Enrolled Copy **H.B. 236**

HEALTH INSURANCE LAW AMENDMENTS

2005 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Allen M. Christensen

LONG TITLE

General Description:

This bill amends provisions of the Insurance Code related to accident and health insurance policies and the Comprehensive Health Insurance Pool Act.

Highlighted Provisions:

This bill:

- adds and amends Insurance Code definitions;
- eliminates a prohibition on requiring health maintenance organizations and limited health plans to provide conversion policies to persons residing outside their service areas;
- amends preexisting condition provisions for accident and health insurance policies;
- amends incontestability provisions for accident and health insurance policies;
- amends the definition of "Medicare Supplement Policy";
- amends the types of adverse benefit determinations which may be submitted for an independent review;
- amends the application of group accident and health policy conversion requirements;
- amends notice of the right to an individual conversion policy;
- amends Comprehensive Health Insurance Pool Act definitions, pool administrator provisions, eligibility requirements, and preexisting condition provisions; and
- makes technical changes.

Monies Appropriated in this Bill:

None

Other Special Clauses:

None

Utah Code Sections Affected:

AMENDS:

31A-1-301, as last amended by Chapters 2 and 267, Laws of Utah 2004

31A-8-402.7, as last amended by Chapter 90, Laws of Utah 2004

31A-22-605, as last amended by Chapter 116, Laws of Utah 2001

31A-22-606, as last amended by Chapter 116, Laws of Utah 2001

31A-22-609, as last amended by Chapter 116, Laws of Utah 2001

31A-22-613, as last amended by Chapter 116, Laws of Utah 2001

31A-22-620, as last amended by Chapter 116, Laws of Utah 2001

31A-22-629, as last amended by Chapter 108, Laws of Utah 2004

31A-22-723, as enacted by Chapter 108, Laws of Utah 2004

31A-29-103, as last amended by Chapter 2, Laws of Utah 2004

31A-29-110, as last amended by Chapter 168, Laws of Utah 2003

31A-29-111, as last amended by Chapter 2, Laws of Utah 2004

31A-29-113, as last amended by Chapters 2 and 329, Laws of Utah 2004

31A-30-107.5, as last amended by Chapter 348, Laws of Utah 2004

ENACTS:

31A-22-605.1, Utah Code Annotated 1953

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

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

31A-1-301. Definitions.

As used in this title, unless otherwise specified:

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

(i) a medical condition including:

(A) medical care expenses; or

(B) the risk of disability;

(ii) accident; or

(iii) sickness.

(b) "Accident and health insurance":

(i) includes a contract with disability contingencies including:

(A) an income replacement contract;

(B) a health care contract;

(C) an expense reimbursement contract;

(D) a credit accident and health contract;

(E) a continuing care contract; and

(F) a long-term care contract; and

(ii) may provide:

(A) hospital coverage;

(B) surgical coverage;

(C) medical coverage; or

(D) loss of income coverage.

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

(2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title 63, Chapter 46a, Utah Administrative Rulemaking Act.

(3) "Administrator" is defined in Subsection [~~(150)~~] (155).

(4) "Adult" means a natural person who has attained the age of at least 18 years.

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

(6) "Agency" means:

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

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

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

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

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

(10) "Application" means a document:

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

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

(A) insure the risk under:

(I) the coverages as originally offered; or

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

(B) decline to insure the risk; or

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

(11) "Articles" or "articles of incorporation" means the original articles, special laws, charters, amendments, restated articles, articles of merger or consolidation, trust instruments, and other constitutive documents for trusts and other entities that are not corporations, and amendments to any of these.

(12) "Bail bond insurance" means a guarantee that a person will attend court when required, or will obey the orders or judgment of the court, as a condition to the release of that person from confinement.

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

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

(15) "Business entity" means a corporation, association, partnership, limited liability company, limited liability partnership, or other legal entity.

(16) "Business of insurance" is defined in Subsection [~~(81)~~] (82).

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

(a) Section 31A-7-201;

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

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

(18) "Bylaws" means the rules adopted for the regulation or management of a corporation's affairs, however designated and includes comparable rules for trusts and other entities that are not corporations.

(19) "Captive insurance company" means:

(a) an insurance company:

(i) owned by another organization; and

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

(b) in the case of groups and associations, an insurance organization:

(i) owned by the insureds; and

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

(A) member organizations;

(B) group members; and

(C) affiliates of:

(I) member organizations; or

(II) group members.

(20) "Casualty insurance" means liability insurance as defined in Subsection [~~(91)~~] (94).

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

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

(b) a third party.

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

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

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

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

(b) When appropriate, the terms listed in Subsection (25)(a) apply to the equivalent supervisory official of another jurisdiction.

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

(i) provides board and lodging;

(ii) provides one or more of the following services:

(A) personal services;

(B) nursing services;

(C) medical services; or

(D) other health-related services; and

(iii) provides the coverage described in Subsection (26)(a)(i) under an agreement effective:

(A) for the life of the insured; or

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

(b) Insurance is continuing care insurance regardless of whether or not the board and lodging are provided at the same location as the services described in Subsection (26)(a)(ii).

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

(i) by contract;

(ii) by common management;

(iii) through the ownership of voting securities; or

(iv) by a means other than those described in Subsections (27)(a)(i) through (iii).

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

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

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

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

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

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

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

(i) a corporation doing business:

(A) as:

(I) an insurance producer;

(II) a limited line producer;

(III) a consultant;

(IV) a managing general agent;

(V) a reinsurance intermediary;

(VI) a third party administrator; or

(VII) an adjuster; and

(B) under:

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

(II) Chapter 25, Third Party Administrators; or

(III) Chapter 26, Insurance Adjusters; or

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

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

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

(32) "Creditable coverage" has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936.

[~~(32)~~] (33) "Credit accident and health insurance" means insurance on a debtor to provide indemnity for payments coming due on a specific loan or other credit transaction while the debtor is disabled.

[~~(33)~~] (34) (a) "Credit insurance" means insurance offered in connection with an extension of credit that is limited to partially or wholly extinguishing that credit obligation.

(b) "Credit insurance" includes:

(i) credit accident and health insurance;

(ii) credit life insurance;

(iii) credit property insurance;

(iv) credit unemployment insurance;

(v) guaranteed automobile protection insurance;

(vi) involuntary unemployment insurance;

(vii) mortgage accident and health insurance;

(viii) mortgage guaranty insurance; and

(ix) mortgage life insurance.

[~~(34)~~] (35) "Credit life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays a person if the debtor dies.

[~~(35)~~] (36) "Credit property insurance" means insurance:

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

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

[~~(36)~~] (37) "Credit unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(37) "Creditable coverage" is as defined in 45 C.F.R. 146.113(a).~~]

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

(a) matured;

(b) unmatured;

(c) liquidated;

(d) unliquidated;

(e) secured;

(f) unsecured;

(g) absolute;

(h) fixed; or

(i) contingent.

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

(i) for the customer service representative's:

(A) producer; or

(B) consultant employer; and

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

(A) customer;

(B) client; or

(C) organization.

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

(40) "Deadline" means the final date or time:

(a) imposed by:

(i) statute;

(ii) rule; or

(iii) order; and

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

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

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

(43) "Department" means the Insurance Department.

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

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

(a) perform the duties of:

(i) that individual's occupation; or

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

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

(i) eating;

(ii) toileting;

(iii) transferring;

(iv) bathing; or

(v) dressing.

(46) "Disability income insurance" is defined in Subsection [~~(72)~~] (73).

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

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

(a) is incorporated;

(b) is organized; or

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

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

(i) an employee who:

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

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

(ii) a person described in Subsection (49)(b).

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

(i) a sole proprietor;

(ii) a partner in a partnership; or

(iii) an independent contractor.

(c) "Eligible employee" does not include, unless eligible under Subsection (49)(b):

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

(ii) an employer's spouse; or

(iii) a dependent of an employer.

(50) "Employee" means any individual employed by an employer.

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

(a) employees; or

(b) dependents of employees.

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

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

(A) one or more employers;

(B) one or more labor organizations; or

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

(ii) that provides employee benefits paid or contracted to be paid, other than income from investments of the fund, by or on behalf of an employer doing business in this state or for the benefit of any person employed in this state.

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

(53) "Endorsement" means a written agreement attached to a policy or certificate to modify one or more of the provisions of the policy or certificate.

(54) "Enrollment date," with respect to a health benefit plan, means the first day of coverage or, if there is a waiting period, the first day of the waiting period.

[~~(54)~~] (55) (a) "Escrow" means:

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

(ii) a settlement or closing involving:

(A) a mobile home;

(B) a grazing right;

(C) a water right; or

(D) other personal property authorized by the commissioner.

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

(i) real estate settlement; or

(ii) real estate closing.

[~~(55)~~] (56) "Escrow agent" means:

(a) an insurance producer with:

(i) a title insurance line of authority; and

(ii) an escrow subline of authority; or

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

[~~(56)~~] (57) "Excludes" is not exhaustive and does not mean that other things are not also

excluded. The items listed are representative examples for use in interpretation of this title.

[~~(57)~~] (58) "Expense reimbursement insurance" means insurance:

(a) written to provide payments for expenses relating to hospital confinements resulting from illness or injury; and

(b) written:

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

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

[~~(58)~~] (59) "Fidelity insurance" means insurance guaranteeing the fidelity of persons holding positions of public or private trust.

[~~(59)~~] (60) (a) "Filed" means that a filing is:

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

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

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

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

(B) rule.

(b) "Filed" does not include a filing that is rejected by the department because it is not submitted in accordance with Subsection [~~(59)~~] (60)(a).

[~~(60)~~] (61) "Filing," when used as a noun, means an item required to be filed with the department including:

(a) a policy;

(b) a rate;

(c) a form;

(d) a document;

(e) a plan;

(f) a manual;

(g) an application;

(h) a report;

(i) a certificate;

(j) an endorsement;

(k) an actuarial certification;

(l) a licensee annual statement;

(m) a licensee renewal application; or

(n) an advertisement.

[~~(61)~~] (62) "First party insurance" means an insurance policy or contract in which the insurer agrees to pay claims submitted to it by the insured for the insured's losses.

[~~(62)~~] (63) "Foreign insurer" means an insurer domiciled outside of this state, including an alien insurer.

[~~(63)~~] (64) (a) "Form" means one of the following prepared for general use:

(i) a policy;

(ii) a certificate;

(iii) an application; or

(iv) an outline of coverage.

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

[~~(64)~~] (65) "Franchise insurance" means individual insurance policies provided through a mass marketing arrangement involving a defined class of persons related in some way other than through the purchase of insurance.

[~~(65)~~] (66) "General lines of authority" include:

(a) the general lines of insurance in Subsection [~~(66)~~] (67);

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

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

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

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

(iv) title marketing representative only;

(c) surplus lines;

(d) workers' compensation; and

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

[~~(66)~~] (67) "General lines of insurance" include:

(a) accident and health;

(b) casualty;

(c) life;

(d) personal lines;

(e) property; and

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

[~~(67)~~] (68) "Group health plan" means an employee welfare benefit plan to the extent that the plan provides medical care:

(a) (i) to employees; or

(ii) to a dependent of an employee; and

(b) (i) directly;

(ii) through insurance reimbursement; or

(iii) through any other method.

[~~(68)~~] (69) "Guaranteed automobile protection insurance" means insurance offered in connection with an extension of credit that pays the difference in amount between the insurance settlement and the balance of the loan if the insured automobile is a total loss.

[~~(69)~~] (70) (a) Except as provided in Subsection [~~(69)~~] (70)(b), "health benefit plan" means a policy or certificate that:

(i) provides health care insurance;

(ii) provides major medical expense insurance; or

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

(A) a hospital confinement indemnity; or

(B) a limited benefit plan.

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

(i) provides benefits solely for:

(A) accident;

(B) dental;

(C) income replacement;

(D) long-term care;

(E) a Medicare supplement;

(F) a specified disease;

(G) vision; or

(H) a short-term limited duration; or

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

[~~(70)~~] (71) "Health care" means any of the following intended for use in the diagnosis, treatment, mitigation, or prevention of a human ailment or impairment:

(a) professional services;

(b) personal services;

(c) facilities;

(d) equipment;

(e) devices;

(f) supplies; or

(g) medicine.

[~~(71)~~] (72) (a) "Health care insurance" or "health insurance" means insurance providing:

(i) health care benefits; or

(ii) payment of incurred health care expenses.

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

(i) replacement of income;

(ii) short-term accident;

(iii) fixed indemnity;

(iv) credit accident and health;

(v) supplements to liability;

(vi) workers' compensation;

(vii) automobile medical payment;

(viii) no-fault automobile;

(ix) equivalent self-insurance; or

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

[~~(72)~~] (73) "Income replacement insurance" or "disability income insurance" means insurance written to provide payments to replace income lost from accident or sickness.

[~~(73)~~] (74) "Indemnity" means the payment of an amount to offset all or part of an insured loss.

[~~(74)~~] (75) "Independent adjuster" means an insurance adjuster required to be licensed under Section 31A-26-201 who engages in insurance adjusting as a representative of insurers.

[~~(75)~~] (76) "Independently procured insurance" means insurance procured under Section 31A-15-104.

[~~(76)~~] (77) "Individual" means a natural person.

[~~(77)~~] (78) "Inland marine insurance" includes insurance covering:

(a) property in transit on or over land;

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

(c) bailee liability;

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

(e) personal and commercial property floaters.

[~~(78)~~] (79) "Insolvency" means that:

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

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

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

[~~(79)~~] (80) (a) "Insurance" means:

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

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

(b) "Insurance" includes:

(i) risk distributing arrangements providing for compensation or replacement for damages or loss through the provision of services or benefits in kind;

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

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

[~~(80)~~] (81) "Insurance adjuster" means a person who directs the investigation, negotiation, or settlement of a claim under an insurance policy other than life insurance or an annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

[~~(81)~~] (82) "Insurance business" or "business of insurance" includes:

(a) providing health care insurance, as defined in Subsection [~~(71)~~] (72), by organizations that are or should be licensed under this title;

(b) providing benefits to employees in the event of contingencies not within the control of the employees, in which the employees are entitled to the benefits as a right, which benefits may be provided either:

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

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

(c) providing annuities, including those issued in return for gifts, except those provided by persons specified in Subsections 31A-22-1305(2) and (3);

(d) providing the characteristic services of motor clubs as outlined in Subsection [~~(107)~~] (110);

(e) providing other persons with insurance as defined in Subsection [~~(79)~~] (80);

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

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

(i) solicitation;

(ii) negotiation preliminary to execution;

(iii) execution of a contract of title insurance;

(iv) insuring; and

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

(h) doing, or proposing to do, any business in substance equivalent to Subsections [~~(81)~~] (82)(a) through (g) in a manner designed to evade the provisions of this title.

[~~(82)~~] (83) "Insurance consultant" or "consultant" means a person who:

(a) advises other persons about insurance needs and coverages;

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

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

[~~(83)~~] (84) "Insurance holding company system" means a group of two or more affiliated persons, at least one of whom is an insurer.

[~~(84)~~] (85) (a) "Insurance producer" or "producer" means a person licensed or required to be licensed under the laws of this state to sell, solicit, or negotiate insurance.

(b) With regards to the selling, soliciting, or negotiating of an insurance product to an insurance customer or an insured:

(i) "producer for the insurer" means a producer who is compensated directly or indirectly by an insurer for selling, soliciting, or negotiating any product of that insurer; and

(ii) "producer for the insured" means a producer who:

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

(B) receives no compensation directly or indirectly from an insurer for selling, soliciting,

or negotiating any product of that insurer to an insurance customer or insured.

[~~(85)~~] (86) (a) "Insured" means a person to whom or for whose benefit an insurer makes a promise in an insurance policy and includes:

(i) policyholders;

(ii) subscribers;

(iii) members; and

(iv) beneficiaries.

(b) The definition in Subsection [~~(85)~~] (86)(a):

(i) applies only to this title; and

(ii) does not define the meaning of this word as used in insurance policies or certificates.

[~~(86)~~] (87) (a) (i) "Insurer" means any person doing an insurance business as a principal including:

(A) fraternal benefit societies;

(B) issuers of gift annuities other than those specified in Subsections 31A-22-1305(2) and (3);

(C) motor clubs;

(D) employee welfare plans; and

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

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

(b) "Admitted insurer" is defined in Subsection [~~(154)~~] (159)(b).

(c) "Alien insurer" is defined in Subsection (7).

(d) "Authorized insurer" is defined in Subsection [~~(154)~~] (159)(b).

(e) "Domestic insurer" is defined in Subsection (47).

(f) "Foreign insurer" is defined in Subsection [~~(62)~~] (63).

(g) "Nonadmitted insurer" is defined in Subsection [~~(154)~~] (159)(a).

(h) "Unauthorized insurer" is defined in Subsection [~~(154)~~] (159)(a).

[~~(87)~~] (88) "Interinsurance exchange" is defined in Subsection [~~(136)~~] (139).

[~~(88)~~] (89) "Involuntary unemployment insurance" means insurance:

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

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

(i) specific loan; or

(ii) credit transaction.

[~~(89)~~] (90) "Large employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

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

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

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

(b) through special enrollment.

[~~(90)~~] (93) (a) Except for a retainer contract or legal assistance described in Section 31A-1-103, "legal expense insurance" means insurance written to indemnify or pay for specified legal expenses.

(b) "Legal expense insurance" includes arrangements that create reasonable expectations of enforceable rights.

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

[~~(91)~~] (94) (a) "Liability insurance" means insurance against liability:

(i) for death, injury, or disability of any human being, or for damage to property,

exclusive of the coverages under:

(A) Subsection [~~(101)~~] (104) for medical malpractice insurance;

(B) Subsection [~~(128)~~] (131) for professional liability insurance; and

(C) Subsection [~~(158)~~] (164) for workers' compensation insurance;

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

(A) Subsection [~~(101)~~] (104) for medical malpractice insurance;

(B) Subsection [~~(128)~~] (131) for professional liability insurance; and

(C) Subsection [~~(158)~~] (164) for workers' compensation insurance;

(iii) for loss or damage to property resulting from accidents to or explosions of boilers, pipes, pressure containers, machinery, or apparatus;

(iv) for loss or damage to any property caused by the breakage or leakage of sprinklers, water pipes and containers, or by water entering through leaks or openings in buildings; or

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

(b) "Liability insurance" includes:

(i) vehicle liability insurance as defined in Subsection [~~(156)~~] (161);

(ii) residential dwelling liability insurance as defined in Subsection [~~(139)~~] (142); and

(iii) making inspection of, and issuing certificates of inspection upon, elevators, boilers, machinery, and apparatus of any kind when done in connection with insurance on them.

[~~(92)~~] (95) (a) "License" means the authorization issued by the commissioner to engage in some activity that is part of or related to the insurance business.

(b) "License" includes certificates of authority issued to insurers.

[~~(93)~~] (96) (a) "Life insurance" means insurance on human lives and insurances pertaining to or connected with human life.

(b) The business of life insurance includes:

(i) granting death benefits;

(ii) granting annuity benefits;

(iii) granting endowment benefits;

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

(v) granting additional benefits to safeguard the policy against lapse in the event of disability; and

(vi) providing optional methods of settlement of proceeds.

[~~(94)~~] (97) "Limited license" means a license that:

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

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

[~~(95)~~] (98) "Limited line credit insurance" includes the following forms of insurance:

(a) credit life;

(b) credit accident and health;

(c) credit property;

(d) credit unemployment;

(e) involuntary unemployment;

(f) mortgage life;

(g) mortgage guaranty;

(h) mortgage accident and health;

(i) guaranteed automobile protection; and

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

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

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

[~~(96)~~] (99) "Limited line credit insurance producer" means a person who sells, solicits, or negotiates one or more forms of limited line credit insurance coverage to individuals through a master, corporate, group, or individual policy.

[~~(97)~~] (100) "Limited line insurance" includes:

(a) bail bond;

(b) limited line credit insurance;

(c) legal expense insurance;

(d) motor club insurance;

(e) rental car-related insurance;

(f) travel insurance; and

(g) any other form of limited insurance that the commissioner determines by rule should be designated a form of limited line insurance.

[~~(98)~~] (101) "Limited lines authority" includes:

(a) the lines of insurance listed in Subsection [~~(97)~~] (100); and

(b) a customer service representative.

[~~(99)~~] (102) "Limited lines producer" means a person who sells, solicits, or negotiates limited lines insurance.

[~~(100)~~] (103) (a) "Long-term care insurance" means an insurance policy or rider advertised, marketed, offered, or designated to provide coverage:

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

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

(A) expenses incurred;

(B) indemnity;

(C) prepayment; or

(D) another method;

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

(A) diagnostic;

(B) preventative;

(C) therapeutic;

(D) rehabilitative;

(E) maintenance; or

(F) personal care; and

(iv) that may be issued by:

(A) an insurer;

(B) a fraternal benefit society;

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

(II) a medical service corporation;

(D) a prepaid health plan;

(E) a health maintenance organization; or

(F) an entity similar to the entities described in Subsections [~~(100)~~] (103)(a)(iv)(A) through (E) to the extent that the entity is otherwise authorized to issue life or health care insurance.

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

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

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

(B) a life insurance policy or rider;

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

(A) cognitive impairment; or

(B) functional capacity; or

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

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

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

(ii) basic hospital expense coverage;

(iii) basic medical/surgical expense coverage;

(iv) hospital confinement indemnity coverage;

(v) major medical expense coverage;

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

(vii) accident only coverage;

(viii) coverage for a specified:

(A) disease; or

(B) accident;

(ix) limited benefit health coverage; or

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

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

(I) benefits; or

(II) eligibility; and

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

(I) terminal illness;

(II) medical conditions requiring extraordinary medical intervention; or

(III) permanent institutional confinement.

[~~(101)~~] (104) "Medical malpractice insurance" means insurance against legal liability incident to the practice and provision of medical services other than the practice and provision of dental services.

[~~(102)~~] (105) "Member" means a person having membership rights in an insurance corporation.

[~~(103)~~] (106) "Minimum capital" or "minimum required capital" means the capital that must be constantly maintained by a stock insurance corporation as required by statute.

[~~(104)~~] (107) "Mortgage accident and health insurance" means insurance offered in connection with an extension of credit that provides indemnity for payments coming due on a mortgage while the debtor is disabled.

[~~(105)~~] (108) "Mortgage guaranty insurance" means surety insurance under which mortgagees and other creditors are indemnified against losses caused by the default of debtors.

[~~(106)~~] (109) "Mortgage life insurance" means insurance on the life of a debtor in connection with an extension of credit that pays if the debtor dies.

[~~(107)~~] (110) "Motor club" means a person:

(a) licensed under:

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

(ii) Chapter 11, Motor Clubs; or

(iii) Chapter 14, Foreign Insurers; and

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

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

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

(iii) trip reimbursement, towing services, emergency road services, stolen automobile services, a combination of these services, or any other services given in Subsections 31A-11-102(1)(b) through (f).

[~~(108)~~] (111) "Mutual" means a mutual insurance corporation.

[~~(109)~~] (112) "Network plan" means health care insurance:

(a) that is issued by an insurer; and

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

[~~(110)~~] (113) "Nonparticipating" means a plan of insurance under which the insured is not entitled to receive dividends representing shares of the surplus of the insurer.

[~~(111)~~] (114) "Ocean marine insurance" means insurance against loss of or damage to:

(a) ships or hulls of ships;

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

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

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

[~~(112)~~] (115) "Order" means an order of the commissioner.

[~~(113)~~] (116) "Outline of coverage" means a summary that explains an accident and health insurance policy.

[~~(114)~~] (117) "Participating" means a plan of insurance under which the insured is entitled to receive dividends representing shares of the surplus of the insurer.

[~~(115)~~] (118) "Participation," as used in a health benefit plan, means a requirement relating to the minimum percentage of eligible employees that must be enrolled in relation to the total number of eligible employees of an employer reduced by each eligible employee who voluntarily declines coverage under the plan because the employee has other group health care insurance coverage.

[~~(116)~~] (119) "Person" includes an individual, partnership, corporation, incorporated or unincorporated association, joint stock company, trust, limited liability company, reciprocal, syndicate, or any similar entity or combination of entities acting in concert.

[~~(117)~~] (120) "Personal lines insurance" means property and casualty insurance coverage sold for primarily noncommercial purposes to:

(a) individuals; and

(b) families.

[~~(118)~~] (121) "Plan sponsor" is as defined in 29 U.S.C. Sec. 1002(16)(B).

[~~(119)~~] (122) "Plan year" means:

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

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

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

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

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

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

(iii) the employer's taxable year if:

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

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

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

(c) in a case not described in Subsection [~~(119)~~] (122)(a) or (b), the calendar year.

[~~(120)~~] (123) (a) (i) "Policy" means any document, including attached endorsements and riders, purporting to be an enforceable contract, which memorializes in writing some or all of the terms of an insurance contract.

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

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

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

(C) a corporation licensed under:

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

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

(iii) "Policy" does not include:

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

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

(b) (i) "Group insurance policy" means a policy covering a group of persons that is issued to a policyholder on behalf of the group, for the benefit of group members who are selected under procedures defined in the policy or in agreements which are collateral to the policy.

(ii) A group insurance policy may include members of the policyholder's family or dependents.

(c) "Blanket insurance policy" means a group policy covering classes of persons without individual underwriting, where the persons insured are determined by definition of the class with or without designating the persons covered.

[~~(121)~~] (124) "Policyholder" means the person who controls a policy, binder, or oral contract by ownership, premium payment, or otherwise.

[~~(122)~~] (125) "Policy illustration" means a presentation or depiction that includes nonguaranteed elements of a policy of life insurance over a period of years.

[~~(123)~~] (126) "Policy summary" means a synopsis describing the elements of a life insurance policy.

[~~(124)~~] (127) "Preexisting condition," [~~in connection~~] with respect to a health benefit plan[~~;~~]:

(a) means[~~: (a)~~] a condition [~~for which~~] that was present before the effective date of coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received [~~during the six months immediately preceding the earlier of:~~] before that day; and

[~~(i) the enrollment date; or~~]

[~~(ii) the effective date of coverage; or~~]

[~~(b) for an individual insurance policy, a pregnancy existing on the effective date of coverage.~~]

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

[~~(125)~~] (128) (a) "Premium" means the monetary consideration for an insurance policy.

(b) "Premium" includes, however designated:

(i) assessments;

(ii) membership fees;

(iii) required contributions; or

(iv) monetary consideration.

(c) (i) Consideration paid to third party administrators for their services is not "premium."

(ii) Amounts paid by third party administrators to insurers for insurance on the risks administered by the third party administrators are "premium."

[~~(126)~~] (129) "Principal officers" of a corporation means the officers designated under Subsection 31A-5-203(3).

[~~(127)~~] (130) "Proceedings" includes actions and special statutory proceedings.

[~~(128)~~] (131) "Professional liability insurance" means insurance against legal liability incident to the practice of a profession and provision of any professional services.

[~~(129)~~] (132) "Property insurance" means insurance against loss or damage to real or personal property of every kind and any interest in that property, from all hazards or causes, and

against loss consequential upon the loss or damage including vehicle comprehensive and vehicle physical damage coverages, but excluding inland marine insurance and ocean marine insurance as defined under Subsections [~~(77)~~] (78) and [~~(111)~~] (114).

[~~(130)~~] (133) "Qualified long-term care insurance contract" or "federally tax qualified long-term care insurance contract" means:

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

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

(i) (A) by rider; or

(B) as a part of the contract; and

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

[~~(131)~~] (134) "Qualified United States financial institution" means an institution that:

(a) is:

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

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

(b) is regulated, supervised, and examined by United States federal or state authorities having regulatory authority over banks and trust companies; and

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

(i) the commissioner by rule; or

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

[~~(132)~~] (135) (a) "Rate" means:

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

(ii) for property-casualty insurance, that cost of insurance per exposure unit either

expressed as:

(A) a single number; or

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

(I) expenses;

(II) profit; and

(III) individual insurer variation in loss experience.

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

[~~(133)~~] (136) (a) Except as provided in Subsection [~~(133)~~] (136)(b), "rate service organization" means any person who assists insurers in rate making or filing by:

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

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

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

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

(i) an employee of an insurer;

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

(iii) a joint underwriting group; or

(iv) a natural person serving as an actuarial or legal consultant.

[~~(134)~~] (137) "Rating manual" means any of the following used to determine initial and renewal policy premiums:

(a) a manual of rates;

(b) classifications;

(c) rate-related underwriting rules; and

(d) rating formulas that describe steps, policies, and procedures for determining initial and renewal policy premiums.

[~~(135)~~] (138) "Received by the department" means:

(a) except as provided in Subsection [~~(135)~~] (138)(b), the date delivered to and stamped received by the department, whether delivered:

(i) in person; or

(ii) electronically; and

(b) if delivered to the department by a delivery service, the delivery service's postmark date or pick-up date unless otherwise stated in:

(i) statute;

(ii) rule; or

(iii) a specific filing order.

[~~(136)~~] (139) "Reciprocal" or "interinsurance exchange" means any unincorporated association of persons:

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

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

[~~(137)~~] (140) "Reinsurance" means an insurance transaction where an insurer, for consideration, transfers any portion of the risk it has assumed to another insurer. In referring to reinsurance transactions, this title sometimes refers to:

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

(b) the insurer assuming the risk as the:

(i) "assuming insurer"; or

(ii) "assuming reinsurer."

[~~(138)~~] (141) "Reinsurer" means any person licensed in this state as an insurer with the authority to assume reinsurance.

[~~(139)~~] (142) "Residential dwelling liability insurance" means insurance against liability resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is a detached single family residence or multifamily residence up to four units.

[~~(140)~~] (143) "Retrocession" means reinsurance with another insurer of a liability assumed under a reinsurance contract. A reinsurer "retrocedes" when it reinsures with another insurer part of a liability assumed under a reinsurance contract.

[~~(141)~~] (144) "Rider" means an endorsement to:

(a) an insurance policy; or

(b) an insurance certificate.

[~~(142)~~] (145) (a) "Security" means any:

(i) note;

(ii) stock;

(iii) bond;

(iv) debenture;

(v) evidence of indebtedness;

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

(vii) collateral-trust certificate;

(viii) preorganization certificate or subscription;

(ix) transferable share;

(x) investment contract;

(xi) voting trust certificate;

(xii) certificate of deposit for a security;

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

(xiv) commodity contract or commodity option;

(xv) any certificate of interest or participation in, temporary or interim certificate for, receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed in Subsections [~~(142)~~] (145)(a)(i) through (xiv); or

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

(b) "Security" does not include:

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

(A) insurance;

(B) endowment policy; or

(C) annuity contract; or

(ii) a burial certificate or burial contract.

[~~(143)~~] (146) "Self-insurance" means any arrangement under which a person provides for spreading its own risks by a systematic plan.

(a) Except as provided in this Subsection [~~(143)~~] (146), "self-insurance" does not include an arrangement under which a number of persons spread their risks among themselves.

(b) "Self-insurance" includes:

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

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

(c) "Self-insurance" does not include any arrangement with independent contractors.

[~~(144)~~] (147) "Sell" means to exchange a contract of insurance:

(a) by any means;

(b) for money or its equivalent; and

(c) on behalf of an insurance company.

[~~(145)~~] (148) "Short-term care insurance" means any insurance policy or rider advertised, marketed, offered, or designed to provide coverage that is similar to long-term care insurance but that provides coverage for less than 12 consecutive months for each covered person.

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

[~~(146)~~] (150) "Small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

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

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

(151) "Special enrollment period," in connection with a health benefit plan, has the same meaning as provided in federal regulations adopted pursuant to the Health Insurance Portability

and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

[~~(147)~~] (152) (a) "Subsidiary" of a person means an affiliate controlled by that person either directly or indirectly through one or more affiliates or intermediaries.

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

[~~(148)~~] (153) Subject to Subsection [~~(79)~~] (80)(b), "surety insurance" includes:

(a) a guarantee against loss or damage resulting from failure of principals to pay or perform their obligations to a creditor or other obligee;

(b) bail bond insurance; and

(c) fidelity insurance.

[~~(149)~~] (154) (a) "Surplus" means the excess of assets over the sum of paid-in capital and liabilities.

(b) (i) "Permanent surplus" means the surplus of a mutual insurer that has been designated by the insurer as permanent.

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

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

(c) "Excess surplus" means:

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

(A) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(152)~~] (157), that exceeds the product of:

(I) 2.5; and

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

(B) that amount of an insurer's or health organization's total adjusted capital, as defined in Subsection [~~(152)~~] (157), that exceeds the product of:

(I) 3.0; and

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

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

(A) 1.5; and

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

[~~(150)~~] (155) "Third party administrator" or "administrator" means any person who collects charges or premiums from, or who, for consideration, adjusts or settles claims of residents of the state in connection with insurance coverage, annuities, or service insurance coverage, except:

(a) a union on behalf of its members;

(b) a person administering any:

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

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

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

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

(d) an insurer licensed under Chapter 5, 7, 8, 9, or 14, but only for a line of insurance for which the insurer holds a license in this state; or

(e) a person:

(i) licensed or exempt from licensing under:

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

(B) Chapter 26, Insurance Adjusters; and

(ii) whose activities are limited to those authorized under the license the person holds or

for which the person is exempt.

[~~(151)~~] (156) "Title insurance" means the insuring, guaranteeing, or indemnifying of owners of real or personal property or the holders of liens or encumbrances on that property, or others interested in the property against loss or damage suffered by reason of liens or encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity or unenforceability of any liens or encumbrances on the property.

[~~(152)~~] (157) "Total adjusted capital" means the sum of an insurer's or health organization's statutory capital and surplus as determined in accordance with:

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

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

[~~(153)~~] (158) (a) "Trustee" means "director" when referring to the board of directors of a corporation.

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

[~~(154)~~] (159) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted insurer" means an insurer:

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

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

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

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

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

[~~(155)~~] (160) "Underwrite" means the authority to accept or reject risk on behalf of the insurer.

[~~(156)~~] (161) "Vehicle liability insurance" means insurance against liability resulting

from or incident to ownership, maintenance, or use of any land vehicle or aircraft, exclusive of vehicle comprehensive and vehicle physical damage coverages under Subsection [~~(129)~~] (132).

[~~(157)~~] (162) "Voting security" means a security with voting rights, and includes any security convertible into a security with a voting right associated with the security.

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

[~~(158)~~] (164) "Workers' compensation insurance" means:

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

(i) compensable accidental injuries; and

(ii) occupational disease disability;

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

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

Section 2. Section **31A-8-402.7** is amended to read:

31A-8-402.7. Discontinuance and nonrenewal limitations.

(1) Subject to Section 31A-4-115, an insurer that elects to discontinue offering a health benefit plan under Subsections 31A-8-402.3(3)(e) and 31A-8-402.5(3)(e) is prohibited from writing new business:

(a) in the market in this state for which the insurer discontinues or does not renew; and

(b) for a period of five years beginning on the date of discontinuation of the last coverage that is discontinued.

(2) If an insurer is doing business in one established geographic service area of the state, Sections 31A-8-402.3 and 31A-8-402.5 apply only to the insurer's operations in that service area.

[~~(3) Notwithstanding whether Chapter 22, Part 7, Group Accident and Health Insurance, requires a conversion policy be available for certain persons who are no longer entitled to group~~

~~coverage, an organization may not be required to provide a conversion policy to a person residing outside of the organization's service area.~~]

[~~(4)~~] (3) The commissioner may, by rule or order, define the scope of service area.

Section 3. Section **31A-22-605** is amended to read:

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 Chapters 7 and 8, 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) As used in this section:

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

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

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

(3) This section applies to all individual and franchise accident and health policies.

(4) The commissioner shall adopt rules 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 persons 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; and

(ix) nursing home and long-term care coverage;

(c) the content and format of the outline of coverage, in addition to that required under Subsection (6);

(d) the method of identification of policies and contracts based upon coverages provided; and

(e) rating practices.

(5) Nothing in Subsection (4)(b) precludes the issuance of policies that combine categories of coverage in that subsection provided that any combination of categories meets the standards of a component category of coverage.

(6) The commissioner may adopt rules 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 coverages;

(ii) the requirements of Subsection (6)(b)(i) apply to all insurance policies and certificates sold to persons eligible for Medicare; and

(c) requiring the disclosures or information brochures to be furnished to the prospective insured on direct response insurance policies, upon his request or, in any event, no later than the time of the policy delivery.

(7) A policy covered by this section may be issued only if it meets the minimum standards established by the commissioner under Subsection (4), 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. The outline of coverage shall include:

(a) a statement identifying the applicable categories of coverage provided by the policy as prescribed under Subsection (4);

(b) a description of the principal benefits and coverage;

(c) a statement of the exceptions, reductions, and limitations contained in the policy;

(d) a statement of the renewal provisions, including any reservation by the insurer of a right to change premiums;

(e) 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

(f) any other contents the commissioner prescribes.

(8) 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.

[~~(9) (a) Notwithstanding Subsection 31A-22-609(2), and except as provided under Subsection (9)(b), an insurer that elects to use an application form without questions concerning the insured's health history or medical treatment history, shall provide coverage under the policy for any loss which occurs more than 12 months after the effective date of the policy due to a preexisting condition which is not specifically excluded from coverage.~~]

[~~(b) (i) An insurer that issues a specified disease policy, regardless of whether the basis of issuance is a detailed application form, a simplified application form, or an enrollment form, may not deny a claim for loss due to a preexisting condition which occurs more than six months after the effective date of coverage.~~]

[~~(ii) A specified disease policy may not define a preexisting condition more restrictively than a 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.~~]

[~~(iii) A specified disease policy may not include wording that provides a defense based upon a preexisting condition except as allowed under this Subsection (9).~~]

[~~(10)~~] (9) Notwithstanding Subsection 31A-22-606(1), limited accident and health policies or certificates issued to persons 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.

Section 4. Section **31A-22-605.1** is enacted to read:

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 provided in this Subsection (4), 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 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.

Section 5. Section **31A-22-606** is amended to read:

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 ten 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[~~(10)~~](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.

Section 6. Section **31A-22-609** is amended to read:

31A-22-609. Incontestability for accident and health insurance.

(1) (a) A statement made by an applicant [~~in the application for individual or franchise accident and health insurance coverage or statement made~~] relating to the person's insurability [~~by a person insured under a group policy~~], except fraudulent misrepresentation, may not be a basis for avoidance of [~~the~~] 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.

[~~(c) The policy may provide for incontestability even for fraudulent misstatements.~~]

(2) Except as [~~otherwise~~] provided under [~~Subsection 31A-22-605(9)~~] 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).

Section 7. Section **31A-22-613** is amended to read:

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) Any provision dealing with preexisting conditions shall be consistent with Subsections 31A-22-605(9)(a) and 31A-22-609(2), and any applicable rule adopted by the commissioner.~~]

[~~(5)~~] (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 [~~(5)~~] (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 [~~(5)~~] (4)(a).

[~~(6)~~] (5) An insurer may only represent that a policy:

(a) offers a vision benefit if the policy:

(i) charges a premium for the benefit; and

(ii) provides reimbursement for materials or services provided under the policy; and

(b) covers laser vision correction, whether photorefractive keratectomy, laser assisted in-situ keratomelusis, or related procedure, if the policy:

(i) charges a premium for the benefit; and

(ii) the procedure is at least a partially covered benefit.

Section 8. Section **31A-22-620** is amended to read:

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 policy, the person who seeks to

contract for insurance benefits; and

(ii) in the case of a group Medicare supplement policy, the proposed certificate holder.

(b) "Certificate" means any certificate delivered or issued for delivery in this state under a group Medicare supplement policy.

(c) "Certificate form" means the form on which the certificate is delivered or issued for delivery by the issuer.

(d) "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 policies or certificates.

(e) "Medicare" means the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

(f) "Medicare Supplement Policy":

(i) means a group or individual policy of disability insurance, other than a policy issued pursuant to a contract under Section 1876 of the federal Social Security Act, 42 U.S.C. Section 1395 et seq., or an issued policy under a demonstration project specified in 41 U.S.C. Section 1395ss(g)(1), that is advertised, marketed, or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, or surgical expenses of persons eligible for Medicare[-]; and

(ii) does not include Medicare Advantage plans established under Medicare Part C, outpatient prescription drug plans established under Medicare Part D, or any health care prepayment plan that provides benefits pursuant to an agreement under Section 1833(a)(1)(A) of the Social Security Act.

(g) "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 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 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 policies or benefit plans.

(3) (a) A Medicare supplement 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 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 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 policies and certificates.

(e) The commissioner may adopt [~~such~~] rules [~~as are necessary~~] to conform Medicare supplement policies and certificates to the requirements of federal law and regulations [~~promulgated thereunder~~], 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; and

(vi) establishing standards for Medicare select policies and certificates.

(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 policy or certificate.

(4) Medicare supplement 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 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 policies, a Medicare supplement 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 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 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 advertisement intended for use in this state, whether through written or broadcast medium, to the commissioner for review.

Section 9. Section **31A-22-629** is amended to read:

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) with respect to individual or group health plans, and income replacement or disability income policies, a 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; and

(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 insurer;

(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) "Insured" is as defined in Section 31A-1-301 and includes a person who is authorized to act on the insured's behalf.

(d) "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.

(e) "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 payment of a claim regarding medical necessity or denial of [~~coverage~~] a claim regarding medical necessity.

(4) Before October 1, 2000, 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 attorneys' 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.

Section 10. Section **31A-22-723** is amended to read:

31A-22-723. Group and blanket conversion coverage.

(1) Notwithstanding Subsection 31A-1-103(3)(f), and except as provided in Subsection (3), all policies of accident and health insurance offered on a group basis under this title, or Title 49, Chapter 20, Public Employees' Benefit and Insurance Program Act, shall provide that a person whose insurance under the group policy has been terminated is entitled to choose a converted individual policy of similar accident and health insurance.

(2) A person who has lost group coverage may elect conversion coverage with the insurer that provided prior group coverage if the person:

(a) has been continuously covered [~~under a group policy~~] for a period of six months by the group policy or the group's preceding policies immediately prior to termination; [~~and~~]

(b) has exhausted either Utah mini-COBRA coverage as required in Section 31A-22-722 or federal COBRA coverage[~~, if offered~~]; [~~and~~]

(c) has not acquired or is not covered under any other group coverage that covers all preexisting conditions, including maternity, if the coverage exists[~~.~~]; and

(d) resides in the insurer's service area.

(3) This section does not apply if the person's prior group coverage:

(a) is a stand alone policy that only provides one of the following:

(i) catastrophic benefits;

(ii) aggregate stop loss benefits;

(iii) specific stop loss benefits;

(iv) benefits for specific diseases;

(v) accidental injuries only;

(vi) dental; or

(vii) vision;

(b) is an income replacement policy; [~~or~~]

(c) was terminated because the insured:

(i) failed to pay any required individual contribution;

(ii) performed an act or practice that constitutes fraud in connection with the coverage; or

(iii) made intentional misrepresentation of material fact under the terms of coverage[.]; or

(d) was terminated pursuant to Subsection 31A-8-402.3(2)(a), 31A-22-721(2)(a), or 31A-30-107(2)(a).

(4) (a) The employer shall provide written notification of the right to an individual conversion policy within 30 days of the insured's termination of coverage to:

(i) the terminated insured;

(ii) the ex-spouse; or

(iii) in the case of the death of the insured:

(A) the surviving spouse; [~~or~~] and

(B) the guardian of any dependents, if different from a surviving spouse.

(b) The notification required by Subsection (4)(a) shall:

(i) be sent by first class mail;

(ii) contain the name, address, and telephone number of the insurer that will provide the conversion coverage; and

(iii) be sent to the insured's last-known address as shown on the records of the employer of:

(A) the insured;

(B) the ex-spouse; and

(C) if the policy terminates by reason of the death of the insured to:

(I) the surviving spouse; [~~or~~] and

(II) the guardian of any dependents, if different from a surviving spouse.

(5) (a) An insurer is not required to issue a converted policy which provides benefits in excess of those provided under the group policy from which conversion is made.

(b) Except as provided in Subsection (5)(c), if the conversion is made from a health benefit plan, the employee or member must be offered at least the basic benefit plan as provided

in Subsection 31A-22-613.5(2)(a).

(c) If the benefit levels required under Subsection (5)(b) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy.

(6) Written application for the converted policy shall be made and the first premium paid to the insurer no later than 60 days after termination of the group accident and health insurance.

(7) The converted policy shall be issued without evidence of insurability.

(8) (a) The initial premium for the converted policy for the first 12 months and subsequent renewal premiums shall be determined in accordance with premium rates applicable to age, class of risk of the person, and the type and amount of insurance provided.

(b) The initial premium for the first 12 months may not be raised based on pregnancy of a covered insured.

(c) The premium for converted policies shall be payable monthly or quarterly as required by the insurer for the policy form and plan selected, unless another mode or premium payment is mutually agreed upon.

(9) The converted policy becomes effective at the time the insurance under the group policy terminates.

(10) (a) A newly issued converted policy covers the employee or the member and must also cover all dependents covered by the group policy at the date of termination of the group coverage.

(b) The only dependents that may be added after the policy has been issued are children and dependents as required by Section 31A-22-610 and Subsections 31A-22-610.5(6) and (7).

(c) At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(11) (a) To the extent the group policy provided maternity benefits, the conversion policy shall provide maternity benefits equal to the lesser of the maternity benefits of the group policy or the conversion policy until termination of a pregnancy that exists on the date of conversion if one of the following is pregnant on the date of the conversion:

(i) the insured;

(ii) a spouse of the insured; or

(iii) a dependent of the insured.

(b) The requirements of this Subsection (11) do not apply to a pregnancy that occurs after the date of conversion.

(12) Except as provided in this Subsection (12), a converted policy is renewable with respect to all individuals or dependents at the option of the insured. An insured may be terminated from a converted policy for the following reasons:

(a) a dependent is no longer eligible under the policy;

(b) for a network plan, if the individual no longer lives, resides, or works in:

(i) the insured's service area; or

(ii) the area for which the covered carrier is authorized to do business; or

(c) the individual fails to pay premiums or contributions in accordance with the terms of the converted policy, including any timeliness requirements;

(d) the individual performs an act or practice that constitutes fraud in connection with the coverage;

(e) the individual makes an intentional misrepresentation of material fact under the terms of the coverage; or

(f) coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

(13) Conditions pertaining to health may not be used as a basis for classification under this section.

Section 11. Section **31A-29-103** is amended to read:

31A-29-103. Definitions.

As used in this chapter:

(1) "Board" means the board of directors of the pool created in Section 31A-29-104.

(2) (a) "Creditable coverage" has the same meaning as provided in [~~the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat.1956, Sec. 2701(c)(1) and 45~~

~~C.F.R. Sec. 146.11(a)(1)~~] Section 31A-1-301.

(b) "Creditable coverage" does not include a period of time in which there is a significant break in coverage [~~as described in the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191, 110 Stat. 1956, Sec. 2701(c)(2)~~], as defined in Section 31A-1-301.

(3) "Domicile" means the place where an individual has a fixed and permanent home and principal establishment:

(a) to which the individual, if absent, intends to return; and

(b) in which the individual, and the individual's family voluntarily reside, not for a special or temporary purpose, but with the intention of making a permanent home.

(4) "Enrollee" means an individual who has met the eligibility requirements of the pool and is covered by a pool policy under this chapter.

(5) "Health care facility" means any entity providing health care services which is licensed under Title 26, Chapter 21, Health Care Facility Licensing and Inspection Act.

(6) "Health care provider" has the same meaning as provided in Section 78-14-3.

(7) "Health care services" means:

(a) any service or product:

(i) used in furnishing to any individual medical care or hospitalization; or

(ii) incidental to furnishing medical care or hospitalization; and

(b) any other service or product furnished for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(8) (a) "Health insurance" means any:

(i) hospital and medical expense-incurred policy;

(ii) nonprofit health care service plan contract; or

(iii) health maintenance organization subscriber contract.

(b) "Health insurance" does not mean:

(i) any insurance arising out of Title 34A, Chapter 2 or 3, or similar law;

(ii) automobile medical payment insurance; or

(iii) insurance under which benefits are payable with or without regard to fault and which

is required by law to be contained in any liability insurance policy.

(9) "Health maintenance organization" has the same meaning as provided in Section 31A-8-101.

(10) (a) "Health plan" means any arrangement by which an individual, including a dependent or spouse, covered or making application to be covered under the pool has:

(i) access to hospital and medical benefits or reimbursement including group or individual insurance or subscriber contract;

(ii) coverage through:

(A) a health maintenance organization;

(B) a preferred provider prepayment;

(C) group practice; or

(D) individual practice plan;

(iii) coverage under an uninsured arrangement of group or group-type contracts including employer self-insured, cost-plus, or other benefits methodologies not involving insurance;

(iv) coverage under a group type contract which is not available to the general public and can be obtained only because of connection with a particular organization or group; and

(v) coverage by Medicare or other governmental benefit.

(b) "Health plan" includes coverage through health insurance.

(11) "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Pub. L. [~~No.~~] 104-191, 110 Stat.[~~1962~~] 1936.

(12) "HIPAA eligible" means an individual who is eligible under the provisions of the Health Insurance Portability and Accountability Act of 1996, Pub. L. [~~No.~~] 104-191, 110 Stat. [~~1979, Sec. 2741(b)~~] 1936.

(13) "Insurer" means:

(a) an insurance company authorized to transact accident and health insurance business in this state;

(b) a health maintenance organization; and

(c) a self-insurer not subject to federal preemption.

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

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

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

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

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

(19) "Pool policy" means a health insurance policy issued under this chapter.

(20) "Preexisting condition" [~~means a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period immediately prior to the enrollment date~~] has the same meaning as defined in Section 31A-1-301.

(21) (a) "Resident" or "residency" means a person who is domiciled in this state.

(b) A resident retains residency if that resident leaves this state:

(i) to serve in the armed forces of the United States; or

(ii) for religious or educational purposes.

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

Section 12. Section **31A-29-110** is amended to read:

31A-29-110. Pool administrator -- Selection -- Powers.

(1) The board shall select a pool administrator in accordance with Title 63, Chapter 56, Utah Procurement Code. The board shall evaluate bids based on criteria established by the board, which shall include:

(a) ability to manage medical expenses;

(b) proven ability to handle accident and health insurance;

(c) efficiency of claim paying procedures;

(d) marketing and underwriting;

(e) proven ability for managed care and quality assurance;

(f) provider contracting and discounts;

(g) pharmacy benefit management;

(h) an estimate of total charges for administering the pool; and

(i) ability to administer the pool in a cost-efficient manner.

(2) A pool administrator may be:

(a) a health insurer;

(b) a health maintenance organization;

(c) a third-party administrator; or

(d) any person or entity which has demonstrated ability to meet the criteria in Subsection (1).

(3) (a) The pool administrator shall serve for a period of three years [~~subject to removal for cause and~~], with two one-year extension options, subject to the terms, conditions, and limitations of the contract between the board and the administrator.

(b) At least one year prior to the expiration of [~~each three-year period of service by~~] the contract between the board and the pool administrator, the board shall invite all interested parties, including the current pool administrator, to submit bids to serve as the pool administrator [~~for the succeeding three-year period~~].

(c) Selection of the pool administrator for a succeeding period shall be made at least six months prior to the expiration of a three-year period of service by the pool administrator.

(4) The pool administrator is responsible for all operational functions of the pool and shall:

(a) have access to all nonpatient specific experience data, statistics, treatment criteria, and guidelines compiled or adopted by the Medicaid program, the Public Employees Health Plan, the Department of Health, or the Insurance Department, and which are not otherwise declared by

statute to be confidential;

(b) perform all marketing, eligibility, enrollment, member agreements, and administrative claim payment functions relating to the pool;

(c) establish, administer, and operate a monthly premium billing procedure for collection of premiums from enrollees;

(d) perform all necessary functions to assure timely payment of benefits to enrollees, including:

(i) making information available relating to the proper manner of submitting a claim for benefits to the pool administrator and distributing forms upon which submission shall be made; and

(ii) evaluating the eligibility of each claim for payment by the pool;

(e) submit regular reports to the board regarding the operation of the pool, the frequency, content, and form of which reports shall be determined by the board;

(f) following the close of each calendar year, determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and submit a report of this information to the board, the commissioner, and the Division of Finance on a form prescribed by the commissioner; and

(g) be paid as provided in the plan of operation for expenses incurred in the performance of the pool administrator's services.

Section 13. Section **31A-29-111** is amended to read:

31A-29-111. Eligibility -- Limitations.

(1) (a) Except as provided in Subsections (1)(b) and (2), an individual who is not HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium;

(ii) is a resident of this state; and

(iii) meets the health underwriting criteria under Subsection (5)(a).

(b) Notwithstanding Subsection (1)(a), an individual who is not HIPAA eligible is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual has terminated coverage in the pool, unless:

(A) 12 months have elapsed since the termination date; or

(B) the individual demonstrates that creditable coverage has been involuntarily terminated for any reason other than nonpayment of premium;

(iii) the pool has paid the maximum lifetime benefit to or on behalf of the individual;

(iv) the individual is an inmate of a public institution;

(v) the individual is eligible for [~~other~~] a public [~~programs for which medical care is provided~~] health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(vi) the individual's health condition does not meet the criteria established under Subsection (5);

(vii) the individual is eligible for coverage under an employer group that offers health insurance or a self-insurance arrangement to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(viii) the individual:

(A) has coverage substantially equivalent to a pool policy, as established by the board in administrative rule, either as an insured or a covered dependent; or

(B) would be eligible for the substantially equivalent coverage if the individual elected to obtain the coverage; or

(ix) at the time of application, the individual has not resided in Utah for at least 12 consecutive months preceding the date of application.

(2) (a) Except as provided in Subsections (1) and (2)(b), an individual who is HIPAA eligible is eligible for pool coverage if the individual:

(i) pays the established premium; and

(ii) is a resident of this state.

(b) Notwithstanding Subsections (1) and (2)(a), a HIPAA eligible individual is not eligible for pool coverage if one or more of the following conditions apply:

(i) the individual is eligible for health care benefits under Medicaid or Medicare, except as provided in Section 31A-29-112;

(ii) the individual is eligible for [~~other public programs for which medical care is provided~~] a public health plan, as defined in federal regulations adopted pursuant to 42 U.S.C. 300gg;

(iii) the individual is covered under any other health insurance;

(iv) the individual is eligible for coverage under an employer group that offers health insurance or self-insurance arrangements to its eligible employees, dependents, or members as:

(A) an eligible employee;

(B) a dependent of an eligible employee; or

(C) a member;

(v) the pool has paid the maximum lifetime benefit to or on behalf of the individual; or

(vi) the individual is an inmate of a public institution.

(3) (a) Notwithstanding Subsection (1)(b)(ix), if otherwise eligible under Subsection (1)(a), an individual whose health insurance coverage from a state high risk pool with similar coverage is terminated because of nonresidency in another state [~~may apply~~] is eligible for coverage under the pool subject to the conditions of Subsections (1)(b)(i) through (viii).

(b) Coverage sought under Subsection (3)(a) shall be applied for within 63 days after the termination date of the previous high risk pool coverage.

(c) The effective date of this state's pool coverage shall be the date of termination of the previous high risk pool coverage.

(d) The waiting period of an individual with a preexisting condition applying for coverage under this chapter shall be waived:

(i) to the extent to which the waiting period was satisfied under a similar plan from another state; and

(ii) if the other state's benefit limitation was not reached.

(4) (a) If an eligible individual applies for pool coverage within 30 days of being denied coverage by an individual carrier, the effective date for pool coverage shall be no later than the first day of the month following the date of submission of the completed insurance application to the carrier.

(b) Notwithstanding Subsection (4)(a), for individuals eligible for coverage under Subsection (3), the effective date shall be the date of termination of the previous high risk pool coverage.

(5) (a) The board shall establish and adjust, as necessary, health underwriting criteria based on:

(i) health condition; and

(ii) expected claims so that the expected claims are anticipated to remain within available funding.

(b) The board, with approval of the commissioner, may contract with one or more providers under Title 63, Chapter 56, Utah Procurement Code, to develop underwriting criteria under Subsection (5)(a).

(c) If an individual is denied coverage by the pool under the criteria established in Subsection (5)(a), the pool shall issue a certificate of insurability to the individual for coverage under Subsection 31A-30-108(3).

Section 14. Section **31A-29-113** is amended to read:

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

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

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

(ii) are not otherwise limited or excluded.

(b) Eligible medical expenses are the allowed charges established by the board for the health care services and items rendered during times for which benefits are extended under the

pool policy.

(2) The coverage to be issued by the pool, its schedule of benefits, exclusions, and other limitations shall be established by the board.

(3) The commissioner shall approve the benefit package developed by the board to ensure its compliance with this chapter.

(4) The pool shall offer at least one benefit plan through a managed care program as authorized under Section 31A-29-106.

(5) This chapter may not be construed to prohibit the pool from issuing additional types of pool policies with different types of benefits which in the opinion of the board may be of benefit to the citizens of Utah.

(6) (a) The board shall design and require an administrator to employ cost containment measures and requirements including preadmission certification and concurrent inpatient review for the purpose of making the pool more cost effective.

(b) Sections 31A-22-617 and 31A-22-618 do not apply to coverage issued under this chapter.

(7) (a) A pool policy may contain provisions under which coverage for a preexisting condition is excluded [~~during a~~] if:

(i) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received, from an individual licensed or similarly authorized to provide such services under state law and operating within the scope of practice authorized by state law, within the six-month period ending on the effective date of plan coverage; and

(ii) except as provided in Subsection (8), the exclusion extends for a period no longer than the six-month period following the effective date of plan coverage for a given individual.

(b) Subsection (7)(a) does not apply to a HIPAA eligible individual.

(8) (a) A pool policy may contain provisions under which coverage for a preexisting pregnancy is excluded during a ten-month period following the effective date of plan coverage for a given individual.

(b) Subsection (8)(a) does not apply to a HIPAA eligible individual.

(9) (a) The pool will waive the preexisting condition exclusion described in Subsections (7)(a) and (8)(a) for an individual that is changing health coverage to the pool, to the extent to which similar exclusions have been satisfied under any prior health insurance coverage if the individual applies not later than 63 days following the date of involuntary termination, other than for nonpayment of premiums, from health coverage.

(b) If this Subsection (9) applies, coverage in the pool shall be effective from the date on which the prior coverage was terminated.

(10) Covered benefits available from the pool may not exceed a $1,000,000 lifetime maximum, which includes a per enrollee calendar year maximum established by the board.

Section 15. Section **31A-30-107.5** is amended to read:

31A-30-107.5. Preexisting condition exclusion -- Condition-specific exclusion riders -- Limitation periods.

(1) A health benefit plan may impose a preexisting condition exclusion only if[~~:~~] the provision complies with Subsection 31A-22-605.1(4).

[~~(a) the exclusion relates to a condition, regardless of the cause of the condition, for which medical advise, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;~~]

[~~(b) the exclusion extends for a period of:~~]

[~~(i) not more than 12 months after the enrollment date; or~~]

[~~(ii) in the case of a late enrollee, 18 months after the enrollment date; and~~]

[~~(c) the period described in Subsection (1)(b) is reduced by the aggregate of the periods of creditable coverage applicable to the participant or beneficiary as of the enrollment date.~~]

[~~(2) Creditable coverage shall be provided for the period of time the individual was previously covered by:~~]

[~~(a) public or private health insurance; or~~]

[~~(b) any other group health plan as defined in 42 U.S.C. Section 300gg-91.~~]

[~~(3) (a) The period of continuous coverage under Subsection (1)(c) may not include any~~

~~waiting period for the effective date of the new coverage applied by the employer or the carrier.~~]

[~~(b) This Subsection (3) does not preclude application of any waiting period applicable to all new enrollees under the plan.~~]

[~~(4) (a) Credit for previous coverage as provided under Subsection (1)(c) need not be given for any condition that was previously excluded under a condition-specific exclusion rider issued pursuant to Subsection (6).~~]

[~~(b) A new preexisting waiting period may be applied to any condition that was excluded by a rider under the terms of previous individual coverage.~~]

[~~(5) (a) For purposes of Subsection (1)(c), a period of creditable coverage may not be counted with respect to enrollment of an individual under a health benefit plan, if:~~]

[~~(i) after the period and before the enrollment date, there was a 63-day period during all of which the individual was not covered under any creditable coverage; or~~]

[~~(ii) the insured fails to provide notification of previous coverage to the covered carrier within 36 months of the coverage effective date if the covered carrier has previously requested the notification.~~]

[~~(b) (i) Credit for previous coverage as provided under Subsection (1)(c) need not be given for any condition that was previously excluded in compliance with Subsection (6).~~]

[~~(ii) A new preexisting waiting period may be applied to any condition that was excluded under the terms of previous individual coverage.~~]

[~~(6)~~] (2) (a) An individual carrier:

[~~(i) shall offer a health benefit plan in compliance with Subsection (1);~~]

[~~(ii)~~] (i) may, when the individual carrier and the insured mutually agree in writing to a condition-specific exclusion rider, offer to issue an individual policy that excludes all treatment and prescription drugs related to a specific physical condition, or any specific or class of prescription drugs consistent with Subsection [~~(6)~~] (2)(b); and

[~~(iii)~~] (ii) may offer an individual policy that may establish separate cost sharing requirements including, deductibles and maximum limits that are specific to covered services and supplies, including specific drugs, when utilized for the treatment and care of the conditions

listed in Subsection [~~(6)~~] (2)(b).

(b) (i) The following may be the subject of a condition-specific exclusion rider except when a mastectomy has been performed or the condition is due to cancer:

(A) conditions of the bones or joints of the ankle, arm, elbow, foot, hand, hip, knee, leg, wrist, shoulder, spine, and toes, including bone spurs, bunions, carpal tunnel syndrome, club foot, hammertoe, syndactylism, and treatment and prosthetic devices related to amputation;

(B) anal fistula, breast implants, breast reduction, cystocele, rectocele enuresis, hemorrhoids, hydrocele, hypospadius, uterine leiomyoma, varicocele, spermatocele, endometriosis;

(C) deviated nasal septum, and other sinus related conditions;

(D) goiter and other thyroid related conditions, hemangioma, hernia, keloids, migraines, scar revisions, varicose veins, abdominoplasty;

(E) cataracts, cornia transplant, detached retina, glaucoma, keratoconus, macular degeneration, strabismus;

(F) Baker's cyst;

(G) allergies; and

(H) any specific or class of prescription drugs.

(ii) A condition-specific exclusion rider:

(A) shall be limited to the excluded condition;

(B) may not extend to any secondary medical condition that may or may not be directly related to the excluded condition; and

(C) must include the following informed consent paragraph: "I agree by signing below, to the terms of this rider, which excludes coverage for all treatment, including medications, related to specific condition(s) stated herein and that if treatment or medications are received that I have the responsibility for payment for those services and items. I further understand that this rider does not extend to any secondary medical condition that may or may not be directly related to the excluded condition(s) herein.

[~~(7)~~] (3) Notwithstanding the other provisions of this section, a health benefit plan may

impose a limitation period if:

(a) each policy that imposes a limitation period under the health benefit plan specifies the physical condition that is excluded from coverage during the limitation period;

(b) the limitation period does not exceed 12 months;

(c) the limitation period is applied uniformly; and

(d) the limitation period is reduced in compliance with [~~Subsection (1)(c)~~] Subsections 31A-22-605.1(4)(a) and (4)(b).