated in the contract of such a value as specified in Subsections (7), (8), (9), (10), and (12):
(A) upon cessation of payment of consideration under a contract; or
(B) upon a written request of the contract owner;
(ii) if a contract provides for a lump-sum settlement at maturity, or at any other time, upon surrender of the contract at or before the commencement of any annuity payments, the company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such amount as is specified in Subsections (7), (8), (10), and (12);
(iii) a statement of the mortality table, if any, and interest rates used in calculating any of the following that are guaranteed under the contract:
(A) minimum paid-up annuity benefit;
(B) cash surrender benefit; or
(C) death benefit;
(iv) sufficient information to determine the amounts of the benefits described in Subsection (3)(b)(iii);
(v) a statement that any paid-up annuity, cash surrender, or death benefits that may be available under the contract are not less than the minimum benefits required by a statute of the state in which the contract is delivered; and
(vi) an explanation of the manner in which a benefit described in Subsection (3)(b)(v) is altered by the existence of any:
(A) additional amounts credited by the company to the contract;
(B) indebtedness to the company on the contract; or
(C) prior withdrawals from or partial surrender of the contract.
(c) Notwithstanding the requirements of this Subsection (3), a deferred annuity contract may provide that if no consideration is received under a contract for a period of two full years and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract arising from consideration paid before the period would be less than $20 monthly:
(i) the company may at the company's option terminate the contract by payment in cash of the then present value of such portion of the paid-up annuity benefit, calculated on the basis of the mortality table specified in the contract, if any, and the interest rate specified in the contract for determining the paid-up annuity benefit; and
(ii) the payment described in Subsection (3)(c)(i), relieves the company of any further obligation under the contract.

(d) A company may reserve the right to defer the payment of cash surrender benefit for a period not to exceed six months after demand for the payment of the cash surrender benefit with surrender of the contract.

(4) For a policy issued before June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (4).

(a)

(i) With respect to a contract providing for flexible considerations, the minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at a rate of interest of 3% per annum of percentages of the net considerations paid before such time:

(A) decreased by the sum of:

(I) any prior withdrawals from or partial surrenders of the contract accumulated at a rate of interest of 3% per annum; and

(II) the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(B) increased by any existing additional amounts credited by the company to the contract.

(ii) For purposes of this Subsection (4)(a), the net consideration for a given contract year used to define the minimum nonforfeiture amount shall be:

(A) an amount not less than zero; and

(B) equal to the corresponding gross considerations credited to the contract during that contract year less:

(I) an annual contract charge of $30; and

(II) a collection charge of $1.25 per consideration credited to the contract during that contract year.

(iii) The percentages of net considerations shall be:

(A) 65% of the net consideration for the first contract year; and

(B) 87-1/2% of the net considerations for the second and later contract years.

(iv) Notwithstanding Subsection (4)(a)(iii), the percentage shall be 65% of the portion of the total net consideration for any renewal contract year that exceeds by not more than two times the sum of those portions of the net considerations in all prior contract years for which the percentage was 65%.

(b)

(i) Except as provided in Subsections (4)(b)(ii) and (iii), with respect to a contract providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:

(A) calculated on the assumption that considerations are paid annually in advance; and

(B) defined as for contracts with flexible considerations that are paid annually.

(ii) The portion of the net consideration for the first contract year to be accumulated shall be equal to an amount that is the sum of:

(A) 65% of the net consideration for the first contract year; and

(B) 22-1/2% of the excess of the net consideration for the first contract year over the lesser of the net considerations for:

(I) the second contract year; and

(II) the third contract year.

(iii) The annual contract charge shall be the lesser of $30 or 10% of the gross annual consideration.

(c) With respect to a contract providing for a single consideration payment, minimum nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:

(i) the percentage of net consideration used to determine the minimum nonforfeiture amount shall be equal to 90%; and

(ii) the net consideration shall be the gross consideration less a contract charge of $75.

(5)

(a) For a policy issued on or after June 1, 2006, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract shall be based upon minimum nonforfeiture amounts as established in this Subsection (5).

(b) The minimum nonforfeiture amount at any time at or before the commencement of any annuity payments shall be equal to an accumulation up to such time, at rates of interest as indicated in Subsection (5)(c), of 87-1/2% of the gross considerations paid before such time decreased by the sum of:

(i) any prior withdrawals from or partial surrenders of the contract accumulated at rates of interest as indicated in Subsection (5)(c);

(ii) an annual contract charge of $50, accumulated at rates of interest as indicated in Subsection (5)(c);

(iii) any premium tax paid by the company for the contract, accumulated at rates of interest as indicated in Subsection (5)(c); and

(iv) the amount of any indebtedness to the company on the contract, including interest due and accrued.

(c)

(i) The interest rate used in determining minimum nonforfeiture amounts shall be an annual rate of interest determined as the lesser of:

(A) 3% per annum; or

(B) the five-year Constant Maturity Treasury Rate reported by the Federal Reserve, rounded to the nearest 1/20th of 1%, as of a date or average over a period no longer than 15 months before the contract issue date or redetermination date under Subsection (5)(c)(iii):

(I) reduced by 125 basis points; and

(II) where the resulting interest rate is not less than 100 basis points, 1% for a policy issued on or after June 1, 2006, and before June 1, 2021, or where the resulting interest rate is not less than 15 basis points, 0.15% for a policy issued on or after June 1, 2021.

(ii) The interest rate shall apply for an initial period and may be redetermined for additional periods.

(iii)

(A) If the interest rate will be reset, the contract shall state:

(I) the initial period;

(II) the redetermination date;

(III) the redetermination basis; and

(IV) the redetermination period.

(B) The basis is the date or average over a specified period that produces the value of the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

(d)

(i) During the period or term that a contract provides substantive participation in an equity indexed benefit, the reduction described in Subsection (5)(c)(i)(B)(I) may be increased by up to an additional 100 basis points to reflect the value of the equity index benefit.

(ii) The present value of the additional reduction at the contract issue date and at each redetermination date may not exceed the market value of the benefit.

(iii)

(A) The commissioner may require a demonstration that the present value of the additional reduction does not exceed the market value of the benefit.

(B) If the demonstration required under Subsection (5)(d)(iii)(A) is not made to the satisfaction of the commissioner, the commissioner may disallow or limit the additional reduction.

(6) Notwithstanding Subsection (4), for a policy issued on or after June 1, 2004 and before June 1, 2006, at the election of a company, on a contract form-by-contract form basis, the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits available under an annuity contract may be based upon minimum nonforfeiture amounts as established in Subsection (5).

(7)

(a) A paid-up annuity benefit available under a contract shall be such that the contract's present value on the date annuity payments are to commence is at least equal to the minimum nonforfeiture amount on that date.

(b) The present value described in Subsection (7)(a) shall be computed using the mortality table, if any, and the interest rate specified in the contract for determining the minimum paid-up annuity benefits guaranteed in the contract.

(8)

(a) For a contract that provides cash surrender benefits, the cash surrender benefits available before maturity may not be less than the present value as of the date of surrender of that portion of the cash surrender value that would be provided under the contract at maturity arising from considerations paid before the time of cash surrender:

(i) decreased by the amount appropriate to reflect any prior withdrawals from or partial surrender of the contract;

(ii) decreased by the amount of any indebtedness to the company on the contract, including interest due and accrued; and

(iii) increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of this Subsection (8), the present value is to be calculated on the basis of an interest rate not more than 1% higher than the interest rate specified in the contract for accumulating the net considerations to determine the maturity value.

(c) In no event shall a cash surrender benefit be less than the minimum nonforfeiture amount at that time.

(d) The death benefit under a contract described in Subsection (8)(a) shall be at least equal to the cash surrender benefit.

(9)

(a) For a contract that does not provide cash surrender benefits, the present value of any paid-up annuity benefit available as a nonforfeiture option at any time before maturity may not be less than the present value of that portion of the maturity value of the paid-up annuity benefit provided under the contract arising from considerations paid before the time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity increased by any existing additional amounts credited by the company to the contract.

(b) For purposes of Subsection (9)(a), the present value for the period before the maturity date is to be calculated on the basis of the interest rate specified in the contract for accumulating the net considerations to determine maturity value.

(c) For a contract that does not provide a death benefit before commencement of any annuity payments, the present values shall be calculated on the basis of the interest rate and the

mortality table specified in the contract for determining the maturity value of the paid-up annuity benefit.

(d) In no event shall the present value of a paid-up annuity benefit be less than the minimum nonforfeiture amount at that time.

(10)

(a) For the purpose of determining the benefits calculated under Subsections (8) and (9), the maturity date shall be considered to be:

(i) in the case of an annuity contract issued on or before May 5, 2002, under which an election may be made to have an annuity payment commence at an optional maturity date, the latest date for which an election is permitted by the contract, except that it may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years old; or

(B) the tenth anniversary of the contract; or

(ii) in the case of an annuity contract issued on or after May 6, 2002, the latest date permitted by the contract, except that the maturity date may not be considered to be later than the later of:

(A) the anniversary of the contract next following the day on which the annuitant becomes 70 years old; or

(B) the tenth anniversary of the contract.

(b) In the case of an annuity contract issued on or after May 6, 2002:

(i) for a contract that provides cash surrender benefits, the cash surrender value on or past the maturity date shall be equal to the amount used to determine the annuity benefit payments; and

(ii) a surrender charge may not be imposed on or past maturity.

(11) A contract that does not provide cash surrender benefits or does not provide death benefits at least equal to the minimum nonforfeiture amount before the commencement of any annuity payments shall include a statement in a prominent place in the contract that these benefits are not provided.

(12) A paid-up annuity, cash surrender, or death benefit available at any time, other than on the contract anniversary under a contract with fixed scheduled considerations, shall be calculated with allowance for the lapse of time and the payment of any scheduled considerations beyond the beginning of the contract year in which cessation of payment of considerations under the contract occurs.

(13)

(a) For a contract that provides, within the same contract by rider or supplemental contract provisions, both annuity benefits and life insurance benefits that are in excess of the greater of cash surrender benefits or a return of the gross considerations with interest, the minimum nonforfeiture benefits shall:

(i) be equal to the sum of:

(A) the minimum nonforfeiture benefits for the annuity portion; and

(B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and

(ii) computed as if each portion were a separate contract.

(b)

(i) Notwithstanding Subsections (7), (8), (9), (10), and (12), additional benefits payable, as described in Subsection (13)(b)(ii), and consideration for the additional benefits payable, shall be disregarded in ascertaining, if required by this section:

(A) the minimum nonforfeiture amounts;

(B) paid-up annuity;
(C) cash surrender; and
(D) death benefits.
(ii) For purposes of this Subsection (13), an additional benefit is a benefit payable:
(A) in the event of total and permanent disability;
(B) as reversionary annuity or deferred reversionary annuity benefits; or
(C) as other policy benefits additional to life insurance, endowment, and annuity benefits.
(iii) The inclusion of the additional benefits described in this Subsection (13) may not be required in any paid-up benefits, unless the additional benefits separately would require:
(A) minimum nonforfeiture amounts;
(B) paid-up annuity;
(C) cash surrender; and
(D) death benefits.

(14) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may adopt rules necessary to implement this section, including:
(a) ensuring that any additional reduction under Subsection (5)(d) is consistent with the requirements imposed by Subsection (5)(d); and
(b) providing for adjustments in addition to the adjustments allowed under Subsection (5)(d) to the calculation of minimum nonforfeiture amounts for:
(i) a contract that provides substantive participation in an equity index benefit; and
(ii) a contract for which the commissioner determines adjustments are justified.

(15)
(a) After this section takes effect, a company may file with the commissioner a written notice of the company's election to comply with this section after a specified date before July 1, 1988.
(b) This section applies to annuity contracts of a company issued on or after the date the company specifies in the notice.
(c) If a company makes no election under Subsection (15)(a), the operative date of this section for such company is July 1, 1988.

Amended by Chapter 252, 2021 General Session

**31A-22-410 Trustee and deposit agreements.**

(1) An insurer may hold as a part of its general assets the proceeds of any life insurance policy or annuity under a trust or other agreement, upon the terms and restrictions as to revocation by the policyholder and control by the beneficiary, and with the exemptions from the claims of creditors of the beneficiary as the insurer and the policyholder agree to in writing and as are otherwise recognized by law.
(2) An insurer may also receive funds in amounts and upon conditions which the insurer and the policyholder agree to in writing:
(a) as premiums in advance upon life insurance policies or annuities; or
(b) to accumulate for the purchase of future life insurance policies or annuities.

Enacted by Chapter 242, 1985 General Session

**31A-22-411 Insurance policies providing variable benefits.**

(1) An insurance policy that provides for payment of a benefit in a variable amount shall contain a statement of the essential features of the procedure to be followed by the insurer in determining the dollar amount of the variable benefits.

(2) A variable insurance policy shall contain:
(a) an appropriate nonforfeiture benefit in lieu of those required by either Section 31A-22-408 or 31A-22-409;
(b) an appropriate reinstatement provision in lieu of those required by Section 31A-22-407; and
(c) a grace period provision appropriate to that type of insurance policy in lieu of those required by Section 31A-22-402.
(3) An individual insurance policy and a certificate issued under a group insurance policy shall conspicuously state on its first page that:
(a) the dollar amount may decrease or increase according to investment experience; and
(b) a benefit under the insurance policy is payable on a variable basis.
(4) A life insurance or annuity policy with a variable benefit issued under a separate account shall, on either the application or the insurance policy, state that the insurer's liabilities with respect to a variable benefit under the insurance policy are subject to satisfaction only out of the insurer's variable account assets.
(5)
(a) A variable insurance policy shall state whether it may be amended as to:
(i) investment policy;
(ii) voting rights; and
(iii) conduct of the business and affairs of a separate account.
(b) Subject to any preemptive provision of federal law, an amendment of the type described in this Subsection (5) is subject to:
(i) filing under Section 31A-21-201; and
(ii) approval by a majority of the policyholders in the separate account.

Amended by Chapter 10, 2010 General Session

**31A-22-412 Assignment of life insurance rights.**
(1) As used in this section, "final termination of a policy" means the day after which an insurer will not reinstate a policy without requiring:
(a) evidence of insurability; or
(b) written application.
(2)
(a) Except as provided under Subsection (4), the owner of any rights in a life insurance policy or annuity contract may assign any of those rights, including any right to designate a beneficiary and the rights secured under Sections 31A-22-517 through 31A-22-521 and any other provision of this title.
(b) An assignment, valid under general contract law, vests the assigned rights in the assignee, subject, so far as reasonably necessary for the protection of the insurer, to any provisions in the insurance policy or annuity contract inserted to protect the insurer against double payment or obligation.
(3) The rights of a beneficiary under a life insurance policy or annuity contract are subordinate to those of an assignee, unless the beneficiary was designated as an irrevocable beneficiary prior to the assignment.
(4) Assignment of insurance rights may be expressly prohibited by an annuity contract which provides annuities as retirement benefits related to employment contracts.
(5)

(a) After July 1, 1986, when a life insurance policy or annuity is assigned in writing as security for an indebtedness, the insurer shall mail to the assignee a copy of any cancellation notice sent with respect to the policy, if the insurer has received:
(i) written notice of the assignment;
(ii) the name and address of the assignee; and
(iii) a request for assignment notice from the assignee.
(b) An insurer shall mail the cancellation notice described in Subsection (5)(a):
(i) prepaid, and addressed to the assignee's address filed with the insured;
(ii) not less than 10 days before the final termination of the policy; and
(iii) each time the insured fails or refuses to transmit a premium payment to the insurer before the commencement of the policy's grace period.
(c) The insurer may charge the insured directly or charge against the policy the reasonable cost of complying with this section, but in no event to exceed $5 for each notice.
(6) In lieu of providing notices to assignees of final termination of the policy under Subsection (5), an insurer may provide an assignee with an identical copy of all notices sent to the owner of the life insurance policy, provided these notices comply with the other requirements of this title.

Amended by Chapter 32, 2020 General Session

**31A-22-413 Designation of beneficiary.**
(1) Subject to Subsection 31A-22-412(3), no life insurance policy or annuity contract may restrict the right of a policyholder or certificate holder:
(a) to make an irrevocable designation of beneficiary effective immediately or at some subsequent time; or
(b) if the designation of beneficiary is not explicitly irrevocable, to change the beneficiary without the consent of the previously designated beneficiary. Subsection 75-6-201(1)(c) applies to designations by will or by separate writing.
(2)
(a) An insurer may prescribe formalities to be complied with for the change of beneficiaries, but those formalities may only be designed for the protection of the insurer. Notwithstanding Section 75-2-804, the insurer discharges its obligation under the insurance policy or certificate of insurance if it pays the properly designated beneficiary unless it has actual notice of either an assignment or a change in beneficiary designation made pursuant to Subsection (1)(b).
(b) The insurer has actual notice if the formalities prescribed by the policy are complied with, or if the change in beneficiary has been requested in the form prescribed by the insurer and delivered to an agent representing the insurer at least three days prior to payment to the earlier properly designated beneficiary.

Amended by Chapter 32, 2020 General Session

**31A-22-414 Evidence as to death.**
The rules relating to determination of death under Section 75-1-107 are applicable to life insurance.

Amended by Chapter 30, 1992 General Session

**31A-22-415 Simultaneous death.**
Section 75-2-702 applies to all policies of life and accident and health insurance.

Amended by Chapter 116, 2001 General Session

**31A-22-416 Reserved.**

Enacted by Chapter 242, 1985 General Session

**31A-22-417 Physical examination and autopsy.**

A life insurer may, at its own expense, examine the body of the insured when and as often as the insurer reasonably requires during the pendency of a claim, and it may make an autopsy in case of death where it is reasonably necessary and not forbidden by law.

Enacted by Chapter 242, 1985 General Session

**31A-22-418 Participating and nonparticipating policies.**

(1)

(a) A stock insurer and a mutual insurer may issue both participating and nonparticipating life insurance policies and annuity contracts, subject to this section.

(b) A fraternal insurer issuing life insurance policies in this state may only issue participating policies, except for the following nonparticipating policies:

(i) paid-up, temporary, pure endowment insurance, and annuity settlements provided in exchange for lapsed, surrendered, or matured policies;

(ii) annuities beginning within one year of the making of the contract; and

(iii) those term insurance policies which the commissioner exempts by rule.

(2) Every participating policy shall by its terms give its holder full right to participate annually in the surplus accumulations from the participating business of the insurer that are distributed.

(3) Every insurer issuing both participating and nonparticipating policies shall separately account for the two classes of business.

(4)

(a) No life insurance policy or certificate may be issued in which the accounting, apportionment, and distribution of surplus is deferred for a period longer than three years.

(b) Every insurer doing a participating business shall annually ascertain the surplus over required reserves and other liabilities. After setting aside the contingency reserves it considers necessary and as are required by law, the reasonable nondistributable surplus needed to permit orderly growth, making provision for the payment of reasonable dividends upon capital stock and those sums as are required by prior contracts to be held for deferred dividend policies, the remaining surplus shall be equitably apportioned and returned as a dividend to the participating policyholders or certificate-holders entitled to share in the dividend. A dividend may be conditioned on the payment of the succeeding year's premium only on the first and second anniversaries of the policy.

Amended by Chapter 204, 1986 General Session

**31A-22-419 Insurer's purchase of and loans on policies.**

Any life insurer may purchase for its own benefit any policy of insurance or other obligation of the company and any claim of its policyholders. The insurer may also lend to the holders of policies of the company a sum which does not exceed the sum of the cash value of the policies and the surplus or dividend additions to the policies. The policies and all additions to them shall be

security for payment of the loan. An insurer's security interest in a policy under this section need not be filed under Title 70A, Chapter 9a, Uniform Commercial Code - Secured Transactions, to be perfected.

Amended by Chapter 252, 2000 General Session

**31A-22-420 Policy loans.**

(1) This section applies to all life insurance policies and annuity contracts, including certificates issued by fraternal insurers, which contain policy loan provisions. A "policy loan" includes any arrangement by which a premium is paid to the life insurer after the normal due date.

(2) As used in this section, "published monthly average" means:

(a) The monthly average of the composite yield on Moody's Corporate Bond Yield Average--Monthly Average Corporates, as published by Moody's Investors Service, Inc., or any successor to that publication; or

(b) in the event that Moody's Corporate Bond Yield Average--Monthly Average Corporates is no longer published, a substantially similar average, established by the commissioner by rule.

(3)

(a) Policies issued on or after May 12, 1981, shall provide for policy loan interest rates by:

(i) a provision permitting a maximum interest rate of not more than 8% per annum; or

(ii) a provision permitting an adjustable maximum interest rate calculated under this section.

(b) The rate of interest charged on a policy loan made under Subsection (3)(a)(ii) may not exceed the higher of:

(i) the published monthly average for the calendar month ending two months before the date on which the rate is determined; or

(ii) the rate used to compute cash surrender values under the policy during the same period, plus 1% per annum.

(c) If the maximum rate of interest is determined under Subsection (3)(a)(ii), the policy shall contain a provision setting forth the frequency at which the rate is to be determined for that policy.

(d) The maximum rate under Subsection (3)(a)(ii) for each policy shall be determined at regular intervals at least once every 12 months, but not more frequently than once in any three-month period. At the intervals specified in the policy:

(i) the rate being charged may be increased whenever the increase determined under Subsection (3)(b) would increase that rate by 1/2% or more per annum; and

(ii) the rate being charged shall be reduced whenever the reduction determined under Subsection (3)(b) would decrease that rate by 1/2% or more per annum.

(e) Every life insurer shall:

(i) notify the policyholder at the time a cash loan is made of the initial rate of interest on the loan;

(ii) notify the policyholder with respect to premium loans of the initial rate of interest on the loan as soon as it is reasonably practical to do so after making the initial loan, but notice need not be given to the policyholder when a further premium loan is added, except as provided in Subsection (3)(e)(iii);

(iii) send to policyholders with loans, reasonable advance notice of any increase in the rate; and

(iv) include in the notices required by Subsection (3)(e)(i), (ii), and (iii) the substance of the pertinent provisions of Subsections (3)(a) and (c).

(f) No policy may terminate during a policy year solely because of a change in the interest rate during that policy year. Coverage shall continue during that policy year until it would have terminated if there had been no change in interest rate during that policy year.
(g) The pertinent provisions of Subsections (3)(a) and (c) shall be set forth in the policies to which they apply.
(4) This section applies to an insurance policy issued before May 12, 1981, only if the policyholder agrees to its application in writing, after receiving explicit disclosure of the provisions regarding premiums, dividends, and nonforfeiture cash values of the existing and amended insurance policies prior to execution of the written agreement. No other rights of the policyholder under the insurance policy are affected by this agreement.
(5) The policy shall contain a provision permitting the insurer, upon the commissioner's approval, to defer granting a policy loan for up to six months after application for the loan. Policy loans for the payment of premium to the insurer may not be deferred under this subsection.

Amended by Chapter 204, 1986 General Session

**31A-22-421 Facility of payment under certain life insurance policies.**

A life insurance policy with a face value of $5,000 or less may provide that if the beneficiary designated in the policy does not make a claim under the policy or does not surrender the policy with due proof of death within a period stated in the policy, which may not be less than 30 days after the death of the insured, or if the beneficiary is the estate of the insured, or is a minor, or dies before the insured, or is not legally competent to give a valid release, then the insurer may make any payment under the policy to the executor or administrator of the insured, or to any relative of the insured by blood or legal adoption or connection by marriage, or to any person appearing to the insurer to be equitably entitled to the payment by reason of having incurred expense for the maintenance, medical attention, or burial of the insured, or for other reasons. The policy may also include a similar provision applicable to any other payment due under the policy.

Enacted by Chapter 242, 1985 General Session

**31A-22-422 Conditional coverage.**

Conditional or binding receipts or other documents issued by a life insurer, whatever they are named, which conditionally grant life insurance coverage prior to physical delivery of the policy are subject to the form filing requirements under Section 31A-21-201.

Enacted by Chapter 242, 1985 General Session

**31A-22-423 Policy and annuity examination period.**

(1)
(a) Except as provided under Subsection (2), a life insurance policy, life insurance certificate, annuity contract, or annuity certificate shall contain a notice prominently printed on or attached to the cover or front page of the policy, contract, or certificate stating that the policyholder, contract holder, or certificate holder has the right to return the policy, contract, or certificate for any reason on or before:
(i) 10 days after the day on which the policy, contract, or certificate is delivered; or
(ii) in case of a replacement policy, contract, or certificate, 30 days after the day on which the replacement policy, contract, or certificate is delivered.
(b) For purposes of this section, "return" means a writing that:

(i) the policy, contract, or certificate is being returned for termination of coverage;
(ii) is:
(A) a written statement on the policy, contract, or certificate; or
(B) a writing that accompanies the policy, contract, or certificate; and
(iii) is delivered to or mailed first class to the insurer or the insurer's agent.
(c) A policy, contract, or certificate returned under this section is void from the date of issuance.
(d) A policyholder, contract holder, or certificate holder returning a policy or certificate is entitled to a refund of any premium paid.
(2) This section does not apply to:
(a) group term life insurance issued under Section 31A-22-502;
(b) a group master policy;
(c) a noncontributory certificate;
(d) a credit life insurance certificate; and
(e) other classes of life insurance policies that the commissioner specifies by rule after finding that a right to return those life insurance policies would be impracticable or unnecessary to protect the policyholder's interests.

Amended by Chapter 307, 2007 General Session

**31A-22-424 Documents constituting entire life insurance policy.**
(1) A life insurance policy shall contain a provision that defines the documents and agreements that constitute the entire contract between the parties.
(2) Except as permitted by Section 31A-21-106, all documents and agreements defined under Subsection (1) shall be attached to the policy.

Enacted by Chapter 116, 2001 General Session

**31A-22-425 Rulemaking authority for standards related to life insurance and annuities.**
In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules to establish standards for any of the following:
(1) if used in connection with the solicitation or sale of life insurance policies and contracts:
(a) a buyer's guide;
(b) a disclosure;
(c) an illustration;
(d) a policy summary; or
(e) a recommendation; and
(2) in a life insurance policy, annuity contract, or life insurance or annuity certificate:
(a) a definition of a term;
(b) a disclosure;
(c) an exclusion; or
(d) a limitation.

Amended by Chapter 382, 2008 General Session

**31A-22-426 Coverage description.**
(1) Each life insurance policy, annuity contract, and certificate of life insurance shall contain a brief description printed on the cover page.
(2) The description shall include:

(a) the type of insurance;
(b) whether it is participating or nonparticipating;
(c) a significant limitation stated or included in the filed policy, contract, or certificate; and
(d) a significant specific feature stated or included in the filed policy, contract, or certificate.

Enacted by Chapter 125, 2005 General Session

**31A-22-427 Life insurance and annuity policy records.**

A life insurer, and its successors, shall maintain all records that affect the legal effect of a life insurance policy, annuity contract, or certificate of life insurance for the term of the insurance plus five years.

Enacted by Chapter 125, 2005 General Session

**31A-22-428 Interest payable on life insurance proceeds.**

(1) For a life insurance policy delivered or issued for delivery in this state on or after May 5, 2008, the insurer shall pay interest on the death proceeds payable upon the death of the insured.
(2)
(a) Except as provided in Subsection (4), for the period beginning on the date of death and ending the day before the day described in Subsection (3)(b), interest under Subsection (1) shall accrue at a rate no less than the greater of:
(i) the rate applicable to policy funds left on deposit; and
(ii) the Two Year Treasury Constant Maturity Rate as published by the Federal Reserve.
(b) If there is no rate applicable to policy funds on deposit as stated in Subsection (2)(a)(i), then the Two Year Treasury Constant Maturity Rates as published by the Federal Reserve applies.
(c) The rate described in Subsection (2)(a) or (b) is the rate in effect on the day on which the death occurs.
(d) Interest is payable until the day on which the claim is paid.
(3)
(a) Unless the claim is paid and except as provided in Subsection (4), beginning on the day described in Subsection (3)(b) and ending the day on which the claim is paid, interest shall accrue at the rate in Subsection (2) plus additional interest at the rate of 10% annually.
(b) Interest accrues under Subsection (3)(a) beginning with the day that is 31 days from the latest of:
(i) the day on which the insurer receives proof of death;
(ii) the day on which the insurer receives sufficient information to determine:
(A) liability;
(B) the extent of the liability; and
(C) the appropriate payee legally entitled to the proceeds; and
(iii) the day on which:
(A) legal impediments to payment of proceeds that depend on the action of parties other than the insurer are resolved; and
(B) the insurer receives sufficient evidence of the resolution of the legal impediments described in Subsection (3)(b)(iii)(A).
(4) A court of competent jurisdiction may require payment of interest from the date of death to the day on which a claim is paid at a rate equal to the sum of:
(a) the rate specified in Subsection (2); and
(b) the legal rate identified in Subsection 15-1-1(2).

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

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

(1) In connection with or as part of each application for life insurance or annuities, the applicant shall complete and the producer shall submit to the insurer the statements required by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as to:
  (a) whether the applicant has existing policies or contracts; and
  (b) whether the proposed life insurance or annuity will replace, discontinue, or change an existing policy or contract.
(2) If an applicant for life insurance or an annuity answers "yes" to the question regarding replacement, discontinuance, or change of an existing policy or contract referred to in Subsection (1), the producer shall present to the applicant, not later than at the time of taking the application, the notice regarding replacements in the form adopted by the commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, or other substantially similar document filed with the commissioner.
(3)
  (a) The notice described in Subsection (2) shall:
    (i) list each existing policy or contract contemplated to be replaced, properly identified by name of insurer, the insured or annuitant, and policy or contract number if available; and
    (ii) include a statement as to whether each policy or contract will be replaced or whether a policy will be used as a source of financing for the new policy or contract.
  (b) If a policy or contract number has not been issued by the existing insurer, alternative identification, such as an application or receipt number, shall be listed.
(4) In connection with a replacement transaction, the producer shall leave with the applicant by no later than at the time of policy or contract delivery the original or a copy of all printed sales material. With respect to electronically presented sales material, it shall be provided to the policy or contract holder in printed form no later than at the time of policy or contract delivery.
(5) Except as provided in rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, in connection with a replacement transaction, the producer shall submit to the insurer to which an application for a policy or contract is presented:
  (a) a copy of each document required by this section;
  (b) a statement identifying any preprinted or electronically presented company approved sales materials used; and
  (c) copies of any individualized sales materials, including any illustrations related to the specific policy or contract purchased.

Enacted by Chapter 319, 2013 General Session

**31A-22-430 Policy notification.**

(1)
  (a) An insurer that delivers or issues for delivery an individual life insurance policy in this state shall notify the applicant for the policy, in writing at the time of application for the policy, of an applicant's right to designate a third party to receive notice of lapse or cancellation of the policy based on nonpayment of premium.

(b) An applicant may make a designation described in Subsection (1)(a) at the time of application for the policy, or at any time the policy is in force, by submitting a written notice to the insurer containing the name and address of the third-party designee.

(2) In accordance with Subsection 31A-22-402(5), an insurer shall transmit a copy of a notice of lapse or cancellation of the policy based on nonpayment of premium to a third party designated in accordance with this section in addition to the transmission of the notice of lapse or cancellation of the policy to the policyholder.

(3) The designation of a third party under this section does not constitute acceptance of any liability on the part of the third party or insurer for a service provided to the policyholder.

Amended by Chapter 221, 2021 General Session

**31A-22-431 Living organ donor coverage.**

(1) For the purposes of this section, "living organ donor" means the same as that term is defined in Section 31A-22-655.

(2) An insurer may not:

(a) deny eligibility for coverage or limit coverage of a individual under a life insurance policy or contract solely due to the status of the individual as a living organ donor;

(b) preclude an individual from donating all or part of an organ as a condition of receiving or continuing to receive coverage under a life insurance policy or contract; or

(c) discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of a life insurance policy or contract for an individual based upon the status of the individual as a living organ donor without any additional actuarial risk.

(3) The commissioner shall make educational materials available to insurers and the public on the access of living organ donors to insurance.

(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

Enacted by Chapter 128, 2020 General Session

## Part 5
## Group Life Insurance

**31A-22-501 Eligible groups.**

A group insurance policy offering life insurance or a blanket insurance policy offering life insurance may not be delivered in Utah unless the insured group:

(1) falls within at least one of the classifications under Sections 31A-22-501.1 through 31A-22-509; and

(2) is formed and maintained in good faith for purposes other than obtaining insurance.

Amended by Chapter 252, 2021 General Session

**31A-22-501.1 Employer groups.**

(1) The lives of a group of individuals may be insured under a policy:

(a) issued as a policyholder, to:

(i) an employer; or

(ii) an employer sponsored trust for the benefit of the employer's employees;
(b) having an insurable interest as stated in Subsection 31A-21-104(3)(d); and
(c) subject to the requirement of Subsection 31A-21-104(3)(d)(v).
(2) A policy issued under this section is not subject to:
(a) Section 31A-21-311; and
(b) Sections 31A-22-516 through 31A-22-522.

Amended by Chapter 263, 2008 General Session

**31A-22-502 Employee groups.**
(1) As used in this section:
(a) "Employees" includes:
(i) for one or more affiliated corporations, proprietorships, or partnerships under common control, their:
(A) officers;
(B) managers;
(C) retired employees; and
(D) individual proprietors or partners; and
(ii) for a trusteeship, if their duties are primarily connected with the trusteeship:
(A) trustees;
(B) employees of trustees; or
(C) both Subsection (1)(a)(ii)(A) and (B).
(b) "Employer" includes a Utah public agency.
(c)
(i) "Utah public agency" means a public institution that:
(A) derives its authority from this state; and
(B) is not privately owned.
(ii) "Utah public agency" includes:
(A) a local political subdivision as defined in Section 11-14-102;
(B) the state;
(C) a department or agency of the state; and
(D) all public educational institutions.
(2) The lives of a group of individuals may be insured under a policy:
(a) issued as policyholder, to:
(i) an employer; or
(ii) the trustees of a fund established by an employer;
(b) insuring employees of the employer for the benefit of persons other than the employer; and
(c) subject to the requirements of Subsections (3) through (5).
(3)
(a) All the employer's employees or all of any class of employees of the employer shall be eligible for insurance under the policy described in Subsection (2).
(b) A policy issued to insure the employees of a public body may include elected or appointed officials.
(4) A Utah public agency may pay or authorize the payment out of the Utah public agency's corporate revenue, the premiums required to maintain the group insurance in force.
(5)
(a) The premiums for the policy described in Subsection (2) shall be paid by the policyholders:
(i) from the employer's funds;

(ii) funds contributed by the insured employees; or
(iii) both the funds described in Subsections (5)(a)(i) and (ii).
(b) Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the insured employees shall insure all eligible employees.

Amended by Chapter 105, 2005 General Session

**31A-22-503 Labor union or similar employee organization groups.**

The lives of a group of individuals may be insured under a policy issued to a labor union or similar employee organization as policyholder. This policy shall insure members of the union or organization for the benefit of persons other than the union or organization or of any of its officials, representatives, or agents, subject to the following requirements:
(1) The members eligible for the insurance are all of the members or all of any classes of the members.
(2) The premium for the policy shall be paid by the policyholder, either from funds of the union or organization, from funds contributed by the insured members specifically for their insurance, or from both. Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the insured members specifically for their insurance shall insure all eligible members.

Enacted by Chapter 242, 1985 General Session

**31A-22-504 Trustee groups.**

(1) A group insurance policy offering life insurance may be issued to:
(a) policyholders who are the trustees of a fund established by two or more employers, by one or more labor unions, or similar employee organizations, or by one or more employers and one or more labor unions or similar employee organizations, to insure employees of the employers or members of the unions or the organizations for the benefit of persons other than the employers, the unions, or the organizations; or
(b) notwithstanding Subsection 31A-22-501(2):
(i) a Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal Labor Management Relations Act; or
(ii) a trustee under a trust established for the purpose of facilitating the continuation of a policy when an individual's coverage would otherwise end, if the participating group through which the original coverage was offered would be eligible under this section, Section 31A-22-502, or Section 31A-22-503.
(2) A group insurance policy offering life insurance is subject to the following requirements:
(a) the persons eligible for insurance are all of the employees of the employers or all of the members of the unions or organizations, or all of any classes of employees or members;
(b) the policy may include retired or former employees or members, elected and appointed officials of a public agency if the employees of the agency are insured, and individual proprietors or partners who are employers;
(c) the policy may include the trustees or the trustees' employees, or both, if their duties are principally connected with the trusteeship;
(d) the premiums for the policy are paid by the policyholders from funds contributed by the employers, unions, or similar employee organizations, or from funds contributed by the insured persons, or any combination of these; and

(e) except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the insured persons specifically for the insured persons' insurance is required to insure all eligible persons.

Amended by Chapter 252, 2021 General Session

**31A-22-505 Association groups.**

(1) An insurer may issue a group insurance policy offering life insurance to an association group or to the trustees of a fund established, created, and maintained for the benefit of the members of the association group if:
(a) the commissioner authorizes the association group;
(b) the benefits of the group insurance policy are reasonable in relation to the premiums charged for the policy; and
(c) the association group:
(i) purchases insurance on a group basis on behalf of the association group's members;
(ii) is formed and maintained for a shared substantially common purpose that:
(A) is not related to obtaining insurance; and
(B) is the same profession, trade, or occupation or has some common economic, representation of interest, or genuine organizational relationship;
(iii) has at least 100 members;
(iv) has been actively in existence for at least five years;
(v) has a constitution and bylaws that require:
(A) the association to hold regular meetings not less than annually to further the purpose of the association's members; and
(B) members of the association to have voting privileges and representation on any governing board or committee;
(vi) does not condition membership in the association group on any health status-related factor;
(vii) makes insurance offered through the association group available exclusively to a member of the association; and
(viii) only offers insurance through the association group in connection with a member of the association group.

(2) A group insurance policy offering life insurance that an insurer issues to an association group may insure members and employees of the association, employees of the members, one or more of the preceding entities, or all of any classes of these named entities for the benefit of persons other than the employees' employer, or any officials, representatives, trustees, or agents of the employer or association.

(3)
(a) The following shall pay the premium under a group insurance policy offering life insurance that an insurer issues to an association group:
(i) the policyholder from funds contributed by the association;
(ii) employer members, from funds contributed by the covered persons; or
(iii) from any combination of Subsections (3)(a)(i) and (ii).
(b) Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by the covered persons, specifically for their insurance, is required to insure all eligible persons.

(4)
(a) An association group that meets the requirements described under Subsection (1) shall disclose the following to each insured member:

(i) each cost related to joining and maintaining membership in the association;
(ii) that membership fees or dues are in addition to the policy premium;
(iii) that the association group holds the master group insurance policy;
(iv) that the association group and insurer determine the amount of the premium charged and the terms and conditions of coverage under the group insurance policy; and
(v) that the association group policyholder and insurer may change the premium and terms and conditions of coverage under the insurance policy:
(A) through agreement; and
(B) without the consent of the individual certificate holder.
(b) If an insurer collects membership fees or dues on behalf of an association, the insurer shall disclose to each member of the association that the insurer is billing and collecting membership fees and dues on behalf of the association.

Amended by Chapter 45, 2026 General Session

**31A-22-506 Creditor groups to insure debtors.**
(1) To insure debtors of a creditor, a group life insurance policy may be issued to a policyholder who is any of the following:
(a) the creditor;
(b) the creditor's parent holding company; or
(c) trustees or agents designated by two or more creditors.
(2) A policy described in Subsection (1) is subject to the requirements of this Subsection (2).
(a)
(i) The persons eligible for insurance are:
(A) all of the debtors of the creditors; or
(B) all of any classes of debtors.
(ii) The policy may provide that "debtors" includes:
(A) borrowers of money, or purchasers or lessees of goods, services, property, rights, or privileges for which payment is arranged through a credit transaction; and
(B) the debtors of one or more affiliated corporations, proprietorships, or partnerships under common control with the policyholder.
(b)
(i) The premiums shall be paid by the policyholder, from:
(A) the creditor's funds;
(B) charges collected from the insured debtors; or
(C) from both Subsections (2)(b)(i)(A) and (B).
(ii) Except as provided under Section 31A-22-512, a policy on which no part of the premium is contributed by insured debtors specifically for their insurance shall insure all eligible debtors.
(c)
(i) To the extent of the creditor's interest, the insurance may be payable to the creditor or to any successor to the right, title, and interest of the creditor.
(ii) The payment shall reduce or extinguish the obligation of the debtor to the extent of the payment.
(iii) When the amount of insurance exceeds the debt, the excess is payable to a beneficiary other than the creditor named by the debtor, or to the debtor's estate.
(d) Group policies issued under this section are not subject to Sections 31A-22-516 through 31A-22-521.

Amended by Chapter 125, 2005 General Session

**31A-22-507 Credit union groups.**

(1) The lives of a group of individuals may be insured under a policy issued to a policyholder who is:
  (a) a credit union; or
  (b) trustees or agents designated by two or more credit unions.
(2) A policy described in Subsection (1) shall insure members of a credit union for the benefit of persons other than:
  (a) the credit union;
  (b) trustees of the credit union;
  (c) agents of the credit union; or
  (d) an official of an entity described in Subsections (2)(a) through (c).
(3) The policies are subject to the requirements of this Subsection (3).
  (a) The persons eligible for insurance are:
    (i) all of the members of the credit union; or
    (ii) all of any classes of the members of the credit union.
  (b) The premiums shall be paid by the policyholder. Except as provided in Section 31A-22-512, a policy on which no part of the premium is collected from the covered members specifically for their insurance shall insure all eligible members.
  (c) A group policy issued under this section is not subject to Sections 31A-22-517 through 31A-22-521.

Amended by Chapter 125, 2005 General Session

**31A-22-508 National Guard groups.**

(1) A policy of group life insurance may be issued to a group comprised solely of members of the Utah National Guard if the group policy is issued to an association of members.
(2) The association is the policyholder to insure members of the Utah National Guard for the benefit of persons other than the association or any of its officials.
(3) The premium for the policy shall be paid by the policyholder, either from the association's own funds, or from charges collected from the insured members specifically for the insurance.

Amended by Chapter 373, 2022 General Session

**31A-22-509 Commissioner's authority to approve other groups.**

(1) A policy may be issued to a group other than those specified under Sections 31A-22-501 through 31A-22-508, if specifically authorized by the commissioner and if granting the permission is not contrary to public policy.
(2)
  (a) The commissioner may not grant permission to issue these types of policies unless the insurer demonstrates to the commissioner's satisfaction that the proposed group will:
    (i) be actuarially sound;
    (ii) result in economies of acquisition and administration that justify a group rate; and
    (iii) not present hazards of adverse selection.
  (b) The policyholders shall pay the premiums for the policy from funds contributed by:
    (i) the policyholder;
    (ii) the covered person; or

(iii) both the policyholder and the covered person.
(c) Premiums for the policy and any contributions by or on behalf of the insured persons shall be reasonable in relation to the benefits provided.

Amended by Chapter 175, 2025 General Session

**31A-22-510 Requirements for group life insurance delivered in another jurisdiction.**
(1) A Utah resident may not be enrolled in a policy of group life insurance delivered in another jurisdiction in violation of Subsection (2) or (3), notwithstanding any contrary provision in Subsection 31A-1-103(3).
(2) Unless specifically authorized by the commissioner under Section 31A-22-509, coverage under a group life insurance policy delivered in another jurisdiction may not be initially provided to any person unless the policy conforms substantially to one of the types of groups specified under Sections 31A-22-502 through 31A-22-508.
(3) Coverage may not be initially provided to any person in Utah under a group life policy issued in another jurisdiction by an insurer not authorized to engage in life insurance business in Utah unless the policyholder conforms substantially to the type of group specified under Section 31A-22-502, 31A-22-503, or 31A-22-504.

Amended by Chapter 116, 2001 General Session

**31A-22-511 Dependents' coverage.**
(1) A group life policy issued under Sections 31A-22-502 through 31A-22-505 or Section 31A-22-509 may insure any class of employee or member and the spouse and dependent children of an employee or member against loss due to death.
(2) The policyholder shall pay the premiums for the insurance from funds contributed by:
(a) the policyholder;
(b) the covered person; or
(c) both the policyholder and the covered person.
(3) Except as provided under Section 31A-22-512, a policy on which no part of the premium for the dependent coverage is contributed by the covered person shall insure each eligible person, including the covered person's spouse and dependent or minor children.

Amended by Chapter 175, 2025 General Session

**31A-22-512 Individual insurability.**
(1) An insurer may exclude or limit the coverage under a group life insurance policy on any person, including a group member's dependent, as to whom the evidence of individual insurability is not satisfactory to the insurer.
(2) The group life insurance policy shall contain a provision setting forth the conditions, if any, under which the insurer reserves the right to require a person eligible for insurance to furnish satisfactory evidence to the insurer of the individual insurability as a condition to part or all of the person's coverage.

Amended by Chapter 175, 2025 General Session
Amended by Chapter 302, 2025 General Session

**31A-22-513 Grace period.**

(1)
(a) Every group life insurance policy shall contain a provision that the policyholder is entitled to a grace period of not less than 31 days for the payment of any premium due except the first payment of premium.
(b) During the grace period described in Subsection (1)(a) the death benefit coverage continues in force, unless the policyholder gives the insurer written notice of discontinuance:
(i) in advance of the date of discontinuance; and
(ii) in accordance with the policy terms.
(2) The policy may require the policyholder to pay the pro rata premium for the time the policy is in force during the grace period.

Amended by Chapter 114, 2000 General Session

**31A-22-514 Incontestability.**
(1) A group life insurance policy shall contain a provision that the validity of the policy may not be contested, except for nonpayment of premiums, after the policy has been in force for two years from its date of issue.
(2) The provision described in Subsection (1) shall state that no statement made by a person insured under the policy relating to the person's insurability may be used:
(a) in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force, prior to the contest, for a period of two years during the person's lifetime; or
(b) unless the statement is in writing and signed by the person.
(3) Nothing in this section precludes the assertion of defenses based upon provisions in the policy which relate to eligibility for coverage.

Amended by Chapter 175, 2025 General Session
Amended by Chapter 302, 2025 General Session

**31A-22-515 Nonforfeiture.**
If the group life insurance policy is not a term policy, it shall contain nonforfeiture provisions which the commissioner determines to be equitable to the insured persons and to the policyholder. The commissioner may not require that group life insurance policies contain the same nonforfeiture provisions which are required for individual life insurance policies.

Enacted by Chapter 242, 1985 General Session

**31A-22-516 Payment of benefits.**
Any sum which is due because of the death of the person insured is payable to the beneficiary designated by the insured person, unless the policy contains conditions providing that the beneficiary is a family member designated by the policy terms. The insurer may reserve in the policy the right, if there is no designated beneficiary living at the death of the person insured as to all or any part of the sum, to pay a part of the sum not exceeding $5,000 to any person appearing to the insurer to be equitably entitled to that money by reason of having incurred expense for the maintenance, medical attention, or burial of the insured or for other reasons.

Enacted by Chapter 242, 1985 General Session

**31A-22-517 Conversion on termination of eligibility.**

(1) Except as provided in Subsection (6), a person is entitled to be issued by an insurer, without evidence of insurability, an individual policy offering life insurance without accident and health or other supplementary benefits, if:
  (a) any portion of insurance on a person covered by a policy ceases because of:
    (i) termination of employment; or
    (ii) termination of membership in the classes eligible for coverage;
  (b) an application for the individual policy is made; and
  (c) the first premium is paid to the insurer within 31 days after the day on which the termination described in Subsection (1)(a) occurs.

(2) The individual policy described in Subsection (1) shall, at the option of the person entitled to the policy, be on any form then customarily provided by the insurer at the age and for the amount applied for, except that the group policy may exclude the option to elect:
  (a) term insurance; or
  (b) flexible premium insurance.

(3)
  (a) The individual policy described in Subsection (1) shall be for an amount equal to or, at the election of the person entitled, less than the life insurance that ceases because of the termination described in Subsection (1)(a), less the amount of any group life insurance for which the person is eligible within 30 days after the day on which the termination described in Subsection (1)(a) occurs.
  (b) Any amount of insurance that matures on or before the termination, as an endowment payable to the person insured, is not included in the amount that is considered to cease because of the termination whether the endowment payment is in:
    (i) one sum;
    (ii) installments; or
    (iii) the form of an annuity.

(4) The premium on the individual policy described in Subsection (1) shall be at the insurer's customary rate at the time of termination, which is applicable to:
  (a) the form and amount of the individual policy;
  (b) the class of risk to which the person belonged when terminated from the group policy; and
  (c) the age attained on the effective date of the individual policy.

(5) Subject to the conditions of this section, the conversion privilege described in this section is available:
  (a) to a surviving dependent, if any, at the death of the employee or member, with respect to the survivor's coverage under the group policy that terminates by reason of the death; and
  (b) to the dependent of the employee or member upon termination of coverage of the dependent, while the employee or member remains insured, because the dependent ceases to be a qualified dependent under the group policy.

(6) This section does not apply to an insured whose coverage will continue being the policy of group life insurance issued to a group as authorized under Subsection 31A-22-504(1)(b)(ii).

Amended by Chapter 252, 2021 General Session

**31A-22-518 Conversion on termination of policy.**

(1) Subject to Subsection (2), if the group policy terminates or is amended to terminate the insurance of any class of covered persons, every insured person whose insurance terminates, including the insured dependent of a covered person who has been insured for at least

five years prior to the termination date, is entitled to have the insurer issue to the person an individual policy of life insurance, subject to the conditions and limitations in Section 31A-22-517.

(2) The group policy described in Subsection (1) shall provide that the amount of the individual policy may not be less than the smaller of:

(a) the amount of the person's life insurance protection ceasing because of the termination or amendment of the group policy, less the amount of any life insurance for which the person is eligible under any group policy issued or reinstated by the same or another insurer within 30 days after the termination; or

(b) $10,000.

Amended by Chapter 116, 2001 General Session

**31A-22-519 Death pending conversion.**

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

Amended by Chapter 319, 2013 General Session

**31A-22-520 Continuation of coverage during total disability.**

(1) An insured person in a group life insurance policy may continue coverage during the total disability of the insured person or dependent by timely payment to the policyholder of that portion, if any, of the premium that would have been required on behalf of the insured person in the absence of total disability.

(2) The continuation shall be on a premium paying basis until the earlier of:

(a) six months from the date of total disability;

(b) approval by the insurer of continuation of the coverage under any disability provision the group insurance policy may contain; or

(c) the discontinuance of the group insurance policy.

(3) If the group policy has a waiting period for an accident and health benefit, the continuation extends to the end of the waiting period, even if the group policy is otherwise discontinued.

Amended by Chapter 116, 2001 General Session

**31A-22-521 Notice of right to convert under group policy.**

Certificates of insurance evidencing coverage under a group life insurance policy shall prominently notify individuals of conversion rights and contain information concerning the time and manner in which conversion to an individual life insurance policy may be made.

Repealed and Re-enacted by Chapter 316, 1994 General Session

**31A-22-522 Required provision for notice of termination.**

(1) A group insurance policy offering life insurance coverage or a blanket insurance policy offering life insurance coverage shall include a provision that obligates the policyholder to notify each employee or group member:
(a) in writing;
(b) 30 days before the day on which the coverage terminates; and
(c)
(i) that the group insurance policy offering life insurance coverage or blanket insurance policy offering life insurance coverage is being terminated; and
(ii) the rights the employee or group member has to convert coverage upon termination.
(2) For a group insurance policy offering life insurance coverage or a blanket insurance policy offering life insurance coverage described in Subsection (1), an insurer shall:
(a) include a statement of a policyholder's obligations under Subsection (1) in the insurer's monthly notice to the policyholder of premium payments due; and
(b) provide a sample notice to the policyholder at least once a year.

Amended by Chapter 252, 2021 General Session

## Part 6
## Accident and Health Insurance

**31A-22-600 Scope of Part 6.**
(1) Except where a provision's application is otherwise specifically limited, this part applies to all:
(a) accident and health insurance contracts, including credit accident and health;
(b) franchise;
(c) group contracts; and
(d) life insurance and annuity policies that directly or through a rider provide:
(i) accident and health insurance benefits; or
(ii) accelerated benefits where the receipt of benefits is contingent on morbidity requirements.
(2) Nothing in this part applies to or affects:
(a) workers' compensation insurance;
(b) reinsurance; or
(c) accident and health insurance when it is part of or supplemental to liability, steam boiler, elevator, automobile, or other insurance covering loss of or damage to property, provided the loss, damage, or expense arises out of a hazard directly related to the other insurance.
(3) Except as provided in Subsection (1), this part does not apply to or affect a life insurance or annuity policy including a life insurance policy:
(a) with a rider or supplemental benefit that accelerates the death benefit contingent upon a mortality risk specifically for one or more of the qualifying events of:
(i) terminal illness;
(ii) medical conditions requiring extraordinary medical intervention; or
(iii) permanent institutional confinement; and
(b) that provides the option of a lump-sum payment for those benefits.

Amended by Chapter 252, 2021 General Session

**31A-22-601 Applicability of life insurance provisions.**

Sections 31A-22-412 through 31A-22-417 apply to death benefits in accident and health insurance policies.

Amended by Chapter 116, 2001 General Session

**31A-22-602 Premium rates.**

(1) Except as provided in Subsection 31A-22-701(4), this section does not apply to group accident and health insurance.
(2) The benefits in an accident and health insurance policy shall be reasonable in relation to the premiums charged.
(3) The commissioner shall prohibit the use of an accident and health insurance form or rates if the form or rates do not satisfy Subsection (2).

Amended by Chapter 198, 2022 General Session

**31A-22-603 Persons insured under an individual accident and health policy.**

A policy of individual accident and health insurance may insure only one person, except that originally or by subsequent amendment, upon the application of an adult policyholder, a policy may insure any two or more eligible members of the policyholder's family, including spouse, dependent children, and any other person dependent upon the policyholder.

Amended by Chapter 138, 2016 General Session

**31A-22-604 Reimbursement by insurers of Medicaid benefits.**

(1) As used in this section, "Medicaid" means the program under Title XIX of the federal Social Security Act.
(2) Any accident and health insurer, including a group accident and health insurance plan, as defined in Section 607(1), Federal Employee Retirement Income Security Act of 1974, or health maintenance organization as defined in Section 31A-8-101, is prohibited from considering the availability or eligibility for medical assistance in this or any other state under Medicaid, when considering eligibility for coverage or making payments under its plan for eligible enrollees, subscribers, policyholders, or certificate holders.
(3) To the extent that payment for covered expenses has been made under the state Medicaid program for health care items or services furnished to an individual in any case when a third party has a legal liability to make payments, the state is considered to have acquired the rights of the individual to payment by any other party for those health care items or services.
(4) Title 26B, Chapter 3, Part 10, Medical Benefits Recovery, applies to reimbursement of insurers of Medicaid benefits.

Amended by Chapter 327, 2023 General Session

**31A-22-605 Accident and health insurance standards.**

(1) The purposes of this section include:
  (a) reasonable standardization and simplification of terms and coverages of individual and franchise accident and health insurance policies, including accident and health insurance contracts of insurers licensed under Chapter 7, Nonprofit Health Service Insurance Corporations, and Chapter 8, Health Maintenance Organizations and Limited Health Plans, to facilitate public understanding and comparison in purchasing;

(b) elimination of provisions contained in individual and franchise accident and health insurance contracts that may be misleading or confusing in connection with either the purchase of those types of coverages or the settlement of claims; and
(c) full disclosure in the sale of individual and franchise accident and health insurance contracts.
(2) This section applies to all individual and franchise accident and health policies.
(3) The commissioner shall adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:
(a) standards for the manner and content of policy provisions, and disclosures to be made in connection with the sale of policies covered by this section, dealing with at least the following matters:
(i) terms of renewability;
(ii) initial and subsequent conditions of eligibility;
(iii) nonduplication of coverage provisions;
(iv) coverage of dependents;
(v) preexisting conditions;
(vi) termination of insurance;
(vii) probationary periods;
(viii) limitations;
(ix) exceptions;
(x) reductions;
(xi) elimination periods;
(xii) requirements for replacement;
(xiii) recurrent conditions;
(xiv) coverage of an individual eligible for Medicare; and
(xv) definition of terms;
(b) minimum standards for benefits under each of the following categories of coverage in policies covered in this section:
(i) basic hospital expense coverage;
(ii) basic medical-surgical expense coverage;
(iii) hospital confinement indemnity coverage;
(iv) major medical expense coverage;
(v) income replacement coverage;
(vi) accident only coverage;
(vii) specified disease or specified accident coverage;
(viii) limited benefit health coverage;
(ix) dental coverage; and
(x) nursing home and long-term care coverage;
(c) the content and format of the outline of coverage, in addition to that required under Subsection (5);
(d) the method of identification of policies and contracts based upon coverages provided; and
(e) rating practices.
(4) Nothing in Subsection (3)(b) precludes the issuance of policies that combine categories of coverage in Subsection (3)(b) provided that any combination of categories meets the standards of a component category of coverage.
(5) The commissioner may adopt rules, made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, relating to the following matters:
(a) establishing disclosure requirements for insurance policies covered in this section, designed to adequately inform the prospective insured of the need for and extent of the coverage

offered, and requiring that this disclosure be furnished to the prospective insured with the application form, unless it is a direct response insurance policy;

(b)

(i) prescribing caption or notice requirements designed to inform prospective insureds that particular insurance coverages are not Medicare supplement insurance; and

(ii) applying the requirements of Subsection (5)(b)(i) to all insurance policies and certificates sold to an individual eligible for Medicare; and

(c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, if the prospective insured requests the disclosure or information brochures or, in any event, no later than the time of the policy delivery.

(6)

(a) A policy covered by this section may be issued only if the policy meets the minimum standards established by the commissioner under Subsection (3), an outline of coverage accompanies the policy or is delivered to the applicant at the time of the application, and, except with respect to direct response insurance policies, an acknowledged receipt is provided to the insurer.

(b) The outline of coverage shall include:

(i) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (3);

(ii) a description of the principal benefits and coverage;

(iii) a statement of the exceptions, reductions, and limitations contained in the policy;

(iv) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(v) a statement that the outline is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions; and

(vi) any other contents the commissioner prescribes.

(7) If a policy is issued on a basis other than that applied for, the outline of coverage shall accompany the policy when it is delivered and it shall clearly state that it is not the policy for which application was made.

(8)

(a) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to an individual eligible for Medicare shall contain a notice prominently printed on or attached to the cover or front page which states that the policyholder or certificate holder has the right to return the policy for any reason within 30 days after its delivery and to have the premium refunded.

(b) This Subsection (8) does not apply to a policy issued to an employer group.

Amended by Chapter 45, 2026 General Session

**31A-22-605.1 Preexisting condition limitations.**

(1) Any provision dealing with preexisting conditions shall be consistent with this section, Section 31A-22-609, and rules adopted by the commissioner.

(2) Except as provided in this section, an insurer that elects to use an application form without questions concerning the insured's health or medical treatment history shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of coverage due to a preexisting condition which is not specifically excluded from coverage.

(3)

(a) An insurer that issues a specified disease policy may not deny a claim for loss due to a preexisting condition that occurs more than six months after the effective date of coverage.

(b) A specified disease policy may impose a preexisting condition exclusion only if the exclusion relates to a preexisting condition which first manifested itself within six months prior to the effective date of coverage or which was diagnosed by a physician at any time prior to the effective date of coverage.

(4)

(a) Except as otherwise provided in this section, a health benefit plan may impose a preexisting condition exclusion only if:

(i) the exclusion relates to a preexisting condition for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date from an individual licensed or similarly authorized to provide those services under state law and operating within the scope of practice authorized by state law;

(ii) the exclusion period ends no later than 12 months after the enrollment date, or in the case of a late enrollee, 18 months after the enrollment date; and

(iii) the exclusion period is reduced by the number of days of creditable coverage the enrollee has as of the enrollment date, in accordance with Subsection (4)(b).

(b)

(i) The amount of creditable coverage allowed under Subsection (4)(a)(iii) is determined by counting all the days on which the individual has one or more types of creditable coverage.

(ii) Days of creditable coverage that occur before a significant break in coverage are not required to be counted.

(A) Days in a waiting period or affiliation period are not taken into account in determining whether a significant break in coverage has occurred.

(B) For an individual who elects federal COBRA continuation coverage during the second election period provided under the federal Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

(c) A group health benefit plan may not impose a preexisting condition exclusion relating to pregnancy.

(d)

(i) An insurer imposing a preexisting condition exclusion shall provide a written general notice of preexisting condition exclusion as part of any written application materials.

(ii) The general notice under this subsection shall include:

(A) a description of the existence and terms of any preexisting condition exclusion under the plan, including the six-month period ending on the enrollment date, the maximum preexisting condition exclusion period, and how the insurer will reduce the maximum preexisting condition exclusion period by creditable coverage;

(B) a description of the rights of individuals:

(I) to demonstrate creditable coverage, including any applicable waiting periods, through a certificate of creditable coverage or through other means; and

(II) to request a certificate of creditable coverage from a prior plan;

(C) a statement that the current plan will assist in obtaining a certificate of creditable coverage from any prior plan or issuer if necessary; and

(D) a person to contact, and an address and telephone number for the person, for obtaining additional information or assistance regarding the preexisting condition exclusion.

(e) An insurer may not impose any limit on the amount of time that an individual has to present a certificate or other evidence of creditable coverage.
(f) This Subsection (4) does not preclude application of any waiting period applicable to all new enrollees under the plan.
(5)
(a) If a short-term limited duration health insurance policy provides for an extension or renewal of the policy, the insurer may not exclude coverage for a loss due to a preexisting condition for a period greater than 12 months following the original effective date of the coverage, unless the insurer specifically and expressly excludes the preexisting condition in the terms of the policy or certificate.
(b)
(i) An insurer that includes a preexisting condition exclusion in a short-term limited duration health insurance policy in accordance with this subsection shall provide a written general notice of the preexisting condition exclusion as part of any written application materials.
(ii) A written general notice described in this subsection shall:
(A) include a description of the existence and terms of any preexisting condition exclusion under the policy, including the maximum preexisting exclusion period; and
(B) state that the exclusion period ends no later than 12 months after the original effective date of the coverage.

Amended by Chapter 193, 2019 General Session

**31A-22-605.5 Application.**
(1) For purposes of this section "insurance mandate":
(a) means a mandatory obligation with respect to coverage, benefits, or the number or types of providers imposed on policies of accident and health insurance; and
(b) does not mean:
(i) an administrative rule imposing a mandatory obligation with respect to coverage, benefits, or providers unless that mandatory obligation was specifically imposed on policies of accident and health insurance by statute; or
(ii) an insurance mandate in an essential health benefits package imposed pursuant to 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 federal rules related to their implementation.
(2)
(a) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), the following shall apply to health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a):
(i) any law enacted under this title that becomes effective after January 1, 2002, which provides for an insurance mandate for policies of accident and health insurance; and
(ii) in accordance with Section 31A-22-613.5, disclosure requirements for coverage limitations.
(b) Notwithstanding the provisions of Subsection 31A-1-103(3)(f), a health insurance mandate enacted under this title after January 1, 2012, shall apply to:
(i) health coverage offered to the state employees' risk pool under Subsection 49-20-202(1)(a); and
(ii) health coverage offered to public school districts, charter schools, and institutions of higher education under Subsection 49-20-201(1)(b).
(c) If health coverage offered to the state employees' risk pool under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) offers coverage in the same manner and to the same extent as

the coverage required by an insurance mandate enacted under this title or coverage that is greater than the insurance mandate enacted under this title, the coverage offered to state employees under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) will be considered in compliance with the insurance mandate.

(d) The programs regulated under Subsections 49-20-201(1)(b) and 49-20-202(1)(a) shall report to the Retirement and Independent Entities Committee created under Section 63E-1-201 by November 30 of each year in which a mandate is enacted under the provisions of this section. The report shall include the costs and benefits of the particular mandatory obligation.

(3)

(a) An insurance mandate for policies of accident and health insurance enacted under this title after January 1, 2012, shall apply to a health plan offered by a public school district, a charter school, or a state funded institution of higher education that is not insured through the Public Employees' Benefit and Insurance Program.

(b) If an insurance mandate for policies of accident and health insurance is enacted under this title after January 1, 2012, the state shall determine whether each entity described in Subsections (2) and (3)(a) offers coverage in the same manner and to the same extent, or greater than the insurance coverage required in the mandate enacted after January 1, 2012.

(c) Before enacting an insurance mandate, the state shall, for each entity that does not offer coverage in accordance with Subsection (3)(b):

(i) determine the cost to the entity of implementing the insurance mandate; and

(ii) appropriate money necessary to fund the full cost to the entity of implementing the insurance mandate.

Amended by Chapter 127, 2012 General Session

**31A-22-606 Policy examination period.**

(1)

(a) Except as provided in Subsection (2), all accident and health policies shall contain a notice prominently printed on or attached to the cover or front page stating that the policyholder has the right to return the policy for any reason within 10 days after its delivery.

(b) "Return" means delivery to the insurer or its agent or mailing of the policy to either, properly addressed and stamped for first class handling, with a written statement on the policy or an accompanying communication that it is being returned for termination of coverage. A policy returned under this Subsection (1) is void from the beginning and a policyholder returning his policy is entitled to a refund of any premium paid.

(2) This section does not apply to:

(a) group policies;

(b) policies issued to persons entitled to a 30-day examination period under Subsection 31A-22-605(9);

(c) single premium nonrenewable policies issued for terms not longer than 60 days;

(d) policies covering accidents only or accidental bodily injury only; and

(e) other classes of policies which the commissioner by rule specifies after a finding that a right to return those policies would be impracticable or unnecessary to protect the policyholder's interests.

Amended by Chapter 78, 2005 General Session

**31A-22-607 Grace period.**

(1)
(a) An individual or franchise accident and health insurance policy shall contain one or more clauses providing for a grace period for premium payment only of:
(i) at least 15 days for a weekly or monthly premium policy; and
(ii) 30 days for a policy that is not a weekly or monthly premium policy, for each premium after the first premium payment.
(b) An insurer may elect to include a grace period that is longer than 15 days for a weekly or monthly policy.
(c) An individual or franchise accident and health insurance policy is not in force during a grace period.
(d) If an insurer receives payment before the day on which a grace period expires, the individual or franchise accident and health insurance policy continues in force with no gap in coverage.
(e) If an insurer does not receive payment before the day on which a grace period expires, the individual or franchise accident and health insurance policy terminates as of the last date for which the premium is paid in full.
(f) A grace period is not required if the policyholder has requested that the individual or franchise accident and health insurance policy be discontinued.
(2)
(a) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance shall provide for a grace period of at least 30 days, unless the policyholder gives written notice of discontinuance before the day on which the policy discontinues, in accordance with the policy terms.
(b) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance is in force during a grace period.
(c) If an insurer does not receive payment before the day on which a grace period expires, the group insurance policy offering accident and health insurance or blanket insurance policy offering accident and health insurance terminates as of the last day on which the grace period is in effect.
(d) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance may provide for payment of a pro rata premium for the period the policy is in effect during a grace period under this Subsection (2).
(3) If an insurer has not guaranteed the insured a right to renew an accident and health insurance policy, a grace period beyond the expiration or anniversary date may, if provided in the accident and health insurance policy, be cut off by compliance with the notice provision under Subsection (4).
(4)
(a) An insurer shall send a written renewal notice to the policyholder or, if the insurer issued the policy to an employer group, the producer:
(i) no sooner than 90 days before, and no later than 14 days before, the day on which an accident and health insurance policy renews; or
(ii) if the renewal notice includes a change in premium, at least 45 days before the day on which an accident and health insurance policy renews.
(b) The renewal notice described in Subsection (4)(a) shall clearly state:
(i) the renewal amount;
(ii) how the policyholder may pay the renewal premium, including the day on which the renewal premium is due; and
(iii) that failure of the policyholder to pay the renewal premium extinguishes the policyholder's right to renew.

(5) The extinguishment of a policyholder's right to renew for nonpayment of premium is effective no sooner than 10 days after the day on which the policyholder receives written notice that the policyholder has failed to pay the premium when due.

Amended by Chapter 252, 2021 General Session

**31A-22-608 Reinstatement of individual or franchise accident and health insurance policies.**

(1) Every individual or franchise accident and health insurance policy shall contain a provision which reads substantially as follows:

"REINSTATEMENT: If any renewal premium is not paid within the time granted the insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly authorized by the insurer to accept the premium, without also requiring an application for reinstatement, shall reinstate the policy. However, if the insurer or agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy shall be reinstated upon approval of this application from the insurer or, lacking this approval, upon the 45th day following the date of the conditional receipt, unless the insurer has previously notified the insured in writing of its disapproval of the application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after that date. In all other respects the insured and insurer have the same rights under the reinstated policy as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed on or attached to this policy in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement."

(2) The last sentence of the provision described in Subsection (1) may be omitted from any policy that the insured has the right to continue in force subject to the policy's terms by the timely payment of premiums until at least age 50, or in the case of a policy issued after age 44, for at least five years from the day on which the insurer issues the policy.

Amended by Chapter 252, 2021 General Session

**31A-22-609 Incontestability for accident and health insurance.**

(1)

(a) A statement made by an applicant relating to the person's insurability, except fraudulent misrepresentation, may not be a basis for avoidance of a policy, coverage, or denial of a claim for loss incurred or disability commencing after the coverage has been in effect for two years.

(b) The insurer has the burden of proving fraud by clear and convincing evidence.

(2) Except as provided under Section 31A-22-605.1, a claim for loss incurred or disability commencing after two years from the date of issue of the policy may not be reduced or denied on the ground that a disease or physical condition existed prior to the effective date of coverage, unless the condition was excluded from coverage by name or specific description in a provision that was in effect on the date of loss.

(3) Except as provided in Subsection (1)(a), a specified disease policy may not include wording that provides a defense based upon a disease or physical condition that existed prior to the effective date of coverage except as allowed under Subsection 31A-22-605.1(2).

Amended by Chapter 78, 2005 General Session

**31A-22-610 Dependent coverage from moment of birth or adoption.**

(1) As used in this section:

(a) "Child" means, in connection with any adoption, or placement for adoption of the child, an individual who is younger than 18 years old as of the date of the adoption or placement for adoption.

(b) "Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

(2)

(a) Except as provided in Subsection (5), if an accident and health insurance policy provides coverage for any members of the policyholder's or certificate holder's family, the policy shall provide that any health insurance benefits applicable to dependents of the insured are applicable on the same basis to:

(i) a newly born child from the moment of birth; and

(ii) an adopted child:

(A) beginning from the moment of birth, if placement for adoption occurs within 30 days of the child's birth; or

(B) beginning from the date of placement, if placement for adoption occurs 30 days or more after the child's birth.

(b) The coverage described in this Subsection (2):

(i) is not subject to any preexisting conditions; and

(ii) includes any injury or sickness, including the necessary care and treatment of medically diagnosed:

(A) congenital defects;

(B) birth abnormalities; or

(C) prematurity.

(c)

(i) Subject to Subsection (2)(c)(ii), a claim for services for a newly born child or an adopted child may be denied until the child is enrolled.

(ii) Notwithstanding Subsection (2)(c)(i), an otherwise eligible claim denied under Subsection (2)(c)(i) is eligible for payment and may be resubmitted or reprocessed once a child is enrolled pursuant to Subsection (2)(d) or (e).

(d) If the payment of a specific premium is required to provide coverage for a child of a policyholder or certificate holder, for there to be coverage for the child, the policyholder or certificate holder shall enroll:

(i) a newly born child within 30 days after the date of birth of the child; or

(ii) an adopted child within 30 days after the day of placement of adoption.

(e) If the payment of a specific premium is not required to provide coverage for a child of a policyholder or certificate holder, for the child to receive coverage the policyholder or certificate holder shall enroll a newly born child or an adopted child no later than 30 days after the first notification of denial of a claim for services for that child.

(3)

(a) The coverage required by Subsection (2) as to children placed for the purpose of adoption with a policyholder or certificate holder continues in the same manner as it would with respect to a child of the policyholder or certificate holder unless:

(i) the placement is disrupted prior to legal adoption; and

(ii) the child is removed from placement.

(b) The coverage required by Subsection (2) ends if the child is removed from placement prior to being legally adopted.
(4) The provisions of this section apply to employee welfare benefit plans as defined in Section 26B-3-1001.
(5) If an accident and health insurance policy that is not subject to the special enrollment rights described in 45 C.F.R. Sec. 146.117(b) provides coverage for one individual, the insurer may choose to:
(a) provide coverage according to this section; or
(b) allow application, subject to the insurer's underwriting criteria for:
(i) a newborn;
(ii) an adopted child; or
(iii) a child placed for adoption.

Amended by Chapter 327, 2023 General Session

**31A-22-610.1 Indemnity benefit for adoption or infertility treatments.**
(1)
(a)
(i) If an insured has coverage for maternity benefits on the date of an adoptive placement, the insured's policy shall provide an adoption indemnity benefit payable to the insured, if a child is placed for adoption with the insured within 90 days of the child's birth. If more than one child from the same birth is placed for adoption with the insured, only one adoption indemnity benefit is required.
(ii) This section does not prevent an accident and health insurer from:
(A) adjusting the benefit payable under this section for cost sharing measures imposed under the policy or contract for maternity benefit coverage; or
(B) providing additional adoption indemnity benefits including:
(I) extending the period of time after birth in which a child must be placed with an insured; or
(II) providing a benefit in excess of the amount specified in Subsection (1)(c).
(b) An insurer that has paid the adoption indemnity benefit under Subsection (1)(a) may seek reimbursement of the benefit if:
(i) the postplacement evaluation disapproves the adoption placement; and
(ii) a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety.
(c)
(i) The amount of the adoption indemnity benefit provided under Subsection (1) is $4,000 subject to the adjustments permitted by Subsection (1)(a)(ii).
(ii) An insurer may comply with the provisions of this section by providing the $4,000 adoption indemnity benefit to an enrollee to be used for the purpose of the enrollee obtaining infertility treatments rather than seeking reimbursement for an adoption in accordance with terms designated by the insurer.
(d) Each insurer shall pay its pro rata share of the adoption indemnity benefit if each adoptive parent:
(i) has coverage for maternity benefits with a different insurer; and
(ii) makes a claim for the adoption indemnity benefit provided in Subsection (1)(a).
(2) If a policy offers optional maternity benefits, it shall also offer coverage for adoption indemnity benefits if:
(a) a child is placed for adoption with the insured within 90 days of the child's birth; and

(b) the adoption is finalized within one year of the child's birth.

(3) If an insured qualifies for the adoption indemnity benefit under this section and receives services from a network provider, the network provider may only collect from the insured the amount that the contracting health care provider is entitled to receive for such services under the contract, including any applicable copayment.

Amended by Chapter 292, 2017 General Session

**31A-22-610.2 Maternity stay minimum limits.**

(1)

(a) If an insured has coverage for maternity benefits, the policy may not be limited to a less than a 48-hour benefit for both mother and newborn with a normal vaginal delivery.

(b) If an insured has coverage for maternity benefits, the policy may not be limited to a less than 96-hour benefit for both mother and newborn with a caesarean section delivery.

(2) Subsection (1) applies to an accident and health insurer who offers maternity coverage.

Amended by Chapter 116, 2001 General Session

**31A-22-610.5 Dependent coverage.**

(1) As used in this section, "child" means the same as that term is defined in Section 81-6-101.

(2)

(a) Any individual or group accident and health insurance policy or managed care organization contract that provides coverage for a policyholder's or certificate holder's dependent:

(i) may not terminate coverage of an unmarried dependent by reason of the dependent's age before the dependent's 26th birthday; and

(ii) shall, upon application, provide coverage for all unmarried dependents up to age 26.

(b) The cost of coverage for unmarried dependents 19 to 26 years old shall be included in the premium on the same basis as other dependent coverage.

(c) This section does not prohibit the employer from requiring the employee to pay all or part of the cost of coverage for unmarried dependents.

(d) An individual or group health insurance policy or managed care organization shall continue in force coverage for a dependent through the last day of the month in which the dependent ceases to be a dependent:

(i) if premiums are paid; and

(ii) notwithstanding Sections 31A-22-618.6 and 31A-22-618.7.

(3)

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

(i) was born out of wedlock and is entitled to coverage under Subsection (4);

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

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

(iv) does not reside with the parent; or

(v) does not reside in the insurer's service area.

(b) A child enrolled as required under Subsection (3)(a)(iv) is subject to the terms of the accident and health insurance plan contract pertaining to services received outside of an insurer's service area.

(4) When a child has accident and health coverage through an insurer of a noncustodial parent, and when requested by the noncustodial or custodial parent, the insurer shall:
(a) provide information to the custodial parent as necessary for the child to obtain benefits through that coverage, but the insurer or employer, or the agents or employees of either of them, are not civilly or criminally liable for providing information in compliance with this Subsection (4)(a), whether the information is provided pursuant to a verbal or written request;
(b) permit the custodial parent or the service provider, with the custodial parent's approval, to submit claims for covered services without the approval of the noncustodial parent; and
(c) make payments on claims submitted in accordance with Subsection (4)(b) directly to the custodial parent, the child who obtained benefits, the provider, or the state Medicaid agency.
(5) When a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family health coverage, the insurer shall:
(a) permit the parent to enroll, under the family coverage, a child who is otherwise eligible for the coverage without regard to an enrollment season restrictions;
(b) if the parent is enrolled but fails to make application to obtain coverage for the child, enroll the child under family coverage upon application of the child's other parent, the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Secs. 651 through 669, the child support enforcement program; and
(c)
(i) when the child is covered by an individual policy, not disenroll or eliminate coverage of the child unless the insurer is provided satisfactory written evidence that:
(A) the court or administrative order is no longer in effect; or
(B) the child is or will be enrolled in comparable accident and health coverage through another insurer which will take effect not later than the effective date of disenrollment; or
(ii) when the child is covered by a group policy, not disenroll or eliminate coverage of the child unless the employer is provided with satisfactory written evidence, which evidence is also provided to the insurer, that Subsection (8)(c)(i), (ii), or (iii) has happened.
(6) An insurer may not impose requirements on a state agency that has been assigned the rights of an individual eligible for medical assistance under Medicaid and covered for accident and health benefits from the insurer that are different from requirements applicable to an agent or assignee of any other individual so covered.
(7) Insurers may not reduce their coverage of pediatric vaccines below the benefit level in effect on May 1, 1993.
(8) When a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer shall:
(a) permit the parent to enroll under family coverage any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;
(b) if the parent is enrolled but fails to make application to obtain coverage of the child, enroll the child under family coverage upon application by the child's other parent, by the state agency administering the Medicaid program, or the state agency administering 42 U.S.C. Sec. 651 through 669, the child support enforcement program;
(c) not disenroll or eliminate coverage of the child unless the employer is provided satisfactory written evidence that:
(i) the court order is no longer in effect;
(ii) the child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or
(iii) the employer has eliminated family health coverage for all of its employees; and

(d) withhold from the employee's compensation the employee's share, if any, of premiums for health coverage and to pay this amount to the insurer.

(9) An order issued under Section 26B-9-225 may be considered a "qualified medical support order" for the purpose of enrolling a child in a group accident and health insurance plan as defined in Section 609(a), Federal Employee Retirement Income Security Act of 1974.

(10) This section does not affect any insurer's ability to require as a precondition of any child being covered under any policy of insurance that:

(a) the parent continues to be eligible for coverage;

(b) the child shall be identified to the insurer with adequate information to comply with this section; and

(c) the premium shall be paid when due.

(11) This section applies to employee welfare benefit plans as defined in Section 26B-3-1001.

(12)

(a) A policy that provides coverage to a child of a group member may not deny eligibility for coverage to a child solely because:

(i) the child does not reside with the insured; or

(ii) the child is solely dependent on a former spouse of the insured rather than on the insured.

(b) A child who does not reside with the insured may be excluded on the same basis as a child who resides with the insured.

Amended by Chapter 366, 2024 General Session

**31A-22-610.6 Special enrollment for individuals receiving premium assistance.**

(1) As used in this section:

(a) "Premium assistance" means assistance under Title 26B, Chapter 3, Health Care - Administration and Assistance, in the payment of premium.

(b) "Qualified beneficiary" means an individual who is approved to receive premium assistance.

(2) Subject to the other provisions in this section, an individual may enroll under this section at a time outside of an employer health benefit plan open enrollment period, regardless of previously waiving coverage, if the individual is:

(a) a qualified beneficiary who is eligible for coverage as an employee under the employer health benefit plan; or

(b) a dependent of the qualified beneficiary who is eligible for coverage under the employer health benefit plan.

(3) To be eligible to enroll outside of an open enrollment period, an individual described in Subsection (2) shall enroll in the employer health benefit plan by no later than 30 days from the day on which the qualified beneficiary receives initial written notification, after July 1, 2008, that the qualified beneficiary is eligible to receive premium assistance.

(4) An individual described in Subsection (2) may enroll under this section only in an employer health benefit plan that is available at the time of enrollment to similarly situated eligible employees or dependents of eligible employees.

(5) Coverage under an employer health benefit plan for an individual described in Subsection (2) may begin as soon as the first day of the month immediately following enrollment of the individual in accordance with this section.

(6) This section does not modify any requirement related to premiums that applies under an employer health benefit plan to a similarly situated eligible employee or dependent of an eligible employee under the employer health benefit plan.

(7) An employer health benefit plan may require an individual described in Subsection (2) to satisfy a preexisting condition waiting period that:
(a) is allowed under the Health Insurance Portability and Accountability Act; and
(b) is not longer than 12 months.

Amended by Chapter 327, 2023 General Session

**31A-22-611 Coverage for children with a disability.**

(1) For the purposes of this section:
(a) "Dependent with a disability" means a child who is and continues to be both:
(i) unable to engage in substantial gainful employment to the degree that the child can achieve economic independence due to a medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or can be expected to last for a continuous period of not less than 12 months; and
(ii) chiefly dependent upon an insured for support and maintenance since the child reached the age specified in Subsection 31A-22-610.5(2).
(b) "Mental impairment" means a mental or psychological disorder such as:
(i) an intellectual disability;
(ii) organic brain syndrome;
(iii) emotional or mental illness; or
(iv) specific learning disabilities as determined by the insurer.
(c) "Physical impairment" means a physiological disorder, condition, or disfigurement, or anatomical loss affecting one or more of the following body systems:
(i) neurological;
(ii) musculoskeletal;
(iii) special sense organs;
(iv) respiratory organs;
(v) speech organs;
(vi) cardiovascular;
(vii) reproductive;
(viii) digestive;
(ix) genito-urinary;
(x) hemic and lymphatic;
(xi) skin; or
(xii) endocrine.
(2) The insurer may require proof of the impairment and dependency be furnished by the person insured under the policy within 30 days of the effective date or the date the child attains the age specified in Subsection 31A-22-610.5(2), and at any time thereafter, except that the insurer may not require proof more often than annually after the two-year period immediately following attainment of the limiting age by the dependent with a disability.
(3) Any individual or group accident and health insurance policy or health maintenance organization contract that provides coverage for a policyholder's or certificate holder's dependent shall, upon application, provide coverage for all unmarried dependents with a disability who have been continuously covered, with no break of more than 63 days, under any accident and health insurance since the age specified in Subsection 31A-22-610.5(2).
(4) Every accident and health insurance policy or contract that provides coverage of a dependent with a disability may not terminate the policy due to an age limitation.

Amended by Chapter 193, 2019 General Session

**31A-22-612 Conversion privileges for insured former spouse.**

(1) An accident and health insurance policy, that in addition to covering the insured also provides coverage to the spouse of the insured, may not contain a provision for termination of coverage of a spouse covered under the policy, except by entry of a valid decree of divorce, legal separation, or annulment between the parties.

(2) Every policy that contains the type of provision described in Subsection (1) shall provide that:

(a) upon the entry of the divorce decree the spouse is entitled to have issued an individual policy offering accident and health insurance without evidence of insurability, upon application to the company and payment of the appropriate premium; and

(b) the individual policy described in Subsection (2)(a) shall:

(i) provide the coverage that is most nearly similar to the terminated coverage; and

(ii) consider a probationary or waiting period satisfied to the extent the coverage was in force under the prior policy.

(3)

(a) When an insurer receives actual notice that the coverage of a spouse is to be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly provide the spouse written notification of the right to obtain individual coverage as provided in Subsection (2), the premium amounts required, and the manner, place, and time in which premiums may be paid.

(b) The premium is determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of the persons to be covered and to the type and amount of coverage provided.

(c) If a spouse applies and tenders the first monthly premium to the insurer within 30 days after the day on which the spouse receives the notice provided by this Subsection (3), the spouse shall receive individual coverage that commences immediately upon termination of coverage under the insured's policy.

(4) This section does not apply to:

(a) a blanket insurance policy offering accident and health insurance; or

(b) a health benefit plan.

Amended by Chapter 252, 2021 General Session

**31A-22-613 Permitted provisions for accident and health insurance policies.**

The following provisions may be contained in an accident and health insurance policy, but if they are in that policy, they shall conform to at least the minimum requirements for the policyholder in this section.

(1) Any provision respecting change of occupation may provide only for a lower maximum benefit payment and for reduction of loss payments proportionate to the change in appropriate premium rates, if the change is to a higher rated occupation, and this provision shall provide for retroactive reduction of premium rates from the date of change of occupation or the last policy anniversary date, whichever is the more recent, if the change is to a lower rated occupation.

(2) Section 31A-22-405 applies to misstatement of age in accident and health policies, with the appropriate modifications of terminology.

(3) Any policy which contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy is not effective, and if that date falls within a period for which a premium is accepted by the insurer or if the insurer accepts a premium after that

date, the coverage provided by the policy continues in force, subject to any right of cancellation, until the end of the period for which the premium was accepted. This Subsection (3) does not apply if the acceptance of premium would not have occurred but for a misstatement of age by the insured.

(4)

(a) If an insured is otherwise eligible for maternity benefits, a policy may not contain language which requires an insured to obtain any additional preauthorization or preapproval for customary and reasonable maternity care expenses or for the delivery of the child after an initial preauthorization or preapproval has been obtained from the insurer for prenatal care. A requirement for notice of admission for delivery is not a requirement for preauthorization or preapproval, however, the maternity benefit may not be denied or diminished for failure to provide admission notice. The policy may not require the provision of admission notice by only the insured patient.

(b) This Subsection (4) does not prohibit an insurer from:

(i) requiring a referral before maternity care can be obtained;

(ii) specifying a group of providers or a particular location from which an insured is required to obtain maternity care; or

(iii) limiting reimbursement for maternity expenses and benefits in accordance with the terms and conditions of the insurance contract so long as such terms do not conflict with Subsection (4)(a).

(5)

(a) An insurer may only represent that a policy offers a vision benefit if the policy provides reimbursement for materials or services provided under the policy.

(b) An insurer may only represent that a policy covers laser vision correction, whether photorefractive keratectomy, laser assisted in-situ keratomelusis, or related procedure, if the procedure is at least a partially covered benefit.

(6) If a policy excludes coverage for the diagnosis and treatment of autism spectrum disorders, the insurer may not deny a claim for a procedure or service that is otherwise covered in the accident and health insurance policy unless the autism spectrum disorder is the primary diagnosis or reason for the service or procedure in the particular claim.

Amended by Chapter 279, 2012 General Session

**31A-22-613.5 Price and value comparisons of health insurance.**

(1)

(a) This section applies to all health benefit plans.

(b) Subsection (2) applies to:

(i) all health benefit plans; and

(ii) coverage offered to state employees under Subsection 49-20-202(1)(a).

(2) The commissioner shall promote informed consumer behavior and responsible health benefit plans by requiring an insurer issuing a health benefit plan to provide to all enrollees, before enrollment in the health benefit plan, written disclosure of:

(a) restrictions or limitations on prescription drugs and biologics, including:

(i) the use of a formulary;

(ii) co-payments and deductibles for prescription drugs; and

(iii) requirements for generic substitution;

(b) coverage limits under the plan;

(c) any limitation or exclusion of coverage, including:

(i) a limitation or exclusion for a secondary medical condition related to a limitation or exclusion from coverage; and
(ii) easily understood examples of a limitation or exclusion of coverage for a secondary medical condition;
(d)
(i)
(A) each drug, device, and covered service that is subject to a preauthorization requirement as defined in Section 31A-22-650; or
(B) if listing each device or covered service in accordance with Subsection (2)(d)(i)(A) is too numerous to list separately, all devices or covered services in a particular category where all devices or covered services have the same preauthorization requirement;
(ii) each requirement for authorization as defined in Section 31A-22-650 for:
(A) each drug, device, or covered service described in Subsection (2)(d)(i)(A); and
(B) each category of devices or covered services described in Subsection (2)(d)(i)(B); and
(iii) sufficient information to allow a network provider or enrollee to submit all of the information to the insurer necessary to meet each requirement for authorization described in Subsection (2)(d)(ii);
(e) whether the insurer permits an exchange of the adoption indemnity benefit in Section 31A-22-610.1 for infertility treatments, in accordance with Subsection 31A-22-610.1(1)(c)(ii) and the terms associated with the exchange of benefits; and
(f) whether the insurer provides coverage for telehealth services in accordance with Section 26B-3-123 and terms associated with that coverage.
(3) An insurer shall provide the disclosure required by Subsection (2) in writing to the commissioner:
(a) upon commencement of operations in the state; and
(b) anytime the insurer amends any of the following described in Subsection (2):
(i) treatment policies;
(ii) practice standards;
(iii) restrictions;
(iv) coverage limits of the insurer's health benefit plan or health insurance policy; or
(v) limitations or exclusions of coverage including a limitation or exclusion for a secondary medical condition related to a limitation or exclusion of the insurer's health insurance plan.
(4)
(a) An insurer shall provide the enrollee with notice of an increase in costs for prescription drug coverage due to a change in benefit design under Subsection (2)(a):
(i) either:
(A) in writing; or
(B) on the insurer's website; and
(ii) at least 30 days prior to the date of the implementation of the increase in cost, or as soon as reasonably possible.
(b) If under Subsection (2)(a) a formulary is used, the insurer shall make available to prospective enrollees and maintain evidence of the fact of the disclosure of:
(i) the drugs included;
(ii) the patented drugs not included;
(iii) any conditions that exist as a precedent to coverage; and
(iv) any exclusion from coverage for secondary medical conditions that may result from the use of an excluded drug.

(c) The commissioner shall develop examples of limitations or exclusions of a secondary medical condition that an insurer may use under Subsection (2)(c).

(5) Examples of a limitation or exclusion of coverage provided under this section or otherwise are for illustrative purposes only, and the failure of a particular fact situation to fall within the description of an example does not, by itself, support a finding of coverage.

(6) An insurer shall:

(a) post the information described in Subsection (2)(d) on the insurer's website and provider portal;

(b) if requested by an enrollee, provide the enrollee with the information required by this section by mail or email; and

(c) if requested by a network provider for a specific drug, device, or covered service, provide the network provider with the information described in Subsection (2)(d) for the drug, device, or covered service by mail or email.

Amended by Chapter 327, 2023 General Session

**31A-22-614 Claims under accident and health policies.**

(1) Section 31A-21-312 applies generally to claims under accident and health policies.

(2)

(a) Subject to Subsection (1), an accident and health insurance policy may not contain a claim notice requirement less favorable to the insured, or an insured's network provider, than one which requires written notice of the claim within 20 days after the occurrence or commencement of any loss covered by the policy. The policy shall specify to whom claim notices may be given.

(b) If a loss of time benefit under a policy may be paid for a period of at least two years, an insurer may require periodic notices that the insured continues to have a disability, unless the insured is legally incapacitated. The insured's, or the insured's network provider's, delay in giving that notice does not impair the insured's, the insured's network provider's, or beneficiary's right to any indemnity which would otherwise have accrued during the six months preceding the date on which that notice is actually given.

(3) An accident and health insurance policy may not contain a time limit on proof of loss which is more restrictive to the insured, or the insured's network provider, than a provision requiring written proof of loss, delivered to the insurer, within the following time:

(a) for a claim where periodic payments are contingent upon continuing loss, within 180 days after the termination of the period for which the insurer is liable; or

(b) for any other claim, within 180 days after the date of the loss.

(4)

(a)

(i) Section 31A-26-301 applies generally to the payment of claims.

(ii) Indemnity for loss of life is paid in accordance with the beneficiary designation effective at the time of payment. If no valid beneficiary designation exists, the indemnity is paid to the insured's estate. Any other accrued indemnities unpaid at the insured's death are paid to the insured's estate.

(b) Reasonable facility of payment clauses, specified by the commissioner by rule or in approving the policy form, are permitted. Payment made in good faith and in accordance with those clauses discharges the insurer's obligation to pay those claims.

(c) All or a portion of any indemnities provided under an accident and health policy on account of hospital, nursing, medical, or surgical services may, at the insurer's option, be paid directly to the hospital or person rendering the services.

Amended by Chapter 175, 2025 General Session

**31A-22-614.5 Uniform claims processing -- Electronic exchange of health information.**

(1)

(a) Except as provided in Subsection (1)(c), an insurer offering health insurance shall use a uniform claim form and uniform billing and claim codes.

(b) Beginning January 1, 2011, all health benefit plans, and dental and vision plans, shall provide for the electronic exchange of uniform:

(i) eligibility and coverage information; and

(ii) coordination of benefits information.

(c) For purposes of Subsection (1)(a), "health insurance" does not include a policy or certificate that provides benefits solely for:

(i) income replacement; or

(ii) long-term care.

(2)

(a) The uniform electronic standards and information required in Subsection (1) shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(b) When adopting rules under this section the commissioner:

(i) shall:

(A) consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to develop the standards for the use and electronic exchange of uniform:

(I) claim forms;

(II) billing and claim codes;

(III) insurance eligibility and coverage information; and

(IV) coordination of benefits information; and

(B) meet federal mandatory minimum standards following the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act;

(ii) may not require an insurer or administrator to use a specific software product or vendor; and

(iii) may require an insurer who participates in the all payer database created under Section 26B-8-504 to allow data regarding demographic and insurance coverage information to be electronically shared with the state's designated secure health information master person index to be used:

(A) in compliance with data security standards established by:

(I) the federal Health Insurance Portability and Accountability Act; and

(II) the electronic commerce agreements established in a business associate agreement; and

(B) for the purpose of coordination of health benefit plans.

(3)

(a) The commissioner shall coordinate the administrative rules adopted under the provisions of this section with the administrative rules adopted by the Department of Health and Human Services for the implementation of the standards for the electronic exchange of clinical

health information under Section 26B-8-411. The department shall establish procedures for developing the rules adopted under this section, which ensure that the Department of Health and Human Services is given the opportunity to comment on proposed rules.

(b)

(i) The commissioner may provide information to health care providers regarding resources available to a health care provider to verify whether a health care provider's practice management software system meets the uniform electronic standards for data exchange required by this section.

(ii) The commissioner may provide the information described in Subsection (3)(b)(i) by partnering with:

(A) a not-for-profit, broad based coalition of state health care insurers and health care providers who are involved in the electronic exchange of the data required by this section; or

(B) some other person that the commissioner determines is appropriate to provide the information described in Subsection (3)(b)(i).

(c) The commissioner shall regulate any fees charged by insurers to the providers for:

(i) uniform claim forms;

(ii) electronic billing; or

(iii) the electronic exchange of clinical health information permitted by Section 26B-8-411.

(4) This section does not require a person to provide information concerning an employer self-insured employee welfare benefit plan as defined in 29 U.S.C. Sec. 1002(1).

Amended by Chapter 328, 2023 General Session

**31A-22-614.7 Uniform claims processing -- Electronic exchange of prescription drug pre-authorization.**

The commissioner shall consult with national and state organizations involved with the standardized exchange of health data, and the electronic exchange of health data, to study and review:

(1) the process of prior authorization of prescription drugs; and

(2) the standards for the use and electronic exchange of a uniform prescription drug prior authorization form that meet federal mandatory minimum standards and follow the adoption of national requirements for transaction and data elements in the federal Health Insurance Portability and Accountability Act.

Amended by Chapter 18, 2017 General Session

**31A-22-618 Nondiscrimination among health care professionals.**

(1) Except as provided under Section 31A-45-303 and Subsection (2), and except as to insurers licensed under Chapter 8, Health Maintenance Organizations and Limited Health Plans, no insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions which exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice and the illness, injury, or condition falls within the coverage of the contract. Upon the written request of an insured alleging an insurer has violated this section, the commissioner shall hold a hearing to determine if the violation exists. The commissioner may consolidate two or more related alleged violations into a single hearing.

(2) Coverage for licensed providers for behavioral analysis may be limited by an insurer in accordance with Section 58-61-714. Nothing in this section prohibits an insurer from electing to provide coverage for other licensed professionals whose scope of practice includes behavior analysis.

Amended by Chapter 136, 2019 General Session

**31A-22-618.5 Coverage of insurance mandates imposed after January 1, 2009.**

(1) The purpose of this section is to increase the range of health benefit plans available in the small group, small employer group, large group, and individual insurance markets.

(2) A health maintenance organization that is subject to Chapter 8, Health Maintenance Organizations and Limited Health Plans:

(a) shall offer to potential purchasers at least one health benefit plan that is subject to the requirements of Chapter 8, Health Maintenance Organizations and Limited Health Plans; and

(b) may offer to a potential purchaser one or more health benefit plans that:

(i) are not subject to one or more of the following:

(A) the limitations on insured indemnity benefits in Subsection 31A-8-105(4);

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

(C) coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that the insurer offers one plan under Subsection (2)(a) that covers the mandate enacted after January 1, 2009; and

(ii) when offering a health plan under this section, provide coverage for an emergency medical condition as required by Section 31A-22-627.

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

(a) may offer a health benefit plan that is not subject to Section 31A-22-618 and Subsection 31A-45-303(3)(b)(iii);

(b) when offering a health plan under this Subsection (3), shall provide coverage of emergency care services as required by Section 31A-22-627; and

(c) is not subject to coverage mandates enacted after January 1, 2009 that are not required by federal law, provided that an insurer offers one plan that covers a mandate enacted after January 1, 2009.

(4) Section 31A-8-106 does not prohibit the offer of a health benefit plan under Subsection (2)(b).

(5)

(a) Any difference in price between a health benefit plan offered under Subsections (2)(a) and (b) shall be based on actuarially sound data.

(b) Any difference in price between a health benefit plan offered under Subsection (3)(a) shall be based on actuarially sound data.

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

Amended by Chapter 292, 2017 General Session

**31A-22-618.6 Discontinuance, nonrenewal, or changes to group health benefit plans.**

(1) Except as otherwise provided in this section, a group health benefit plan for a plan sponsor is renewable and continues in force:

(a) with respect to all eligible employees and dependents; and

(b) at the option of the plan sponsor.

(2) A group health benefit plan for a plan sponsor may be discontinued or nonrenewed:
(a) for noncompliance with the insurer's employer contribution requirements;
(b) if there is no longer any enrollee under the group health benefit plan who lives, resides, or works in:
(i) the service area of the insurer; or
(ii) the area for which the insurer is authorized to do business;
(c) for coverage made available in the small or large employer market only through an association, if:
(i) the employer's membership in the association ceases; and
(ii) the coverage is discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered individual; or
(d) for noncompliance with the insurer's minimum employee participation requirements, except as provided in Subsection (3).
(3) If a small employer no longer employs at least one eligible employee, a carrier may not discontinue or not renew the group health benefit plan until the first renewal date following the beginning of a new plan year, even if the carrier knows at the beginning of the plan year that the employer no longer has at least one eligible employee.
(4)
(a) A small employer that, after purchasing a group health benefit plan in the small group market, employs on average more than 50 eligible employees on each business day in a calendar year may continue to renew the group health benefit plan purchased in the small group market.
(b) A large employer that, after purchasing a group health benefit plan in the large group market, employs on average fewer than 51 eligible employees on each business day in a calendar year may continue to renew the group health benefit plan purchased in the large group market.
(5) A health benefit plan for a plan sponsor may be discontinued or nonrenewed if:
(a) a condition described in Subsection (2) exists;
(b) the plan sponsor fails to pay premiums or contributions in accordance with the terms of the contract;
(c) the plan sponsor:
(i) performs an act or practice that constitutes fraud; or
(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;
(d) the insurer:
(i) elects to discontinue offering a particular group health benefit plan delivered or issued for delivery in this state;
(ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee, at least 90 days before the day on which the coverage discontinues;
(iii) provides notice of the discontinuation in writing to the commissioner, and at least three working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee;
(iv) offers to each plan sponsor, on a guaranteed issue basis, the option to purchase all other group health benefit plans currently being offered by the insurer in the market or, in the case of a large employer, any other group health benefit plans currently being offered in that market; and
(v) in exercising the option to discontinue the group health benefit plan and in offering the option of coverage in this section, acts uniformly without regard to the claims experience

of a plan sponsor, any health status-related factor relating to any covered participant or beneficiary, or any health status-related factor relating to any new participant or beneficiary who may become eligible for the coverage; or

(e) the insurer:

(i) elects to discontinue offering all of the insurer's group health benefit plans in:

(A) the small employer market;

(B) the large employer market; or

(C) both the small employer and large employer markets;

(ii) provides notice of the discontinuation in writing to each plan sponsor, employee, and dependent of an employee at least 180 days before the day on which the coverage discontinues;

(iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected insured individual is known to reside and, at least 30 working days before the day on which the notice is sent to each affected plan sponsor, employee, and dependent of an employee;

(iv) discontinues and nonrenews all plans issued or delivered for issuance in the market described in Subsection (5)(e)(i) ; and

(v)

(A) provides a plan of orderly withdrawal as required by Section 31A-4-115; or

(B) places the plan with an affiliate of the insurer with a plan of the same or similar coverage.

(6)

(a) Except as provided in Subsection (6)(d), an eligible employee may be discontinued if after issuance of coverage the eligible employee:

(i) engages in an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact in connection with the coverage.

(b) An eligible employee whose coverage is discontinued under Subsection (6)(a) may reenroll:

(i) 12 months after the day on which the employee's coverage discontinues; and

(ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies to reenroll.

(c) At the time the eligible employee's coverage discontinues under Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll as described in Subsection (6)(b).

(d) An eligible employee's coverage may not be discontinued under this Subsection (6) because of a fraud or misrepresentation that relates to health status.

(7) For purposes of this section, a reference to "plan sponsor" includes a reference to the employer:

(a) with respect to coverage provided to an employer member of the association; and

(b) if the group health benefit plan is made available by an insurer in the employer market only through:

(i) an association;

(ii) a trust; or

(iii) a discretionary group.

(8) An insurer may modify a group health benefit plan for a plan sponsor only:

(a) at the time of coverage renewal; and

(b) if the modification is effective uniformly among all plans.

Amended by Chapter 198, 2022 General Session

**31A-22-618.7 Discontinuance, nonrenewal, and modification for individual health benefit plans.**

(1)

(a) Except as otherwise provided in this section, a health benefit plan offered on an individual basis is renewable and continues in force:

(i) with respect to all enrollees or dependents; and

(ii) at the option of the enrollee.

(b) Subsection (1)(a) applies regardless of:

(i) whether the contract is issued through:

(A) a trust;

(B) an association;

(C) a discretionary group; or

(D) other similar grouping; or

(ii) the situs of delivery of the policy or contract.

(2) An individual health benefit plan may be discontinued or nonrenewed:

(a) if:

(i) there is no longer an enrollee under the individual health benefit plan who lives, resides, or works in:

(A) the service area of the insurer; or

(B) the area for which the insurer is authorized to do business; and

(ii) coverage is discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee; or

(b) for coverage made available through an association, if:

(i) the enrollee's membership in the association ceases; and

(ii) the coverage is discontinued or nonrenewed uniformly without regard to any health status-related factor relating to any covered enrollee.

(3) An individual health benefit plan may be discontinued or nonrenewed if:

(a) a condition described in Subsection (2) exists;

(b) the enrollee fails to pay premiums or contributions in accordance with the terms of the health benefit plan, including any timeliness requirements;

(c) the enrollee:

(i) performs an act or practice in connection with the coverage that constitutes fraud; or

(ii) makes an intentional misrepresentation of material fact under the terms of the coverage;

(d) the insurer:

(i) elects to discontinue offering a particular individual health benefit plan delivered or issued for delivery in this state; and

(ii)

(A) provides notice of the discontinuation in writing to each enrollee provided coverage at least 90 days before the day on which the coverage discontinues;

(B) provides notice of the discontinuation in writing to the commissioner and, at least three working days before the day on which the notice is sent, to each affected enrollee;

(C) offers to each covered enrollee on a guaranteed issue basis the option to purchase all other individual health benefit plans currently being offered by the insurer for individuals in that market; and

(D) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage; or

(e) the insurer:

(i) elects to discontinue offering all of the insurer's individual health benefit plans in the individual market;
(ii) provides notice of the discontinuation in writing to each enrollee provided coverage at least 180 days before the day on which the coverage discontinues;
(iii) provides notice of the discontinuation in writing to the commissioner in each state in which an affected enrollee is known to reside and, at least 30 working days before the day on which the insurer sends the notice, to each affected enrollee;
(iv) discontinues and nonrenews all individual health benefit plans the insurer issues or delivers for issuance in the individual market;
(v) acts uniformly without regard to any health status-related factor of covered enrollees or dependents of covered enrollees who may become eligible for coverage; and
(vi)
(A) provides a plan of orderly withdrawal in accordance with Section 31A-4-115; or
(B) places the plan with an affiliate of the insurer with a plan of the same or similar coverage.
(4) An insurer may modify an individual health benefit plan only:
(a) at the time of coverage renewal; and
(b) if the modification is effective uniformly among all individual health benefit plans.

Amended by Chapter 198, 2022 General Session

**31A-22-618.8 Discontinuance and nonrenewal limitations for health benefit plans.**
(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsection 31A-22-618.6(5)(e) or 31A-22-618.7(3)(e) is prohibited from writing new business:
(a) in the market in this state for which the insurer discontinues or does not renew; and
(b) for a period of five years beginning on the day on which the last coverage that is discontinued.
(2) If an insurer is doing business in one established geographic service area of the state, Subsections 31A-22-618.6(5)(e) and 31A-22-618.7(3)(e) apply only to the insurer's operations in that service area.
(3) The commissioner may, by rule or order, define the scope of service area.

Amended by Chapter 198, 2022 General Session

**31A-22-619 Coordination of benefits.**
(1) The commissioner shall:
(a) adopt rules concerning the coordination of benefits between accident and health insurance policies;
(b) publish a coordination of benefits guide;
(c) post the coordination of benefits guide on the state insurance exchange; and
(d) work with the Health Data Authority, health care provider groups, and with state and national organizations that are developing uniform standards for the electronic exchange of health insurance claims to develop standardized language regarding coordination of benefits for the purpose of including the standardized language in an insurer's explanation of benefits.
(2) Rules adopted by the commissioner under Subsection (1):
(a) may not prohibit coordination of benefits with individual accident and health insurance policies;
(b) shall apply equally to all accident and health insurance policies without regard to whether the policies are group or individual policies; and

(c) shall include standardized language regarding the coordination of benefits process that shall be included in each insurer's accident and health insurance policy.

Amended by Chapter 285, 2010 General Session

**31A-22-620 Medicare Supplement Insurance Minimum Standards Act.**

(1) As used in this section:

(a) "Applicant" means:

(i) in the case of an individual Medicare supplement insurance policy, the person who seeks to contract for insurance benefits; and

(ii) in the case of a group Medicare supplement insurance policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement insurance policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "Enrollee" means an individual enrolled in Medicare supplement insurance.

(e) "Issuer" includes insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering, or issuing for delivery in this state, Medicare supplement insurance policies or certificates.

(f) "Policy form" means the form on which the policy is delivered or issued for delivery by the issuer.

(2)

(a) Except as otherwise specifically provided, this section applies to:

(i) all Medicare supplement insurance policies delivered or issued for delivery in this state on or after the effective date of this section;

(ii) all certificates issued under group Medicare supplement insurance policies, that have been delivered or issued for delivery in this state on or after the effective date of this section; and

(iii) policies or certificates that were in force prior to the effective date of this section, with respect to requirements for benefits, claims payment, and policy reporting practice under Subsection (3)(d), and loss ratios under Subsection (4).

(b) This section does not apply to a policy of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or a combination of employers and labor unions, for employees or former employees or a combination of employees and former employees, or for members or former members of the labor organizations, or a combination of members and former members of labor organizations.

(c) This section does not prohibit, nor does it apply to insurance policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons that are not marketed or held out to be Medicare supplement insurance policies or benefit plans.

(3)

(a) A Medicare supplement insurance policy or certificate in force in the state may not contain benefits that duplicate benefits provided by Medicare.

(b) Notwithstanding any other provision of law of this state, a Medicare supplement policy or certificate may not exclude or limit benefits for loss incurred more than six months from the effective date of coverage because it involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than: "A condition for which

medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage."

(c) The commissioner shall adopt rules to establish specific standards for policy provisions of Medicare supplement insurance policies and certificates. The standards adopted shall be in addition to and in accordance with applicable laws of this state. A requirement of this title relating to minimum required policy benefits, other than the minimum standards contained in this section, may not apply to Medicare supplement insurance policies and certificates. The standards may include:

(i) terms of renewability;

(ii) initial and subsequent conditions of eligibility;

(iii) nonduplication of coverage;

(iv) probationary periods;

(v) benefit limitations, exceptions, and reductions;

(vi) elimination periods;

(vii) requirements for replacement;

(viii) recurrent conditions; and

(ix) definitions of terms.

(d) The commissioner shall adopt rules establishing minimum standards for benefits, claims payment, marketing practices, compensation arrangements, and reporting practices for Medicare supplement insurance policies and certificates.

(e) The commissioner may adopt rules to conform Medicare supplement insurance policies and certificates to the requirements of federal law and regulations, including:

(i) requiring refunds or credits if the policies do not meet loss ratio requirements;

(ii) establishing a uniform methodology for calculating and reporting loss ratios;

(iii) assuring public access to policies, premiums, and loss ratio information of issuers of Medicare supplement insurance;

(iv) establishing a process for approving or disapproving policy forms and certificate forms and proposed premium increases;

(v) establishing a policy for holding public hearings prior to approval of premium increases;

(vi) establishing standards for Medicare select policies and certificates; and

(vii) nondiscrimination for genetic testing or genetic information.

(f) The commissioner may adopt rules that prohibit policy provisions not otherwise specifically authorized by statute that, in the opinion of the commissioner, are unjust, unfair, or unfairly discriminatory to any person insured or proposed to be insured under a Medicare supplement insurance policy or certificate.

(g)

(i) Each year, beginning on an enrollee's birthday and ending 60 days later, an issuer shall allow an enrollee that is enrolled in one of the issuer's Medicare supplement insurance plans to choose a different Medicare supplement insurance plan that is:

(A) offered by the issuer; and

(B) considered a comparable or lower tier plan than the enrollee's current plan.

(ii) An issuer may not deny enrollment based on medical underwriting when an enrollee selects a plan in accordance with Subsection (3)(g)(i).

(4) Medicare supplement insurance policies shall return to policyholders benefits that are reasonable in relation to the premium charged. The commissioner shall make rules to establish minimum standards for loss ratios of Medicare supplement insurance policies on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a

health maintenance organization on a service basis rather than on a reimbursement basis, and earned premiums in accordance with accepted actuarial principles and practices.

(5)

(a) To provide for full and fair disclosure in the sale of Medicare supplement insurance, a Medicare supplement insurance policy or certificate may not be delivered in this state unless an outline of coverage is delivered to the applicant at the time application is made.

(b) The commissioner shall prescribe the format and content of the outline of coverage required by Subsection (5)(a).

(c) For purposes of this section, "format" means style arrangements and overall appearance, including such items as the size, color, and prominence of type and arrangement of text and captions. The outline of coverage shall include:

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

(ii) a statement of the renewal provisions, including any reservation by the issuer of a right to change premiums; and disclosure of the existence of any automatic renewal premium increases based on the policyholder's age; and

(iii) a statement that the outline of coverage is a summary of the policy issued or applied for and that the policy should be consulted to determine governing contractual provisions.

(d) The commissioner may make rules for captions or notice if the commissioner finds that the rules are:

(i) in the public interest; and

(ii) designed to inform prospective insureds that particular insurance coverages are not Medicare supplement coverages, for all accident and health insurance policies sold to persons eligible for Medicare, other than:

(A) a Medicare supplement insurance policy; or

(B) a disability income policy.

(e) The commissioner may prescribe by rule a standard form and the contents of an informational brochure for persons eligible for Medicare, that is intended to improve the buyer's ability to select the most appropriate coverage and improve the buyer's understanding of Medicare. Except in the case of direct response insurance policies, the commissioner may require by rule that the informational brochure be provided concurrently with delivery of the outline of coverage to any prospective insureds eligible for Medicare. With respect to direct response insurance policies, the commissioner may require by rule that the prescribed brochure be provided upon request to any prospective insureds eligible for Medicare, but in no event later than the time of policy delivery.

(f) The commissioner may adopt reasonable rules to govern the full and fair disclosure of the information in connection with the replacement of accident and health policies, subscriber contracts, or certificates by persons eligible for Medicare.

(6) Notwithstanding Subsection (1), Medicare supplement insurance policies and certificates shall have a notice prominently printed on the first page of the policy or certificate, or attached to the front page, stating in substance that the applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the applicant is not satisfied for any reason. Any refund made pursuant to this section shall be paid directly to the applicant by the issuer in a timely manner.

(7) Every issuer of Medicare supplement insurance policies or certificates in this state shall provide a copy of any Medicare supplement insurance advertisement intended for use in this state, whether through written or broadcast medium, to the commissioner for review.

(8) The commissioner may adopt rules:

(a) to conform Medicare and Medicare supplement insurance policies and certificates to the marketing requirements of federal law and regulation; or
(b) to implement Medicare supplement insurance open enrollment as described in Subsection (3)(g).

Amended by Chapter 376, 2025 General Session

**31A-22-623 Coverage of inborn metabolic errors.**

(1) As used in this section:
(a) "Dietary products" means medical food or a low protein modified food product that:
(i) is specifically formulated to treat inborn errors of amino acid or urea cycle metabolism;
(ii) is not a natural food that is naturally low in protein; and
(iii) is used under the direction of a physician.
(b) "Inborn errors of amino acid or urea cycle metabolism" means a disease caused by an inherited abnormality of body chemistry which is treatable by the dietary restriction of one or more amino acid.
(2) The commissioner shall establish, by rule, minimum standards of coverage for dietary products used for the treatment of inborn errors of amino acid or urea cycle metabolism at levels consistent with the major medical benefit provided under an accident and health insurance policy.

Amended by Chapter 116, 2001 General Session

***Superseded 1/1/2027***

**31A-22-624 Primary care physician, physician assistant, or physical therapist.**

(1) An accident and health insurance policy that requires an insured to select a primary care provider or physician to receive optimum coverage shall permit an insured to select a participating provider who is:
(a)
(i) an obstetrician;
(ii) a gynecologist;
(iii) a pediatrician; or
(iv) a physician assistant who has trained in a primary care physician's office and completed the physician assistant's collaboration requirement described in Section 58-70a-307; and
(b) qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received.
(2) Subject to Subsection (5), an accident and health insurance policy that requires an insured to select a primary care provider or physician to receive optimum coverage may permit an insured to select a participating provider who is a physical therapist to provide physical therapy services.
(3) An accident and health insurance policy shall clearly state in literature explaining the policy the options available to insureds under Subsections (1) and (2).
(4) An accident and health insurance policy may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured because the insured selected a primary care physician in accordance with this section.
(5) Notwithstanding Subsection (2), nothing in this section permits a physical therapist to practice physical therapy outside of the physical therapist's scope of practice under Title 58, Chapter 24b, Physical Therapy Practice Act.

Amended by Chapter 69, 2026 General Session

***Effective 1/1/2027***

**31A-22-624 Primary care physician, physician assistant, or physical therapist.**

(1) An accident and health insurance policy that requires an insured to select a primary care provider or physician to receive optimum coverage shall permit an insured to select a participating provider who is:

(a)

(i) an obstetrician;

(ii) a gynecologist;

(iii) a pediatrician; or

(iv) a physician assistant who has trained in a primary care physician's office and completed the physician assistant's collaboration requirement described in Section 58-70a-307; and

(b) qualified and willing to provide primary care services, as defined by the health care plan, as the insured's provider from whom primary care services are received.

(2) Subject to Subsection (6), an accident and health insurance policy that requires an insured to select a primary care provider or physician to receive optimum coverage shall permit an insured to select a participating provider who is a physical therapist to provide physical therapy services.

(3)

(a) An accident and health insurance policy that provides coverage for physical therapy services may not impose a copayment, coinsurance, or office visit deductible for a covered physical therapy visit that exceeds the copayment, coinsurance, or office visit deductible applicable to a visit with a primary care provider.

(b) Subsection (3)(a) applies to a health benefit plan renewed or entered into on or after January 1, 2027.

(4) An accident and health insurance policy shall clearly state in literature explaining the policy the options available to insureds under Subsections (1) and (2).

(5) An accident and health insurance policy may not impose a higher premium, higher copayment requirement, or any other additional expense on an insured because the insured selected a primary care physician in accordance with this section.

(6) Notwithstanding Subsection (2), nothing in this section permits a physical therapist to practice physical therapy outside of the physical therapist's scope of practice under Title 58, Chapter 24b, Physical Therapy Practice Act.

Amended by Chapter 128, 2026 General Session

**31A-22-625 Catastrophic coverage of mental health conditions.**

(1) As used in this section:

(a)

(i) "Catastrophic mental health coverage" means coverage in a health benefit plan that does not impose a lifetime limit, annual payment limit, episodic limit, inpatient or outpatient service limit, or maximum out-of-pocket limit that places a greater financial burden on an insured for the evaluation and treatment of a mental health condition than for the evaluation and treatment of a physical health condition.

(ii) "Catastrophic mental health coverage" may include a restriction on cost sharing factors, such as deductibles, copayments, or coinsurance, before reaching a maximum out-of-pocket limit.

(iii) "Catastrophic mental health coverage" may include one maximum out-of-pocket limit for physical health conditions and another maximum out-of-pocket limit for mental health conditions, except that if separate out-of-pocket limits are established, the out-of-pocket limit for mental health conditions may not exceed the out-of-pocket limit for physical health conditions.

(b)

(i) "50/50 mental health coverage" means coverage in a health benefit plan that pays for at least 50% of covered services for the diagnosis and treatment of mental health conditions.

(ii) "50/50 mental health coverage" may include a restriction on:

(A) episodic limits;

(B) inpatient or outpatient service limits; or

(C) maximum out-of-pocket limits.

(c) "Large employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(d)

(i) "Mental health condition" means a condition or disorder involving mental illness that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.

(ii) "Mental health condition" does not include the following when diagnosed as the primary or substantial reason or need for treatment:

(A) a marital or family problem;

(B) a social, occupational, religious, or other social maladjustment;

(C) a conduct disorder;

(D) a chronic adjustment disorder;

(E) a psychosexual disorder;

(F) a chronic organic brain syndrome;

(G) a personality disorder;

(H) a specific developmental disorder or learning disability; or

(I) an intellectual disability.

(e) "Small employer" is as defined in 42 U.S.C. Sec. 300gg-91.

(2)

(a) At the time of purchase and renewal, an insurer shall offer to a small employer that it insures or seeks to insure a choice between:

(i)

(A) catastrophic mental health coverage; or

(B) federally qualified mental health coverage as described in Subsection (3); and

(ii) 50/50 mental health coverage.

(b) In addition to complying with Subsection (2)(a), an insurer may offer to provide:

(i) catastrophic mental health coverage, 50/50 mental health coverage, or both at levels that exceed the minimum requirements of this section; or

(ii) coverage that excludes benefits for mental health conditions.

(c) A small employer may, at its option, regardless of the employer's previous coverage for mental health conditions, choose either:

(i) coverage offered under Subsection (2)(a)(i);

(ii) 50/50 mental health coverage; or

(iii) coverage offered under Subsection (2)(b).

(d) An insurer is exempt from the 30% index rating restriction in Section 31A-30-106.1 and, for the first year only that the employer chooses coverage that meets or exceeds catastrophic mental health coverage, the 15% annual adjustment restriction in Section 31A-30-106.1, for a small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds catastrophic mental health coverage.

(3)

(a) An insurer shall offer a large employer mental health and substance use disorder benefit in compliance with Section 2705 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(b) An insurer shall provide in an individual or small employer health benefit plan, mental health and substance use disorder benefits in compliance with Sections 2705 and 2711 of the Public Health Service Act, 42 U.S.C. Sec. 300gg-26, and federal regulations adopted pursuant to that act.

(4)

(a) An insurer may provide catastrophic mental health coverage to a small employer through a managed care organization or system in a manner consistent with Chapter 8, Health Maintenance Organizations and Limited Health Plans, regardless of whether the insurance policy uses a managed care organization or system for the treatment of physical health conditions.

(b)

(i) Notwithstanding any other provision of this title, an insurer may:

(A) establish a closed panel of providers for catastrophic mental health coverage; and

(B) refuse to provide a benefit to be paid for services rendered by a nonpanel provider unless:

(I) the insured is referred to a nonpanel provider with the prior authorization of the insurer; and

(II) the nonpanel provider agrees to follow the insurer's protocols and treatment guidelines.

(ii) If an insured receives services from a nonpanel provider in the manner permitted by Subsection (4)(b)(i)(B), the insurer shall reimburse the insured for not less than 75% of the average amount paid by the insurer for comparable services of panel providers under a noncapitated arrangement who are members of the same class of health care providers.

(iii) This Subsection (4)(b) may not be construed as requiring an insurer to authorize a referral to a nonpanel provider.

(c) To be eligible for catastrophic mental health coverage, a diagnosis or treatment of a mental health condition shall be rendered:

(i) by a mental health therapist as defined in Section 58-60-102; or

(ii) in a health care facility:

(A) licensed or otherwise authorized to provide mental health services pursuant to:

(I) Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection; or

(II) Title 26B, Chapter 2, Part 1, Human Services Programs and Facilities; and

(B) that provides a program for the treatment of a mental health condition pursuant to a written plan.

(5) The commissioner may prohibit an insurance policy that provides mental health coverage in a manner that is inconsistent with this section.

(6) The commissioner may adopt rules, in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, as necessary to ensure compliance with this section.

Amended by Chapter 328, 2023 General Session

**31A-22-626 Coverage of diabetes.**

(1) As used in this section:

(a) "Diabetes" includes individuals with:

(i) complete insulin deficiency or type 1 diabetes;

(ii) insulin resistant with partial insulin deficiency or type 2 diabetes; or

(iii) elevated blood glucose levels induced by pregnancy or gestational diabetes.

(b) "High deductible health plan" means the same as that term is defined in Section 223(c)(2), Internal Revenue Code.

(c) "Lowest tier" means:

(i) the lowest cost tier of a health benefit plan;

(ii) the lowest cost-sharing level of a high deductible health plan that preserves the enrollee's ability to claim tax exempt contributions from the enrollee's health savings account under federal laws and regulations; or

(iii) a discount or other cost-savings program that has the effect of equating cost-sharing of insulin to the health plan's lowest-cost tier.

(d) "Therapy category" means a type of insulin that is distinct from other types of insulin due to a difference in onset, peak time, or duration.

(2) The commissioner shall establish, by rule, minimum standards of coverage for diabetes for accident and health insurance policies that provide a health insurance benefit before July 1, 2000.

(3) In making rules under Subsection (2), the commissioner shall require rules:

(a) with durational limits, amount limits, deductibles, and coinsurance for the treatment of diabetes equitable or identical to coverage provided for the treatment of other illnesses or diseases; and

(b) that provide coverage for:

(i) diabetes self-management training and patient management, including medical nutrition therapy as defined by rule, provided by an accredited or certified program and referred by an attending physician within the plan and consistent with the health plan provisions for self-management education:

(A) recognized by the federal Centers for Medicare and Medicaid Services; or

(B) certified by the Department of Health; and

(ii) the following equipment, supplies, and appliances to treat diabetes when medically necessary:

(A) blood glucose monitors, including those for the legally blind;

(B) test strips for blood glucose monitors;

(C) visual reading urine and ketone strips;

(D) lancets and lancet devices;

(E) insulin;

(F) injection aides, including those adaptable to meet the needs of the legally blind, and infusion delivery systems;

(G) syringes;

(H) prescriptive oral agents for controlling blood glucose levels; and

(I) glucagon kits.

(4) If a health benefit plan entered into or renewed on or after January 1, 2021, provides coverage for insulin for diabetes, the health benefit plan shall:

(a) cap the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $30 per prescription of a 30-day supply of insulin for the treatment of diabetes; and

(b) apply the cap to an insured regardless of whether the insured has met the plan's deductible.

(5) Subsection (4) does not apply to a health benefit plan that:

(a) covers at least one insulin for the treatment of diabetes in each therapy category under the lowest tier of drugs; and

(b) does not require cost-sharing other than a co-payment of an insured before the plan will cover insulin at the lowest tier.

(6) Subsection (4) does not apply to a health benefit plan that:

(a) guarantees an insured that the insured will not pay more out-of-pocket for insulin the insured obtains through the health benefit plan than the insured would pay to obtain insulin through the discount program described in Section 49-20-421; and

(b) caps the total amount that an insured is required to pay for at least one insulin in each therapy category at an amount not to exceed $100 per prescription of a 30-day supply of insulin for the treatment of diabetes.

(7) A health benefit plan that provides coverage for insulin may condition the coverage of insulin at a cost-sharing method described in Subsection (4), (5), or (6) on:

(a) the insured's participation in wellness-related activities for diabetes;

(b) purchasing the insulin at an in-network pharmacy; or

(c) choosing an insulin from the lowest tier of the health benefit plan's formulary.

(8) The department may issue a waiver from the requirements described in Subsection (4) to a health benefit plan if the health benefit plan can demonstrate to the department that the plan provides an insured with substantially similar consumer cost reductions to those that result from Subsections (4) and (5).

(9) The department shall annually adjust the caps described in Subsections (4)(a) and (6)(b) for inflation based on an index that reflects the change in the previous year in the average wholesale price of insulin sold in Utah.

(10) The department shall annually provide the price of insulin available under the discount program described in Section 49-20-421 to a health benefit plan that adopts the cost-sharing method described in Subsection (6).

(11) A health benefit plan entered into or renewed on or after January 1, 2021, that provides coverage of insulin is not required to reimburse a participant, as that term is defined in Subsection 49-20-421(1), for insulin the participant obtains through the discount program described in Section 49-20-421.

(12) The department may request information from insurers to monitor the impact of the requirements of this section on insulin prices charged by pharmaceutical manufacturers.

(13) The department shall classify records provided in response to the request described in Subsection (12) as protected records under Title 63G, Chapter 2, Government Records Access and Management Act.

(14) The department may not publish information submitted in response to the request described in Subsection (12) in a manner that:

(a) makes a specific submission from a contracting insurer identifiable; or

(b) discloses information that is a trade secret, as defined in Section 13-24-2.

Amended by Chapter 310, 2020 General Session

**31A-22-627 Coverage of emergency medical services.**

(1) A health insurance policy or managed care organization contract:

(a) shall provide coverage of emergency services; and

(b) may not:

(i) require any form of preauthorization for treatment of an emergency medical condition until after the insured's condition has been stabilized;
(ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered treatment considered medically necessary to stabilize the emergency medical condition of an insured; or
(iii) impose any cost-sharing requirement for out-of-network that exceeds the cost-sharing requirement imposed for in-network.

(2)
(a) A health insurance policy or managed care organization contract may require authorization for the continued treatment of an emergency medical condition after the insured's condition has been stabilized.
(b) If authorization described in Subsection (2)(a) is required, an insurer who does not accept or reject a request for authorization may not deny a claim for any evaluation, diagnostic testing, or other treatment considered medically necessary that occurred between the time the request was received and the time the insurer rejected the request for authorization.

(3) For purposes of this section:
(a) "Hospital emergency department" means that area of a hospital in which emergency services are provided on a 24-hour-a-day basis.
(b) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

(4) Nothing in this section may be construed as:
(a) altering the level or type of benefits that are provided under the terms of a contract or policy; or
(b) restricting a policy or contract from providing enhanced benefits for certain emergency medical conditions that are identified in the policy or contract.

(5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has violated this section, the commissioner may:
(a) work with the insurer to improve the insurer's compliance with this section; or
(b) impose the following fines:
(i) not more than $5,000; or
(ii) twice the amount of any profit gained from violations of this section.

Amended by Chapter 198, 2022 General Session

**31A-22-627.1 Ground ambulance reimbursement.**

(1) As used in this section,"base rate" means the same as that term is defined in Section 53-2d-503.

(2) For a mileage rate established in a rule created under Section 53-2d-503, a health benefit plan shall accept a correctly charged mileage rate as an allowable expense for a claim.

(3) For claims made under Section 53-2d-503, a health benefit plan shall accept a correctly charged amount that is equal to the base rate as an allowable expense.

(4) A health benefit plan shall make a payment for claims described in this section directly to the provider, including an out-of-network provider.

Amended by Chapter 468, 2026 General Session

**31A-22-628 Standing referral to a specialist.**

(1) With respect to a health insurance policy or managed care organization contract that does not allow an insured to have direct access to a health care specialist, the insurer shall establish

and implement a procedure by which an insured may obtain a standing referral to a health care specialist.

(2) The procedure established under Subsection (1):

(a) shall provide for a standing referral to a specialist if the insured's primary care provider determines, in consultation with the specialist, that the insured needs continuing care from the specialist; and

(b) may require the insurer's approval of a treatment plan designed by the specialist, in consultation with the primary care provider and the insured, which may include:

(i) a limit on the number of visits to the specialist;

(ii) a time limit on the duration of the referral; and

(iii) mandatory updates on the insured's condition.

Amended by Chapter 292, 2017 General Session

**31A-22-629 Adverse benefit determination review process.**

(1) As used in this section:

(a)

(i) "Adverse benefit determination" means the:

(A) denial of a benefit;

(B) reduction of a benefit;

(C) termination of a benefit; or

(D) failure to provide or make payment, in whole or in part, for a benefit.

(ii) "Adverse benefit determination" includes:

(A) denial, reduction, termination, or failure to provide or make payment that is based on a determination of an insured's or a beneficiary's eligibility to participate in a plan;

(B) denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for, a benefit resulting from the application of a utilization review; or

(C) failure to cover an item or service for which benefits are otherwise provided because it is determined to be:

(I) experimental;

(II) investigational; or

(III) not medically necessary or appropriate.

(b) "Independent review" means a process that:

(i) is a voluntary option for the resolution of an adverse benefit determination;

(ii) is conducted at the discretion of the claimant;

(iii) is conducted by an independent review organization designated by the commissioner;

(iv) renders an independent and impartial decision on an adverse benefit determination submitted by an insured; and

(v) may not require the insured to pay a fee for requesting the independent review.

(c) "Independent review organization" means a person, subject to Subsection (6), who conducts an independent external review of adverse determinations.

(d) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(e) "Insurer" is as defined in Section 31A-1-301 and includes:

(i) a health maintenance organization; and

(ii) a third party administrator that offers, sells, manages, or administers a health insurance policy or health maintenance organization contract that is subject to this title.

(f) "Internal review" means the process an insurer uses to review an insured's adverse benefit determination before the adverse benefit determination is submitted for independent review.

(2) This section applies generally to health insurance policies, health maintenance organization contracts, and income replacement or disability income policies.

(3)

(a) An insured may submit an adverse benefit determination to the insurer.

(b) The insurer shall conduct an internal review of the insured's adverse benefit determination.

(c) An insured who disagrees with the results of an internal review may submit the adverse benefit determination for an independent review if the adverse benefit determination involves:

(i) payment of a claim regarding medical necessity; or

(ii) denial of a claim regarding medical necessity.

(4) The commissioner shall adopt rules that establish minimum standards for:

(a) internal reviews;

(b) independent reviews to ensure independence and impartiality;

(c) the types of adverse benefit determinations that may be submitted to an independent review; and

(d) the timing of the review process, including an expedited review when medically necessary.

(5) Nothing in this section may be construed as:

(a) expanding, extending, or modifying the terms of a policy or contract with respect to benefits or coverage;

(b) permitting an insurer to charge an insured for the internal review of an adverse benefit determination;

(c) restricting the use of arbitration in connection with or subsequent to an independent review; or

(d) altering the legal rights of any party to seek court or other redress in connection with:

(i) an adverse decision resulting from an independent review, except that if the insurer is the party seeking legal redress, the insurer shall pay for the reasonable attorney fees of the insured related to the action and court costs; or

(ii) an adverse benefit determination or other claim that is not eligible for submission to independent review.

(6)

(a) An independent review organization in relation to the insurer may not be:

(i) the insurer;

(ii) the health plan;

(iii) the health plan's fiduciary;

(iv) the employer; or

(v) an employee or agent of any one listed in Subsections (6)(a)(i) through (iv).

(b) An independent review organization may not have a material professional, familial, or financial conflict of interest with:

(i) the health plan;

(ii) an officer, director, or management employee of the health plan;

(iii) the enrollee;

(iv) the enrollee's health care provider;

(v) the health care provider's medical group or independent practice association;

(vi) a health care facility where service would be provided; or

(vii) the developer or manufacturer of the service that would be provided.

Amended by Chapter 319, 2018 General Session

**31A-22-630 Mastectomy coverage.**

(1) If an insured has coverage that provides medical and surgical benefits with respect to a mastectomy, it shall provide coverage, with consultation of the attending physician and the patient, for:
  (a) reconstruction of the breast on which the mastectomy has been performed;
  (b) surgery and reconstruction of the breast on which the mastectomy was not performed to produce symmetrical appearance; and
  (c) prostheses and physical complications with regards to all stages of mastectomy, including lymphedemas.

(2)
  (a) This section does not prevent an accident and health insurer from imposing cost-sharing measures for health benefits relating to this coverage, if cost-sharing measures are not greater than those imposed on any other medical condition.
  (b) For purposes of this Subsection (2), cost-sharing measures include imposing a deductible or coinsurance requirement.

(3) Written notice of the availability of the coverage described in Subsection (1) shall be delivered to the participant:
  (a) upon enrollment; and
  (b) annually after the enrollment.

Amended by Chapter 116, 2001 General Session

***Effective 1/1/2027***

**31A-22-630.1 Mobile mammography screening coverage.**

(1) As used in this section:
  (a) "Approved mobile mammography unit" means a mobile mammography bus or vehicle that is:
    (i) equipped with mammography equipment to perform a mobile mammography screening; and
    (ii) approved by an accrediting body designated by the federal Food and Drug Administration to perform mammography screenings.
  (b) "Rural area" means a county of the third, fourth, fifth, or sixth class as classified under Section 17-60-104.

(2) A health benefit plan that covers a mammography screening shall provide coverage of a mobile mammography screening if the mobile mammography screening is performed:
  (a) by an approved mobile mammography unit; and
  (b) in a rural area.

(3) Coverage described in Subsection (2) shall reimburse the approved mobile mammography unit at the same rate that a health benefit plan reimburses for an in-network mammography screening performed in another setting.

(4) An approved mobile mammography unit:
  (a) shall accept the amount reimbursed in Subsection (3) and any applicable enrollee cost sharing as payment in full; and
  (b) may only provide mammography screening services for an enrollee in accordance with the United States Preventative Services Task Force Guidelines on age and frequency.

Enacted by Chapter 152, 2026 General Session

**31A-22-631 Policy summary or illustration.**

(1)

(a) Except as provided in Subsection (1)(b), at the time a life insurance policy is delivered, a policy summary or illustration shall be delivered for the life insurance policy if:
(i) the life insurance policy includes riders or supplemental benefits, including accelerated benefits; and
(ii) receipt of benefits under the life insurance policy is contingent upon morbidity requirements.
(b) In the case of a direct response solicitation, the insurer shall deliver the policy summary or illustration at the sooner of:
(i) the applicant's request; or
(ii) at the time of policy delivery regardless of whether the applicant requests a policy summary or illustration.
(2) In addition to complying with all applicable requirements, the policy summary or illustration shall include:
(a) a clear and prominent disclosure of how the rider or supplemental benefit interacts with other components of the policy, including deductions from death benefits and policy values;
(b) an illustration for each covered person of:
(i) the amount of benefits;
(ii) the length of benefits; and
(iii) the guaranteed lifetime benefits, if any;
(c) a disclosure of the maximum premiums for the rider or supplemental benefit;
(d) any exclusions, reductions, or limitations on the benefits of the rider or supplemental benefit; and
(e) if applicable to the policy type:
(i) a disclosure of the effects of exercising other rights under the policy; and
(ii) guaranteed maximum lifetime benefits.

Enacted by Chapter 116, 2001 General Session

**31A-22-632 Report to policy holder.**
(1) An insurer shall provide the policyholder a monthly report if an accident and health rider or supplemental benefit is:
(a) funded through a life insurance vehicle by acceleration of the death benefit; and
(b) in benefit payment status.
(2) The report required by Subsection (1) shall include:
(a) any rider or supplemental benefits paid out during the month;
(b) an explanation of any changes in the policy due to rider or supplemental benefits being paid out such as:
(i) death benefits; or
(ii) cash values; and
(c) the amount of the rider or supplemental benefits existing or remaining.

Enacted by Chapter 116, 2001 General Session

**31A-22-633 Exemptions from standards.**
Notwithstanding the provisions of this title, any accident and health insurer or health maintenance organization may offer a choice of coverage that is less or different than is otherwise required by applicable state law if:

(1) the Department of Health and Human Services offers a choice of coverage as part of a Medicaid waiver under Title 26B, Chapter 3, Health Care - Administration and Assistance, which includes:
  (a) less or different coverage than the basic coverage;
  (b) less or different coverage than is otherwise required in an insurance policy or health maintenance organization contract under applicable state law; or
  (c) less or different coverage than required by Subsection 31A-22-605(4)(b); and
(2) the choice of coverage offered by the carrier:
  (a) is the same or similar coverage as the coverage offered by the Department of Health and Human Services under Subsection (1);
  (b) is offered to the same or similar population as the coverage offered by the Department of Health and Human Services under Subsection (1); and
  (c) contains an explanation for each insured of coverage exclusions and limitations.

Amended by Chapter 328, 2023 General Session

**31A-22-634 Prohibition against certain use of Social Security number -- Exceptions -- Applicability of section.**

(1) As used in this section:
  (a) "Insurer" means:
    (i) insurers governed by this part as described in Section 31A-22-600, and includes:
      (A) a health maintenance organization; and
      (B) a third-party administrator that is subject to this title; and
    (ii) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, dental, medical, Medicare supplement, or conversion program offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
  (b) "Publicly display" or "publicly post" means to intentionally communicate or otherwise make available to the general public.
(2) An insurer or its subcontractors, including a pharmacy benefit manager, may not do any of the following:
  (a) publicly display or publicly post in any manner an individual's Social Security number; or
  (b) print an individual's Social Security number on any card required for the individual to access products or services provided or covered by the insurer.
(3) This section does not prevent the collection, use, or release of a Social Security number as required by state or federal law, or the use of a Social Security number for internal verification or administrative purposes, or the release of a Social Security number to a health care provider for claims administration purposes, or as part of the verification, eligibility, or payment process.
(4) If a federal law takes effect requiring the United States Department of Health and Human Services to establish a national unique patient health identifier program, an insurer that complies with the federal law shall be considered in compliance with this section.
(5) An insurer shall comply with the provisions of this section by July 1, 2004.
(6)
  (a) An insurer may obtain an extension for compliance with the requirements of this section in accordance with Subsections (6)(b) and (c).
  (b) The request for extension:
    (i) shall be submitted in writing to the department prior to July 1, 2004; and
    (ii) shall provide an explanation as to why the insurer cannot comply with the requirements of this section by July 1, 2004.

(c) The commissioner shall grant a request for extension:
(i) for a period of time not to exceed March 1, 2005; and
(ii) if the commissioner finds that the explanation provided under Subsection (6)(b)(ii) is a reasonable explanation.

Amended by Chapter 297, 2011 General Session

**31A-22-635 Uniform application -- Uniform waiver of coverage.**

(1) For purposes of this section, "insurer":
(a) is defined in Subsection 31A-22-634(1); and
(b) includes the state employee's risk pool under Section 49-20-202.
(2)
(a) Insurers offering a health benefit plan to an individual or small employer shall use a uniform application form.
(b) The uniform application form:
(i) may not include questions about an applicant's health history; and
(ii) shall be shortened and simplified in accordance with rules adopted by the commissioner.
(c) Insurers offering a health benefit plan to a small employer shall use a uniform waiver of coverage form, which may not include health status related questions, and is limited to:
(i) information that identifies the employee;
(ii) proof of the employee's insurance coverage; and
(iii) a statement that the employee declines coverage with a particular employer group.
(3) Notwithstanding the requirements of Subsection (2)(a), the uniform application and uniform waiver of coverage forms may, if the combination or modification is approved by the commissioner, be combined or modified to facilitate a more efficient and consumer friendly experience for insurers using electronic applications.
(4)
(a) The uniform application form, and uniform waiver form, shall be adopted and approved by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(b) The commissioner shall regulate the fees charged by insurers to an enrollee for a uniform application form or electronic submission of the application forms.

Amended by Chapter 292, 2017 General Session

**31A-22-636 Standardized health insurance information cards.**

(1) As used in this section, "insurer" means:
(a) an insurer governed by this part as described in Section 31A-22-600;
(b) a health maintenance organization governed by Chapter 8, Health Maintenance Organizations and Limited Health Plans;
(c) a third party administrator; and
(d) notwithstanding Subsection 31A-1-103(3)(f) and Section 31A-22-600, a health, medical, or conversion policy offered under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act.
(2) In accordance with Subsection (3), an insurer shall use and issue a health benefit plan information card for the insurer's enrollees upon the purchase or renewal of, or enrollment in, a health benefit plan.
(3) The health benefit plan information card shall include:
(a) the covered person's name;

(b) the name of the carrier and the carrier network name;
(c) the contact information for the carrier or health benefit plan administrator;
(d) general information regarding copayments and deductibles; and
(e) an indication of whether the health benefit plan is regulated by the state.

(4)
(a) The commissioner shall work with the Department of Health and Human Services, the Health Data Authority, health care providers groups, and with state and national organizations that develop uniform standards for the electronic exchange of health insurance claims or uniform standards for the electronic exchange of clinical health records.
(b) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to adopt standardized electronic interchange technology.
(c) After rules are adopted under Subsection (4)(a), health care providers and their licensing boards under Title 58, Occupations and Professions, and health facilities licensed under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection, shall work together to implement the adoption of card swipe technology.

Amended by Chapter 328, 2023 General Session

**31A-22-637 Health care provider payment information -- Notice of admissions.**

(1) For purposes of this section, "insurer" is as defined in Section 31A-22-636.

(2)
(a) An insurer shall provide its health care providers who are under contract with the insurer access to current information necessary for the health care provider to determine:
(i) the effect of procedure codes on payment or compensation before a claim is submitted for a procedure;
(ii) the plans and carrier networks that the health care provider is subject to as part of the contract with the carrier; and
(iii) in accordance with Subsection 31A-26-301.6(10)(f), the specific rate and terms under which the provider will be paid for health care services.
(b) The information required by Subsection (2)(a) may be provided through a website, and if requested by the health care provider, notice of the updated website shall be provided by the carrier.

(3)
(a) An insurer may not require a health care provider by contract, reimbursement procedure, or otherwise to notify the insurer of a hospital in-patient emergency admission within a period of time that is less than one business day of the hospital in-patient admission, if compliance with the notification requirement would result in notification by the health care provider on a weekend or federal holiday.
(b) Subsection (3)(a) does not prohibit the applicability or administration of other contract provisions between an insurer and a health care provider that require pre-authorization for scheduled in-patient admissions.

Amended by Chapter 297, 2011 General Session

**31A-22-638 Coverage for prosthetic devices.**

(1) For purposes of this section:

(a) "Orthotic device" means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back, or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back, or neck.

(b)

(i) "Prosthetic device" means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

(ii) "Prosthetic device" does not include an orthotic device.

(2)

(a) Beginning January 1, 2011, an insurer, other than an insurer described in Subsection (2)(b), that provides a health benefit plan shall offer at least one plan, in each market where the insurer offers a health benefit plan, that provides coverage for benefits for prosthetics that includes:

(i) a prosthetic device;

(ii) all services and supplies necessary for the effective use of a prosthetic device, including:

(A) formulating its design;

(B) fabrication;

(C) material and component selection;

(D) measurements and fittings;

(E) static and dynamic alignments; and

(F) instructing the patient in the use of the prosthetic device;

(iii) all materials and components necessary to use the prosthetic device; and

(iv) any repair or replacement of a prosthetic device that is determined medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

(b) Beginning January 1, 2011, an insurer that is subject to Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall offer to a covered employer at least one plan that:

(i) provides coverage for prosthetics that complies with Subsections (2)(a)(i) through (iv); and

(ii) requires an employee who elects to purchase the coverage described in Subsection (2)(b)(i) to pay an increased premium to pay the costs of obtaining that coverage.

(c) At least one of the plans with the prosthetic benefits described in Subsections (2)(a) and (b) that is offered by an insurer described in this Subsection (2) shall have a coinsurance rate, that applies to physical injury generally and to prosthetics, of 80% to be paid by the insurer and 20% to be paid by the insured, if the prosthetic benefit is obtained from a person that the insurer contracts with or approves.

(d) For policies issued on or after July 1, 2010 until July 1, 2015, an insurer is exempt from the 30% index rating restrictions in Section 31A-30-106.1, and for the first year only that coverage under this section is chosen, the 15% annual adjustment restriction in Section 31A-30-106.1, for any small employer with 20 or less enrolled employees who chooses coverage that meets or exceeds the coverage under this section.

(3) The coverage described in this section:

(a) shall, except as otherwise provided in this section, be made subject to cost-sharing provisions, including dollar limits, deductibles, copayments, and co-insurance, that are not less favorable to the insured than the cost-sharing provisions of the health benefit plan that apply to physical illness generally; and

(b) may limit coverage for the purchase, repair, or replacement of a microprocessor component for a prosthetic device to $30,000, per limb, every three years.

(4) If the coverage described in this section is provided through a managed care plan, offered under Chapter 45, Managed Care Organizations, the insured shall have access to medically necessary prosthetic clinical care, and to prosthetic devices and technology, from one or more prosthetic providers in the managed care plan's provider network.

Amended by Chapter 193, 2019 General Session

**31A-22-639 Statement of preauthorization.**

(1) An insurer who requires preauthorization or preapproval for coverage under accident and health insurance shall, beginning January 1, 2011, provide an enrollee with a statement of preauthorization if:
  (a) the applicable CPT codes have been submitted to the insurer to determine whether a particular procedure is covered under the terms of the accident and health insurance policy;
  (b) the enrollee has met the requirements for preauthorization of the procedure or encounter; and
  (c) the enrollee requests a statement of preauthorization.
(2) A statement of preauthorization under Subsection (1) may be sent:
  (a) by mail; or
  (b) electronically.
(3) A statement of preauthorization shall include a statement that the preauthorization is:
  (a) not a guarantee of payment by an insurer; and
  (b) subject to the policy and contract provisions of the accident and health insurance contract.

Enacted by Chapter 204, 2010 General Session

**31A-22-641 Cancer treatment parity.**

(1) For purposes of this section:
  (a) "Cost sharing" means the enrollee's maximum out-of-pocket costs as defined by the health benefit plan.
  (b) "Health insurer" is as defined in Subsection 31A-22-634(1).
  (c) "Intravenously administered chemotherapy" means a physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is administered through injection directly into the patient's circulatory system by a physician, physician assistant, nurse practitioner, nurse, or other medical personnel under the supervision of a physician, and in a hospital, medical office, or other clinical setting.
  (d) "Oral chemotherapy" means a United States Food and Drug Administration-approved, physician-prescribed cancer treatment that is used to kill or slow the growth of cancer cells, that is taken orally in the form of a tablet or capsule, and may be administered in a hospital, medical office, or other clinical setting or may be delivered to the patient for self-administration under the direction or supervision of a physician outside of a hospital, medical office, or other clinical setting.
(2) This section applies to health benefit plans renewed or entered into on or after October 1, 2013.
(3) A health benefit plan that covers prescribed oral chemotherapy and intravenously administered chemotherapy shall:
  (a) except as provided in Subsection (3)(b), ensure that the cost sharing applied to the covered oral chemotherapy is no more restrictive than the cost sharing applied to the covered intravenously administered chemotherapy; or

(b) if the cost sharing for oral chemotherapy is more restrictive than the cost sharing for intravenous chemotherapy, the health benefit plan may not apply cost sharing for the oral chemotherapy that exceeds $300 per filled prescription.

(4)

(a) A health insurer shall not increase the cost sharing for intravenously administered chemotherapy for the purpose of achieving compliance with this section.

(b) The commissioner may adopt administrative rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to enforce the provisions of this section.

Enacted by Chapter 164, 2013 General Session

**31A-22-642 Insurance coverage for autism spectrum disorder.**

(1) As used in this section:

(a) "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

(b) "Autism spectrum disorder" means pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

(c) "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

(i) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and

(ii) provided or supervised by a:

(A) board certified behavior analyst; or

(B) person licensed under Title 58, Chapter 1, Division of Professional Licensing Act, whose scope of practice includes mental health services.

(d) "Diagnosis of autism spectrum disorder" means medically necessary assessments, evaluations, or tests:

(i) performed by a licensed physician who is board certified in neurology, psychiatry, or pediatrics and has experience diagnosing autism spectrum disorder, or a licensed psychologist with experience diagnosing autism spectrum disorder; and

(ii) necessary to diagnose whether an individual has an autism spectrum disorder.

(e) "Mental health therapist" means the same as that term is defined in Section 58-60-102.

(f) "Pharmacy care" means medications prescribed by a licensed physician and any health-related services considered medically necessary to determine the need or effectiveness of the medications.

(g) "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

(h) "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

(i) "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists, or physical therapists.

(j) "Treatment for autism spectrum disorder":

(i) means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a physician or a licensed psychologist described in Subsection (1)(d) who determines the care to be medically necessary; and

(ii) includes:

(A) behavioral health treatment, provided or supervised by a person described in Subsection (1)(c)(ii);
(B) pharmacy care;
(C) psychiatric care;
(D) psychological care; and
(E) therapeutic care.

(2)
(a) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2016, and before January 1, 2020, shall provide coverage for the diagnosis and treatment of autism spectrum disorder:
(i) for a child who is at least two years old, but younger than 10 years old; and
(ii) in accordance with the requirements of this section and rules made by the commissioner.
(b) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2020, shall provide coverage for the diagnosis and treatment of autism spectrum disorder in accordance with the requirements of this section and rules made by the commissioner.

(3) The commissioner may adopt rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to set the minimum standards of coverage for the treatment of autism spectrum disorder.

(4) Subject to Subsection (5), the rules described in Subsection (3) shall establish durational limits, amount limits, deductibles, copayments, and coinsurance for the treatment of autism spectrum disorder that are similar to, or identical to, the coverage provided for other illnesses or diseases.

(5)
(a) Coverage for behavioral health treatment for a person with an autism spectrum disorder shall cover at least 600 hours a year.
(b) Notwithstanding Subsection (5)(a), for a health benefit plan offered in the individual market or the large group market and entered into or renewed on or after January 1, 2020, coverage for behavioral health treatment for a person with an autism spectrum disorder may not have a limit on the number of hours covered.
(c) Other terms and conditions in the health benefit plan that apply to other benefits covered by the health benefit plan apply to coverage required by this section.
(d) Notwithstanding Section 31A-45-303, a health benefit plan providing treatment under Subsections (5)(a) and (b) shall include in the plan's provider network both board certified behavior analysts and mental health providers qualified under Subsection (1)(c)(ii).

(6)
(a) A health care provider shall submit a treatment plan for autism spectrum disorder to the insurer within 14 business days of starting treatment for an individual.
(b) If an individual is receiving treatment for an autism spectrum disorder, an insurer shall have the right to request a review of that treatment not more than once every three months.
(c) A review of treatment under this Subsection (6) may include a review of treatment goals and progress toward the treatment goals.
(d) If an insurer makes a determination to stop treatment as a result of the review of the treatment plan under this Subsection (6), the determination of the insurer may be reviewed under Section 31A-22-629.

(7)
(a) Before July 1, 2027, and before July 1 each year after, a health benefit plan shall report the following to the department for the prior insurance plan year:

(i) the average wait time for an enrollee to receive an autism assessment;
(ii) if the health benefit plan has prior authorization requirements related to autism assessment or treatment;
(iii) the number of enrollees under age 18 that were diagnosed with autism spectrum disorder;
(iv) of the number of diagnoses described in Subsection (7)(a)(iii), the number of diagnoses disaggregated based on provider license type that made the diagnosis;
(v) of the number of diagnoses described in Subsection (7)(a)(iii), the number of enrollees that received applied behavior analysis treatment;
(vi) for enrollees that received applied behavior analysis treatment:
(A) the average number of hours of applied behavior analysis treatment received; and
(B) the average cost of applied behavior analysis treatment received; and
(vii) if the health benefit plan accepts state defrayal payments under Subsection 31A-30-118(2) for coverage described in this section.

(b) The department shall compile the information described in Subsection (7)(a) and provide a report to the Health and Human Services Interim Committee on or before September 1.

(c) Beginning September 1, 2027, the department shall provide on the department's website, in a form that is easily accessible, information regarding which health benefit plans reimburse a mental health therapist that is not a physician or a psychologist for autism spectrum disorder treatment.

Amended by Chapter 119, 2026 General Session

**31A-22-643 Prescription synchronization -- Copay and dispensing fee restrictions -- Rebate requirements -- Pharmacy networks.**

(1) For purposes of this section:
(a) "Administrative fee" means the same as that term is defined in Section 31A-46-102.
(b) "Copay" means the copay normally charged for a prescription drug.
(c) "Health insurer" means an insurer, as defined in Subsection 31A-22-634(1).
(d) "Network pharmacy" means a pharmacy included in a health insurance plan's network of pharmacy providers.
(e) "Pharmacy benefit manager" means the same as that term is defined in Section 31A-46-102.
(f) "Prescription drug" means a prescription drug, as defined in Section 58-17b-102, that is prescribed for a chronic condition.
(g) "Rebate" means the same as that term is defined in Section 31A-46-102.
(h) "Standard rebate amount" means a rebate amount that:
(i) is estimated and set by a health benefit plan for a drug product;
(ii) adjusts each quarter based on rebate underpayments or overpayments; and
(iii) is applied when the drug product is dispensed.

(2) A health insurance plan may not charge an amount in excess of the copay for the dispensing of a prescription drug in a quantity less than the prescribed amount if:
(a) the pharmacy dispenses the prescription drug in accordance with the health insurer's synchronization policy; and
(b) the prescription drug is dispensed by a network pharmacy.

(3) A health insurance plan that includes a prescription drug benefit:
(a) shall implement a synchronization policy for the dispensing of prescription drugs to the plan's enrollees; and

(b) may not base the dispensing fee for an individual prescription on the quantity of the prescription drug dispensed to fill or refill the prescription unless otherwise agreed to by the plan and the contracted pharmacy at the time the individual requests synchronization.

(4)

(a) A health benefit plan shall ensure that each pharmaceutical manufacturer rebate is used exclusively to benefit enrollees using one or multiple of the following methods:

(i) passing down the rebate to the point of sale to offset an enrollee's deductible or coinsurance;

(ii) using the rebate to reduce premiums paid by the enrollee; or

(iii) using the rebate to enhance enrollee health benefits.

(b) When passing down a rebate as described in Subsection (4)(a)(i), a health benefit plan may:

(i) divide the rebate between the health benefit plan and the enrollee in a manner that is proportional to the enrollee's payment obligation; or

(ii) use a standard rebate amount.

(5) A health benefit plan may not prohibit or condition participation in one pharmacy network on participation in another pharmacy network.

(6) Subsections (4) and (5) apply to a health benefit plan renewed or entered into on or after July 1, 2026.

Amended by Chapter 525, 2025 General Session

**31A-22-644 Denial of coverage under a health benefit plan because of life expectancy or terminal condition.**

(1) As used in this section:

(a) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

(b) "Terminal condition" means an irreversible condition:

(i) caused by disease, illness, or injury; and

(ii) if:

(A) the irreversible condition will result in imminent death within a six-month period after the date the condition is diagnosed; and

(B) the application of life-sustaining treatment only prolongs the process of dying.

(2) This section applies to a health benefit plan under:

(a) this part; or

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

(3) Except as provided by law, and subject to the other provisions of this section, a health benefit plan may not deny coverage for medically necessary treatment if the medically necessary treatment is:

(a) prescribed by a physician;

(b) agreed to:

(i) by a person who is:

(A) insured under the health benefit plan; and

(B) fully informed regarding the person's life expectancy or diagnosis with a terminal condition; or

(ii) if the person described in Subsection (3)(b)(i) lacks legal capacity to consent, by another person who:

(A) has legal authority to consent on behalf of the person described in Subsection (3)(b)(i); and

(B) is fully informed regarding the life expectancy or diagnosis with a terminal condition of the person described in Subsection (3)(b)(i); and

(c) denied solely because:
(i) of the life expectancy of the person described in Subsection (3)(b)(i); or
(ii) the person has been diagnosed with a terminal condition.
(4) A denial of coverage described in Subsection (3) for medically necessary treatment is a violation of this section.
(5) Whether treatment is considered to be medically necessary treatment is determined by the defined standards and policies of the health benefit plan.
(6) This section may not be interpreted to:
(a) require an insurer to offer a particular benefit or service as part of a health benefit plan; or
(b) alter the clinical policies of a health benefit plan regarding the appropriate location for services.
(7) This section does not create a new or additional private right of action.

Enacted by Chapter 375, 2015 General Session

**31A-22-645 Alcohol and drug dependency treatment.**
(1) An insurer offering a health benefit plan providing coverage for alcohol or drug dependency treatment may require an inpatient facility to be licensed by:
(a)
(i) the Department of Health and Human Services, under Title 26B, Chapter 2, Part 1, Human Services Programs and Facilities; or
(ii) the Department of Health and Human Services; or
(b) for an inpatient facility located outside the state, a state agency similar to one described in Subsection (1)(a).
(2) For inpatient coverage provided pursuant to Subsection (1), an insurer may require an inpatient facility to be accredited by the following:
(a) the Joint Commission; and
(b) one other nationally recognized accrediting agency.

Amended by Chapter 328, 2023 General Session

**31A-22-646 Dental insurance -- Contract provision for noncovered services.**
(1) For purposes of this section:
(a) "Covered services" means dental services for which reimbursement:
(i) is available or would be reimbursable under an enrollee's dental plan but for the application of one or more of the following contractual provisions:
(A) deductibles;
(B) copayments;
(C) coinsurance;
(D) waiting periods;
(E) annual or lifetime maximums;
(F) frequency limitations; or
(G) alternative benefit payments; and
(ii) is not merely nominal, for the purpose of avoiding the requirements of this section.
(b) "Dental plan" means:
(i) a health benefit plan that includes coverage for dental services; and
(ii) a policy or certificate that provides coverage solely for dental services.

(c) "Dental provider" means an individual licensed under Title 58, Chapter 69, Dentist and Dental Hygienist Practice Act.

(2)

(a) This section applies to:

(i) a dental plan that is entered into or renewed on or after January 1, 2018; and

(ii) an administrator providing third-party administration services or a provider network for a dental plan.

(b) This section does not apply to a self-insured dental plan that is regulated by federal law.

(3) A contract between a dental plan and a dentist to provide covered services may not:

(a) require, directly or indirectly, that a dentist provide dental services to a covered individual at a fee set by, or a fee subject to the approval of, the dental plan unless:

(i) the dental services are covered services under the dental plan; or

(ii)

(A) the dental services are not reimbursed by the dental plan;

(B) the dental services are discounted for individuals who are part of a discount dental rates plan; and

(C) the dentist who provided the dental services has elected to participate in the discount dental rates plan; and

(b) prohibit a dentist from offering or providing noncovered dental services to a covered individual at a fee determined by the dentist and the individual who will receive the noncovered services.

Amended by Chapter 45, 2026 General Session

**31A-22-646.1 Leasing requirements for dental plans.**

(1) As used in this section:

(a) "Contracting entity" means a person that enters into a direct contract with a provider for the delivery of dental services in the ordinary course of business, including a third party administrator or a dental carrier.

(b) "Dental carrier" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide a dental plan.

(c) "Dental plan" means the same as that term is defined in Section 31A-22-646.

(d)

(i) "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.

(ii) "Dental services" does not include services that a provider delivers and bills as medical expenses under a health benefit plan.

(e)

(i) "Dental service contractor" means an individual who:

(A) accepts prepayment for dental services; or

(B) for the benefit of another individual, accepts payment for providing to the individual the opportunity to receive dental services in the future.

(ii) "Dental service contractor" does not include a provider or professional dental corporation that accepts prepayment on a fee-for-service basis for providing specific dental services to individual patients for whom the services have been pre-diagnosed.

(f)

(i) "Provider" means a person who, acting within the scope of licensure or certification, provides dental services or supplies defined by the dental plan.

(ii) "Provider" does not include a physician organization or physician hospital organization that leases or rents the physician organization's or physician hospital organization's network to a third party.

(g) "Provider network contract" means a contract between a contracting entity and a provider that:

(i) specifies the rights and responsibilities of the contracting entity; and

(ii) provides for the delivery and payment of dental services to an enrollee.

(h)

(i) "Third party" means a person that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract.

(ii) "Third party" does not include an employer or other group for whom the dental carrier or contracting entity provides administrative services.

(2) A contracting entity may grant a third party access to a provider network contract regarding dental services, including a provider's dental services, or a contractual discount provided under a provider network contract for dental services if:

(a) if the contracting entity is an insurer, the insurer complies with Subsection (3);

(b) the contract between the contracting entity and a person subject to the third-party access complies with Subsection (4); and

(c) the contracting entity complies with Subsection (5).

(3) An insurer shall:

(a) at the time a contract is entered into or renewed, or when there is a material modification to a contract that is relevant to third-party access to a provider network contract, allow a provider which is part of the insurer's provider network to:

(i) choose to not participate in third-party access; or

(ii) enter into a contract directly with the third party that acquired the provider network;

(b) allow a provider to opt out of lease arrangements without canceling or ending a contractual relationship with the insurer; and

(c) when initially contracting with a provider, accept a qualified provider even if a provider rejects a network lease provision.

(4) A contracting entity described in Subsection (2) shall ensure that the contract described in Subsection (2)(b) includes the following:

(a) a provision indicating the contracting entity may enter into an agreement with a third party to allow the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity;

(b) if the contracting entity is a dental carrier, a provision indicating that the provider chose to participate in third-party access at the time the provider network contract was entered into or renewed; and

(c) if the contracting entity is an insurer, a provision indicating:

(i) that the contract grants a third party access to the provider network; and

(ii) for a contract with a dental carrier, the dentist has the right to choose not to participate in third-party access.

(5) A contracting entity shall:

(a) provide a provider, in writing or electronic form, each third party in existence as of the date the contract is entered into;

(b) maintain a list of each third party in existence on the contracting entity's website that is updated at least once every 90 days;

(c) require a third party to identify the source of the discount on all remittance advices or explanations of payment under which a discount is taken unless the transaction is an electronic transaction mandated by the Health Insurance Portability and Accountability Act;
(d) notify a third party of the termination of a provider network contract no later than 30 days after the day on which the contract terminates with the contracting entity;
(e) at least 30 days before the day on which a third party begins leasing a network provider, notify each network provider subject to the lease;
(f) make available to a participating provider, within 30 days after the day on which the provider makes a request, a copy of the provider network contract at issue in the adjudication of a claim; and
(g) maintain a list of the contracting entity's affiliates on the contracting entity's website.
(6) A third party that gains access to a contract under this section:
(a) shall comply with each term of the contract to which the third party gains access; and
(b) loses all rights to a provider's discounted rate as of the termination date of the provider network contract.
(7) A contracting entity or third party may not require a provider to perform services under a provider network contract if a third party gains access to a contract in violation of this section.
(8) This section does not apply to:
(a) a contracting entity granting access to a provider network contract to:
(i) an entity that operates in accordance with the brand licensee program of the contracting entity; or
(ii) an entity that is an affiliate of the contracting entity; and
(b) a provider network contract for dental services provided to beneficiaries of a state sponsored health program, including Medicaid and the Children's Health Insurance Program.
(9) A contract executed or renewed on or after January 1, 2022:
(a) may not waive the provisions of this section; and
(b) is null and void if the contract contains provisions that conflict with the provisions of this section or that purports to waive a requirement of this section.

Enacted by Chapter 288, 2021 General Session

**31A-22-646.2 Dental services jurisdiction.**
(1)
(a) Notwithstanding Section 31A-1-103, an insurer that provides coverage for dental services that are completed in Utah to a patient that is a Utah resident shall comply with all Utah laws related to covered services, non-covered services, and reimbursement for services if 10% or more of the certificate holders or insureds are residents of this state.
(b) Subsection (1)(a) applies regardless of:
(i) the location of the insurer's domicile or principle place of business;
(ii) the location where the dental plan was written, issued, or delivered; or
(iii) a contractual choice-of-law provision.
(2)
(a) A signed provider agreement shall govern the contractual rights and obligations of the parties for dental services provided in Utah.
(b) A provider handbook that is provided to a dental provider by an insurer in connection with a provider agreement shall be deemed part of the provider contract.
(c) An insurer may not require a dental provider to comply with a provider handbook or policy that is not provided to the dental provider.

(d) An insurer shall notify a dental provider if the insurer issues a new provider handbook or updates an existing provider handbook.

Enacted by Chapter 45, 2026 General Session

**31A-22-647 Insurer shared savings program.**

(1) As used in this section:
(a) "Insurer" means a person who offers health care insurance, including a health maintenance organization as that term is defined in Section 31A-8-101.
(b) "PEHP" means the Public Employees' Benefit and Insurance Program created in Section 49-20-103.
(c) "Savings reward program" means a program to reward a health insurance enrollee if the enrollee receives services:
(i) covered by the enrollee's health plan; and
(ii) from a provider whose costs for services are lower than the average costs for the services.
(2) An insurer may, in accordance with Subsection (4), establish a savings reward program for a health benefit plan that is:
(a) offered by the insurer; and
(b) entered into or renewed on or after January 1, 2019.
(3) PEHP shall, in accordance with Subsection (4), establish a savings reward program for a health plan that is:
(a) offered to state employees under Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act; and
(b) entered into or renewed on or after July 1, 2019.
(4) A savings reward program described in Subsection (2) or (3) may include, in accordance with federal and state law, rewards to the enrollee through:
(a) premium discounts;
(b) rebates;
(c) reduction of out-of-pocket costs; or
(d) other rewards or incentives developed by the insurer.

Enacted by Chapter 181, 2018 General Session

**31A-22-648 Vision insurance -- Contract provisions.**

(1) As used in this section:
(a) "Covered individual" means an individual who has insurance coverage under a vision plan.
(b) "Covered service" means a vision service that:
(i) is reimbursable under or would be reimbursable under an enrollee's vision plan, but for the application of at least one of the following contractual provisions:
(A) a deductible;
(B) a copayment;
(C) coinsurance;
(D) a waiting period;
(E) an annual or lifetime maximum;
(F) a frequency limitation; or
(G) an alternative benefit payment; and
(ii) is not merely nominal, for the purpose of avoiding the requirements of this section.

(c) "Optometrist" means an individual licensed under Title 58, Chapter 16a, Utah Optometry Practice Act.
(d) "Vendor" means a person who provides ophthalmic goods to a vision service provider.
(e) "Vision plan" means a health insurance policy or contract that provides vision coverage.
(f) "Vision service" means:
(i) professional work performed by a vision service provider; or
(ii) an opthalmic medical device, such as lenses, opthalmic frames, contact lenses, or a prosthetic device that treats a condition of the human eye or the areas surrounding the human eye.
(g) "Vision service provider" means:
(i) an optometrist; or
(ii) an individual who provides a vision service and is licensed under:
(A) Title 58, Chapter 67, Utah Medical Practice Act; or
(B) Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.
(2)
(a) This section applies to:
(i) a vision plan that a person enters into or renews on or after January 1, 2019; and
(ii) an administrator providing third-party administration services or a provider network for a vision plan.
(b) This section does not apply to a self-insured vision plan that is regulated by federal law.
(3) A contract between a vision plan and a vision service provider to provide a covered service may not:
(a) except as provided in Subsection (4), require that a vision service provider provide a vision service to a covered individual at a fee set by, or a fee subject to the approval of, the vision plan unless the vision service is a covered service;
(b) prohibit a vision service provider from offering or providing a vision service that is not a covered service to a covered individual at a fee determined by:
(i) the vision service provider; or
(ii) the vision service provider and the covered individual; or
(c) require a vision service provider to use one or more specific vendors to replenish the vision service provider's inventory of spectacle lenses after the vision service provider dispenses the vision service provider's inventory to eligible members of the vision plan as a covered vision service.
(4)
(a) In accordance with Subsections (4)(b) and (c), a vision service provider may, in a contract with a vision plan, agree to participate in a discount program sponsored by the vision plan.
(b) A contract between a vision service provider and a vision plan to provide a covered service may not be contingent on whether the vision service provider agrees to participate in a discount program sponsored by the vision plan.
(c) Regardless of whether a vision service provider participates in a discount program sponsored by the vision plan, a vision plan shall offer equal treatment to a vision service provider under contract with the vision plan to provide a covered service, regarding:
(i) promotional treatment;
(ii) marketing benefits;
(iii) materials; and
(iv) contract terms for providing a covered service.

(5) Notwithstanding Subsection (4)(c), a vision plan may, when providing a typically-formatted list of vision service providers that accept the vision plan, identify whether a vision service provider participates in a discount program sponsored by the vision plan.

Amended by Chapter 193, 2019 General Session

**31A-22-649 Coverage of telepsychiatric consultations.**

(1) As used in this section:
(a) "Telehealth services" means the same as that term is defined in Section 26B-4-704.
(b) "Telepsychiatric consultation" means a consultation between a physician and a board certified psychiatrist, both of whom are licensed to engage in the practice of medicine in the state, that utilizes:
(i) the health records of the patient, provided from the patient or the referring physician;
(ii) a written, evidence-based patient questionnaire; and
(iii) telehealth services that meet industry security and privacy standards, including compliance with the:
(A) Health Insurance Portability and Accountability Act; and
(B) Health Information Technology for Economic and Clinical Health Act, Pub. L. No. 111-5, 123 Stat. 226, 467, as amended.
(2) Beginning January 1, 2019, a health benefit plan that offers coverage for mental health services shall:
(a) provide coverage for a telepsychiatric consultation during or after an initial visit between the patient and a referring in-network physician;
(b) provide coverage for a telepsychiatric consultation from an out-of-network board certified psychiatrist if a telepsychiatric consultation is not made available to a physician within seven business days after the initial request is made by the physician to an in-network provider of telepsychiatric consultations; and
(c) reimburse for the services described in Subsections (2)(a) and (b) at the equivalent in-network or out-of-network rate set by the health benefit plan after taking into account cost-sharing that may be required under the health benefit plan.
(3) A single telepsychiatric consultation includes all contacts, services, discussion, and information review required to complete an individual request from a referring physician for a patient.
(4) An insurer may satisfy the requirement to cover a telepsychiatric consultation described in Subsection (2)(a) for a patient by:
(a) providing coverage for behavioral health treatment, as defined in Section 31A-22-642, in person or using telehealth services; and
(b) ensuring that the patient receives an appointment for the behavioral health treatment in person or using telehealth services on a date that is within seven business days after the initial request is made by the in-network referring physician.
(5) A referring physician who uses a telepsychiatric consultation for a patient shall, at the time that the questionnaire described in Subsection (1)(b)(ii) is completed, notify the patient that:
(a) the referring physician plans to request a telepsychiatric consultation; and
(b) additional charges to the patient may apply.
(6)
(a) An insurer may receive a temporary waiver from the department from the requirements in this section if the insurer demonstrates to the department that the insurer is unable to provide the benefits described in this section due to logistical reasons.

(b) An insurer that receives a waiver from the department under Subsection (6)(a) is subject to the requirements of this section beginning July 1, 2019.
(7) This section does not limit an insurer from engaging in activities that ensure payment integrity or facilitate review and investigation of improper practices by health care providers.

Amended by Chapter 328, 2023 General Session

**31A-22-649.5 Insurance parity for telemedicine services -- Method of technology used.**
(1) As used in this section:
(a) "Mental health condition" means a mental disorder or a substance-related disorder that falls under a diagnostic category listed in the Diagnostic and Statistical Manual, as periodically revised.
(b) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.
(2) Notwithstanding the provisions of Section 31A-22-618.5, a health benefit plan offered in the individual market, the small group market, or the large group market shall:
(a) provide coverage for:
(i) telemedicine services that are covered by Medicare; and
(ii) treatment of a mental health condition through telemedicine services if:
(A) the health benefit plan provides coverage for the treatment of the mental health condition through in-person services; and
(B) the health benefit plan determines treatment of the mental health condition through telemedicine services meets the appropriate standard of care; and
(b) reimburse a network provider that provides the telemedicine services described in Subsection (2)(a) at a negotiated commercially reasonable rate.
(3)
(a) Notwithstanding Section 31A-45-303, a health benefit plan providing coverage under Subsection (2)(a) may not impose originating site restrictions, geographic restrictions, or distance-based restrictions.
(b) A network provider that provides the telemedicine services described in Subsection (2)(a) may utilize any synchronous audiovisual technology for the telemedicine services that is compliant with the federal Health Insurance Portability and Accountability Act of 1996.

Amended by Chapter 328, 2023 General Session

***Superseded 1/1/2027***
**31A-22-650 Health care preauthorization requirements.**
(1) As used in this section:
(a) "Adverse preauthorization determination" means a determination by an insurer that health care does not meet the preauthorization requirement for the health care.
(b) "Authorization" means a determination by an insurer that for health care with a preauthorization requirement:
(i) the proposed drug, device, or covered service meets all requirements, restrictions, limitations, and clinical criteria for authorization that the insurer establishes;
(ii) the drug, device, or covered service is covered by the enrollee's insurance policy; and
(iii) the insurer will provide coverage for the drug, device, or covered service subject to the provisions of the insurance policy, including any cost sharing responsibilities of the enrollee.
(c) "Device" means a prescription device as defined in Section 58-17b-102.
(d) "Drug" means the same as that term is defined in Section 58-17b-102.

(e) "Insurer" means the same as that term is defined in Section 31A-22-634.

(f) "Preauthorization requirement" means a requirement by an insurer that an enrollee obtain authorization for a drug, device, or service covered by the insurance policy, before receiving the drug, device, or service.

(2)

(a) An insurer may not modify an existing requirement for authorization unless, at least 30 days before the day on which the modification takes effect, the insurer:

(i) posts a notice of the modification on the website described in Subsection 31A-22-613.5(6)(a); and

(ii) if requested by a network provider or the network provider's representative, provides to the network provider by mail or email a written notice of modification to a particular requirement for authorization described in the request from the network provider.

(b) Subsection (2)(a) does not apply if:

(i) complying with Subsection (2)(a) would create a danger to the enrollee's health or safety; or

(ii) the modification is for a newly covered drug or device.

(c) An insurer may not revoke an authorization for a drug, device, or covered service if:

(i) the network provider submits a request for authorization for the drug, device, or covered service to the insurer;

(ii) the insurer grants the authorization requested under Subsection (2)(c)(i);

(iii) the network provider renders the drug, device, or covered service to the enrollee in accordance with the authorization and any terms and conditions of the network provider's contract with the insurer;

(iv) on the day on which the network provider renders the drug, device, or covered service to the enrollee:

(A) the enrollee is eligible for coverage under the enrollee's insurance policy; and

(B) the enrollee's condition or circumstances related to the enrollee's care have not changed;

(v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection (2)(c)(i); and

(vi) the authorization was not based on fraudulent or materially incorrect information from the network provider.

(3)

(a) An insurer that receives a request for authorization shall treat the request as a pre-service claim as that term is defined in 29 C.F.R. Sec. 2560.503-1 and process the request in accordance with:

(i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an individual or group health insurance policy;

(ii) Subsection 31A-4-116(2); and

(iii) Section 31A-22-629.

(b) If a network provider submits a claim to an insurer that includes an unintentional error that results in a denial of the claim, the insurer shall permit the network provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time.

(c) Except as provided in Subsection (3)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.

(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:
(i) a physician and surgeon; or
(ii) a pharmacist.
(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:
(i) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or
(ii) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination.
(f) An insurer shall specify how long an authorization is valid.
(4)
(a) An insurer that removes a drug from the insurer's formulary shall:
(i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and
(ii) have a process to review and make a decision regarding an exemption requested under Subsection (4)(a)(i).
(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.
(5)
(a) Each April 1, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.
(b) Before April 1, 2026, and each April 1 thereafter, an insurer shall report to the department the following for the previous calendar year:
(i) a list of services that have preauthorization requirements;
(ii) for pre-service preauthorization requests that were not urgent, the percentage of individual service requests that:
(A) were approved;
(B) were denied;
(C) were approved after appeal;
(D) the time frame for review was extended, and the request was approved;
(E) were denied due to incomplete information from the health care provider; and
(F) were received through fax, phone, and electronic portal; and
(iii) for urgent pre-service preauthorization requests, the percentage of individual service requests that:
(A) were approved;
(B) were denied;
(C) were denied due to incomplete information from the health care provider; and
(D) were received through fax, phone, and electronic portal.

(c) Data provided to the department under Subsections (5)(b)(ii) and (iii) shall be aggregated for all services.
(d) Subsection (5)(b) does not require an insurer to report information regarding prescription drugs.
(e) The department shall compile the information described in Subsection (5)(b) and publish the information on the department's website.
(6) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.
(7) For each adverse preauthorization determination an insurer makes, the insurer shall provide to the enrollee and the enrollee's health care provider:
(a) a detailed and specific explanation that explains why the insurer made the determination; and
(b) a notice explaining the enrollee may appeal the determination and the process for appealing the determination, including how to begin an expedited appeal process as described in Section 31A-22-629.
(8) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules to implement Subsection (5)(b).

Amended by Chapter 45, 2026 General Session

***Effective 1/1/2027***

**31A-22-650 Health care preauthorization requirements -- Notice -- Reporting -- Retroactive denial prohibited.**

(1) As used in this section:
(a) "Adverse preauthorization determination" means a determination by an insurer that health care does not meet the preauthorization requirement for the health care.
(b)
(i) "Artificial intelligence" means the same as that term is defined in Section 53-25-901.
(ii) "Artificial intelligence" includes generative artificial intelligence.
(c) "Authorization" means a determination by an insurer that for health care with a preauthorization requirement:
(i) the proposed drug, device, or covered service meets all requirements, restrictions, limitations, and clinical criteria for authorization that the insurer establishes;
(ii) the drug, device, or covered service is covered by the enrollee's insurance policy; and
(iii) the insurer will provide coverage for the drug, device, or covered service subject to the provisions of the insurance policy, including any cost sharing responsibilities of the enrollee.
(d) "Authorization validity period" means how long an authorization is valid as specified by the insurer under Subsection 31A-22-650(7).
(e) "Chronic or long-term care condition" means a condition that lasts at least three months and:
(i) requires ongoing medical attention; or
(ii) limits the activities of daily life.
(f) "Decision" means an authorization or an adverse preauthorization determination.
(g) "Device" means a prescription device as defined in Section 58-17b-102.
(h) "Drug" means the same as that term is defined in Section 58-17b-102.
(i) "Duration of authorized covered service" means the duration of a covered service that an insurer authorizes.
(j) "Generative artificial intelligence" means the same as that term is defined in Section 53-25-901.
(k) "Health benefit plan" means the same as that term is defined in Section 31A-1-301.

(l) "Insurer" means the same as that term is defined in Section 31A-22-634.
(m) "Preauthorization requirement" means a requirement by an insurer that an enrollee obtain authorization for a drug, device, or service covered by the insurance policy, before receiving the drug, device, or service.
(n) "Urgent care services" means health care services with respect to which the application of the time periods for making a non-expedited authorization, which in the opinion of a physician with knowledge of the enrollee's medical condition, and as supported by documentation:
(i) could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or
(ii) could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request for authorization.
(2) In addition to the requirements described in Section 31A-22-613.5, an insurer shall post on the insurer's website in a conspicuous location accessible by the general public:
(a) all preauthorization requirements in detail and in easily understandable language;
(b) statistics of the insurer's authorizations and adverse preauthorization determinations, including categories for:
(i) the number of authorizations and adverse preauthorization determinations;
(ii) the number of decisions appealed;
(iii) the outcomes of appeals; and
(iv) the average time between an appeal submission and the response to the appeal;
(c) adverse preauthorization determinations that are the result of a provider's failure to submit a request for authorization or a request for authorization's failure to meet the insurer's preauthorization requirements; and
(d) a notice that the insurer uses artificial intelligence in the insurer's processes for reviewing an authorization request, if applicable.
(3) An insurer shall disclose to the department, to each health care provider in the insurer's network, and to each enrollee if the insurer uses artificial intelligence in the insurer's processes for reviewing an authorization request.
(4)
(a) An insurer may not modify an existing requirement for authorization unless, at least 30 days before the day on which the modification takes effect, the insurer:
(i) posts a notice of the modification on the website described in Subsection 31A-22-613.5(6)(a);
(ii) if requested by a network provider or the network provider's representative, provides to the network provider by mail or email a written notice of modification to a particular requirement for authorization described in the request from the network provider; and
(iii) updates on the insurer's website the information required under Subsection (2)(a) to reflect the modification.
(b) Subsection (4)(a) does not apply if:
(i) complying with Subsection (4)(a) would create a danger to the enrollee's health or safety; or
(ii) the modification is for a newly covered drug or device.
(c) An insurer may not revoke an authorization for a drug, device, or covered service if:
(i) the network provider submits a request for authorization for the drug, device, or covered service to the insurer;
(ii) the insurer grants the authorization requested under Subsection (4)(c)(i);
(iii) the network provider renders the drug, device, or covered service to the enrollee in accordance with the authorization and any terms and conditions of the network provider's contract with the insurer;

(iv) on the day on which the network provider renders the drug, device, or covered service to the enrollee:
(A) the enrollee is eligible for coverage under the enrollee's insurance policy; and
(B) the enrollee's condition or circumstances related to the enrollee's care have not changed;
(v) the network provider submits an accurate claim that matches the information in the request for authorization under Subsection (4)(c)(i); and
(vi) the authorization was not based on fraudulent or materially incorrect information from the network provider.

(5)
(a) Except as provided in Subsections (5)(b) and (c), an insurer that receives a request for authorization shall make and notify the network provider of a decision no later than seven calendar days after the day on which the insurer receives all necessary information required to make the decision.
(b) If an insurer that receives a request for authorization for urgent care services and receives all information required to make a decision, the insurer shall make and notify the network provider of a decision no later than 72 hours after the insurer receives all necessary information required to make the decision.
(c) If an insurer receives a request for authorization for urgent care services and does not receive all necessary information for the insurer to make a decision, the insurer shall:
(i) notify the network provider as soon as reasonably possible, but no later than one business day after the day on which the insurer receives the claim, what additional information is required to make a decision;
(ii) allow a network provider a reasonable amount of time, but not less than two business days, to provide the additional information described in Subsection (5)(c)(i); and
(iii) notify the network provider of the decision no later than two business days after the day on which the insurer receives the additional information described in Subsection (5)(c)(ii).

(6)
(a) An insurer that receives a request for authorization shall treat the request as a pre-service claim as that term is defined in 29 C.F.R. Sec. 2560.503-1 and process the request in accordance with:
(i) 29 C.F.R. Sec. 2560.503-1, regardless of whether the coverage is offered through an individual or group health insurance policy;
(ii) Subsection 31A-4-116(2); and
(iii) Section 31A-22-629.
(b) If a network provider submits a claim to an insurer that includes an unintentional error that results in a denial of the claim, the insurer shall permit the network provider with an opportunity to resubmit the claim with corrected information within a reasonable amount of time.
(c) Except as provided in Subsection (6)(d), the appeal of an adverse preauthorization determination regarding clinical or medical necessity as requested by a physician may only be reviewed by a physician who is currently licensed as a physician and surgeon in a state, district, or territory of the United States.
(d) The appeal of an adverse determination requested by a physician regarding clinical or medical necessity of a drug, may only be reviewed by an individual who is currently licensed in a state, district, or territory of the United States as:
(i) a physician and surgeon; or
(ii) a pharmacist.

(e) An insurer shall ensure that an adverse preauthorization determination regarding clinical or medical necessity is made by an individual who:

(i)

(A) has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested; or

(B) consults with a specialist who has knowledge of the medical condition or disease of the enrollee for whom the authorization is requested regarding the request before making the determination;

(ii) except as provided in Subsection (6)(e)(i)(B), exercises independent medical judgment; and

(iii) does not rely solely on recommendations from any other source.

(7)

(a) An insurer shall specify how long an authorization is valid and the duration of authorized covered service.

(b) Except as provided in Subsections (7)(c), (d), and (e), for a drug, device, or covered service to treat a chronic or long-term care condition, an authorization validity period may not be less than 12 months.

(c) An authorization validity period for a drug to treat a chronic or long-term care condition may be for a period shorter than 12 months if the authorization is for an experimental drug.

(d) An insurer may modify the authorization validity period for a drug to treat a chronic or long-term care condition if:

(i) the originally authorized drug is not effective in treating the chronic or long-term care condition;

(ii) a more effective drug is available to treat the chronic or long-term care condition;

(iii) a less costly and equally effective drug is available to treat the chronic or long-term care condition; or

(iv) the originally authorized drug ceases to be covered by the enrollee's health benefit plan.

(e) An authorization validity period for an outpatient covered service may not be less than six months.

(8)

(a) An insurer that removes a drug from the insurer's formulary shall:

(i) permit an enrollee, an enrollee's designee, or an enrollee's network provider to request an exemption from the change to the formulary for the purpose of providing the patient with continuity of care; and

(ii) have a process to review and make a determination regarding an exemption requested under Subsection (8)(a)(i).

(b) If an insurer makes a change to the formulary for a drug in the middle of a plan year, the insurer may not implement the changes for an enrollee that is on an active course of treatment for the drug unless the insurer provides the enrollee with notice at least 30 days before the day on which the change is implemented.

(9)

(a) Each April 1, an insurer with a preauthorization requirement shall report to the department, for the previous calendar year, the percentage of authorizations, not including a claim involving urgent care as defined in 29 C.F.R. Sec. 2560.503-1, for which the insurer notified a provider regarding an authorization or adverse preauthorization determination more than one week after the day on which the insurer received the request for authorization.

(b) Before April 1, 2026, and each April 1 thereafter, an insurer shall report to the department the following for the previous calendar year:

(i) a list of services that have preauthorization requirements;

(ii) for pre-service preauthorization requests that were not urgent, the number and percentage of individual service requests that:
(A) were approved;
(B) were denied;
(C) were approved after appeal;
(D) the time frame for review was extended, and the request was approved;
(E) were denied due to incomplete information from the health care provider; and
(F) were received through fax, phone, and electronic portal;
(iii) for urgent pre-service preauthorization requests, the number and percentage of individual service requests that:
(A) were approved;
(B) were denied;
(C) were denied due to incomplete information from the health care provider; and
(D) were received through fax, phone, and electronic portal;
(iv) the average and median time between when the insurer received a request for authorization and a decision; and
(v) the average and median time to process an appeal that a health care provider submitted for an adverse preauthorization determination.
(c) Data provided to the department under Subsections (9)(b)(ii) through (v) shall be aggregated for all services.
(d) The department shall compile the information described in Subsection (9)(b) and publish the information on the department's website.
(10) An insurer may not have a preauthorization requirement for emergency health care as described in Section 31A-22-627.
(11) An insurer shall pay a contracted health care provider under the terms of the plan for a service that was authorized unless:
(a) the health care provider:
(i) was no longer contracted with the enrollee's health benefit plan on the date the service was provided;
(ii) failed to meet the insurer's timely filing requirements; or
(iii) bills a code or service that was not included in the request for authorization and would have resulted in an adverse preauthorization determination if it had been included in the request;
(b) the service was no longer a covered benefit on the day the service was provided;
(c) the insurer does not have liability for a claim; or
(d) the enrollee was no longer eligible for health care coverage on the day the service was provided.
(12) For each adverse preauthorization determination an insurer makes, the insurer shall provide to the enrollee and the enrollee's health care provider:
(a) a detailed and specific explanation that explains why the insurer made the determination;
(b) a notice that includes the following information for each health care billing code included in the requested authorization on the first page of the notice:
(i) the health care billing codes that were approved; and
(ii) the health care billing codes that were denied; and
(c) a notice explaining the enrollee may appeal the determination and the process for appealing the determination, including how to begin an expedited appeal process as described in Section 31A-22-629.
(13) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may make rules to implement Subsection (9)(b).

Amended by Chapter 240, 2026 General Session

**31A-22-651 Insurance coverage for assisted outpatient treatment.**

(1) As used in this section, "assisted outpatient treatment" means the same as that term is defined in Section 26B-5-301.

(2) A health insurance provider may not deny an insured the benefits of the insured's policy solely because the health care that the insured receives is provided under a court order for assisted outpatient treatment, as provided in Section 26B-5-351.

Amended by Chapter 328, 2023 General Session

**31A-22-652 Coverage for mental health services in schools.**

(1) As used in this section, "local education agency" means:
  (a) a school district;
  (b) a charter school; or
  (c) the Utah Schools for the Deaf and the Blind.

(2) A health benefit plan that is entered into or renewed on or after January 1, 2020, may not deny a claim for a covered mental health service solely because the mental health service is provided:
  (a) at a local education agency building or facility; or
  (b) by an employee or contractor of a local education agency.

(3) Nothing in this section:
  (a) prohibits a health benefit plan from denying a claim:
    (i) by an individual that is not a licensed health care provider;
    (ii) by a health care provider practicing outside the health care provider's scope of practice;
    (iii) that is submitted by a person that is not a network provider;
    (iv) for a mental health service that is not medically necessary as determined by the health benefit plan; or
    (v) that does not otherwise comply with the health benefit plan's policies; or
  (b) requires a health benefit plan to pay a claim for a service that is:
    (i) provided under an individualized education program as defined in Section 53E-4-301; or
    (ii) administrative in nature to the local education agency.

Enacted by Chapter 172, 2019 General Session

**31A-22-654 Study of coverage for in vitro fertilization and genetic testing -- Reporting -- Coverage requirements.**

(1) As used in this section:
  (a) "Qualified condition" means the same as that term is defined in Section 49-20-420.
  (b) "Qualified insurer" means an insurer that provides a health benefit plan as defined in Section 31A-1-301 to more than 25,000 enrollees in the state as of December 31 of the preceding reporting year.
  (c) "Qualified enrollee" means an enrollee of a qualified insurer who:
    (i) has been diagnosed by a physician as having a genetic trait associated with a qualified condition; and
    (ii) intends to get pregnant with a partner who is diagnosed by a physician as having a genetic trait associated with the same qualified condition as the enrollee.

(2)
(a) A qualified insurer shall submit the information described in this Subsection (2) to the department for a plan year beginning:
(i) on or after January 1, 2022, but before December 31, 2022; and
(ii) on or after January 1, 2025, but before December 31, 2025.
(b) A qualified insurer shall study whether providing the coverage for the services described in Subsections (3)(a) and (b) for qualified enrollees will result in cost savings for the qualified insurer.
(c)
(i) If a qualified insurer determines that providing the coverage described in Subsection (3) for qualified enrollees will result in cost savings for the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b), and:
(A) describe how the qualified insurer intends to provide the coverage described in Subsection (3); or
(B) submit an explanation of why the insurer will not provide the coverage described in Subsection (3).
(ii) If a qualified insurer determines that providing the coverage described in Subsection (3) will not result in cost savings to the qualified insurer, the qualified insurer shall submit a summary of the results of the study described in Subsection (2)(b).
(d) A qualified insurer shall provide the information required under this Subsection (2) to the department no later than:
(i) January 1, 2022, for a plan year beginning on or after January 1, 2022, but before December 31, 2022; and
(ii) January 1, 2025, for a plan year beginning on or after January 1, 2025, but before December 31, 2025.
(3) A qualified insurer shall consider coverage for:
(a) in vitro fertilization services for a qualified enrollee; and
(b) genetic testing of a qualified enrollee who received in vitro fertilization services under Subsection (3)(a).
(4) The department shall report the information received under Subsection (2) to the Health and Human Services Interim Committee on or before:
(a) for information submitted under Subsection (2)(a)(i), November 1, 2022; and
(b) for information submitted under Subsection (2)(a)(ii), November 1, 2025.

Amended by Chapter 252, 2021 General Session

**31A-22-655 Living organ donor coverage.**
(1) For the purposes of this section, "living organ donor" means an individual who has donated all or part of an organ and is not deceased.
(2) An insurer may not:
(a) deny eligibility for coverage or limit coverage of a individual under an accident and health insurance policy or contract solely due to the status of the individual as a living organ donor;
(b) preclude an individual from donating all or part of an organ as a condition of receiving or continuing to receive coverage under an accident and health insurance policy or contract; or
(c) discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of an accident and health insurance policy or contract for an individual based upon the status of the individual as a living organ donor without any additional actuarial risk.

(3) The commissioner shall make educational materials available to insurers and the public on the access of living organ donors to insurance.
(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

Enacted by Chapter 128, 2020 General Session

**31A-22-656 Coverage of epinephrine auto-injector.**

A health benefit plan entered into or renewed on or after July 1, 2021, that provides coverage of an epinephrine auto-injector is not required to reimburse a participant, as that term is defined in Section 49-20-421, for an epinephrine auto-injector the participant obtains through the discount program described in Section 49-20-421.

Enacted by Chapter 255, 2021 General Session

**31A-22-657 Application of health insurance mandates.**

(1) As used in this section:
(a) "Cost-sharing mandate" means a statutory requirement limiting a cost-sharing requirement.
(b) "Cost-sharing requirement" means a copayment, coinsurance, or deductible required by or on behalf of an enrollee in order to receive a benefit under a qualified high-deductible health plan.
(c) "Health savings account" means the same as that term is defined in 26 U.S.C. Sec. 223(d)(1).
(d) "Qualified high-deductible health plan" means a high-deductible health plan as defined in 26 U.S.C. Sec. 223(c)(2)(A) that is used in conjunction with a health savings account.
(2)
(a) Except as provided in Subsection (2)(b), if under federal law, a cost-sharing mandate would result in an enrollee becoming ineligible for a health savings account, the cost-sharing mandate applies only to the enrollee's qualified high-deductible health plan after the enrollee satisfies the enrollee's health plan deductible.
(b) Subsection (2)(a) does not apply to an item or service that is preventive care under 26 U.S.C. Sec. 223(c)(2)(C).

Amended by Chapter 139, 2023 General Session

**31A-22-658 Health care provider behavioral health treatment -- Single case agreement.**

(1) As used in this section:
(a) "Mental health condition" means the same as that term is defined in Section 31A-22-649.5.
(b) "Mental health provider" means:
(i) a mental health therapist, as defined in Section 58-60-102; or
(ii) an individual practicing within the scope of practice described in Title 58, Chapter 60, Part 5, Substance Use Disorder Counselor Act.
(c) "Mental health treatment" means treatment for a mental health condition.
(2)
(a) Except as provided in Subsection (3), and subject to Subsections (4) and (5), beginning January 1, 2024, a health benefit plan that offers coverage for mental health treatment shall, upon request of a health benefit plan enrollee who is employed as a health care provider, offer a single case agreement that allows the enrollee to receive covered mental health treatment from an out-of-network mental health provider selected by the enrollee.

(b) A single case agreement described in Subsection (2)(a) shall:
(i) reimburse the out-of-network mental health provider for the covered mental health treatment at the equivalent out-of-network rate set by the health benefit plan, subject to the member cost-sharing requirements imposed by the health benefit plan;
(ii) include the same coinsurance, copayments, and deductibles that would be applied for the mental health treatment if the mental health treatment was provided by a mental health provider who is a network provider;
(iii) include the terms that a network provider is subject to under the health benefit plan; and
(iv) define the length and scope of the single case agreement.
(3)
(a) Subsection (2) does not apply if:
(i)
(A) the health benefit plan has network providers for the covered mental health treatment; and
(B) the network providers described in Subsection (3)(a)(i) do not provide the covered mental health treatment in the location where the enrollee works as a health care provider; or
(ii) the enrollee selects a mental health provider for the covered mental health treatment who the health benefit plan knows or reasonably suspects has committed a fraudulent insurance act as described in Section 31A-31-103.
(b) For purposes of this Subsection (3), the location where an enrollee works as a health care provider includes all locations or facilities of the enrollee's employer.
(4) Mental health treatment provided pursuant to a single case agreement under this section:
(a) shall be:
(i) within the out-of-network mental health provider's scope of practice; and
(ii) a service that is otherwise covered under the enrollee's health benefit plan; and
(b) may not be experimental.
(5)
(a) An enrollee shall request a single case agreement under Subsection (2) prior to receiving mental health treatment from an out-of-network mental health provider.
(b) With a request for a single case agreement under Subsection (2), an enrollee shall provide information about where the enrollee works as a health care provider sufficient for the health benefit plan to determine whether the circumstances described in Subsection (3)(a)(i) exist.

Enacted by Chapter 449, 2023 General Session

**31A-22-659 Provider administered drugs.**
(1) As used in this section:
(a) "Clinician-administered drug" means an outpatient prescription drug as defined in Section 58-17b-102 that:
(i) cannot reasonably be self-administered by the patient to whom the drug is prescribed or by an individual assisting the patient with self-administration;
(ii) is typically administered:
(A) by a health care provider; and
(B) in a physician's office or a health care facility as defined in Section 26B-2-201; and
(iii) is not a vaccine.
(b) "Health insurer" means a person who offers health care insurance, including a health maintenance organization as defined in Section 31A-8-101.

(2) A health insurer may not require a pharmacy to dispense a clinician-administered drug directly to an enrollee with the intention that the enrollee will transport the drug to a health care provider for administering.

Enacted by Chapter 323, 2023 General Session

**31A-22-660 Definitions -- Prohibitions concerning organ harvesting -- Severability.**

(1) As used in this section, "forced organ harvesting" means the removal of one or more organs from a living individual, or from an individual killed for the purpose of removal of one or more of the individual's organs, by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

(2) An issuer of accident and health insurance may not cover a human organ transplant or post-transplant care if:

(a) the human organ transplant operation is performed in the People's Republic of China or any other country known to have participated in forced organ harvesting, as designated pursuant to Subsection (3); or

(b) the human organ to be transplanted was procured by sale or donation originating in the People's Republic of China or any other country known to have participated in forced organ harvesting, as designated pursuant to Subsection (3).

(3)

(a) The deputy director of the Department of Health and Human Services described in Subsection 26B-1-203(4) may designate additional countries with governments that fund, sponsor, or otherwise facilitate forced organ harvesting.

(b) If the deputy director designates an additional country under Subsection (3)(a), the deputy director shall provide written notice to the executive director of the Department of Health and Human Services and the insurance commissioner.

(4) If any provision of this section or the application of any provision of this section to any person or circumstance is held to be invalid, the remainder of this section shall be given effect without the invalid provision or application. The provisions of Section 31A-22-661 are severable.

Enacted by Chapter 273, 2024 General Session

**31A-22-661 Health benefit plan procedures related to prescription drugs.**

(1) As used in this section, "long-term drug" means an enrollee's prescription drug where the prescription has been active for at least 180 days with the health benefit plan.

(2)

(a) Except as provided in Subsection (2)(b), before a health benefit plan requires an enrollee to change from a prescribed long-term drug to another drug, the health benefit plan shall:

(i) at least 30 days before the day on which the health benefit plan will require the enrollee to change from the long-term drug to another drug, provide notice that the health benefit plan will require the individual to change to another drug; and

(ii) provide a justification for the change upon request.

(b) Subsection (2)(a) does not apply if:

(i) the change requires the individual to try a generic or a biosimilar of the long-term drug; or

(ii) the long-term drug is not on the health benefit plan's formulary.

(3) A health benefit plan shall provide an enrollee a justification as to why an enrollee must try a certain drug before a health benefit plan will cover a different prescribed drug.

(4) This section does not apply to a drug that is provided under the health benefit plan's medical benefit.

Enacted by Chapter 262, 2024 General Session

**31A-22-662 Pharmacist as a health care provider.**

(1) As used in this section, "pharmacist" means the same as that term is defined in Section 58-17b-102.

(2) An insurer that provides a health benefit plan shall consider a pharmacist as a health care provider for a consultation that is provided to an enrollee regarding the pharmacist:

(a) prescribing a nebulizer, a spacer for use with a nebulizer or inhaler, or a diabetic supply as described in Subsection 58-17b-610.8(3); or

(b) prescribing a prescription drug or device as described in Section 58-17b-627.

(3) Subsection (2) only applies if the health benefit plan covers the prescription drug or device.

(4) This section applies to a health benefit plan renewed or entered into on or after January 1, 2026.

Enacted by Chapter 486, 2025 General Session

**31A-22-663 Timely access to behavioral health services -- Single case agreement.**

(1) As used in this section:

(a) "Covered insurer" means an insurer that offers health insurance that includes coverage for behavioral health services.

(b)

(i) "Behavioral health services" means:

(A) mental health treatment or services; or

(B) substance use treatment or services.

(ii) "Behavioral health services" includes telehealth services and telemedicine services.

(c) "Insurer" means the same as that term is defined in Section 31A-22-634.

(d) "Mental health provider" means the same as that term is defined in Section 31A-22-658.

(e) "Telehealth services" means the same as that term is defined in Section 26B-4-704.

(f) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.

(g) "Timely manner" means:

(i) no more than 15 days after the day on which an insured first attempts to access behavioral health services; and

(ii) no more than 24 hours after the date and time that an insured first seeks to access urgent, emergency, or crisis behavioral health services.

(2) Beginning January 1, 2027, a covered insurer shall:

(a) establish a procedure to assist an enrollee to access behavioral health services from an out-of-network mental health provider when no in-network mental health provider is available in a timely manner; and

(b) if an enrollee in a covered insurer's health benefit plan is unable to obtain covered behavioral health services from an in-network mental health provider in a timely manner, enter into a single case agreement that allows the enrollee to receive covered behavioral health services from an out-of-network mental health provider.

(3)

(a) A covered insurer shall include in a negotiated single case agreement described in Subsection (2)(b):

(i) a requirement that the covered insurer reimburse the out-of-network mental health provider for the covered behavioral health services at a rate negotiated by the provider and insurer, subject to the member cost-sharing requirements imposed by the health benefit plan;
(ii) a requirement that the covered insurer apply the same coinsurance, copayments, and deductibles that would apply for the behavioral health services if the behavioral health services were provided by a mental health provider that is an in-network mental health provider;
(iii) any terms that a network provider is subject to under the health benefit plan; and
(iv) the length and scope of the single case agreement.
(b) Notwithstanding Subsection (3)(a)(ii):
(i) a covered insurer's payment under a single case agreement described in Subsection (2)(b) constitutes payment in full to the provider for the behavioral health services the enrollee receives; and
(ii) the provider may not seek additional payment from the enrollee except for applicable cost sharing.
(4) A covered insurer shall ensure that a single case agreement described in Subsection (2)(b) only permits an insured to receive behavioral health services:
(a) that are:
(i) within the out-of-network mental health provider's scope of practice; and
(ii) behavioral health services that are otherwise covered under the enrollee's health benefit plan; and
(b) that are not experimental, unless the insurer covers experimental treatments for physical health conditions in compliance with the Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343.
(5) A covered insurer shall:
(a) document all payments the covered insurer makes under a health benefit plan to a mental health provider under this section; and
(b) provide the documentation described in Subsection (5)(a) to the department upon request.
(6) Subsections (2)(b), (3), and (4) do not apply if behavioral health services are available in a timely manner.
(7) The commissioner may:
(a) make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section; and
(b) bring an action in accordance with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act, for a violation of this section.

Enacted by Chapter 50, 2026 General Session

**31A-22-664 Health care provider directories.**
(1) As used in this section:
(a) "Division" means the Division of Professional Licensing created in Section 58-1-103.
(b) "Exempt health care professional" means a person exempt from licensure under a title listed in Subsection 58-13-3(2)(c).
(c) "Exempt mental health provider" means an individual exempt from licensure under Section 58-60-107.
(d) "Health care facility" means the same as that term is defined in Section 26B-2-201.
(e) "Health care professional" means the same as that term is defined in Section 58-13-3.

(f) "Hospital" means a facility licensed under Title 26B, Chapter 2, Part 2, Health Care Facility Licensing and Inspection, as a general acute hospital or specialty hospital.
(g) "Insurer" means the same as that term is defined in Section 31A-22-634.
(h) "Mental health provider" means the same as that term is defined in Section 31A-22-658.
(i) "Pharmacy" means the same as that term is defined in Section 58-17b-102.
(j) "Provider" means:
(i) a health care professional;
(ii) an exempt health care professional;
(iii) a mental health provider;
(iv) an exempt mental health provider; or
(v) a pharmacy.
(k) "Provider directory" means a list of in-network providers for each of an insurer's health benefit plans.
(l) "Telehealth services" means the same as that term is defined in Section 26B-4-704.
(m) "Telemedicine services" means the same as that term is defined in Section 26B-4-704.
(2) Beginning January 1, 2027, an insurer shall:
(a) publish a provider directory for each of the insurer's health benefit plans; and
(b) update the provider directory no less frequently than every 60 days.
(3) An insurer shall ensure that, except as provided in Subsection (7):
(a) a provider directory:
(i) is easily and publicly accessible:
(A) through a conspicuous link on the home page of the insurer's website; and
(B) without requiring an individual to create an account or submit a policy or contract number; and
(ii) is in a format that is searchable and downloadable; and
(b) a provider may update the provider's information, including contact information and whether the provider is accepting new patients, in the provider directory:
(i) electronically;
(ii) on the insurer's website; and
(iii) through a conspicuous link on the home page of the insurer's website.
(4) A provider directory shall include:
(a) in plain language:
(i) a description of the criteria the insurer used to build the health benefit plan's provider network; and
(ii) if applicable:
(A) a description of the criteria the insurer used to tier health care providers;
(B) how the health benefit plan designates health care provider tiers or levels; and
(C) a notice that authorization or referral may be required to access some health care providers; and
(b) contact information an insured or member of the public may use to report to the health benefit plan inaccurate information in a provider directory, which may include:
(i) a phone number;
(ii) an email address; or
(iii) a link to a website or online reporting form.
(5) In addition to the information required under Subsection (4):
(a) a provider directory of health care professionals and exempt health care professionals shall include:
(i) each health care professional's and exempt health care professional's:

(A) name;
(B) contact information, including:
(I) internet address, if applicable;
(II) physical address; and
(III) phone number; and
(C) specialty, if applicable;
(ii) whether the health care professional or exempt health care professional is accepting new patients; and
(iii) whether the health care professional or exempt health care professional offers telehealth services or telemedicine services;
(b) a provider directory of health care facilities that are hospitals shall include each hospital's:
(i) name;
(ii) if the hospital is a specialty hospital, specialty type;
(iii) location or locations;
(iv) accreditation status;
(v) phone number; and
(vi) internet address, if applicable;
(c) a provider directory of health care facilities other than hospitals shall include each health care facility's:
(i) name;
(ii) type;
(iii) services provided;
(iv) location or locations;
(v) phone number; and
(vi) internet address, if applicable;
(d) a provider directory of pharmacies shall include each pharmacy's:
(i) name;
(ii) type;
(iii) services provided, including whether the pharmacy offers mail-order or specialty pharmacy services;
(iv) location or locations;
(v) phone number; and
(vi) internet address, if applicable; and
(e) a provider directory of mental health providers and exempt mental health providers shall include:
(i) each mental health provider's:
(A) name;
(B) contact information, including:
(I) internet address, if applicable;
(II) physical address; and
(III) phone number; and
(C) specialty, if applicable;
(ii) whether the mental health provider or exempt mental health provider is accepting new patients; and
(iii) whether the mental health provider or exempt mental health provider offers telehealth services or telemedicine services.
(6)

(a) For purposes of Subsection (5)(a)(ii), a health care professional is accepting new patients if an exempt health care professional who treats patients under the supervision of the health care professional is available to see new patients.
(b) For purposes of Subsection (5)(e)(ii), a mental health provider is accepting new patients if an exempt mental health provider who treats patients under the supervision of a mental health provider is available to see new patients.
(7)
(a) An insurer may provide, in addition to an electronic provider directory, a provider directory in print format.
(b) An insurer shall provide a provider directory in print format to an insured upon request of the insured.
(c) In addition to the requirements described in Subsections (4) and (5), a provider directory in print format shall include:
(i) the internet address of the insurer's website where the insurer's electronic provider directory is published;
(ii) the health benefit plan's customer service phone number;
(iii) a disclosure that the information in the provider directory is accurate, to the best of the insurer's knowledge, based on the information the provider provided, as of the date of printing; and
(iv) a notice that an insured or prospective insured should consult the health benefit plan's electronic provider directory or call the health benefit plan's customer service phone number to obtain current provider directory information.
(8) When an insurer receives a report of inaccurate information in a provider directory, the insurer shall:
(a) promptly investigate the report; and
(b) no later than the end of the 20th business day after the day on which the insurer receives the report:
(i) verify the accuracy of the information in the provider directory; or
(ii) for an electronic provider directory, update the inaccurate information with accurate information.
(9)
(a) An insurer shall take steps to ensure the accuracy of the information in a provider directory, including contacting providers to verify that provider information is up to date.
(b) When an insurer contacts a provider to verify the accuracy of a provider's information in a provider directory, the provider shall respond to the insurer's request for verification no later than 15 business days after the day on which the insurer contacts the provider.
(10)
(a) An insurer shall, at least annually, audit each provider directory for accuracy.
(b)
(i)
(A) include the two mental health specialties and four physical health specialties most utilized by insureds; and
(B) include at least one specialty related to mental health; or
(ii) audit a reasonable sample size of providers, if the sample size includes mental health providers.
(c) An insurer shall:
(i) retain documentation of each audit performed under this Subsection (10);
(ii) submit the audit to the commissioner upon the commissioner's request; and

(iii) based on the results of the audit:
(A) verify and attest to the accuracy of the information in a provider directory; and
(B) update inaccurate information in a provider directory with accurate information.

(11)
(a) An insurer shall report to the commissioner upon request on:
(i) the number of reports of inaccuracies in provider directories the insurer received;
(ii) the timeliness of the insurer's response to a report of inaccuracies in a provider directory;
(iii) any corrective action the insurer took in response to a report of inaccuracies in a provider directory;
(iv) the identity of providers that failed to timely respond to the insurer's request for verification as required under Subsection (9);
(v) all audits the insurer conducted in accordance with this section; and
(vi) any other information related to provider directory accuracy the commissioner considers relevant.
(b) The commissioner may request the information described in Subsection (11)(a) no more frequently than annually.
(c)
(i) If an insurer finds that a provider demonstrates a repeated pattern of violations of Subsection (9), the insurer shall:
(A) issue an educational letter to the provider; and
(B) send a copy of the educational letter to the commissioner and the division.
(ii) If an insurer notifies the commissioner that a provider demonstrates a repeated pattern of violations of Subsection (9), the commissioner shall send an educational letter to the provider.

(12) An insurer, a health care facility, a hospital, or a provider that is subject to this section shall comply with all applicable requirements of the No Surprises Act, 42 U.S.C. Secs. 300gg-111 through 300gg-139, and federal regulations adopted in accordance with that act.

(13) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

(14) In addition to the penalties authorized under Section 31A-2-308, if the commissioner determines that, when an insured received services under the insured's health benefit plan, the insured reasonably relied on inaccurate information in a provider directory, the commissioner may:
(a) if the commissioner determines that the insurer knew or reasonably should have known the information was inaccurate:
(i) require the insurer to provide coverage for all covered health care services the insured received; and
(ii) reimburse the insured for the amount the insured paid for the health care services that exceeds what the insured would have paid if the services were delivered by an in-network provider; and
(b) if the commissioner determines that the provider provided inaccurate information or failed to update the information, require the insurer to reimburse the provider at the in-network rate.

Enacted by Chapter 50, 2026 General Session

**31A-22-665 Continuity of mental health treatment and services for a child leaving foster care.**

(1) As used in this section:

(a)
(i) "Covered child" means an insured child who:
(A) while in the custody of the Division of Child and Family Services, was receiving mental health treatment or services from a covered mental health therapist; and
(B) is no longer in the custody of the Division of Child and Family Services.
(ii) "Covered child" includes a covered child's parent or guardian acting on behalf of the covered child.
(iii) "Covered child" does not include an insured child who, while in the custody of the Division of Child and Family Services, was receiving mental health treatment or services from:
(A) a residential treatment program, as that term is defined in Section 26B-2-101;
(B) a day treatment program or partial hospitalization program; or
(C) any other facility that provides a level of care higher than traditional outpatient services where mental health treatment or services are integrated into the facility's specialized program of care.
(b) "Covered insurer" means an insurer that offers a health benefit plan that includes coverage for mental health treatment or services.
(c) "Covered mental health therapist" means a mental health therapist who provides mental health treatment and services to a covered child while the covered child is in the custody of the Division of Child and Family Services.
(d) "Insurer" means the same as that term is defined in Section 31A-22-634.
(e) "Insured child" means a child who is an enrollee in a covered insurer's health benefit plan that offers health insurance that includes coverage for mental health treatment or services.
(f) "Mental health therapist" means a mental health therapist as that term is defined in Section 58-60-102.
(2) A covered insurer shall, upon request of a covered child, offer a single case agreement that allows a covered child to receive covered mental health treatment and services from an out-of-network covered mental health therapist, if:
(a) the covered child was in the custody of the Division of Child and Family Services no more than 90 days before the day on which the covered child requests the single case agreement; and
(b) the covered mental health therapist agrees to enter the single case agreement.
(3) A covered insurer shall include in a single case agreement described in Subsection (2):
(a) a requirement that the covered insurer reimburse the out-of-network provider for the covered mental health treatment and services at an in-network rate by the covered insurer, subject to the member cost-sharing requirements imposed by the health benefit plan;
(b) a requirement that the covered insurer apply the same coinsurance, copayments, and deductibles that would apply for the mental health treatment and services if the mental health treatment and services were provided by a mental health therapist that is a network provider;
(c) any terms that a network provider is subject to under the health benefit plan; and
(d) the length and scope of the single case agreement.
(4) Nothing in this section may be construed to require a covered insurer to pay an out-of-network covered mental health therapist for services that are not otherwise covered under the covered child's health benefit plan.
(5) A covered child shall:
(a) request a single case agreement under Subsection (2) before the covered child receives mental health treatment or services from the covered mental health therapist; and
(b) provide documentation with the request for a single case agreement under Subsection (2):

(i) that the covered child received mental health treatment from the covered mental health therapist while in the custody of the Division of Child and Family Services; and
(ii) of when the covered child left the custody of the Division of Child and Family Services.
(6) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement this section.

Enacted by Chapter 212, 2026 General Session

**31A-22-666 Coverage for reversal of sex transition procedures.**
(1) As used in this section:
(a) "Hormonal transgender treatment" means the same as that term is defined in Section 58-1-603.
(b) "Primary sex characteristic surgical procedure" means the same as that term is defined in Section 58-67-102.
(c) "Secondary sex characteristic surgical procedure" means the same as that term is defined in Section 58-67-102.
(d) "Sex transition procedure" means:
(i) a primary sex characteristic surgical procedure; or
(ii) a secondary sex characteristic surgical procedure.
(2) A health benefit plan that covers hormonal transgender treatments for an individual's sex transition shall also cover any hormonal treatments necessary to reverse an individual's sex transition.
(3) A health benefit plan that covers a sex transition procedure shall also cover any surgical procedures necessary to reverse an individual's sex transition procedure.
(4) This section applies to a health benefit plan renewed or entered into on or after January 1, 2027.

Enacted by Chapter 89, 2026 General Session

**31A-22-667 Anesthesia services.**
(1) A health benefit plan shall provide coverage for medically necessary anesthesia services, regardless of the duration, for any procedure covered by the health benefit plan.
(2) A health benefit plan is prohibited from denying payment or reimbursement for anesthesia services solely because the duration of care exceeded a preset time limit.
(3) This section applies to a health benefit plan contract entered into or renewed on or after January 1, 2027.

Enacted by Chapter 90, 2026 General Session

## Part 7
## Group Accident and Health Insurance

**31A-22-701 Groups eligible for group or blanket insurance.**
(1) A group insurance policy offering accident and health insurance may be issued to:
(a) a group:

(i) to which a group life insurance policy may be issued under Section 31A-22-502, 31A-22-503, 31A-22-504, 31A-22-505, 31A-22-506, 31A-22-507, or 31A-22-508; and
(ii) that is formed and maintained in good faith for a purpose other than obtaining insurance;
(b) a group that the commissioner specifically authorizes, upon a finding that:
(i) authorization is not contrary to the public interest;
(ii) the group is actuarially sound;
(iii) formation of the proposed group may result in economies of scale in acquisition, administrative, marketing, and brokerage costs;
(iv) the insurance policy, insurance certificate, or other indicia of coverage that will be offered to the proposed group is substantially equivalent to insurance policies that are otherwise available to similar groups;
(v) the group would not present hazards of adverse selection;
(vi) the premiums for the insurance policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided; and
(vii) the group is formed and maintained in good faith for a purpose other than obtaining insurance; or
(c) a postsecondary educational institution covering students, upon a finding that:
(i) the policy provides standards for financial soundness;
(ii) the policy protects the students covered;
(iii) the policy provides for the establishment of a financially viable alternative to traditional health care plans;
(iv) authorization is not contrary to the public interest;
(v) the policy would not present hazards of adverse selection; and
(vi) the premiums for the policy and any contributions by or on behalf of the insured persons are reasonable in relation to the benefits provided.
(2) A blanket insurance policy offering accident and health insurance:
(a) covers a defined class of persons;
(b) may not be offered or underwritten on an individual basis;
(c) shall cover only a group that is:
(i) actuarially sound; and
(ii) formed and maintained in good faith for a purpose other than obtaining insurance; and
(d) may be issued only to:
(i) a common carrier or an operator, owner, or lessee of a means of transportation, as policyholder, covering persons who may become passengers as defined by reference to the person's travel status;
(ii) an employer, as policyholder, covering any group of employees, dependents, or guests, as defined by reference to specified hazards incident to any activities of the policyholder;
(iii) an institution of learning, including a school district, a school jurisdictional unit, or the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering students, teachers, or employees;
(iv) a religious, charitable, recreational, educational, or civic organization, or branch of one of those organizations, as policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities sponsored or supervised by the policyholder;
(v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering members, campers, employees, officials, or supervisors;
(vi) a volunteer fire department, first aid, civil defense, or other similar volunteer organization, as policyholder, covering a group of members or participants as defined by reference to

specified hazards incident to activities sponsored, supervised, or participated in by the policyholder;

(vii) a newspaper or other publisher, as policyholder, covering a newspaper's or publisher's carriers;

(viii) a labor union, as a policyholder, covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder;

(ix) an association that has a constitution and bylaws covering a group of members or participants as defined by reference to specified hazards incident to the activities or operations sponsored or supervised by the policyholder; or

(x) any other class of risks that, in the judgment of the commissioner, may be properly eligible for a blanket insurance policy offering accident and health insurance.

(3) The judgment of the commissioner may be exercised on the basis of:

(a) individual risks;

(b) a class of risks; or

(c) both risks described in Subsections (3)(a) and (b).

(4) A group insurance policy offering accident and health insurance issued to a group authorized under Subsection 31A-22-504(1)(b)(ii) is subject to the provisions of Section 31A-22-602.

Amended by Chapter 45, 2026 General Session

**31A-22-702 Adjustment of premium rate and application of dividends or rate reductions.**

Any group accident and health insurance policy may provide for the adjustment of the rate of premium based upon the experience under the contract. If a policy dividend is declared or a reduction in rate is made or continued for the first or any subsequent year of insurance under any policy of group accident and health insurance, the excess, if any, of the aggregate dividends or rate reductions under the policy and all other group insurance policies of the policyholder over the aggregate expenditure for insurance under those policies made from funds contributed by the policyholder, including expenditures made in connection with the administration of the policies, shall be applied by the policyholder for the sole benefit of insured employees or members unless the insured employee or member explicitly elects otherwise.

Amended by Chapter 116, 2001 General Session

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

(1) A group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance shall include a provision that obligates the policyholder:

(a) to give written notice of termination to each employee or group member 30 days before the day on which the policy terminates; and

(b) to notify each employee or group member of the employee's or group member's rights to continue coverage upon termination.

(2)

(a) An insurer's monthly notice to the policyholder of premium payments due shall include a statement of the policyholder's obligations as set forth in Subsection (1).

(b) Insurers shall provide a sample notice to the policyholder at least once a year.

Amended by Chapter 252, 2021 General Session

**31A-22-717 Provisions pertaining to service members and their families affected by mobilization into the armed forces.**

For a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer:

(1) may not refuse to reinstate an insured or the insured's family whose coverage lapsed due to the insured's mobilization into the United States armed forces provided application is made within 180 days after the day on which the insured is released from active duty;

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

(3) may not increase the insured's premium in excess of what the premium would have been increased to in the normal course of time had the insured not been mobilized into the United States armed forces.

Amended by Chapter 252, 2021 General Session

**31A-22-719 Mastectomy coverage.**

(1) A group policy subject to Section 31A-22-630 may not deny a person's eligibility or continued eligibility to enroll or renew coverage under the terms of the group policy plan solely for the purpose of avoiding the requirements of this section or Section 31A-22-630.

(2) A group policy subject to Section 31A-22-630 may not do any of the following to induce a provider to provide care to an insured in a manner inconsistent with this section or Section 31A-22-630:

(a) penalize or otherwise reduce or limit the reimbursement of an attending provider; or

(b) provide incentives to an attending provider whether or not the incentives are monetary.

Enacted by Chapter 114, 2000 General Session

**31A-22-722 Utah mini-COBRA benefits for employer group coverage.**

(1) An employer's group policy shall offer an employee's coverage to be extended under the current employer's group policy for a period of 12 months, except as provided in Subsection (2). The right to extend coverage includes:

(a) voluntary termination;

(b) involuntary termination;

(c) retirement;

(d) death;

(e) divorce or legal separation;

(f) loss of dependent status;

(g) sabbatical;

(h) a disability;

(i) leave of absence; or

(j) reduction of hours.

(2)

(a) Notwithstanding Subsection (1), an employee may not extend coverage under the current employer's group insurance policy if the employee:

(i) fails to pay premiums or contributions in accordance with the terms of the insurance policy;

(ii) acquires other group coverage covering all preexisting conditions including maternity, if the coverage exists;

(iii) performs an act or practice that constitutes fraud in connection with the coverage;
(iv) makes an intentional misrepresentation of material fact under the terms of the coverage;
(v) is terminated from employment for gross misconduct;
(vi) is not continuously covered under the current employer's group policy for a period of three months immediately before the termination of the insurance policy due to an event set forth in Subsection (1);
(vii) is eligible for an extension of coverage required by federal law;
(viii) establishes residence outside of this state;
(ix) moves out of the insurer's service area;
(x) is eligible for similar coverage under another group insurance policy; or
(xi) has the employee's coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).

(b) The right to extend coverage under Subsection (1) applies to spouse or dependent coverage, including a surviving spouse or dependents whose coverage under the insurance policy terminates by reason of the death of the employee or member.

(3)

(a) The employer shall notify the following in writing of the right to extend group coverage and the payment amounts required for extension of coverage, including the manner, place, and time in which the payments shall be made:
(i) a terminated insured;
(ii) an ex-spouse of an insured; or
(iii) if Subsection (2)(b) applies:
(A) a surviving spouse; and
(B) the guardian of surviving dependents, if different from a surviving spouse.

(b) The notification required in Subsection (3)(a) shall be sent first class mail within 30 days after the termination date of the group coverage to:
(i) the terminated insured's home address as shown on the records of the employer;
(ii) the address of the surviving spouse, if different from the insured's address and if shown on the records of the employer;
(iii) the guardian of any dependents address, if different from the insured's address, and if shown on the records of the employer; and
(iv) the address of the ex-spouse, if shown on the records of the employer.

(4) The insurer shall provide the employee, spouse, or any eligible dependent the opportunity to extend the group coverage at the payment amount stated in Subsection (5) if:
(a) the employer policyholder does not provide the terminated insured the written notification required by Subsection (3)(a); and
(b) the employee or other individual eligible for extension contacts the insurer within 60 days of coverage termination.

(5)

(a) A premium amount for extended group coverage may not exceed 102% of the group rate in effect for a group member, including an employer's contribution, if any, for a group insurance policy.
(b) Except as provided in Subsection (5)(a), an insurer may not charge an insured an additional fee, an additional premium, interest, or any similar charge for electing extended group coverage.

(6) Except as provided in this Subsection (6), coverage extends without interruption for 12 months and may not terminate if the terminated insured or, with respect to a minor, the parent or guardian of the terminated insured:

(a) elects to extend group coverage within 60 days of losing group coverage; and
(b) tenders the amount required to the employer or insurer.
(7) The insured's coverage may be terminated before 12 months if the terminated insured:
(a) establishes residence outside of this state;
(b) moves out of the insurer's service area;
(c) fails to pay premiums or contributions in accordance with the terms of the insurance policy, including any timeliness requirements;
(d) performs an act or practice that constitutes fraud in connection with the coverage;
(e) makes an intentional misrepresentation of material fact under the terms of the coverage;
(f) becomes eligible for similar coverage under another group insurance policy; or
(g) has the coverage terminated because the employer's coverage is terminated, except as provided in Subsection (8).
(8) If the current employer coverage is terminated and the employer replaces coverage with similar coverage under another group insurance policy, without interruption, the terminated insured, spouse, or the surviving spouse and guardian of dependents if Subsection (2)(b) applies, may obtain extension of coverage under the replacement group insurance policy:
(a) for the balance of the period the terminated insured would have extended coverage under the replaced group insurance policy; and
(b) if the terminated insured is otherwise eligible for extension of coverage.
(9) An insurer shall require an insured employer to offer to the following individuals an open enrollment period at the same time as other regular employees:
(a) an individual who extends group coverage and is current on payment; and
(b) during the applicable grace period described in Subsection (3) or (4), an individual who is eligible to elect to extend group coverage.

Amended by Chapter 193, 2019 General Session

**31A-22-725 Special enrollment periods relating to Medicaid and Children's Health Insurance Program.**

(1) A person is eligible to enroll for coverage under the terms of an employer's group health benefit plan if:
(a) the person is:
(i) an employee who is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; or
(ii) a dependent of an employee, if the dependent is eligible, but not enrolled, for coverage under the terms of the employer's group health benefit plan; and
(b) the conditions of either Subsection (2) or (3) are met.
(2) Subsection (1) applies if:
(a) the employee or dependent is covered under:
(i) a Medicaid health benefit plan under Title XIX of the Social Security Act; or
(ii) a state child health benefit plan under Title XXI of the Social Security Act;
(b) coverage of the employee or dependent described in Subsection (2)(a) is terminated as a result of loss of eligibility for the coverage; and
(c) the employee requests coverage under the employer's group health plan no later than 60 days after the date of termination of the coverage described in Subsection (2)(a).
(3) Subsection (1) applies if:
(a) the employee or dependent becomes eligible for assistance, with respect to coverage under the employer's group health plan under a plan described in Subsection (2)(a), including

under a waiver or demonstration project conducted under or in relation to a plan described in Subsection (2)(a); and

(b) the employee requests coverage under the employer's group health plan no later than 60 days after the date the employee or dependent is determined to be eligible for the assistance described in Subsection (3)(a).

Enacted by Chapter 10, 2010 General Session

**31A-22-726 Abortion coverage restriction in health benefit plan and on health insurance exchange.**

(1) As used in this section, "permitted abortion coverage" means coverage for abortion:

(a) that is necessary to avert:

(i) the death of the woman on whom the abortion is performed; or

(ii) a serious risk of substantial and irreversible impairment of a major bodily function of the woman on whom the abortion is performed;

(b) of a fetus that has a defect that is documented by a physician or physicians to be uniformly diagnosable and uniformly lethal; or

(c) where the woman is pregnant as a result of:

(i) rape, as described in Section 76-5-402;

(ii) rape of a child, as described in Section 76-5-402.1; or

(iii) incest, as described in Subsection 76-5-406(2)(j) or Section 76-7-102.

(2) A person may not offer coverage for an abortion in a health benefit plan, unless the coverage is a type of permitted abortion coverage.

(3) A person may not offer a health benefit plan that provides coverage for an abortion in a health insurance exchange created under the federal Patient Protection and Affordable Care Act, 111 P.L. 148, unless the coverage is a type of permitted abortion coverage.

Amended by Chapter 189, 2019 General Session
Amended by Chapter 193, 2019 General Session

**31A-22-727 Renewal, cancellation, and modification.**

(1) Except as provided in Section 31A-22-618.6, for a group insurance policy offering accident and health insurance or a blanket insurance policy offering accident and health insurance, an insurer may:

(a) decline to renew the policy on the date the policy term expires for a reason stated in the policy; or

(b) cancel the policy at any time for:

(i) nonpayment of a premium when due;

(ii) intentional misrepresentation of a material fact in connection with the coverage;

(iii) performance of an act or practice that constitutes fraud in connection with the coverage; or

(iv) noncompliance with an employer eligibility provision.

(2) Except for a modification required by law, an insurer may only modify a policy at renewal.

(3) Subsection (2) does not apply to an endorsement by which the insurer:

(a) effectuates a request the policyholder made in writing; or

(b) exercises a specifically reserved right under the policy.

Enacted by Chapter 198, 2022 General Session

**31A-22-728 Large employer health benefit plan required report.**

(1) As used in this section:

(a) "Claims run-out period" means the period beginning on the first day following the last day of a plan year and ending on the 90th day following the last day of a plan year.

(b) "Large employer" means an employer who:

(i) with respect to a calendar year and to a plan year:

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

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

(ii) has at least 51 but fewer than 100 enrolled eligible employees enrolled in a group health benefit plan during each consecutive month during the plan year.

(c) "Medical loss ratio" means a group health benefit plan's paid claims incurred during a plan year, including the claims run-out period, divided by the total premium revenue collected for the plan year.

(2) Except as provided in Subsection (6), beginning on January 1, 2024, an insurer that offers a large employer health benefit plan to a large employer shall annually provide a report, upon request of:

(a) the large employer;

(b) the large employer's appointed producer; or

(c) the large employer's consultant.

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

(a) after the first renewal, the health benefit plan's aggregate performance from the immediately preceding plan year that describes whether the health benefit plan had a medical loss ratio of:

(i) less than 85%;

(ii) between 85% and 125%; or

(iii) greater than 125%; and

(b) after the second renewal and each subsequent renewal thereafter, a summary of the health benefit plan's aggregate 24-month medical loss ratio from the immediately preceding two plan years combined.

(4) An insurer that offers a large employer health benefit plan shall provide the requested report described in Subsection (2) not less than 30 days after the claims run-out period.

(5)

(a) The report described in Subsection (2) is proprietary to the large employer, the large employer's appointed producer, or the large employer's consultant.

(b) A person may not share the report described in Subsection (2) with a party other than a party described in Subsection (5)(a).

(6) An insurer is not required to provide a report as described in this section if:

(a) the health benefit plan is a qualified health plan as defined in 45 C.F.R. Sec. 155.20;

(b) the health benefit plan is issued to a group other than an employee group described in Section 31A-22-502;

(c) the large employer has not had continuous large employer health benefit plan coverage with the insurer for at least 18 months before the date on which the large employer requests the report;

(d) the large employer does not renew coverage with the insurer; or

(e) the insurer reasonably believes that providing the report would disclose information described in Subsection 13-61-102(2)(g).

(7) An insurer that provides a report in compliance with this section is immune from civil liability for the insurer's acts or omissions in providing information required under Subsection (3).

Enacted by Chapter 194, 2023 General Session

## Part 8
## Credit Life and Accident and Health Insurance

**31A-22-801 Scope of part.**

(1) Except as provided under Subsection (2), all life insurance and accident and health insurance in connection with loans or other credit transactions are subject to this part.

(2)

(a) Insurance written in connection with a credit transaction is not subject to this part, but is subject to other provisions of this title, if the credit transaction is:

(i) secured by a first mortgage or deed of trust; and

(ii) made to finance the purchase of real property or the construction of a dwelling thereon, or to refinance a prior credit transaction made for such a purpose.

(b) Isolated transactions on the part of an insurer that are not related to an agreement or plan for insuring debtors of the creditor are not subject to this part.

Amended by Chapter 168, 2017 General Session

**31A-22-802 Definitions.**

As used in this part:

(1) "Credit transaction" means any transaction under which the payment for money loaned or for goods, services, or properties sold or leased is to be made on future dates.

(2) "Creditor" means the lender of money or the vendor or lessor of goods, services, or property, for which payment is arranged through a credit transaction, or any successor to the right, title, or interest of any lender or vendor.

(3) "Debtor" means a borrower of money or a purchaser, including a lessee under a lease intended as security, of goods, services, or property, for which payment is arranged through a credit transaction.

(4) "Indebtedness" means the total amount payable by a debtor to a creditor in connection with a credit transaction, including principal finance charges and interest.

(5) "Net indebtedness" means the total amount required to liquidate the indebtedness, exclusive of any unearned interest, any insurance on the monthly outstanding balance coverage, or any finance charge.

(6) "Net written premiums" means gross written premiums minus refunds on termination.

Amended by Chapter 120, 2024 General Session

**31A-22-803 Forms of insurance permitted.**

Credit life insurance and credit accident and health insurance may be issued only in the following forms:

(1) individual policies of term life insurance issued to debtors;

(2) individual policies of term accident and health insurance issued to debtors, or accident and health benefit provisions in individual policies of credit life insurance;

(3) group policies of term life insurance issued to creditors, providing insurance upon the lives of debtors;
(4) group policies of term accident and health insurance issued to creditors insuring debtors, or accident and health benefit provisions in group credit life insurance policies.

Amended by Chapter 116, 2001 General Session

**31A-22-804 Limitations on amounts of insurance.**

(1) Except as provided under Subsection (2), the initial amount of credit life insurance on the life of any one debtor may not exceed the total amount repayable under the contract of indebtedness. Where an indebtedness is repayable in substantially equal periodic installments, the amount of insurance may not exceed the scheduled or actual amount of unpaid indebtedness, whichever is greater.
(2) Subsection (1) does not apply to:
  (a) insurance on agricultural credit transaction commitments not exceeding the commitment period, which may be written for the amount of the commitment on a nondecreasing or level term plan;
  (b) insurance on educational credit transaction commitments, which may be written to include the portion of the commitment that has not been advanced by the creditor;
  (c) insurance on preauthorized lines of credit not exceeding the commitment period which may be written for the preauthorized amount on a nondecreasing or level term plan, whether secured or unsecured; and
  (d) insurance on any other class of lawful credit transaction or commitment, which in the commissioner's opinion does not require the application of the restrictions under Subsection (1), in which case the commissioner may authorize by rule a class exception to Subsection (1).
(3) The total amount of indemnity payable by credit accident and health insurance in the event of disability, as defined in the policy, may not exceed the aggregate of the periodic scheduled unpaid installments of the indebtedness. The amount of each periodic indemnity payment may not exceed the total amount repayable under the contract of indebtedness divided by the number of periodic installments.

Amended by Chapter 116, 2001 General Session

**31A-22-805 Beginning date of insurance.**

(1) Except as provided under Subsection (2), any credit life insurance or credit accident and health insurance, subject to acceptance by the insurer, commences on the date when the debtor becomes obligated to the creditor.
(2)
  (a) Where a group policy provides coverage for existing obligations, the insurance on a debtor with respect to that indebtedness commences on the effective date of the policy.
  (b) Where evidence of insurability is required and the evidence is furnished more than 30 days after the debtor becomes obligated to the creditor, the insurance may commence when the insurance company determines the evidence of insurability to be satisfactory. In this event, the insurer shall make an appropriate refund or adjustment of any charge to the debtor for insurance.
(3) The insurance may not extend more than 15 days beyond the scheduled maturity date of the indebtedness, unless it does so at no additional cost to the debtor.

(4) If the indebtedness is discharged due to renewal or refinancing prior to the scheduled maturity date, the insurance in force shall terminate before any new insurance may be issued in connection with the renewed or refinanced indebtedness. In all cases of termination prior to scheduled maturity, a refund shall be paid or credited as provided in Section 31A-22-808.

Amended by Chapter 116, 2001 General Session

**31A-22-806 Provisions of policies and certificates.**

(1) All credit life insurance and credit accident and health insurance shall be evidenced by an individual policy, or, in the case of group insurance, by a certificate of insurance delivered to the debtor.

(2) Each of these types of policies or certificates shall, in addition to satisfying the requirements of Chapter 21, Insurance Contracts in General, set forth:

(a) the name and home office address of the insurer;

(b) the identity, by name or otherwise, of the persons insured;

(c) the rate, premium, or amount of payment by the debtor, if any, given separately for credit life insurance and credit accident and health insurance;

(d) a description of the amount, term, and coverage, including any exceptions, limitations, and restrictions;

(e) that the benefits shall be paid to the creditor to reduce or extinguish the unpaid indebtedness; and

(f) that whenever the amount of insurance exceeds the unpaid indebtedness, that excess is payable to a beneficiary, other than the creditor, named by the debtor or to the debtor's estate.

(3) Except as provided in Subsection (4), the policy or certificate shall be delivered to the debtor within 30 days after the date when the indebtedness is incurred.

(4)

(a) If the policy or certificate is not delivered to the debtor within 30 days after the date the indebtedness is incurred, a copy of the application for the policy or a notice of proposed insurance shall be delivered to the debtor.

(b) The application or the notice shall be signed by the debtor and shall set forth:

(i) the name and home office address of the insurer;

(ii) the name of the debtor;

(iii) the premium or amount of payment by the debtor, if any, separately for credit life insurance and credit accident and health insurance; and

(iv) the amount, term, and a brief description of the coverage provided.

(c) The copy of the application for or notice of proposed insurance, shall also refer exclusively to insurance coverage, and shall be separate from the loan, sale, or other credit statement of account or instrument, unless the information required by this Subsection (4)(c) is prominently set forth therein.

(d) Upon acceptance of the insurance by the insurer and within 60 days after the later of the date on which the indebtedness is incurred or the date on which the credit life or credit accident and health policy was purchased, the insurer shall deliver the individual policy or group certificate of insurance to the debtor.

(e) The application or notice shall state that upon acceptance by the insurer, the insurance is effective as provided in Section 31A-22-805.

(5) If the named insurer does not accept the risk, the debtor shall receive a policy or certificate of insurance setting forth the name and home office address of the substituted insurer and the

amount of the premium to be charged. If the premium is less than that set forth in the notice of proposed insurance, an appropriate refund shall be made.

(6) If a creditor makes available to the debtors more than one plan of credit life or credit accident and health insurance, all debtors shall be informed of the plans applicable to the specific type of loan transaction for which the debtor is applying.

Amended by Chapter 297, 2011 General Session

**31A-22-807 Filing and approval of forms -- Loss ratio standards.**

(1) A policy, certificate of insurance, statement of insurance, or endorsement form intended for use in Utah is subject to Section 31A-21-201.

(2) In addition to the grounds for prohibiting use of a form under Subsection 31A-21-201(3), it is a ground to prohibit the use of a form that the benefits provided in the form are not reasonable in relation to the premium charge.

(3)

(a) In ascertaining whether the benefits are reasonable in relation to the premium charged, the commissioner shall consider:

(i) the mortality cost of the life insurance;

(ii) the morbidity cost of the accident and health insurance; and

(iii) the reserves set up for the payment of claims unreported or in the process of settlement.

(b) For purposes of this section, benefits are considered reasonable in relation to the premium charged if, given the costs described in this Subsection (3), the premium rate charged develops or may reasonably be expected to develop a loss ratio of:

(i) not less than 50% for credit life insurance; and

(ii) not less than 55% for credit accident and health insurance.

(4) Benefits are considered reasonable in relation to premium charged if the ratio of claims incurred to premium earned during the most recent four-year period at the rates in use produces a loss ratio that is equal to or exceeds the minimum loss ratio standard specified in Subsection (3).

(5) If the minimum loss ratio test produces a loss ratio that exceeds the minimum loss ratio standard in Subsection (4) by five percentage points or more, the insurer may file for approval and use a rate that is higher than the prima facie rate, if it can be expected that the use of the higher rate will continue to produce a loss ratio for an account to which it is applied that will satisfy the minimum loss ratio test.

(6) If the minimum loss ratio test produces a loss ratio that is lower than the minimum loss standard in Subsection (4) by five percentage points or more, the commissioner may require that the insurer:

(a) file an adjusted rate that can be expected to produce a loss ratio that will satisfy the minimum loss ratio test; or

(b) submit reasons acceptable to the commissioner why the insurer should not be required to file an adjusted rate.

Amended by Chapter 345, 2008 General Session

**31A-22-808 Premiums and refunds.**

(1) Each policy, certificate, or statement of insurance shall provide that in the event of termination of the insurance prior to the scheduled maturity date of the indebtedness, any refund of an amount paid by the debtor for insurance shall be paid or credited promptly to the person entitled to it. The formula used in computing the refund shall be filed with and approved by the

commissioner under Chapter 21, Part 2, Approval of Forms. No refund is required if it would be less than $5.

(2) If a creditor requires a debtor to make any payment for credit life or credit accident and health insurance and an individual policy, certificate, or statement of insurance is not issued, the creditor shall immediately give written notice to the debtor and credit the account.

(3) The amount charged the debtor for credit life or accident and health insurance may not exceed the premiums charged by the insurer as computed at the time the charge to the debtor is determined.

Amended by Chapter 90, 2004 General Session

**31A-22-809 Right of debtor to choose insurer.**

When credit life insurance or credit accident and health insurance is required as security for any indebtedness, the creditor shall inform the debtor of the debtor's option to furnish the required insurance through existing policies of insurance owned or controlled by the debtor or to procure and furnish the required coverage through any insurer authorized to transact life or accident and health insurance in Utah.

Amended by Chapter 116, 2001 General Session

## Part 9
## Contracts of Fraternal Insurers

**31A-22-901 Laws applicable to contracts of fraternal insurers.**

Except as otherwise provided under this part, or in Chapter 9, Insurance Fraternals, insurance contracts issued by fraternal insurers are subject to the contract provisions of the Insurance Code in the same manner as contracts issued by any other insurer.

Enacted by Chapter 242, 1985 General Session

**31A-22-902 Fraternal contract.**

(1) A fraternal shall issue to each benefit member a policy or certificate specifying the benefits provided and containing at least the substance of all sections of the laws of the fraternal which might result in the termination of coverage or the reduction of benefits. The policy or certificate, any riders or endorsements attached to them, the laws of the fraternal, and the application and declarations made in connection with these which are signed by the applicant, constitute the agreement between the fraternal and the member, and the policy or certificate shall state this.

(2) Any changes in the laws of a fraternal which are made subsequent to the issuance of a policy or certificate bind the member and beneficiary as if they had been in force at the time of the application, so long as they do not destroy or diminish any benefits provided in the policy or certificate.

(3) Copies of any documents mentioned in Subsections (1) and (2), certified by the secretary or corresponding officer of the fraternal, are evidence of the terms and conditions of the contract.

(4) Section 31A-21-106 does not apply to fraternal contracts.

(5) If a fraternal's laws provide for expulsion or suspension of a member for any reason other than nonpayment of premium, the fraternal's insurance certificate shall contain a provision that if

a member is expelled or suspended for any reason other than nonpayment of premium, the expelled member has the right to maintain the policy in force by continuing to pay the required premium.

(6) The policy or certificate shall contain a maintenance of solvency provision pursuant to Subsection 31A-9-209(2).

(7) This section applies to all contracts made by a fraternal beginning July 1, 1986. A fraternal may elect to have this section apply at an earlier date, as long as it applies simultaneously to all of its contracts and the fraternal gives the commissioner at least 30 days notice of its intention to apply this section.

Amended by Chapter 204, 1986 General Session

**31A-22-903 Fraud in obtaining membership.**

Subject to Sections 31A-22-403 and 31A-22-405, any certificate of membership secured by misrepresentation with reference to any application for membership, document, or other proof, for the purpose of obtaining membership in, or an insurance benefit from, the fraternal is void, if the fraternal relied on it and it is either material or fraudulent.

Enacted by Chapter 242, 1985 General Session

**31A-22-904 Beneficiaries in fraternal contracts.**

(1) Any member may designate as beneficiary any person permitted by the laws of the fraternal. Those laws shall allow the designation of the member's estate as beneficiary.

(2) Subject to Subsection (1), Section 31A-22-413 applies.

Enacted by Chapter 242, 1985 General Session

## Part 10
## Workers' Compensation Insurance Contracts

**31A-22-1001 Obligation to write workers' compensation insurance.**

(1) As used in this section, "Workers' Compensation Fund" means the mutual corporation that is the successor to the quasi-public corporation created under Chapter 33, Workers' Compensation Fund, which is the chapter repealed by Laws of Utah 2017, Chapter 363.

(2) The Workers' Compensation Fund shall write all workers' compensation insurance for which application is made to the Workers' Compensation Fund until the time designated by the commissioner, but no later than December 31, 2020. As a condition of the rights granted under this Subsection (2), the Workers' Compensation Fund agrees to provide notice by no later than July 1, 2018, if the Workers' Compensation Fund does not intend to seek a contract under Subsection (3).

(3)

(a) Before entering the contract required under Subsection (3)(b), the commissioner shall work with the Workers' Compensation Fund and other workers' compensation insurance carriers to determine what constitutes the residual market within this state. After consulting with the Workers' Compensation Fund and other workers' compensation insurance carriers, the commissioner shall make the final decision of how to define the residual market. As part of

the process of determining the residual market, the commissioner may make reasonable requests of data from the Workers' Compensation Fund and other workers' compensation insurance carriers.

(b) Beginning no later than January 1, 2021, the commissioner shall enter into a contract with a workers' compensation insurance carrier to write all workers' compensation insurance for which application is made to the workers' compensation insurance carrier.

(c) The commissioner shall comply with Title 63G, Chapter 6a, Utah Procurement Code, in selecting the workers' compensation insurance carrier described in Subsection (3)(b). Criteria the commissioner may consider include:

(i) the rating of the workers' compensation insurance carrier by a nationally recognized statistical ratings organization;

(ii) the financial size category of the workers' compensation insurance carrier as determined by a nationally recognized statistical ratings organization;

(iii) the length of time the workers' compensation insurance carrier has held a certificate of authority and has been active in the Utah workers' compensation insurance market; and

(iv) the workers' compensation insurance carrier's demonstration of the intent to provide statewide:

(A) safety consultation, employer training ability, and accident prevention expertise;

(B) claims handling, medical case management, rehabilitation, cost containment, and employee return to work capabilities; and

(C) physical offices and electronic access for the convenience of Utah employers and employees.

(d) A contract entered into under this Subsection (3) shall:

(i) notwithstanding Section 63G-6a-1204, be for a term of at least 10 years;

(ii) provide for an option to renew the contract;

(iii) require a workers' compensation insurance carrier with whom the commissioner contracts to provide notice that the workers' compensation carrier will not seek to renew the contract at least three years before the end of the contract; and

(iv) contain other terms necessary to ensure that the workers' compensation insurance carrier awarded the contract will provide workers' compensation insurance to the residual market.

(4) The commissioner shall annually submit a written report in accordance with Section 68-3-14 to the Business and Labor Interim Committee by no later than October 1 that:

(a) describes the status of the commissioner's activities under Subsection (3); and

(b) the need, if any, for legislation to address the residual market.

Revisor instructions Chapter 273, 2018 General Session
Amended by Chapter 363, 2017 General Session
Revisor instructions Chapter 363, 2017 General Session

**31A-22-1002 Duration of coverage.**

(1) Any insurer assuming a workers' compensation risk shall carry it until the policy is canceled, either:

(a) by agreement between the Division of Industrial Accidents in the Labor Commission, the insurer, and the employer; or

(b) after:

(i) notice by the insurer to the employer as provided in Section 31A-21-303; and

(ii) notice to the Division of Industrial Accidents in the Labor Commission as provided in Section 34A-2-205.

(2) Subsection (1) does not affect the requirements of Section 31A-22-1001.

Amended by Chapter 116, 2001 General Session

**31A-22-1003 Comprehensive coverage.**

Every insurance policy covering the liability of an employer under Title 34A, Chapter 2, Workers' Compensation Act, shall cover all types of workers' compensation benefits required to be provided under that chapter. This section does not preclude primary and excess coverage being provided under different contracts.

Amended by Chapter 375, 1997 General Session

**31A-22-1004 Direct enforcement by employees.**

All workers' compensation insurance policies shall contain a provision that employees may enforce, in their own names, the liability of the insurer.

Enacted by Chapter 242, 1985 General Session

**31A-22-1005 Payment as bar to recovery.**

Payment of compensation under a workers' compensation insurance policy, whether in whole or in part, by either the employer or the insurer, bars recovery by the employee or the employee's dependents to the extent of the payment.

Amended by Chapter 302, 2025 General Session

**31A-22-1006 Insurer's constructive knowledge.**

Every workers' compensation policy or contract shall contain a provision that, as between the employee and the insurer, notice to or knowledge of the occurrence of the injury on the part of the employer is considered to be notice or knowledge to the insurer. This provision shall also state that the insurer is bound by and subject to the orders, findings, decisions, and awards rendered against the employer for the payment of compensation on account of compensable accidental injuries or occupational disease disability.

Enacted by Chapter 242, 1985 General Session

**31A-22-1007 Employer's insolvency.**

Every workers' compensation policy or contract shall contain a provision that the insolvency of the employer and the employer's discharge does not relieve the insurer from the payment of compensation for injuries or death sustained by an employee during the life of that policy or contract.

Amended by Chapter 302, 2025 General Session

**31A-22-1008 Employer's breach of safety rules.**

No condition in a workers' compensation policy requiring the insured employer to comply with certain safety rules may excuse the workers' compensation insurer from paying the required benefits to an employee injured as a result of the employer's breach of a safety rule that is a

condition to the workers' compensation policy. However, the insurer may bring a claim against the insured employer for breach of the policy condition.

Enacted by Chapter 242, 1985 General Session

**31A-22-1009 Other applicable provisions.**

Workers' compensation insurance contracts are subject to any applicable requirements of Title 34A, Chapter 2, Workers' Compensation Act.

Amended by Chapter 375, 1997 General Session

**31A-22-1010 Workers' compensation deductible policies.**

(1) An insurer authorized to transact the business of workers' compensation in this state may issue a workers' compensation insurance policy that provides for the insured to participate in the payment of the insurance claims and losses covered by the policy in accordance with rules made by the department.
(2) Notwithstanding Subsection (1), an insurer:
  (a) shall assume responsibility to pay all claims and losses under a workers' compensation insurance policy in accordance with Title 34A, Chapter 2, Workers' Compensation Act, and Chapter 3, Utah Occupational Disease Act;
  (b) may not permit the insured to participate in the payment of the insurance claims and losses by any means except reimbursement of the insurer; and
  (c) may not permit an employee to participate in the payment of claims or losses.
(3) For policies issued under this section, the department shall make rules consistent with this section governing:
  (a) the terms of the policies; and
  (b) reporting requirements for the policies.

Enacted by Chapter 277, 1998 General Session

**31A-22-1012 Workers' compensation insurance availability.**

(1) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department shall make rules to monitor the following related to employers who can only obtain workers' compensation insurance pursuant to Section 31A-22-1001 because of an underwriting standard or guideline described in Subsection (2):
  (a) the number of employers;
  (b) the type of employers;
  (c) the underwriting standard or guideline that causes the employer to obtain workers' compensation under Section 31A-22-1001; or
  (d) similar information to the information described in Subsections (1)(a) through (c).
(2) An underwriting standard or guideline described in Subsection (1) includes a standard or guideline regarding:
  (a) premium size;
  (b) class code and risk characteristics;
  (c) payroll and loss experience;
  (d) another factor identified by the department; or
  (e) a combination of the factors listed in Subsections (2)(a) through (d).

Enacted by Chapter 348, 2008 General Session

**31A-22-1014 Conversion of Workers' Compensation Fund to mutual insurance corporation.**

(1) As used in this section, "Workers' Compensation Fund" means the mutual corporation that is the successor to the quasi-public corporation created under Chapter 33, Workers' Compensation Fund, which is the chapter repealed by Laws of Utah 2017, Chapter 363.

(2) As a consequence of the repeal of Chapter 33, Workers' Compensation Fund, effective January 1, 2018:

(a) The Workers' Compensation Fund shall convert from a quasi-public corporation to a mutual insurance corporation subject to Chapter 5, Domestic Stock and Mutual Insurance Corporations.

(b) On or before December 31, 2017, the Workers' Compensation Fund shall file amended and restated articles of incorporation with the Department of Insurance and the Division of Corporations and Commercial Code that comply with Chapter 5, Domestic Stock and Mutual Insurance Corporations.

(c) Following the filing of the Workers' Compensation Fund's amended and restated articles of incorporation, if the commissioner determines that the Workers' Compensation Fund complies with Chapter 5, Domestic Stock and Mutual Insurance Corporations, the commissioner shall:

(i) reissue a certificate of authority effective January 1, 2018, for the Workers' Compensation Fund to write workers' compensation insurance in Utah as a mutual insurance corporation; and

(ii) reauthorize the Workers' Compensation Fund's existing filings, rates, forms, or other administrative matters on file with the department as a result of, or related to, Workers' Compensation Fund's existing insurance business in the state, so that the filings, rates, forms, or other administrative matters on file shall be effective January 1, 2018, with respect to the Workers' Compensation Fund's insurance business activities as a mutual insurance corporation.

(d) The Workers' Compensation Fund may adopt and conduct business under any name that complies with state law.

(3) Subject to Subsection (2), the commissioner may, because of the Workers' Compensation Fund's developed status, waive or otherwise not impose requirements imposed on mutual insurance corporations by Chapter 5, Domestic Stock and Mutual Insurance Corporations, to facilitate the conversion of the Workers' Compensation Fund to a mutual insurance corporation effective January 1, 2018, so long as the commissioner finds those requirements unnecessary to protect policyholders and the public.

(4)

(a) From and after the Workers' Compensation Fund's conversion to a mutual insurance corporation, the Workers' Compensation Fund shall retain title to all assets of, and remain responsible for all liabilities incurred by, the Workers' Compensation Fund as a quasi-public corporation before the Workers' Compensation Fund conversion described in this section.

(b) The state is not liable for the expenses, liabilities, or debts of:

(i) the mutual insurance company described in this section;

(ii) the nonprofit, quasi-public corporation that preceded the mutual insurance company; or

(iii) a subsidiary or joint enterprise involving the mutual insurance company or quasi-public corporation.

Revisor instructions Chapter 273, 2018 General Session
Enacted by Chapter 363, 2017 General Session

Revisor instructions Chapter 363, 2017 General Session

**31A-22-1016 Workers' compensation coverage for medical cannabis operations.**

A licensed and admitted workers' compensation insurer may issue coverage to:

(1) a cannabis production establishment as defined in Section 4-41a-102; or

(2) a medical cannabis pharmacy as defined in Section 26B-4-201.

Amended by Chapter 328, 2023 General Session

**31A-22-1017 Attestation required.**

(1) As used in this section, "zero estimated exposure policy" means a policy of insurance that an employer obtains to cover the employer's liability to pay compensation under Title 34A, Chapter 2, Workers' Compensation Act, or Title 34A, Chapter 3, Utah Occupational Disease Act, after reporting the employer's total estimated exposure is zero.

(2) An insurer shall require each applicant for a zero estimated exposure policy to sign an attestation in capital letters with substantially the following form and content: "I ATTEST THAT ALL INFORMATION PROVIDED IN THIS APPLICATION IS CURRENT, TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF. I FURTHER ATTEST THAT I HAVE NO EMPLOYEES AND AN ESTIMATED EXPOSURE OF ZERO. IF I EMPLOY ANY EMPLOYEES DURING THE POLICY PERIOD, I SHALL PROVIDE WRITTEN NOTICE TO MY WORKERS' COMPENSATION INSURER WITHIN 60 DAYS AFTER THE EMPLOYMENT BEGINS, AND INCLUDE THE ESTIMATED PAYROLL AND CLASSIFICATION CODES FOR THOSE EMPLOYEES. I UNDERSTAND THAT AN OMISSION OR MISREPRESENTATION MADE WITH INTENT TO DEFRAUD IN THIS APPLICATION CONSTITUTES A CRIMINAL ACTION."

Enacted by Chapter 198, 2026 General Session

## Part 11
## Legal Expense Insurance

**31A-22-1101 Combination of lines.**

(1) Legal expense insurance may be transacted alone or together with life insurance, accident and health insurance, or casualty insurance.

(2) An insurer may not transact liability insurance and also issue legal expense insurance policies providing coverage for the expense of enforcing claims against third persons, unless the requirements of Subsection (3) are met and the commissioner is satisfied that the interests of policyholders of legal expense insurance policies are not endangered by potential conflicts of interest within the insurer.

(3) Adequate precautions shall be taken to make sure that the handling of an insured's claim for legal assistance in enforcing a claim against a third person is not affected by the insurer's actual or potential obligation as a liability insurer to pay the claim for the third person. These precautions may include:

(a) a provision in the policy that claims against third persons shall be handled exclusively by attorneys selected by the insureds themselves rather than by the insurer, that no information about the case other than the name of the defendant and the nature of the claim may be

made available to the insurer, and that the insurer may not interfere with the handling of the case; or

(b) organizational separation between the legal expense and the liability insurance departments with respect to management, accounting, record keeping, and claims handling, with appropriate rules and procedures, satisfactory to the commissioner, to prevent the exchange of information between the two departments about details of cases.

Amended by Chapter 116, 2001 General Session

**31A-22-1102 Policy and certificate forms.**

(1) Legal expense insurance may be written as individual, group, blanket, or franchise insurance. Each contractual obligation for legal expense insurance shall be evidenced by a policy. Each person insured under a group policy shall be issued a certificate of coverage.

(2) Policies and certificates of legal expense insurance are subject to Section 31A-21-201.

(3) The commissioner may not approve any form that does not meet all of the following requirements:

(a) Policies shall contain a list and description of the legal services promised or the legal matters for which expenses are to be reimbursed, and any limits on the amounts to be reimbursed.

(b) Certificates issued under group policies shall contain a full statement of the benefits provided, but may summarize the other terms of the master policy.

(c) Policies promising legal services to be provided by a limited number of attorneys who have concluded provider contracts with the insurer, whether the attorney in an individual case is to be selected by the insured or by the insurer, shall provide for alternative benefits in case the insured is unable to find a participating attorney willing to perform the promised services or the attorney selected by the insurer is disqualified or otherwise unable to perform the promised services. The alternative benefit may consist of furnishing the services of an attorney selected and paid by the insurer or paying the fee of an attorney selected by the insured. The policy shall also provide a procedure that includes impartial review for settling disagreements about the grounds for demanding an alternative benefit.

(d) No policy, except one issued by a mutual insurance company, may provide for assessments on policyholders or for reductions of benefits to maintain the insurer's solvency.

(4) The commissioner may disapprove a policy or certificate form if the commissioner finds that it:

(a) is unfair, unfairly discriminatory, misleading, or encourages misrepresentation or misunderstanding of the contract;

(b) provides coverage or benefits or contains other provisions that would endanger the solidity of the insurer; or

(c) is contrary to law.

(5) The commissioner may require the submission of relevant information the commissioner considers to be reasonably necessary in determining whether to approve or disapprove a filing.

Amended by Chapter 302, 2025 General Session

## Part 12
## Reinsurance

**31A-22-1201 Assumption agreement.**

(1) Subject to Subsection (2), a credit for reinsurance ceded under Section 31A-17-404 or 31A-17-404.1 is not allowed unless, in addition to meeting the requirements of Section 31A-17-404 or 31A-17-404.1, the reinsurance agreement provides in substance that if the ceding insurer is insolvent, the reinsurance is payable by the assuming insurer:
  (a) on the basis of the liability of the ceding insurer under the contract or contracts reinsured;
  (b) without diminution because of the insolvency of the ceding insurer; and
  (c) directly to the ceding insurer or to its domiciliary liquidator or receiver.
(2) Subsection (1) applies except if:
  (a) a contract specifically provides another payee of the insurance in the event of the insolvency of the ceding insurer; or
  (b) the assuming insurer, with the consent of the one or more direct insureds, assumes the policy obligations of the ceding insurer:
    (i) as direct obligations of the assuming insurer to the payees under the policies; and
    (ii) in substitution for the obligations of the ceding insurer to the payees.

Amended by Chapter 138, 2016 General Session

**31A-22-1202 Other reinsurance contracts.**
(1) If there is no assumption agreement under Subsection 31A-22-1201(2), the reinsurer's sole obligation is to the ceding insurer.
(2) No guaranty fund, security fund, or any other person, except the estate of the ceding insurer, has a claim against a reinsurer.
(3) Subject to contractual rights of offset, if a ceding insurer is put into receivership, the reinsurer shall pay any amount due under the contract in full, without reduction because of the receivership:
  (a) to the domiciliary receiver if there is one; or
  (b) if there is not domiciliary receiver, to a Utah receiver.

Amended by Chapter 257, 2008 General Session

**31A-22-1203 Right of reinsurer to defend claim.**
A reinsurance contract may provide that the receiver of a ceding insurer shall, within a specified or reasonable time after the claim is filed in court or in the receivership, give written notice to an assuming reinsurer of all or part of the claim against the ceding insurer. During the pendency of the claim, any assuming reinsurer may investigate the claim and unless forbidden to do so by the reinsurance agreement, may intervene in the proceeding in which the claim is pending and interpose any defenses it considers available which have not been raised by the ceding insurer or its receiver. The expenses incurred by the assuming reinsurer in this type of action are payable up to the amount of the expenses or the amount of the benefit produced, whichever is less, as expenses of the receivership. If two or more assuming reinsurers have potential liability because of the same claim, the expenses shall be apportioned among them in proportion to the benefit received.

Enacted by Chapter 242, 1985 General Session

**31A-22-1204 Approval required for bulk insurance.**

Reinsurance credit is not allowed to a domestic insurer for reinsurance ceded when such reinsurance constitutes all or substantially all of the insurance in force of the domestic insurer, unless the agreement purporting to transfer the reinsurance is in writing and:
(1) approved by the commissioner prior to execution of the agreement; or
(2) provides that the agreement is subject to the approval of the commissioner.

Enacted by Chapter 258, 1992 General Session

## Part 13
## Miscellaneous Provisions

**31A-22-1300 Aircraft public liability insurance.**

Policies containing aircraft public liability insurance coverage for an aircraft shall include minimum coverage of:
(1) $50,000 per person for bodily injury or death in any one accident;
(2) $50,000 for property damage in any one accident; and
(3) $100,000 in any one accident, whether for property damage, or bodily injury or death.

Amended by Chapter 253, 2021 General Session

**31A-22-1301 Liability insurance for armored car companies and contract security companies.**

Section 58-63-302 applies to liability insurance for armored car companies and contract security companies.

Amended by Chapter 246, 2008 General Session

**31A-22-1302 Insurance requirements for vehicles of unusual physical nature.**

Section 72-9-103 applies to the insurance requirements for vehicles of an unusual physical nature.

Amended by Chapter 270, 1998 General Session

**31A-22-1303 Liability insurance for motor carriers.**

Motor carrier safety regulations adopted under Section 72-9-103 specify liability insurance for motor carriers.

Amended by Chapter 270, 1998 General Session

**31A-22-1305 Persons authorized to issue annuities.**

No person may issue an annuity to another person unless the issuer is:
(1) an insurer authorized to issue annuities under Chapter 5, Domestic Stock and Mutual Insurance Corporations, Chapter 9, Insurance Fraternals, or Chapter 14, Foreign Insurers;
(2) a domestic corporation created under Title 16, Chapter 6a, Utah Revised Nonprofit Corporation Act, or other applicable law, or a foreign corporation conducted without profit, which is engaged

solely in bona fide charitable, religious, missionary, educational, medical, or philanthropic activities; or

(3) a natural person who issues an annuity to the person's spouse, children, grandchildren, great-grandchildren, parents, grandparents, uncles, aunts, brothers, sisters, nieces, or nephews, whether those relationships are by birth, marriage, or legal adoption.

Amended by Chapter 302, 2025 General Session

**31A-22-1306 Transition provision for existing policy forms.**

Insurance policy forms need not conform to the requirements of this chapter until July 1, 1987. However, insurance policies issued after July 1, 1986, are subject to Section 31A-21-107.

Amended by Chapter 204, 1986 General Session

**31A-22-1307 Use of consumer reports by residential dwelling liability insurers.**

(1) An insurer who uses consumer reports in connection with the underwriting of residential dwelling liability insurance shall establish and adhere to written procedures that:

(a) identify the circumstances under which the insurer may request and the manner in which it will use consumer reports in its underwriting decisions;

(b) provide prior notice of the possible or intended use of a consumer report to an applicant for a residential liability insurance policy; and

(c) ensure compliance with the Consumer Credit Reporting Act, 15 U.S.C. Sec. 1681 et seq., including the duties that arise from taking adverse action based on information contained in a consumer report.

(2) An insurer that requests or uses a consumer report in connection with an application for a residential dwelling liability insurance policy shall maintain evidence of its compliance with the written procedures established by the insurer under Subsection (1).

(3) An insurer shall submit to the commissioner, upon request, evidence of compliance maintained in accordance with Subsection (2).

(4) As used in this section, the terms "consumer report" and "adverse action" are defined in 15 U.S.C. Sec. 1681a.

Enacted by Chapter 105, 1997 General Session

**31A-22-1308 Use of loss history by insurers.**

(1) For purposes of this section:

(a) "Adverse eligibility or rate decision" means:

(i) declining insurance coverage;

(ii) terminating insurance coverage;

(iii) not renewing insurance coverage; or

(iv) the charging of a higher rate for insurance coverage.

(b)

(i) "Loss reporting agency" means any person who regularly engages, in whole or in part, in the business of assembling or collecting information for the primary purpose of providing the information to insurers or insurance producers for insurance transactions including assembling or collecting loss or claims information.

(ii) Notwithstanding Subsection (1)(b)(i), the following persons are not loss reporting agents:

(A) a governmental entity;

(B) an insurer;
(C) an insurance producer;
(D) an insurance consultant;
(E) a medical care institution or professional; or
(F) a peer review committee.
(iii) Notwithstanding Subsection (1)(b)(i), the following are not considered a report from a loss reporting agency:
(A) a report specifically provided for fraud prevention; and
(B) that portion of a report that includes information related to consumer credit behavior.
(iv) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the department may define by rule what constitutes:
(A) a report specifically provided for fraud prevention; and
(B) information related to consumer credit behavior.
(c)
(i) "Score" means a numerical value, categorization, or classification that is:
(A) derived from a statistical tool, modeling system, or method; and
(B) developed to predict the likelihood of future insurance claims.
(ii) A numerical value, categorization, or classification described in Subsection (1)(c)(i) is a score if it is developed to predict the likelihood of future insurance claims regardless of whether it is developed to predict other factors in addition to predicting future insurance claims.
(2)
(a) An insurer may not make an adverse eligibility or rate decision related to personal lines insurance in whole or in part on the basis of:
(i) a report by a loss reporting agency of a loss if the loss did not result in the insured requesting the payment of a claim;
(ii) a telephone call or other inquiry by an insured of a loss if the loss did not result in the insured requesting payment of a claim;
(iii) a loss that occurred when real property covered by the personal lines insurance was owned by a person other than the:
(A) insured; or
(B) person seeking insurance; or
(iv) a score if the score is determined in whole or in part on the basis of information described in Subsection (2)(a)(i), (ii), or (iii).
(b) Notwithstanding Subsection (2)(a), an insurer may:
(i) use the information described in Subsection (2)(a)(iii) to require a review of the condition of the premises; and
(ii) make an adverse eligibility or rate decision on the basis of the condition of the premises.
(3)
(a) If an insurer uses a score that is derived from information obtained from a loss reporting agency or an insured, the insurer shall file with the department a certification that the method used to derive the score complies with the provisions of Subsection (2)(a)(iv).
(b) the insurer shall file a certification required under Subsection (3)(a) within 30 days of the day on which the score described in Subsection (3)(a) is first used by the insurer.
(c) The department shall classify a certification filed under this Subsection (3) as a protected record under Subsection 63G-2-305(2) except that the insurer is not required to file the information specified in Section 63G-2-309.

(d) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner shall make rules providing for the form and procedure of filing the certification required by Subsection (3)(a).

Amended by Chapter 382, 2008 General Session

**31A-22-1309 Return of unearned premium upon cancellation of errors and omissions insurance.**

(1) As used in this section, "unearned premium" means the amount of the premium that is collected by the insurer in excess of premium earned as of the date of the cancellation of the errors and omissions insurance policy.

(2) For an errors and omissions policy issued on or after May 14, 2013:

(a) the policyholder may cancel the errors and omissions insurance policy before its expiration or renewal date according to the procedure for cancellation set forth in the errors and omissions policy; and

(b) an insurer may not issue an errors and omissions policy that has fully earned premium upon issuance of the errors and omissions policy.

(3) If the errors and omissions insurance policy is cancelled as provided in Subsection (2), the insurer shall refund the unearned premium to the policyholder minus any charge imposed by the insurer.

Enacted by Chapter 205, 2013 General Session

**31A-22-1310 Insuring wildland urban interface property.**

(1) As used in this section:

(a) "High risk wildland urban interface property" means the same as that term is defined in Section 65A-8-401.

(b) "Wildland urban interface" means the same as that term is defined in Section 65A-8-401.

(c) "Wildland urban interface property and casualty insurer" means an insurer that issues property or casualty insurance for wildland urban interface property.

(2)

(a) For purposes of determining whether property is high risk wildland urban interface property, a wildland urban interface property and casualty insurer may only use the boundary provided in the wildfire risk assessment mapping tool maintained by the Division of Forestry, Fire, and State Lands in accordance with Subsection 65A-8-203(8) to determine whether the property is high risk wildland urban interface property.

(b) A wildland urban interface property and casualty insurer may use additional fire hazard data, beyond the wildfire risk assessment mapping tool described in Subsection (2)(a), in connection with setting a rate for, or the underwriting of, high risk wildland urban interface property if the wildland urban interface property and casualty insurer's use of additional fire hazard data is in compliance with:

(i) the boundary determination made in Subsection (2)(a); and

(ii) this title and department rules made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

(c) If a property is determined not to be high risk wildland urban interface in accordance with Subsection (2)(a), this Subsection (2) does not apply to the use of fire hazard data in connection with rate setting or underwriting of the property.

(d) This Subsection (2) does not restrict the use of data or underwriting tools in determining risks that are unrelated to fire risk.

(3)

(a) If an owner of property located within the wildland urban interface files a complaint with the department asserting that a wildland urban interface property and casualty insurer has violated, or is violating, this section, the department may investigate the wildland urban interface property and casualty insurer to determine whether a violation has occurred or is occurring.

(b) If after an investigation under this Subsection (3) the department finds that a wildland urban interface property and casualty insurer has violated or is violating this section, the department may:

(i) issue prohibitory, mandatory, and other orders as necessary to secure compliance with this section; and

(ii) impose penalties against the wildland urban interface property and casualty insurer in accordance with Section 31A-2-308.

(4) In addition to complying with relevant requirements of Section 31A-21-303, if due to risks of wildfire a wildland urban interface property and casualty insurer:

(a) cancels or nonrenews property and casualty insurance covering wildland urban interface property, the wildland urban interface property and casualty insurer shall include in the notice of cancellation or nonrenewal the facts on which the wildland urban interface property and casualty insurer's decision is based with reasonable precision; and

(b) increases the premium by more than 20% of the previous term's premium for property and casualty insurance covering wildland urban interface property, after receipt of a request for the information by the insured the wildland urban interface property and casualty insurer shall provide the insured the facts on which the wildland urban interface property and casualty insurer's decision is based with reasonable precision.

(5) Subsections (1) through (4) apply on and after January 1, 2026.

(6) This section does not:

(a) create a cause of action for an act or failure to act under this section against:

(i) the state;

(ii) the department;

(iii) the Division of Forestry, Fire, and State Lands;

(iv) an officer, consultant, or employee of the department or Division of Forestry, Fire, and State Lands;

(v) a wildland urban interface coordinator, as defined in Section 65A-8-401; or

(vi) a county;

(b) waive governmental immunity in accordance with Subsection 63G-7-201(5); or

(c) create a cause of action against a wildland urban interface property and casualty insurer for use in accordance with Subsection (2)(a) of the boundary provided in the wildfire risk assessment mapping tool maintained by the Division of Forestry, Fire, and State Lands in accordance with Subsection 65A-8-203(8).

Enacted by Chapter 74, 2025 General Session

## Part 14
## Long-Term Care Insurance Standards

**31A-22-1401 Application.**

(1) The requirements of this part apply to individual policies and to group policies and certificates marketed in this state on or after July 1, 2001.
(2) Entities subject to this part shall comply with other applicable insurance laws and rules unless they are in conflict with this part.
(3) The laws, regulations, and rules designed and intended to apply to Medicare supplement insurance policies may not be applied to long-term care insurance.
(4) Any policy or rider advertised, marketed, or offered as long-term care or nursing home insurance shall comply with the provisions of this part.

Amended by Chapter 193, 2019 General Session

**31A-22-1402 Definitions.**

Unless the context requires otherwise, the following definitions apply in this part:
(1) "Applicant" means:
(a) in the case of an individual long-term care insurance policy, the person who seeks to contract for benefits; and
(b) in the case of a group long-term care insurance policy, the proposed certificate holder.
(2) Notwithstanding Section 31A-1-301,"certificate" means a certificate issued under a group long-term care insurance policy if the group long-term care insurance policy is delivered or issued for delivery in this state.
(3) Notwithstanding Section 31A-1-301, "policy" means a policy, contract subscriber agreement, rider, or endorsement, if the policy, contract subscriber agreement, rider, or endorsement is delivered or issued:
(a) in this state; and
(b) by:
(i) an insurer;
(ii) a fraternal benefit society;
(iii) a nonprofit health, hospital, or medical service corporation;
(iv) a prepaid health plan;
(v) a health maintenance organization; or
(vi) an entity similar to an entity described in Subsections (3)(b)(i) through (v).

Amended by Chapter 116, 2001 General Session

**31A-22-1403 Filing required for policies issued in another state.**

Group long-term care insurance coverage may not be offered to a resident of this state under a group policy issued in another state unless the policy and certificate have been filed with the commissioner.

Enacted by Chapter 243, 1991 General Session

**31A-22-1404 Rulemaking authority.**

The commissioner may adopt rules that may permit or include:
(1) the increase of benefits over time;
(2) standards for full and fair disclosure of the manner, content, and required disclosures for the sale of long-term care insurance policies;

(3) terms of renewability;
(4) initial and subsequent conditions of eligibility;
(5) nonduplication of coverage provisions;
(6) coverage of dependents;
(7) termination of coverage;
(8) continuation or conversion;
(9) probationary periods;
(10) limitations, exceptions, and reductions of coverage;
(11) preexisting conditions;
(12) elimination and waiting periods;
(13) requirements for replacement;
(14) recurrent conditions;
(15) definition of terms;
(16) loss ratio requirements;
(17) post claim underwriting;
(18) waiver of premium;
(19) independent review of benefit determinations;
(20) inflation protection benefits; and
(21) premium rate filing and review.

Amended by Chapter 252, 2021 General Session

**31A-22-1405 Restrictions on terms of coverage.**

No long-term care insurance policy may:
(1) be canceled, nonrenewed, or otherwise terminated on the grounds of the age or the deterioration of the mental or physical health of the insured individual or certificate holder;
(2) contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except with respect to an increase in benefits voluntarily selected by the insured individual or group policyholder; or
(3) provide coverage for skilled nursing care only or provide significantly more coverage for skilled care in a facility than coverage for lower levels of care.

Enacted by Chapter 243, 1991 General Session

**31A-22-1406 Preexisting conditions.**

(1) A long-term care insurance policy or certificate may not use a definition of a preexisting condition which is more restrictive than the following: "Preexisting condition means a condition for which medical advice or treatment was recommended by or received from a provider of health care services, within six months preceding the effective date of coverage of an insured person."
(2) A long-term care insurance policy or certificate may not exclude coverage for a loss or confinement which is the result of a preexisting condition unless such loss or confinement begins within six months following the effective date of coverage of an insured person.
(3) The commissioner may extend the preexisting condition periods provided in Subsections (1) and (2) as to specific age group categories in specific policy forms upon finding that the extension is in the best interest of the public.
(4)

(a) The definition of preexisting condition does not prohibit an insurer from using an application form designed to elicit the complete health history of an applicant and from underwriting in accordance with that insurer's established underwriting standards on the basis of the answers on that application.
(b) Unless otherwise provided in the policy or certificate, a preexisting condition, regardless of whether it is disclosed on the application, need not be covered until the waiting period described in Subsection (2) expires.
(c) A long-term care insurance policy or certificate may not exclude or use waivers or riders of any kind to exclude, limit, or reduce coverage or benefits for specifically named or described preexisting diseases or physical condition beyond the waiting period described in Subsection (2).

Amended by Chapter 297, 2011 General Session

**31A-22-1407 Restricted conditional terms.**

(1) A long-term care insurance policy may not contain a provision that conditions eligibility:
  (a) for any benefits on a prior hospitalization requirement;
  (b) for benefits provided in an institutional care setting on the receipt of a higher level of institutional care; or
  (c) for any benefits on a prior institutionalization requirement except for eligibility for:
    (i) waiver of premium;
    (ii) post confinement;
    (iii) post-acute care; or
    (iv) recuperative benefits.
(2) A long-term care insurance policy containing post confinement, post-acute care, or recuperative benefits shall clearly label the limitations or conditions, including any required number of days of confinement in a separate paragraph of the policy or certificate that is entitled "Limitations or Conditions on Eligibility for Benefits."
(3) A long-term care insurance policy or rider that conditions eligibility of noninstitutional benefits on the prior receipt of institutional care may not require a prior institutional stay of more than 30 days.

Amended by Chapter 116, 2001 General Session

**31A-22-1408 Right of return -- Notice.**

Individual long-term care insurance policyholders and certificate holders other than employee and labor union certificate holders have the right to return the policy within 30 days of its delivery and to have the premium refunded if the policyholder is not satisfied for any reason after examination of the policy. Individual long-term care insurance policies shall have a notice prominently printed on the first page of the policy or attached to the policy stating in substance that the policyholder has the right to return the policy within 30 days of its delivery and to have the premium refunded if the policyholder is not satisfied for any reason after examination of the policy.

Enacted by Chapter 243, 1991 General Session

**31A-22-1409 Statements of coverage.**

(1) An outline of coverage shall be delivered to a prospective applicant for long-term care insurance at the time of initial solicitation through means which prominently direct the attention of the applicant to the document and its purpose.
(2) The commissioner may prescribe a standard format of an outline of coverage, including style, arrangement, and overall appearance, and the content.
(3) In the case of agent solicitations an agent shall deliver the outline of coverage prior to the presentation of any application or enrollment form.
(4) In the case of direct response solicitations, the outline of coverage shall be presented in conjunction with any application or enrollment form.
(5) An outline of coverage under this section shall include:
  (a) a description of the principal benefits and coverage provided in the policy;
  (b) a statement of the principal exclusions, reductions, and limitations contained in the policy;
  (c) a statement of the terms under which the policy or certificate, or both, may be continued in force or discontinued, including any reservation in the policy of a right to change premium;
  (d) a specific description of continuation or conversion provisions of group coverage;
  (e) a statement that the outline of coverage is not a contract of insurance but a summary only and that the policy or group master policy contains governing contractual provisions;
  (f) a description of the terms under which the policy or certificate may be returned and premium refunded;
  (g) a brief description of the relationship of cost of care and benefits; and
  (h) a statement that discloses to the policyholder or certificate holder whether the policy is intended to be a federally tax-qualified, long-term care insurance contract under Section 7702B(b), Internal Revenue Code.
(6) A certificate issued pursuant to a group long-term care insurance policy, which policy is delivered or issued for delivery in this state, shall include:
  (a) a description of the principal benefits and coverage provided in the policy;
  (b) a statement of the principal exclusions, reductions, and limitations contained in the policy;
  (c) a statement that the group master policy determines governing contractual provisions; and
  (d) a statement that any long-term care inflation protection option required by rule is not available under the policy.
(7) If an application for a long-term care contract or certificate is approved, the issuer shall deliver the contract or certificate of insurance to the applicant no later than 30 days after the date of approval.
(8) At the time of policy delivery, a policy summary shall be delivered for an individual life insurance policy which provides long-term care benefits within the policy or by rider. In the case of direct response solicitations, the insurer shall deliver the policy summary upon the applicant's request. However, the insurer shall deliver the summary to the applicant no later than at the time of policy delivery regardless of request. In addition to complying with all applicable requirements, the summary shall also include:
  (a) an explanation of how the long-term care benefit interacts with other components of the policy, including deductions from death benefits;
  (b) an illustration for each covered person of the amount of benefits, the length of benefit, and the guaranteed lifetime benefits if any;
  (c) any exclusions, reductions, and limitations on benefits of long-term care; and
  (d) if applicable to the policy type, the summary shall also include:
    (i) a disclosure of the effects of exercising other rights under the policy;
    (ii) a disclosure of guarantees related to long-term care costs of insurance charges; and
    (iii) current and projected maximum lifetime benefits.

(9) The provisions of the policy summary required under Subsection (8) may be incorporated into:
(a) a basic illustration; or
(b) the life insurance policy summary required to be delivered in accordance with rule.

Amended by Chapter 297, 2011 General Session

**31A-22-1410 Report to policyholder.**

A monthly report shall be provided to the policyholder any time a long-term care benefit funded through a life insurance vehicle by the acceleration of the death benefit is in benefit payment status. The report shall include:
(1) any long-term care benefits paid out during the month;
(2) an explanation of any changes in the policy due to long-term care benefits being paid out such as death benefits or cash values; and
(3) the amount of long-term care benefits existing or remaining.

Enacted by Chapter 243, 1991 General Session

**31A-22-1411 Incontestability period.**

(1) For a policy or certificate that has been in force for less than six months, an insurer may rescind a long-term care insurance policy or certificate upon a showing of misrepresentation that is material to the acceptance for coverage.
(2) For a policy or certificate that has been in force for at least six months but less than two years, an insurer may rescind a long-term care insurance policy or certificate upon a showing of misrepresentation that:
(a) is material to the acceptance for coverage; and
(b) pertains to the condition for which benefits are sought.

Enacted by Chapter 344, 1995 General Session

**31A-22-1412 Nonforfeiture benefits.**

(1)
(a) A long-term care insurance policy or certificate may not be delivered or issued for delivery in this state unless the policyholder or certificate holder has been offered the option of purchasing a policy or certificate including a nonforfeiture benefit.
(b) The offer of a nonforfeiture benefit under Subsection (1)(a) may be in the form of a rider that is attached to the policy.
(c) If the policyholder or certificate holder declines the nonforfeiture benefit offered under this Subsection (1), the insurer shall provide a contingent benefit upon lapse of the policy or certificate that is available for a specified period of time following a substantial increase in premium rates.
(d)
(i) Except as provided in Subsection (1)(d)(ii), if a group long-term care insurance policy is issued, the offer required in this Subsection (1) shall be made to the group policyholder.
(ii) If the policy is issued to a group authorized under Section 31A-22-509, the offer required under this Subsection (1) shall be made to each proposed certificate holder.
(2) The commissioner shall make rules:
(a) specifying the types of nonforfeiture benefits to be offered as part of a long-term care insurance policy or certificate;

(b) specifying the standards for nonforfeiture benefits; and
(c) regarding contingent benefits upon lapse, including a determination of:
(i) the specified period of time during which a contingent benefit upon lapse will be available as provided in Subsection (1); and
(ii) the substantial premium rate increase that triggers a contingent benefit upon lapse as provided in Subsection (1).

Amended by Chapter 116, 2001 General Session

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

If a claim under a long-term care insurance contract is denied, within 60 days of the date a written request by the policyholder or a representative of a policyholder is filed with the insurer, the insurer shall:
(1) provide a written explanation of the reason for the denial; and
(2) make available all information directly related to the denial.

Enacted by Chapter 116, 2001 General Session

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

A policy or rider shall comply with this part if it is advertised, marketed, or offered as:
(1) long-term care insurance; or
(2) nursing home insurance.

Enacted by Chapter 116, 2001 General Session

**31A-22-1415 Living organ donor coverage.**

(1) For the purposes of this section, "living organ donor" means the same as that term is defined in Section 31A-22-655.
(2) An insurer may not:
(a) deny eligibility for coverage or limit coverage of a individual under a long-term care insurance policy or contract solely due to the status of the individual as a living organ donor;
(b) preclude an individual from donating all or part of an organ as a condition of receiving or continuing to receive coverage under a long-term care insurance policy or contract; or
(c) discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of a long-term care insurance policy or contract for an individual based upon the status of the individual as a living organ donor without any additional actuarial risk.
(3) The commissioner shall make educational materials available to insurers and the public on the access of living organ donors to insurance.
(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, to implement the provisions of this section.

Enacted by Chapter 128, 2020 General Session

## Part 15
## Liability Insurance for Motorboats

**31A-22-1501 Definitions.**

As used in this part:

(1) "Motorboat" has the same meaning as defined under Section 73-18c-102.

(2) "Motorboat business" means a motorboat sales agency, repair shop, service station, storage garage, or public marina.

(3) "Operator" has the same meaning as under Section 73-18c-102.

(4) "Owner" has the same meaning as under Section 73-18c-102.

(5) "Rental company" means any person or organization in the business of providing motorboats to the public.

(6) "Renter" means any person or organization obtaining the use of a motorboat from a rental company under the terms of a rental agreement.

Amended by Chapter 211, 2006 General Session

**31A-22-1502 Motorboat liability coverage.**

(1) A liability insurance policy purchased to satisfy the owner's or operator's security requirement of Section 73-18c-301 shall:

(a) name the motorboat owner or operator in whose name the policy was purchased, state that named insured's address, the coverage afforded, the premium charged, the policy period, and the limits of liability;

(b)

(i) if it is an owner's policy:

(A) designate by appropriate reference each motorboat on which coverage is granted;

(B) insure the person named in the policy;

(C) insure any other person using any named motorboat with the express or implied permission of the named insured; and

(D) except as provided in Subsection (7), insure any person included in Subsection (1)(c) against loss from the liability imposed by law for damages arising out of the ownership, maintenance, or use of the named motorboat within the United States and Canada, subject to limits exclusive of interest and costs, for each motorboat, in amounts not less than the minimum limits specified under Section 31A-22-1503; or

(ii) if it is an operator's policy, insure the person named as insured against loss from the liability imposed upon him or her by law for damages arising out of the insured's use of any motorboat not owned by the insured, within the same territorial limits and with the same limits of liability as in an owner's policy under Subsection (1)(b)(i); and

(c) except as provided in Subsection (7), insure persons related to the named insured by blood, marriage, adoption, or guardianship who are residents of the named insured's household, including those who usually make their home in the same household but temporarily live elsewhere, to the same extent as the named insured.

(2) A liability insurance policy covering a motorboat may:

(a) provide for the prorating of the insurance under that policy with other valid and collectible insurance;

(b) grant any lawful coverage in addition to the required motorboat liability coverage;

(c) if the policy is issued to a person other than a motorboat business, limit the coverage afforded to a motorboat business or its officers, agents, or employees to the minimum limits under Section 31A-22-1503, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent; and

(d) if issued to a motorboat business, restrict coverage afforded to anyone other than the motorboat business or its officers, agents, or employees to the minimum limits under Section 31A-22-1503, and to those instances when there is no other valid and collectible insurance with at least those limits, whether the other insurance is primary, excess, or contingent.

(3) Motorboat liability coverage need not insure any liability:

(a) under any workers' compensation law under Title 34A, Utah Labor Code;

(b) resulting from bodily injury to or death of an employee of the named insured, other than a domestic employee, while engaged in the employment of the insured, or while engaged in the operation, maintenance, or repair of a designated motorboat; or

(c) resulting from damage to property owned by, rented to, bailed to, or transported by the insured.

(4) An insurance carrier providing motorboat liability coverage has the right to settle any claim covered by the policy, and if the settlement is made in good faith, the amount of the settlement is deductible from the limits of liability specified under Section 31A-22-1503.

(5) A policy containing motorboat liability coverage imposes on the insurer the duty to defend, in good faith, any person insured under the policy against any claim or suit seeking damages which would be payable under the policy.

(6)

(a) If a policy containing motorboat liability coverage provides an insurer with the defense of lack of cooperation on the part of the insured, that defense is not effective against a third person making a claim against the insurer, unless there was collusion between the third person and the insured.

(b) If the defense of lack of cooperation is not effective against the claimant, after payment, the insurer is subrogated to the injured person's claim against the insured to the extent of the payment and is entitled to reimbursement by the insured after the injured third person has been made whole with respect to the claim against the insured.

(7) A policy of motorboat liability coverage may specifically exclude from coverage a person who is a resident of the named insured's household, including a person who usually makes his or her home in the same household but temporarily lives elsewhere, if each person excluded from coverage satisfies the owner's or operator's security requirement of Section 73-18c-301, independently of the named insured's proof of owner's or operator's security.

Amended by Chapter 211, 2006 General Session

**31A-22-1503 Motorboat liability policy minimum limits.**

Policies containing motorboat liability coverage may not limit the insurer's liability under that coverage below the following:

(1)

(a) $25,000 because of liability for bodily injury to or death of one person, arising out of the use of a motorboat in any one accident;

(b) subject to the limit for one person in Subsection (1)(a), in the amount of $50,000 because of liability for bodily injury to or death of two or more persons arising out of the use of a motorboat in any one accident; and

(c) in the amount of $15,000 because of liability for injury to, or destruction of, property of others arising out of the use of a motorboat in any one accident; or

(2) $65,000 in any one accident whether arising from bodily injury to or the death of others, or from destruction of, or damage to, the property of others.

Amended by Chapter 211, 2006 General Session

**31A-22-1504 Mandatory coverage.**

(1) A rental company shall provide its renters with primary coverage meeting the requirements of Title 73, Chapter 18c, Financial Responsibility of Motorboat Owners and Operators Act.

(2) All coverage shall include primary defense costs and may not be waived.

Amended by Chapter 211, 2006 General Session

## Part 16
## Genetic Testing Restrictions on Insurers

**31A-22-1601 Title.**

This part is known as the "Genetic Testing Restrictions on Insurers Act."

Enacted by Chapter 120, 2002 General Session

**31A-22-1602 Genetic testing restrictions.**

Except as provided under Section 31A-22-620, with respect to a matter related to genetic testing and private genetic information, an insurer shall comply with the applicable provisions of Title 13, Chapter 60, Part 2, Genetic Testing and Procedure Privacy Act, including Section 13-60-205.

Amended by Chapter 328, 2023 General Session

## Part 17
## Property and Casualty Certificate of Insurance Act

**31A-22-1701 Title -- Scope of part.**

(1) This part is known as the "Property and Casualty Certificate of Insurance Act."

(2)

(a) Except as provided in Subsection (2)(b), this part applies to a certificate of insurance issued on or after May 10, 2011, as evidence of insurance coverage on property, operations, or risks located in this state.

(b) This part applies on and after July 1, 2012, to a certificate of insurance that is issued as evidence of insurance coverage on property, operations, or risks located in this state if the certificate of insurance is an exhibit to a contract executed before July 1, 2012.

(c) This part applies, regardless of where located, to the following in relation to a certificate of insurance described in Subsection (2)(b):

(i) a certificate holder;

(ii) a policyholder;

(iii) an insurer; or

(iv) an insurance producer.

Enacted by Chapter 253, 2011 General Session

**31A-22-1702 Definitions.**

Notwithstanding Section 31A-1-301, as used in this part:

(1) "Certificate holder" means a person who:
  (a) requests, obtains, or possesses a certificate of insurance; and
  (b) is not a policyholder.
(2) "Certificate of insurance" means a document that is prepared for or issued to a person who is not a policyholder as evidence of insurance, regardless of how it is titled or described.
(3) "Insurer" means:
  (a) an insurer as defined in Section 31A-1-301; and
  (b) any other person engaged in the business of making insurance or a surety contract.
(4) "Person," in addition to the definition in Section 31A-1-301, includes:
  (a) to the extent not prohibited by federal law:
    (i) the federal government; or
    (ii) an administrative unit of the federal government;
  (b) the state;
  (c) an administrative unit of the state;
  (d) a political subdivision of the state; or
  (e) an administrative unit of a political subdivision of the state.
(5) "Policyholder" means a person who contracts with a property and casualty insurer for insurance coverage.

Enacted by Chapter 253, 2011 General Session

**31A-22-1703 Filing of form.**

(1) Notwithstanding Section 31A-21-201, a person may not:
  (a) prepare, issue, or request the issuance of a certificate of insurance unless the certificate of insurance form is filed with the commissioner; or
  (b) modify a filed certificate of insurance form unless filed with the commissioner.
(2) The commissioner shall object to the use of, or prohibit the use of, a certificate of insurance form filed under this section if the certificate of insurance form:
  (a) is unfair, misleading, or deceptive;
  (b) violates public policy;
  (c) fails to comply with Section 31A-22-1704; or
  (d) violates any law, including a rule made by the commissioner in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.
(3) A standard certificate of insurance form filed for use by a nationally recognized insurance rating organization that is licensed by the commissioner, is considered filed for use for purposes of this section or Section 31A-21-201.

Enacted by Chapter 253, 2011 General Session

**31A-22-1704 Scope of certificate of insurance.**

(1) A certificate of insurance is not an insurance policy and does not affirmatively or negatively amend, extend, or alter the coverage afforded by an insurance policy to which a certificate of insurance refers.
(2) A certificate of insurance may not confer to a certificate holder a right that is not provided by an insurance policy to which the certificate of insurance refers.

(3)
(a) A certificate of insurance may not refer to a contract that is not an insurance policy, including a construction or service contract.
(b) Notwithstanding any requirement, term, or condition of a document with respect to which a certificate of insurance may be issued or may pertain, the insurance coverage afforded by a referenced insurance policy is subject to the terms, exclusions, and conditions of the insurance policy itself.

Enacted by Chapter 253, 2011 General Session

**31A-22-1705 False or misleading practices.**
(1) A person may not knowingly request or require the issuance of a certificate of insurance from an insurer, insurance producer, or policyholder that contains false or misleading information concerning an insurance policy to which the certificate of insurance refers.
(2) A person may not knowingly prepare or issue a certificate of insurance that:
(a) contains false or misleading information; or
(b) purports to affirmatively or negatively alter, amend, or extend the coverage provided by an insurance policy to which the certificate of insurance refers.
(3)
(a) A person may not prepare, issue, or request an opinion letter or other document, either in addition to or in lieu of a certificate of insurance that is inconsistent with this part.
(b) An insurer or insurance producer may prepare or issue an addendum to a certificate of insurance that clarifies or explains the coverage provided by an insurance policy if the addendum complies with this part.

Enacted by Chapter 253, 2011 General Session

**31A-22-1706 Notice of cancellation, nonrenewal, or material change.**
(1) A certificate holder only has a right to a notice of cancellation, nonrenewal, a material change, or to a similar notice if the certificate holder has rights to the notice under the terms of the insurance policy to which the certificate of insurance refers, or under any rider, or endorsement to the insurance policy.
(2) The terms and conditions of a notice described in Subsection (1), including the required timing of the notice, is governed by the insurance policy. A certificate of insurance may not alter a term or condition of the notice.

Enacted by Chapter 253, 2011 General Session

**31A-22-1707 Enforcement -- Rulemaking.**
(1) A certificate of insurance or other document that is prepared, issued, or requested in violation of this part is void.
(2) The commissioner may bring action in accordance with Section 31A-2-308 and Title 63G, Chapter 4, Administrative Procedures Act, for a violation of this part.
(3) The commissioner may:
(a) examine and investigate the activities of any person who the commissioner believes has been or is engaged in an act prohibited by this part;
(b) enforce this part; and
(c) impose a penalty or enforce a remedy authorized by this title for a violation of this part.

(4) The commissioner may make rules in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, that are necessary and proper to carry out this part.

Enacted by Chapter 253, 2011 General Session

## Part 18
## Portable Electronics Insurance Act

**31A-22-1801 Title.**

This part is known as the "Portable Electronics Insurance Act."

Enacted by Chapter 151, 2012 General Session

**31A-22-1802 Definitions.**

As used in this part:

(1) "Customer" means a person who purchases portable electronics.

(2) "Enrolled customer" means a customer who elects coverage under a portable electronics insurance policy issued to a vendor of portable electronics.

(3) "Location" means a physical location in the state or a website, call center site, or similar location directed to residents of the state.

(4) "Portable electronics" means:

(a) an electronic device that is portable in nature; and

(b) an accessory or service related to the use of the portable electronic device.

(5)

(a) "Portable electronics insurance" means insurance providing coverage for the repair or replacement of portable electronics that provides coverage for portable electronics against any one or more of the following:

(i) loss;

(ii) theft;

(iii) inoperability due to mechanical failure;

(iv) malfunction;

(v) damage; or

(vi) other similar cause of loss.

(b) "Portable electronics insurance" does not include:

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

(ii) a service contract;

(iii) a policy of insurance covering a vendor's or manufacturer's obligations under a warranty; or

(iv) a homeowner's, renter's, private passenger motor vehicle, commercial multi-peril, or similar policy.

(6) "Portable electronics transaction" means:

(a) the sale or lease of portable electronics by a vendor to a customer; or

(b) the sale by a vendor to a customer of an accessory or a service related to the use of portable electronics.

(7) "Service contract" means a contract or agreement for the repair or maintenance of goods or property, for their operational or structural failure due to a defect in materials, workmanship, or

normal wear and tear, with or without additional provisions for incidental payment of indemnity under limited circumstances.

(8) "Supervising entity" mean a business entity that is:

(a) a licensed insurer; or

(b) an insurance producer that is appointed by an insurer to supervise the administration of a portable electronics insurance program.

(9) "Vendor" means a person in the business of engaging in portable electronics transactions directly or indirectly.

(10) "Warranty" means a promise made solely by the manufacturer, importer, seller, or lessor of property or services without consideration, that is not negotiated or separated from the sale of the product and is incidental to the sale of the product, that guarantees indemnity for defective parts, mechanical or electrical breakdown, labor, or other remedial measures, such as repair or replacement of the property or repetition of services.

Enacted by Chapter 151, 2012 General Session

**31A-22-1803 Licensure required.**

(1) Subject to Subsection 31A-22-1804(2) and Section 31A-23a-103, a vendor is required to hold a portable electronics limited lines license to sell or offer coverage under a portable electronics insurance policy.

(2) A portable electronics limited lines license issued under this section authorizes an employee or authorized representative of the vendor to sell or offer coverage under a portable electronics insurance policy to a customer at each location at which the vendor who holds the limited lines license engages in portable electronics transactions.

(3) Notwithstanding any other provision of law, a limited lines license issued under this section authorizes the licensee and the licensee's employees or authorized representatives to engage in those activities that are permitted by this section.

(4) A supervising entity shall maintain a registry of vendor locations at which the vendor is authorized to sell or offer portable electronics insurance coverage in this state. Upon request by the commissioner and with three business days notice to the supervising entity, the supervising entity shall make the registry open to inspection and examination by the commissioner during regular business hours of the supervising entity.

Enacted by Chapter 151, 2012 General Session

**31A-22-1804 Application for license and fees.**

(1) To obtain or renew a portable electronics insurance limited lines license under this part, a person shall:

(a) file with the department an application for a portable electronics limited lines license on forms and in the manner the commissioner prescribes;

(b) subject to Subsection (4), provide the name and other information required by the commissioner for a licensed individual who is designated by the applicant as the person responsible for the vendor's compliance with the requirements of this chapter; and

(c) pay a fee established by the department in accordance with Section 31A-3-103, except for an initial or renewal portable electronics limited lines license in no event may the fee exceed $100 per location in the state at which the vendor engages in portable electronics transactions.

(2) A vendor engaged in portable electronics insurance transactions before July 1, 2012, shall apply for licensure within 90 days of the application being made available by the department. An applicant commencing operations on or after July 1, 2012, shall obtain a portable electronics limited lines license before offering portable electronics insurance.
(3) A portable electronics limited lines license under this part has a term of two years and expires two years after issuance, unless renewed.
(4) If the vendor derives more than 50% of its revenue from the sale of portable electronics insurance, the applicant shall provide the information listed in Subsection (1)(b) for all officers, directors, and shareholders of record having beneficial ownership of 10% or more of any class of securities registered under the federal securities law.

Enacted by Chapter 151, 2012 General Session

**31A-22-1805 Employees and authorized representatives of a vendor.**

(1) An employee or authorized representative of a vendor may sell or offer portable electronics insurance to a customer and is not subject to licensure as an insurance producer under this title if:
  (a) the vendor obtains a portable electronics limited lines license that authorizes the vendor's employee or authorized representative to sell or offer portable electronics insurance pursuant to this section;
  (b) the insurer issuing the portable electronics insurance either directly supervises or appoints a supervising entity to supervise the administration of the portable electronics insurance program, including development of a training program for each employee or authorized representative of the vendor that complies with the following:
    (i) the training shall be delivered to an employee or authorized representative of a vendor who is directly engaged in the activity of selling or offering portable electronics insurance;
    (ii) the training may be provided in electronic form if the supervising entity implements a supplemental education program regarding the portable electronics insurance product that is conducted and overseen by a licensed employee of the supervising entity that holds a portable electronics limited lines producer license; and
    (iii) each employee and authorized representative shall receive basic instruction about the portable electronics insurance offered to customers and the disclosures required under Section 31A-22-1807; and
  (c) an employee or authorized representative of a vendor of portable electronics may not advertise, represent, or otherwise hold the individual out as an insurance producer of any type.
(2) Notwithstanding any other provision of law, an employee or authorized representative of a vendor of portable electronics may not be compensated based primarily on the number of customers enrolled for portable electronics insurance coverage, but may receive compensation for activities under the limited lines license that are incidental to the employee's or authorized representative's overall compensation.

Enacted by Chapter 151, 2012 General Session

**31A-22-1806 Penalties.**

Notwithstanding Section 31A-2-308, if a vendor or the vendor's employee or authorized representative violate this part, the commissioner may do any of the following in accordance with Title 63G, Chapter 4, Administrative Procedures Act:

(1) impose a fine not to exceed:
  (a)
    (i) $2,500 per violation by a licensed individual; or
    (ii) $5,000 per violation by an entity; or
  (b) $40,000 in the aggregate for the conduct; or
(2) impose other penalties that the commissioner considers necessary and reasonable to carry out the purpose of this part, including:
  (a) suspending or revoking the privilege of transacting portable electronics insurance pursuant to this part at a specific location where violations have occurred; and
  (b) suspending or revoking the ability of individual employees or authorized representatives to act under the vendor's limited lines license.

Enacted by Chapter 151, 2012 General Session

**31A-22-1807 Requirements for sale of portable electronics insurance -- Policy provides primary coverage.**

(1) At each location where a vendor offers portable electronics insurance to a customer, the vendor shall make available to a prospective customer written materials that:
  (a) disclose that portable electronics insurance may provide a duplication of coverage already provided by the customer's homeowner's insurance policy, renter's insurance policy, private passenger motor vehicle policy, or other source of coverage;
  (b) state that the enrollment by the customer in a portable electronics insurance program is not required in order to purchase or lease portable electronics;
  (c) summarize the material terms of the portable electronics insurance coverage, including:
    (i) the identity of the insurer;
    (ii) the identity of the supervising entity;
    (iii) the amount of any applicable deductible and how it is to be paid;
    (iv) benefits of the coverage; and
    (v) key terms and conditions of coverage, such as whether portable electronics may be repaired or replaced with similar make and model reconditioned or non-original manufacturer parts or equipment;
  (d) summarize the process for filing a claim, including a description of how to return portable electronics and the maximum fee applicable in the event the customer fails to comply with any equipment return requirements; and
  (e) state the cancellation rights under Subsection (2).
(2) An enrolled customer may cancel enrollment for coverage under a portable electronics insurance policy at any time, and the person paying the premium shall receive a refund or credit of any applicable unearned premium.
(3) Portable electronics insurance may be offered on a month to month or other periodic basis as a group or master commercial inland marine policy issued to a vendor of portable electronics for its enrolled customers. Notwithstanding any other provision of law to the contrary, forms for portable electronics insurance shall be filed with the commissioner in accordance with Section 31A-21-201, and rates for portable electronics insurance shall be filed in accordance with Section 31A-19a-203.
(4) Eligibility and underwriting standards for customers electing to enroll in coverage shall be filed with the department for each portable electronics insurance program.
(5) A policy of portable electronics insurance shall provide primary coverage in the event of a covered loss under more than one policy.

Enacted by Chapter 151, 2012 General Session

**31A-22-1808 Termination of or changes to portable electronics insurance.**

Notwithstanding any other provision of law:

(1)

(a) An insurer may terminate or otherwise change the terms and conditions of a policy of portable electronics insurance only upon providing the policyholder and enrolled customers with at least 30 days notice.

(b) Notwithstanding Subsection (1)(a), an insurer may terminate an enrolled customer's enrollment under a portable electronics insurance policy upon 30 days notice for discovery of fraud or material misrepresentation in obtaining coverage or in the presentation of a claim under the portable electronics insurance policy.

(c) Notwithstanding Subsection (1)(a), an insurer may immediately terminate an enrolled customer's enrollment under a portable electronics insurance policy:

(i) for nonpayment of premium;

(ii) if the enrolled customer ceases to have an active service with the vendor of the portable electronics; or

(iii) subject to Subsection (2), if the enrolled customer exhausts the aggregate limit of liability, if any, under the terms of the portable electronics insurance policy and the insurer sends notice of termination to the enrolled customer within 30 days after exhaustion of the limit.

(2) If notice is not timely sent under Subsection (1)(c)(iii), enrollment shall continue notwithstanding the aggregate limit of liability until the insurer sends notice of termination to the enrolled customer.

(3) If an insurer changes the terms and conditions of a portable electronics insurance policy, the insurer shall provide:

(a) the vendor policyholder with a revised policy or endorsement; and

(b) each enrolled customer with:

(i) a revised certificate, endorsement, brochure, or other evidence indicating a change in the terms and conditions has occurred; and

(ii) a summary of material changes.

(4) When a vendor policyholder of a portable electronics insurance policy terminates the portable electronics insurance policy, the vendor policyholder shall mail or deliver written notice to each enrolled customer advising the enrolled customer of the termination of the portable electronics insurance policy and the effective date of termination. The vendor shall mail or deliver the written notice to the enrolled customer at least 30 days before the termination.

(5)

(a) When notice or correspondence with respect to coverage under a policy of portable electronics insurance is required under this section or is otherwise required by law, the notice or correspondence shall be in writing and be mailed or delivered to the vendor at the vendor's mailing address and to its affected enrolled customers' last known mailing addresses on file with the insurer.

(b) If mailed, the insurer or vendor, as the case may be, shall maintain proof of mailing in a form authorized or accepted by the United States Postal Service or other commercial mail delivery service.

(c) An insurer or vendor policyholder may comply with this Subsection (5) by providing notice or correspondence to a vendor or its affected enrolled customers, as the case may be, by electronic means. If accomplished through electronic means, the insurer or vendor, as the

case may be, shall maintain proof that the notice or correspondence was sent. For purposes of this Subsection (5)(c) and Title 46, Chapter 4, Uniform Electronic Transactions Act, the provision of an electronic mail address to an insurer or vendor by an enrolled customer is considered consent to receive notice and correspondence by electronic means as long as a disclosure to the effect is provided to the customer.

(6) Notice or correspondence required by this section or otherwise required by law may be sent on behalf of an insurer or vendor by the supervising entity appointed by the insurer.

Enacted by Chapter 151, 2012 General Session

**31A-22-1809 Billing.**

(1) A vendor may bill and collect the premium for portable electronics insurance coverage.

(2)

(a) Any charge to an enrolled customer for portable electronics insurance coverage that is not included in the cost associated with the purchase or lease of portable electronics or related services shall be separately itemized on the enrolled customer's bill.

(b) If the portable electronics insurance coverage is included with the purchase or lease of portable electronics or related services, the vendor shall clearly and conspicuously disclose to the enrolled customer that the portable electronics insurance coverage is included with the portable electronics or related services.

(3) A vendor who bills and collects the premium for the portable electronics insurance may not be required to maintain the money in a segregated account if the vendor is authorized by the insurer to hold the money in an alternative manner and remits the money to the supervising entity within 60 days of receipt. Money received by a vendor from an enrolled customer for the sale of portable electronics insurance is considered money held in trust by the vendor in a fiduciary capacity for the benefit of the insurer.

(4) A vendor may receive compensation for billing and collection services.

Enacted by Chapter 151, 2012 General Session

**31A-22-1810 Applicability.**

This part is not applicable to a loan or lease originated by a federally insured depository institution, or a subsidiary or affiliate of a federally insured depository institution, or originated by any other entity as part of a plan to sell or assign an interest in the loan or lease to a federally insured depository institution, or a subsidiary or affiliate of a federally insured depository institution.

Enacted by Chapter 151, 2012 General Session

## Part 19
## Unclaimed Life Insurance and Annuity Benefits Act

**31A-22-1901 Title.**

This part is known as the "Unclaimed Life Insurance and Annuity Benefits Act."

Enacted by Chapter 259, 2015 General Session

**31A-22-1902 Definitions.**

As used in this part:

(1) "Administrator" means the same as that term is defined in Section 67-4a-102.

(2) "Asymmetric conduct" means an insurer's use of the death master file or other similar database before July 1, 2015, in connection with searching for information regarding whether annuitants under the insurer's annuities might be deceased, but not in connection with whether the insureds under the insurer's policies might be deceased.

(3)

(a) "Contract" means an annuity contract.

(b) "Contract" does not include an annuity used to fund an employment-based retirement plan or program when:

(i) the insurer does not perform the record keeping services; or

(ii) the insurer is not committed by terms of the annuity contract to pay death benefits to the beneficiaries of specific plan participants.

(4) "Death master file" means the United States Social Security Administration's Death Master File or another database or service that is at least as comprehensive as the United States Social Security Administration's Death Master File for determining that a person has reportedly died.

(5) "Death master file match" means a search of a death master file that results in a match of the Social Security number, or the name and date of birth of an insured, annuity owner, or retained asset account holder.

(6)

(a) "Policy" means a policy or certificate of life insurance that provides a death benefit.

(b) "Policy" does not include:

(i) a policy or certificate of life insurance that provides a death benefit under an employee benefit plan:

(A) subject to the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1002, as periodically amended; or

(B) under a federal employee benefit program;

(ii) a policy or certificate of life insurance that is used to fund a preneed funeral contract or prearrangement;

(iii) a policy or certificate of credit life or accidental death insurance; or

(iv) a policy issued to a group master policyholder for which the insurer does not provide record keeping services.

(7) "Record keeping services" means those circumstances under which the insurer agrees with a group policy or contract customer to be responsible for obtaining, maintaining, and administering, in its own or its agents' systems, information about each individual insured under an insured's group insurance contract, or a line of coverage under the group insurance contract, at least the following information:

(a) social security number, or name and date of birth;

(b) beneficiary designation information;

(c) coverage eligibility;

(d) benefit amount; and

(e) premium payment status.

(8) "Retained asset account" means a mechanism whereby the settlement of proceeds payable under a policy or contract is accomplished by the insurer or an entity acting on behalf of the insurer by depositing the proceeds into an account with check or draft writing privileges, where those proceeds are retained by the insurer or its agent, pursuant to a supplementary contract not involving annuity benefits other than death benefits.

Amended by Chapter 168, 2017 General Session

**31A-22-1903 Insurer conduct.**

(1) An insurer shall perform a comparison of its insureds' in-force policies, contracts, and retained asset accounts against a death master file, on at least a semi-annual basis, by using the full death master file once and thereafter using the death master file update files for future comparisons to identify potential matches of its insureds. For those potential matches identified as a result of a death master file match:

(a) The insurer shall within 90 days of a death master file match:

(i) complete a good faith effort, that the insurer documents, to confirm the death of the insured or retained asset account holder against other available records and information; and

(ii) determine whether benefits are due in accordance with the applicable policy or contract, and if benefits are due in accordance with the applicable policy or contract:

(A) use good faith efforts, that the insurer documents, to locate the beneficiary or beneficiaries; and

(B) provide the appropriate claims forms or instructions to the beneficiary or beneficiaries to make a claim including the need to provide an official death certificate, if applicable under the policy or contract.

(b) With respect to group life insurance, an insurer shall confirm the possible death of an insured when the insurer maintains at least the following information of those covered under a policy or certificate:

(i) social security number, or name and date of birth;

(ii) beneficiary designation information;

(iii) coverage eligibility;

(iv) benefit amount; and

(v) premium payment status.

(c) An insurer shall implement procedures to account for:

(i) initials used in lieu of a first or middle name, use of a middle name, compound first and middle names, and interchanged first and middle names;

(ii) compound last names, hyphens, and blank spaces or apostrophes in last names; and

(iii) transposition of the "month" and "date" portions of the date of birth.

(d) To the extent permitted by law, the insurer may disclose minimum necessary personal information about the insured or beneficiary to a person who the insurer reasonably believes may be able to assist the insurer locate the beneficiary or a person otherwise entitled to payment of the claims proceeds.

(2)

(a) An insurer that has not engaged in asymmetric conduct before July 1, 2015, is not required to comply with the requirements of this section with respect to a policy, annuity, or retained asset account issued or delivered before July 1, 2015.

(b) Notwithstanding Subsection (2)(a), an insurer, regardless of whether it has engaged in asymmetric conduct, shall comply with the requirements of this section for a policy, annuity, or retained asset account issued on or after July 1, 2015.

(3) An insurer or the insurer's service provider may not charge a beneficiary or other authorized representative for fees or costs associated with a death master file search or verification of a death master file match conducted pursuant to this section.

(4) The benefits from a policy, contract, or retained asset account, plus any applicable accrued contractual interest shall first be payable to the designated beneficiaries or owners and in

the event said beneficiaries or owners can not be found, shall be transferred to the state as unclaimed property pursuant to Subsection 67-4a-201(8). Interest payable under Section 31A-22-428 may not be payable as unclaimed property under Subsection 67-4a-201(8) .

(5) An insurer shall notify the administrator upon the expiration of the statutory holding period under Subsection 67-4a-201(8) that:

(a) a policy, contract beneficiary, or retained asset account holder has not submitted a claim with the insurer; and

(b) the insurer has complied with Subsection (1) and has been unable, after good faith efforts documented by the insurer, to contact the retained asset account holder, beneficiary, or beneficiaries.

(6) Upon such notice, an insurer shall immediately submit the unclaimed policy or contract benefits or unclaimed retained asset accounts, plus any applicable accrued interest, to the administrator.

Amended by Chapter 459, 2018 General Session

## Part 20
## Limited Long-term Care Insurance Act

**31A-22-2002 Definitions.**

As used in this part:

(1) "Limited long-term care" means coverage:

(a) for less than 12 consecutive months for each covered person;

(b) on an expense-incurred, indemnity, prepaid or other basis; and

(c) for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting other than an acute care unit of a hospital.

(2)

(a) "Limited long-term care insurance" means an insurance policy, endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage for limited long-term care.

(b) "Limited long-term care insurance" does not include an insurance policy that is offered primarily to provide:

(i) basic Medicare supplement insurance coverage;

(ii) basic hospital expense coverage;

(iii) basic medical-surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accidental only coverage;

(viii) specified disease or specified accident coverage; or

(ix) limited benefit health coverage.

Amended by Chapter 45, 2026 General Session

**31A-22-2006 Rulemaking.**

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, the commissioner may make rules:

(1) establishing minimum standards for limited long-term care insurance;

(2) prescribing the content and a standard format, including style, arrangement, and overall appearance of an outline of coverage; and

(3) establishing loss-ratio standards for individual limited long-term care insurance policies.

Amended by Chapter 45, 2026 General Session