

INSURANCE REVISIONS

2021 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: James A. Dunnigan

Senate Sponsor: Curtis S. Bramble

LONG TITLE

General Description:

This bill amends the Insurance Code.

Highlighted Provisions:

This bill:

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

- 30 and genetic testings;
- 31 ▶ amends provisions regarding group life insurance related to trustee groups and
32 conversion on termination of eligibility;
- 33 ▶ amends provisions related to premium rates for accident and health insurance;
- 34 ▶ amends provisions related to the issuance of a group insurance policy offering life
35 insurance to an association group;
- 36 ▶ amends provisions regarding an association group to whom a group accident and
37 health insurance policy may be issued;
- 38 ▶ permits the Utah Insurance Commissioner to adopt rules permitting or including
39 independent review of benefit determinations for long-term care insurance;
- 40 ▶ amends the definition of "limited long-term care insurance" under the Limited
41 Long-term Care Insurance Act;
- 42 ▶ amends provisions related to the lapse of a license under Title 31A, Chapter 23a,
43 Insurance Marketing - Licensing Producers, Consultants, and Reinsurance
44 Intermediaries;
- 45 ▶ amends provisions of Title 31A, Chapter 23a, Insurance Marketing - Licensing
46 Producers, Consultants, and Reinsurance Intermediaries, in relation to inducements
47 and compensation;
- 48 ▶ amends provisions regarding a title insurance producer's business;
- 49 ▶ amends provisions related to certain trust obligations for a person authorized to
50 engage in the insurance business;
- 51 ▶ amends the definition of "company adjuster";
- 52 ▶ amends the coverage and limitations of guaranty association coverage;
- 53 ▶ amends the minimum financial requirements for a bail bond agency license;
- 54 ▶ amends the requirements for initial licensure and license renewal of a bail bond
55 agency license;
- 56 ▶ amends required unimpaired paid-in capital and other capital for capital insurance
57 companies;

- 58 ▶ permits a captive insurance company to provide coverage for punitive damages
- 59 awarded under certain conditions;
- 60 ▶ amends provisions allowing a captive insurance company to reinsure risks;
- 61 ▶ amends provisions related to a captive insurance company's certificate of dormancy;
- 62 and
- 63 ▶ makes technical and conforming changes.

64 Money Appropriated in this Bill:

65 None

66 Other Special Clauses:

67 None

68 Utah Code Sections Affected:

69 AMENDS:

- 70 **31A-1-103**, as last amended by Laws of Utah 2020, Chapter 32
- 71 **31A-1-301**, as last amended by Laws of Utah 2020, Chapter 32
- 72 **31A-17-404**, as last amended by Laws of Utah 2020, Chapter 32
- 73 **31A-21-101**, as last amended by Laws of Utah 2017, Chapter 363
- 74 **31A-21-201**, as last amended by Laws of Utah 2020, Chapter 32
- 75 **31A-21-402**, as last amended by Laws of Utah 2001, Chapter 116
- 76 **31A-21-404**, as last amended by Laws of Utah 2011, Chapter 62
- 77 **31A-22-409**, as last amended by Laws of Utah 2008, Chapters 345 and 382
- 78 **31A-22-501**, as last amended by Laws of Utah 2019, Chapter 193
- 79 **31A-22-504**, as last amended by Laws of Utah 2015, Chapter 244
- 80 **31A-22-505**, as last amended by Laws of Utah 2020, Chapter 32
- 81 **31A-22-517**, as last amended by Laws of Utah 2006, Chapter 175
- 82 **31A-22-522**, as last amended by Laws of Utah 2002, Chapter 308
- 83 **31A-22-600**, as last amended by Laws of Utah 2001, Chapter 116
- 84 **31A-22-602**, as last amended by Laws of Utah 2002, Chapter 308
- 85 **31A-22-607**, as last amended by Laws of Utah 2011, Chapter 284

86 **31A-22-608**, as last amended by Laws of Utah 2001, Chapter 116
87 **31A-22-612**, as last amended by Laws of Utah 2018, Chapter 319
88 **31A-22-618.6**, as last amended by Laws of Utah 2018, Chapter 319
89 **31A-22-618.7**, as last amended by Laws of Utah 2017, Chapter 168 and renumbered
90 and amended by Laws of Utah 2017, Chapter 292
91 **31A-22-618.8**, as renumbered and amended by Laws of Utah 2017, Chapter 292
92 **31A-22-627**, as last amended by Laws of Utah 2019, Chapter 193
93 **31A-22-654**, as enacted by Laws of Utah 2020, Chapter 187
94 **31A-22-701**, as last amended by Laws of Utah 2019, Chapter 193
95 **31A-22-716**, as last amended by Laws of Utah 2017, Chapter 168
96 **31A-22-717**, as last amended by Laws of Utah 2004, Chapter 108
97 **31A-22-1404**, as last amended by Laws of Utah 1995, Chapter 344
98 **31A-22-2002**, as enacted by Laws of Utah 2020, Chapter 32
99 **31A-23a-113**, as last amended by Laws of Utah 2015, Chapter 244
100 **31A-23a-201**, as renumbered and amended by Laws of Utah 2003, Chapter 298
101 **31A-23a-402.5**, as last amended by Laws of Utah 2018, Chapter 181
102 **31A-23a-406**, as last amended by Laws of Utah 2019, Chapter 231
103 **31A-23a-409**, as last amended by Laws of Utah 2012, Chapter 253
104 **31A-23a-501**, as last amended by Laws of Utah 2017, Chapter 168
105 **31A-26-102**, as last amended by Laws of Utah 2018, Chapter 319
106 **31A-28-103**, as last amended by Laws of Utah 2018, Chapter 391
107 **31A-35-404**, as last amended by Laws of Utah 2016, Chapter 234
108 **31A-35-406**, as last amended by Laws of Utah 2016, Chapter 234
109 **31A-37-102**, as last amended by Laws of Utah 2019, Chapter 193
110 **31A-37-202**, as repealed and reenacted by Laws of Utah 2019, Chapter 193
111 **31A-37-204**, as last amended by Laws of Utah 2017, Chapter 168
112 **31A-37-303**, as last amended by Laws of Utah 2020, Chapter 32
113 **31A-37-701**, as last amended by Laws of Utah 2020, Chapter 32

114 **31A-45-501**, as renumbered and amended by Laws of Utah 2017, Chapter 292

115

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

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

118 **31A-1-103. Scope and applicability of title.**

119 (1) This title does not apply to:

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

121 (i) with an individual client; and

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

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

126 (c) an arrangement for providing benefits that do not exceed a limited amount of
127 consultations, advice on simple legal matters, either alone or in combination with referral
128 services, or the promise of fee discounts for handling other legal matters;

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

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

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

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

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

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

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

- 142 (II) for a designated period of time; and
- 143 (III) for which no compensation, other than expenses, is paid; or
- 144 (B) the time since the service under Subsection (1)(f)(iii)(A) was completed is no more
- 145 than 18 months; or
- 146 (g) a prepaid contract of limited duration that provides for scheduled maintenance only.
- 147 (2) (a) This title restricts otherwise legitimate business activity.
- 148 (b) What this title does not prohibit is permitted unless contrary to other provisions of
- 149 Utah law.
- 150 (3) Except as otherwise expressly provided, this title does not apply to:
- 151 (a) those activities of an insurer where state jurisdiction is preempted by Section 514 of
- 152 the federal Employee Retirement Income Security Act of 1974, as amended;
- 153 (b) ocean marine insurance;
- 154 (c) death, accident, health, or disability benefits provided by an organization if the
- 155 organization:
- 156 (i) has as the organization's principal purpose to achieve charitable, educational, social,
- 157 or religious objectives rather than to provide death, accident, health, or disability benefits;
- 158 (ii) does not incur a legal obligation to pay a specified amount; and
- 159 (iii) does not create reasonable expectations of receiving a specified amount on the part
- 160 of an insured person;
- 161 (d) other business specified in rules adopted by the commissioner on a finding that:
- 162 (i) the transaction of the business in this state does not require regulation for the
- 163 protection of the interests of the residents of this state; or
- 164 (ii) it would be impracticable to require compliance with this title;
- 165 (e) except as provided in Subsection (4), a transaction independently procured through
- 166 negotiations under Section [31A-15-104](#);
- 167 (f) self-insurance;
- 168 (g) reinsurance;
- 169 (h) subject to Subsection (5), an employee [~~and~~] or labor union group [~~or~~] insurance

170 policy covering risks in this state or an employee or labor union blanket insurance policy
171 covering risks in this state, if:

- 172 (i) the policyholder exists primarily for purposes other than to procure insurance;
- 173 (ii) the policyholder:
 - 174 (A) is not a resident of this state;
 - 175 (B) is not a domestic corporation; or
 - 176 (C) does not have the policyholder's principal office in this state;
- 177 (iii) no more than 25% of the certificate holders or insureds are residents of this state;
- 178 (iv) on request of the commissioner, the insurer files with the department a copy of the
179 policy and a copy of each form or certificate; and
- 180 (v) (A) the insurer agrees to pay premium taxes on the Utah portion of the insurer's
181 business, as if the insurer were authorized to do business in this state; and
- 182 (B) the insurer provides the commissioner with the security the commissioner
183 considers necessary for the payment of premium taxes under Title 59, Chapter 9, Taxation of
184 Admitted Insurers;
 - 185 (i) to the extent provided in Subsection (6):
 - 186 (i) a manufacturer's or seller's warranty; and
 - 187 (ii) a manufacturer's or seller's service contract;
 - 188 (j) except to the extent provided in Subsection (7), a public agency insurance mutual;

189 or

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

192 (4) A transaction described in Subsection (3)(e) is subject to taxation under Section
193 [31A-3-301](#).

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

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

- 201 (i) the insurer to be authorized to do business in this state; or
- 202 (ii) that any of the insurer's transactions be subject to this title.

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

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

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

207 (A) made available by:

208 (I) a manufacturer of a product;

209 (II) a seller of a product; or

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

211 (B) made available:

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

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

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

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

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

219 (II) a seller of a product; or

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

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

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

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

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

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

228 (i) a warranty;

229 (ii) a guaranty; or

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

231 (c) This title does not apply to:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

253 (B) risk management.

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

- 257 (i) a third party administrator licensed under Chapter 25, Third Party Administrators;
- 258 (ii) an admitted insurer; or
- 259 (iii) a program authorized by Title 49, Chapter 20, Public Employees' Benefit and
260 Insurance Program Act.

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

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

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

268 **31A-1-301. Definitions.**

269 As used in this title, unless otherwise specified:

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

272 (i) a medical condition including:

273 (A) a medical care expense; or

274 (B) the risk of disability;

275 (ii) accident; or

276 (iii) sickness.

277 (b) "Accident and health insurance":

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

279 (A) an income replacement contract;

280 (B) a health care contract;

281 (C) an expense reimbursement contract;

- 282 (D) a credit accident and health contract;
- 283 (E) a continuing care contract; and
- 284 (F) a long-term care contract; and
- 285 (ii) may provide:
 - 286 (A) hospital coverage;
 - 287 (B) surgical coverage;
 - 288 (C) medical coverage;
 - 289 (D) loss of income coverage;
 - 290 (E) prescription drug coverage;
 - 291 (F) dental coverage; or
 - 292 (G) vision coverage.
- 293 (c) "Accident and health insurance" does not include workers' compensation insurance.
- 294 (d) For purposes of a national licensing registry, "accident and health insurance" is the
295 same as "accident and health or sickness insurance."
- 296 (2) "Actuary" is as defined by the commissioner by rule, made in accordance with Title
297 63G, Chapter 3, Utah Administrative Rulemaking Act.
- 298 (3) "Administrator" means the same as that term is defined in Subsection [~~(179)~~] (178).
- 299 (4) "Adult" means an individual who has attained the age of at least 18 years.
- 300 (5) "Affiliate" means a person who controls, is controlled by, or is under common
301 control with, another person. A corporation is an affiliate of another corporation, regardless of
302 ownership, if substantially the same group of individuals manage the corporations.
- 303 (6) "Agency" means:
 - 304 (a) a person other than an individual, including a sole proprietorship by which an
305 individual does business under an assumed name; and
 - 306 (b) an insurance organization licensed or required to be licensed under Section
307 [31A-23a-301](#), [31A-25-207](#), or [31A-26-209](#).
- 308 (7) "Alien insurer" means an insurer domiciled outside the United States.
- 309 (8) "Amendment" means an endorsement to an insurance policy or certificate.

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

314 (10) "Application" means a document:

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

316 and

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

318 whether to:

319 (A) insure the risk under:

320 (I) the coverage as originally offered; or

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

322 (B) decline to insure the risk; or

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

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

326 (a) the original articles;

327 (b) a special law;

328 (c) a charter;

329 (d) an amendment;

330 (e) restated articles;

331 (f) articles of merger or consolidation;

332 (g) a trust instrument;

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

334 and

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

336 (12) "Bail bond insurance" means a guarantee that a person will attend court when
337 required, up to and including surrender of the person in execution of a sentence imposed under

- 338 Subsection 77-20-7(1), as a condition to the release of that person from confinement.
- 339 (13) "Binder" means the same as that term is defined in Section 31A-21-102.
- 340 (14) "Blanket insurance policy" or "blanket contract" means a group insurance policy
- 341 covering a defined class of persons:
- 342 (a) without individual underwriting or application; and
- 343 (b) that is determined by definition without designating each person covered.
- 344 (15) "Board," "board of trustees," or "board of directors" means the group of persons
- 345 with responsibility over, or management of, a corporation, however designated.
- 346 (16) "Bona fide office" means a physical office in this state:
- 347 (a) that is open to the public;
- 348 (b) that is staffed during regular business hours on regular business days; and
- 349 (c) at which the public may appear in person to obtain services.
- 350 (17) "Business entity" means:
- 351 (a) a corporation;
- 352 (b) an association;
- 353 (c) a partnership;
- 354 (d) a limited liability company;
- 355 (e) a limited liability partnership; or
- 356 (f) another legal entity.
- 357 (18) "Business of insurance" means the same as that term is defined in Subsection (94).
- 358 (19) "Business plan" means the information required to be supplied to the
- 359 commissioner under Subsections 31A-5-204(2)(i) and (j), including the information required
- 360 when these subsections apply by reference under:
- 361 (a) Section 31A-8-205; or
- 362 (b) Subsection 31A-9-205(2).
- 363 (20) (a) "Bylaws" means the rules adopted for the regulation or management of a
- 364 corporation's affairs, however designated.
- 365 (b) "Bylaws" includes comparable rules for a trust or other entity that is not a

366 corporation.

367 (21) "Captive insurance company" means:

368 (a) an insurer:

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

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

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

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

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

375 (i) owned by the insureds; and

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

377 (A) a member organization;

378 (B) a group member; or

379 (C) an affiliate of:

380 (I) a member organization; or

381 (II) a group member.

382 (22) "Casualty insurance" means liability insurance.

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

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

385 (b) a third party.

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

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

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

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

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

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

- 397 (i) provides board and lodging;
- 398 (ii) provides one or more of the following:

399 (A) a personal service;

400 (B) a nursing service;

401 (C) a medical service; or

402 (D) any other health-related service; and

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

405 (A) for the life of the insured; or

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

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

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

412 (i) by contract;

413 (ii) by common management;

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

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

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

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

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

422 voting securities of another person.

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

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

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

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

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

434 (i) a corporation doing business:

435 (A) as:

436 (I) an insurance producer;

437 (II) a surplus lines producer;

438 (III) a limited line producer;

439 (IV) a consultant;

440 (V) a managing general agent;

441 (VI) a reinsurance intermediary;

442 (VII) a third party administrator; or

443 (VIII) an adjuster; and

444 (B) under:

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

447 (II) Chapter 25, Third Party Administrators; or

448 (III) Chapter 26, Insurance Adjusters; or

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

450 Holding Companies.

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

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

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

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

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

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

460 (iii) the Ryan White Program Comprehensive AIDS Resources Emergency Act, Pub. L.
461 No. 101-381, and Ryan White HIV/AIDS Treatment Modernization Act of 2006, Pub. L. No.
462 109-415.

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

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

468 (b) "Credit insurance" includes:

469 (i) credit accident and health insurance;

470 (ii) credit life insurance;

471 (iii) credit property insurance;

472 (iv) credit unemployment insurance;

473 (v) guaranteed automobile protection insurance;

474 (vi) involuntary unemployment insurance;

475 (vii) mortgage accident and health insurance;

476 (viii) mortgage guaranty insurance; and

477 (ix) mortgage life insurance.

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

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

- 481 (a) matured;
- 482 (b) unmatured;
- 483 (c) liquidated;
- 484 (d) unliquidated;
- 485 (e) secured;
- 486 (f) unsecured;
- 487 (g) absolute;
- 488 (h) fixed; or
- 489 (i) contingent.

490 (40) "Credit property insurance" means insurance:

- 491 (a) offered in connection with an extension of credit; and
- 492 (b) that protects the property until the debt is paid.

493 (41) "Credit unemployment insurance" means insurance:

- 494 (a) offered in connection with an extension of credit; and
- 495 (b) that provides indemnity if the debtor is unemployed for payments coming due on a:
 - 496 (i) specific loan; or
 - 497 (ii) credit transaction.

498 (42) (a) "Crop insurance" means insurance providing protection against damage to
499 crops from unfavorable weather conditions, fire or lightning, flood, hail, insect infestation,
500 disease, or other yield-reducing conditions or perils that is:

- 501 (i) provided by the private insurance market; or
- 502 (ii) subsidized by the Federal Crop Insurance Corporation.

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

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

- 506 (i) for the customer service representative's:
- 507 (A) producer;
- 508 (B) surplus lines producer; or
- 509 (C) consultant employer; and
- 510 (ii) to the customer service representative's employer's:
- 511 (A) customer;
- 512 (B) client; or
- 513 (C) organization.
- 514 (b) A customer service representative may only operate within the scope of authority of
- 515 the customer service representative's producer, surplus lines producer, or consultant employer.
- 516 (44) "Deadline" means a final date or time:
- 517 (a) imposed by:
- 518 (i) statute;
- 519 (ii) rule; or
- 520 (iii) order; and
- 521 (b) by which a required filing or payment must be received by the department.
- 522 (45) "Deemer clause" means a provision under this title under which upon the
- 523 occurrence of a condition precedent, the commissioner is considered to have taken a specific
- 524 action. If the statute so provides, a condition precedent may be the commissioner's failure to
- 525 take a specific action.
- 526 (46) "Degree of relationship" means the number of steps between two persons
- 527 determined by counting the generations separating one person from a common ancestor and
- 528 then counting the generations to the other person.
- 529 (47) "Department" means the Insurance Department.
- 530 (48) "Director" means a member of the board of directors of a corporation.
- 531 (49) "Disability" means a physiological or psychological condition that partially or
- 532 totally limits an individual's ability to:
- 533 (a) perform the duties of:

- 534 (i) that individual's occupation; or
- 535 (ii) an occupation for which the individual is reasonably suited by education, training,
- 536 or experience; or
- 537 (b) perform two or more of the following basic activities of daily living:
- 538 (i) eating;
- 539 (ii) toileting;
- 540 (iii) transferring;
- 541 (iv) bathing; or
- 542 (v) dressing.
- 543 (50) "Disability income insurance" means the same as that term is defined in
- 544 Subsection (85).
- 545 (51) "Domestic insurer" means an insurer organized under the laws of this state.
- 546 (52) "Domiciliary state" means the state in which an insurer:
- 547 (a) is incorporated;
- 548 (b) is organized; or
- 549 (c) in the case of an alien insurer, enters into the United States.
- 550 (53) (a) "Eligible employee" means:
- 551 (i) an employee who:
- 552 (A) works on a full-time basis; and
- 553 (B) has a normal work week of 30 or more hours; or
- 554 (ii) a person described in Subsection (53)(b).
- 555 (b) "Eligible employee" includes:
- 556 (i) an owner who:
- 557 (A) works on a full-time basis;
- 558 (B) has a normal work week of 30 or more hours; and
- 559 (C) employs at least one common employee; and
- 560 (ii) if the individual is included under a health benefit plan of a small employer:
- 561 (A) a sole proprietor;

- 562 (B) a partner in a partnership; or
- 563 (C) an independent contractor.
- 564 (c) "Eligible employee" does not include, unless eligible under Subsection (53)(b):
- 565 (i) an individual who works on a temporary or substitute basis for a small employer;
- 566 (ii) an employer's spouse who does not meet the requirements of Subsection (53)(a)(i);
- 567 or
- 568 (iii) a dependent of an employer who does not meet the requirements of Subsection
- 569 (53)(a)(i).
- 570 (54) "Employee" means:
- 571 (a) an individual employed by an employer; and
- 572 (b) an owner who meets the requirements of Subsection (53)(b)(i).
- 573 (55) "Employee benefits" means one or more benefits or services provided to:
- 574 (a) an employee; or
- 575 (b) a dependent of an employee.
- 576 (56) (a) "Employee welfare fund" means a fund:
- 577 (i) established or maintained, whether directly or through a trustee, by:
- 578 (A) one or more employers;
- 579 (B) one or more labor organizations; or
- 580 (C) a combination of employers and labor organizations; and
- 581 (ii) that provides employee benefits paid or contracted to be paid, other than income
- 582 from investments of the fund:
- 583 (A) by or on behalf of an employer doing business in this state; or
- 584 (B) for the benefit of a person employed in this state.
- 585 (b) "Employee welfare fund" includes a plan funded or subsidized by a user fee or tax
- 586 revenues.
- 587 (57) "Endorsement" means a written agreement attached to a policy or certificate to
- 588 modify the policy or certificate coverage.
- 589 (58) (a) "Enrollee" means:

- 590 (i) a policyholder;
- 591 (ii) a certificate holder;
- 592 (iii) a subscriber; or
- 593 (iv) a covered individual:
 - 594 (A) who has entered into a contract with an organization for health care; or
 - 595 (B) on whose behalf an arrangement for health care has been made.
- 596 (b) "Enrollee" includes an insured.
- 597 (59) "Enrollment date," with respect to a health benefit plan, means:
 - 598 (a) the first day of coverage; or
 - 599 (b) if there is a waiting period, the first day of the waiting period.
- 600 (60) "Enterprise risk" means an activity, circumstance, event, or series of events
- 601 involving one or more affiliates of an insurer that, if not remedied promptly, is likely to have a
- 602 material adverse effect upon the financial condition or liquidity of the insurer or its insurance
- 603 holding company system as a whole, including anything that would cause:
 - 604 (a) the insurer's risk-based capital to fall into an action or control level as set forth in
 - 605 Sections [31A-17-601](#) through [31A-17-613](#); or
 - 606 (b) the insurer to be in hazardous financial condition set forth in Section [31A-27a-101](#).
- 607 (61) (a) "Escrow" means:
 - 608 (i) a transaction that effects the sale, transfer, encumbering, or leasing of real property,
 - 609 when a person not a party to the transaction, and neither having nor acquiring an interest in the
 - 610 title, performs, in accordance with the written instructions or terms of the written agreement
 - 611 between the parties to the transaction, any of the following actions:
 - 612 (A) the explanation, holding, or creation of a document; or
 - 613 (B) the receipt, deposit, and disbursement of money;
 - 614 (ii) a settlement or closing involving:
 - 615 (A) a mobile home;
 - 616 (B) a grazing right;
 - 617 (C) a water right; or

- 618 (D) other personal property authorized by the commissioner.
- 619 (b) "Escrow" does not include:
- 620 (i) the following notarial acts performed by a notary within the state:
- 621 (A) an acknowledgment;
- 622 (B) a copy certification;
- 623 (C) jurat; and
- 624 (D) an oath or affirmation;
- 625 (ii) the receipt or delivery of a document; or
- 626 (iii) the receipt of money for delivery to the escrow agent.
- 627 (62) "Escrow agent" means an agency title insurance producer meeting the
- 628 requirements of Sections [31A-4-107](#), [31A-14-211](#), and [31A-23a-204](#), who is acting through an
- 629 individual title insurance producer licensed with an escrow subline of authority.
- 630 (63) (a) "Excludes" is not exhaustive and does not mean that another thing is not also
- 631 excluded.
- 632 (b) The items listed in a list using the term "excludes" are representative examples for
- 633 use in interpretation of this title.
- 634 (64) "Exclusion" means for the purposes of accident and health insurance that an
- 635 insurer does not provide insurance coverage, for whatever reason, for one of the following:
- 636 (a) a specific physical condition;
- 637 (b) a specific medical procedure;
- 638 (c) a specific disease or disorder; or
- 639 (d) a specific prescription drug or class of prescription drugs.
- 640 (65) "Expense reimbursement insurance" means insurance:
- 641 (a) written to provide a payment for an expense relating to hospital confinement
- 642 resulting from illness or injury; and
- 643 (b) written:
- 644 (i) as a daily limit for a specific number of days in a hospital; and
- 645 (ii) to have a one or two day waiting period following a hospitalization.

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

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

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

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

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

654 (A) Section [31A-3-103](#); or

655 (B) rule.

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

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

660 (a) a policy;

661 (b) a rate;

662 (c) a form;

663 (d) a document;

664 (e) a plan;

665 (f) a manual;

666 (g) an application;

667 (h) a report;

668 (i) a certificate;

669 (j) an endorsement;

670 (k) an actuarial certification;

671 (l) a licensee annual statement;

672 (m) a licensee renewal application;

673 (n) an advertisement;

674 (o) a binder; or

675 (p) an outline of coverage.

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

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

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

681 (i) a policy;

682 (ii) a certificate;

683 (iii) an application;

684 (iv) an outline of coverage; or

685 (v) an endorsement.

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

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

691 (73) "General lines of authority" include:

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

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

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

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

696 (iii) title marketing representative only;

697 (c) surplus lines;

698 (d) workers' compensation; and

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

701 (74) "General lines of insurance" include:

- 702 (a) accident and health;
- 703 (b) casualty;
- 704 (c) life;
- 705 (d) personal lines;
- 706 (e) property; and
- 707 (f) variable contracts, including variable life and annuity.
- 708 (75) "Group health plan" means an employee welfare benefit plan to the extent that the
- 709 plan provides medical care:
 - 710 (a) (i) to an employee; or
 - 711 (ii) to a dependent of an employee; and
 - 712 (b) (i) directly;
 - 713 (ii) through insurance reimbursement; or
 - 714 (iii) through another method.
- 715 (76) (a) "Group insurance policy" means a policy covering a group of persons that is
- 716 issued:
 - 717 (i) to a policyholder on behalf of the group; and
 - 718 (ii) for the benefit of a member of the group who is selected under a procedure defined
 - 719 in:
 - 720 (A) the policy; or
 - 721 (B) an agreement that is collateral to the policy.
 - 722 (b) A group insurance policy may include a member of the policyholder's family or a
 - 723 dependent.
- 724 (77) "Group-wide supervisor" means the commissioner or other regulatory official
- 725 designated as the group-wide supervisor for an internationally active insurance group under
- 726 Section [31A-16-108.6](#).
- 727 (78) "Guaranteed automobile protection insurance" means insurance offered in
- 728 connection with an extension of credit that pays the difference in amount between the
- 729 insurance settlement and the balance of the loan if the insured automobile is a total loss.

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

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

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

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

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

739 (iv) workers' compensation or similar insurance;

740 (v) automobile medical payment insurance;

741 (vi) credit-only insurance;

742 (vii) coverage for on-site medical clinics;

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

746 (ix) the following benefits if they are provided under a separate policy, certificate, or
747 contract of insurance or are otherwise not an integral part of the plan:

748 (A) limited scope dental or vision benefits;

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

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

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

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

- 758 (B) hospital indemnity or other fixed indemnity insurance;
- 759 (xi) the following if offered as a separate policy, certificate, or contract of insurance:
- 760 (A) Medicare supplemental health insurance as defined under the Social Security Act,
- 761 42 U.S.C. Sec. 1395ss(g)(1);
- 762 (B) coverage supplemental to the coverage provided under United States Code, Title
- 763 10, Chapter 55, Civilian Health and Medical Program of the Uniformed Services
- 764 (CHAMPUS); or
- 765 (C) similar supplemental coverage provided to coverage under a group health insurance
- 766 plan;
- 767 (xii) short-term~~[, limited-duration]~~ limited duration health insurance; and
- 768 (xiii) student health insurance, except as required under 45 C.F.R. Sec. 147.145.
- 769 (80) "Health care" means any of the following intended for use in the diagnosis,
- 770 treatment, mitigation, or prevention of a human ailment or impairment:
- 771 (a) a professional service;
- 772 (b) a personal service;
- 773 (c) a facility;
- 774 (d) equipment;
- 775 (e) a device;
- 776 (f) supplies; or
- 777 (g) medicine.
- 778 (81) (a) "Health care insurance" or "health insurance" means insurance providing:
- 779 (i) a health care benefit; or
- 780 (ii) payment of an incurred health care expense.
- 781 (b) "Health care insurance" or "health insurance" does not include accident and health
- 782 insurance providing a benefit for:
- 783 (i) replacement of income;
- 784 (ii) short-term accident;
- 785 (iii) fixed indemnity;

786 (iv) credit accident and health;
787 (v) supplements to liability;
788 (vi) workers' compensation;
789 (vii) automobile medical payment;
790 (viii) no-fault automobile;
791 (ix) equivalent self-insurance; or
792 (x) a type of accident and health insurance coverage that is a part of or attached to
793 another type of policy.

794 (82) "Health care provider" means the same as that term is defined in Section
795 [78B-3-403](#).

796 (83) "Health insurance exchange" means an exchange as defined in 45 C.F.R. Sec.
797 155.20.

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

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

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

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

806 (88) "Independently procured insurance" means insurance procured under Section
807 [31A-15-104](#).

808 (89) "Individual" means a natural person.

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

- 810 (a) property in transit on or over land;
- 811 (b) property in transit over water by means other than boat or ship;
- 812 (c) bailee liability;
- 813 (d) fixed transportation property such as bridges, electric transmission systems, radio

814 and television transmission towers and tunnels; and

815 (e) personal and commercial property floaters.

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

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

818 (b) an insurer's total adjusted capital is less than the insurer's mandatory control level

819 RBC under Subsection [31A-17-601](#)(8)(c); or

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

821 (92) (a) "Insurance" means:

822 (i) an arrangement, contract, or plan for the transfer of a risk or risks from one or more

823 persons to one or more other persons; or

824 (ii) an arrangement, contract, or plan for the distribution of a risk or risks among a

825 group of persons that includes the person seeking to distribute that person's risk.

826 (b) "Insurance" includes:

827 (i) a risk distributing arrangement providing for compensation or replacement for

828 damages or loss through the provision of a service or a benefit in kind;

829 (ii) a contract of guaranty or suretyship entered into by the guarantor or surety as a

830 business and not as merely incidental to a business transaction; and

831 (iii) a plan in which the risk does not rest upon the person who makes an arrangement,

832 but with a class of persons who have agreed to share the risk.

833 (93) "Insurance adjuster" means a person who directs or conducts the investigation,

834 negotiation, or settlement of a claim under an insurance policy other than life insurance or an

835 annuity, on behalf of an insurer, policyholder, or a claimant under an insurance policy.

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

837 (a) providing health care insurance by an organization that is or is required to be

838 licensed under this title;

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

840 control of the employee, in which the employee is entitled to the benefit as a right, which

841 benefit may be provided either:

- 842 (i) by a single employer or by multiple employer groups; or
- 843 (ii) through one or more trusts, associations, or other entities;
- 844 (c) providing an annuity:
 - 845 (i) including an annuity issued in return for a gift; and
 - 846 (ii) except an annuity provided by a person specified in Subsections 31A-22-1305(2)
- 847 and (3);
- 848 (d) providing the characteristic services of a motor club as outlined in Subsection
- 849 (125);
- 850 (e) providing another person with insurance;
- 851 (f) making as insurer, guarantor, or surety, or proposing to make as insurer, guarantor,
- 852 or surety, a contract or policy ~~[of]~~ offering title insurance;
- 853 (g) transacting or proposing to transact any phase of title insurance, including:
 - 854 (i) solicitation;
 - 855 (ii) negotiation preliminary to execution;
 - 856 (iii) execution of a contract of title insurance;
 - 857 (iv) insuring; and
 - 858 (v) transacting matters subsequent to the execution of the contract and arising out of
 - 859 the contract, including reinsurance;
- 860 (h) transacting or proposing a life settlement; and
- 861 (i) doing, or proposing to do, any business in substance equivalent to Subsections
- 862 (94)(a) through (h) in a manner designed to evade this title.
- 863 (95) "Insurance consultant" or "consultant" means a person who:
 - 864 (a) advises another person about insurance needs and coverages;
 - 865 (b) is compensated by the person advised on a basis not directly related to the insurance
 - 866 placed; and
 - 867 (c) except as provided in Section 31A-23a-501, is not compensated directly or
 - 868 indirectly by an insurer or producer for advice given.
- 869 (96) "Insurance group" means the persons that comprise an insurance holding company

870 system.

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

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

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

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

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

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

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

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

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

887 (i) a policyholder;

888 (ii) a subscriber;

889 (iii) a member; and

890 (iv) a beneficiary.

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

892 (i) applies only to this title;

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

895 (iii) includes an enrollee.

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

- 898 (i) a fraternal benefit society;
- 899 (ii) an issuer of a gift annuity other than an annuity specified in Subsections
- 900 [31A-22-1305](#)(2) and (3);
- 901 (iii) a motor club;
- 902 (iv) an employee welfare plan;
- 903 (v) a person purporting or intending to do an insurance business as a principal on that
- 904 person's own account; and
- 905 (vi) a health maintenance organization.
- 906 (b) "Insurer" does not include a governmental entity.
- 907 (101) "Interinsurance exchange" means the same as that term is defined in Subsection
- 908 (160).
- 909 (102) "Internationally active insurance group" means an insurance holding company
- 910 system:
- 911 (a) that includes an insurer registered under Section [31A-16-105](#);
- 912 (b) that has premiums written in at least three countries;
- 913 (c) whose percentage of gross premiums written outside the United States is at least
- 914 10% of its total gross written premiums; and
- 915 (d) that, based on a three-year rolling average, has:
- 916 (i) total assets of at least \$50,000,000,000; or
- 917 (ii) total gross written premiums of at least \$10,000,000,000.
- 918 (103) "Involuntary unemployment insurance" means insurance:
- 919 (a) offered in connection with an extension of credit; and
- 920 (b) that provides indemnity if the debtor is involuntarily unemployed for payments
- 921 coming due on a:
- 922 (i) specific loan; or
- 923 (ii) credit transaction.
- 924 (104) "Large employer," in connection with a health benefit plan, means an employer
- 925 who, with respect to a calendar year and to a plan year:

- 926 (a) employed an average of at least 51 employees on business days during the
927 preceding calendar year; and
- 928 (b) employs at least one employee on the first day of the plan year.
- 929 (105) "Late enrollee," with respect to an employer health benefit plan, means an
930 individual whose enrollment is a late enrollment.
- 931 (106) "Late enrollment," with respect to an employer health benefit plan, means
932 enrollment of an individual other than:
- 933 (a) on the earliest date on which coverage can become effective for the individual
934 under the terms of the plan; or
- 935 (b) through special enrollment.
- 936 (107) (a) Except for a retainer contract or legal assistance described in Section
937 [31A-1-103](#), "legal expense insurance" means insurance written to indemnify or pay for a
938 specified legal expense.
- 939 (b) "Legal expense insurance" includes an arrangement that creates a reasonable
940 expectation of an enforceable right.
- 941 (c) "Legal expense insurance" does not include the provision of, or reimbursement for,
942 legal services incidental to other insurance coverage.
- 943 (108) (a) "Liability insurance" means insurance against liability:
- 944 (i) for death, injury, or disability of a human being, or for damage to property,
945 exclusive of the coverages under:
- 946 (A) medical malpractice insurance;
- 947 (B) professional liability insurance; and
- 948 (C) workers' compensation insurance;
- 949 (ii) for a medical, hospital, surgical, and funeral benefit to a person other than the
950 insured who is injured, irrespective of legal liability of the insured, when issued with or
951 supplemental to insurance against legal liability for the death, injury, or disability of a human
952 being, exclusive of the coverages under:
- 953 (A) medical malpractice insurance;

- 954 (B) professional liability insurance; and
- 955 (C) workers' compensation insurance;
- 956 (iii) for loss or damage to property resulting from an accident to or explosion of a
- 957 boiler, pipe, pressure container, machinery, or apparatus;
- 958 (iv) for loss or damage to property caused by:
- 959 (A) the breakage or leakage of a sprinkler, water pipe, or water container; or
- 960 (B) water entering through a leak or opening in a building; or
- 961 (v) for other loss or damage properly the subject of insurance not within another kind
- 962 of insurance as defined in this chapter, if the insurance is not contrary to law or public policy.
- 963 (b) "Liability insurance" includes:
- 964 (i) vehicle liability insurance;
- 965 (ii) residential dwelling liability insurance; and
- 966 (iii) making inspection of, and issuing a certificate of inspection upon, an elevator,
- 967 boiler, machinery, or apparatus of any kind when done in connection with insurance on the
- 968 elevator, boiler, machinery, or apparatus.
- 969 (109) (a) "License" means authorization issued by the commissioner to engage in an
- 970 activity that is part of or related to the insurance business.
- 971 (b) "License" includes a certificate of authority issued to an insurer.
- 972 (110) (a) "Life insurance" means:
- 973 (i) insurance on a human life; and
- 974 (ii) insurance pertaining to or connected with human life.
- 975 (b) The business of life insurance includes:
- 976 (i) granting a death benefit;
- 977 (ii) granting an annuity benefit;
- 978 (iii) granting an endowment benefit;
- 979 (iv) granting an additional benefit in the event of death by accident;
- 980 (v) granting an additional benefit to safeguard the policy against lapse; and
- 981 (vi) providing an optional method of settlement of proceeds.

- 982 (111) "Limited license" means a license that:
- 983 (a) is issued for a specific product of insurance; and
- 984 (b) limits an individual or agency to transact only for that product or insurance.
- 985 (112) "Limited line credit insurance" includes the following forms of insurance:
- 986 (a) credit life;
- 987 (b) credit accident and health;
- 988 (c) credit property;
- 989 (d) credit unemployment;
- 990 (e) involuntary unemployment;
- 991 (f) mortgage life;
- 992 (g) mortgage guaranty;
- 993 (h) mortgage accident and health;
- 994 (i) guaranteed automobile protection; and
- 995 (j) another form of insurance offered in connection with an extension of credit that:
- 996 (i) is limited to partially or wholly extinguishing the credit obligation; and
- 997 (ii) the commissioner determines by rule should be designated as a form of limited line
- 998 credit insurance.
- 999 (113) "Limited line credit insurance producer" means a person who sells, solicits, or
- 1000 negotiates one or more forms of limited line credit insurance coverage to an individual through
- 1001 a master, corporate, group, or individual policy.
- 1002 (114) "Limited line insurance" includes:
- 1003 (a) bail bond;
- 1004 (b) limited line credit insurance;
- 1005 (c) legal expense insurance;
- 1006 (d) motor club insurance;
- 1007 (e) car rental related insurance;
- 1008 (f) travel insurance;
- 1009 (g) crop insurance;

1010 (h) self-service storage insurance;
1011 (i) guaranteed asset protection waiver;
1012 (j) portable electronics insurance; and
1013 (k) another form of limited insurance that the commissioner determines by rule should
1014 be designated a form of limited line insurance.

1015 (115) "Limited lines authority" includes the lines of insurance listed in Subsection
1016 (114).

1017 (116) "Limited lines producer" means a person who sells, solicits, or negotiates limited
1018 lines insurance.

1019 (117) (a) "Long-term care insurance" means an insurance policy or rider advertised,
1020 marketed, offered, or designated to provide coverage:

1021 (i) in a setting other than an acute care unit of a hospital;
1022 (ii) for not less than 12 consecutive months for a covered person on the basis of:

1023 (A) expenses incurred;

1024 (B) indemnity;

1025 (C) prepayment; or

1026 (D) another method;

1027 (iii) for one or more necessary or medically necessary services that are:

1028 (A) diagnostic;

1029 (B) preventative;

1030 (C) therapeutic;

1031 (D) rehabilitative;

1032 (E) maintenance; or

1033 (F) personal care; and

1034 (iv) that may be issued by:

1035 (A) an insurer;

1036 (B) a fraternal benefit society;

1037 (C) (I) a nonprofit health hospital; and

- 1038 (II) a medical service corporation;
- 1039 (D) a prepaid health plan;
- 1040 (E) a health maintenance organization; or
- 1041 (F) an entity similar to the entities described in Subsections (117)(a)(iv)(A) through (E)
- 1042 to the extent that the entity is otherwise authorized to issue life or health care insurance.
- 1043 (b) "Long-term care insurance" includes:
- 1044 (i) any of the following that provide directly or supplement long-term care insurance:
- 1045 (A) a group or individual annuity or rider; or
- 1046 (B) a life insurance policy or rider;
- 1047 (ii) a policy or rider that provides for payment of benefits on the basis of:
- 1048 (A) cognitive impairment; or
- 1049 (B) functional capacity; or
- 1050 (iii) a qualified long-term care insurance contract.
- 1051 (c) "Long-term care insurance" does not include:
- 1052 (i) a policy that is offered primarily to provide basic Medicare supplement coverage;
- 1053 (ii) basic hospital expense coverage;
- 1054 (iii) basic medical/surgical expense coverage;
- 1055 (iv) hospital confinement indemnity coverage;
- 1056 (v) major medical expense coverage;
- 1057 (vi) income replacement or related asset-protection coverage;
- 1058 (vii) accident only coverage;
- 1059 (viii) coverage for a specified:
- 1060 (A) disease; or
- 1061 (B) accident;
- 1062 (ix) limited benefit health coverage; or
- 1063 (x) a life insurance policy that accelerates the death benefit to provide the option of a
- 1064 lump sum payment:
- 1065 (A) if the following are not conditioned on the receipt of long-term care:

- 1066 (I) benefits; or
- 1067 (II) eligibility; and
- 1068 (B) the coverage is for one or more the following qualifying events:
- 1069 (I) terminal illness;
- 1070 (II) medical conditions requiring extraordinary medical intervention; or
- 1071 (III) permanent institutional confinement.
- 1072 (118) "Managed care organization" means a person:
- 1073 (a) licensed as a health maintenance organization under Chapter 8, Health Maintenance
- 1074 Organizations and Limited Health Plans; or
- 1075 (b) (i) licensed under:
- 1076 (A) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
- 1077 (B) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1078 (C) Chapter 14, Foreign Insurers; and
- 1079 (ii) that requires an enrollee to use, or offers incentives, including financial incentives,
- 1080 for an enrollee to use, network providers.
- 1081 (119) "Medical malpractice insurance" means insurance against legal liability incident
- 1082 to the practice and provision of a medical service other than the practice and provision of a
- 1083 dental service.
- 1084 (120) "Member" means a person having membership rights in an insurance
- 1085 corporation.
- 1086 (121) "Minimum capital" or "minimum required capital" means the capital that must be
- 1087 constantly maintained by a stock insurance corporation as required by statute.
- 1088 (122) "Mortgage accident and health insurance" means insurance offered in connection
- 1089 with an extension of credit that provides indemnity for payments coming due on a mortgage
- 1090 while the debtor has a disability.
- 1091 (123) "Mortgage guaranty insurance" means surety insurance under which a mortgagee
- 1092 or other creditor is indemnified against losses caused by the default of a debtor.
- 1093 (124) "Mortgage life insurance" means insurance on the life of a debtor in connection

1094 with an extension of credit that pays if the debtor dies.

1095 (125) "Motor club" means a person:

1096 (a) licensed under:

1097 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;

1098 (ii) Chapter 11, Motor Clubs; or

1099 (iii) Chapter 14, Foreign Insurers; and

1100 (b) that promises for an advance consideration to provide for a stated period of time

1101 one or more:

1102 (i) legal services under Subsection [31A-11-102\(1\)\(b\)](#);

1103 (ii) bail services under Subsection [31A-11-102\(1\)\(c\)](#); or

1104 (iii) (A) trip reimbursement;

1105 (B) towing services;

1106 (C) emergency road services;

1107 (D) stolen automobile services;

1108 (E) a combination of the services listed in Subsections (125)(b)(iii)(A) through (D); or

1109 (F) other services given in Subsections [31A-11-102\(1\)\(b\)](#) through (f).

1110 (126) "Mutual" means a mutual insurance corporation.

1111 (127) "Network plan" means health care insurance:

1112 (a) that is issued by an insurer; and

1113 (b) under which the financing and delivery of medical care is provided, in whole or in
1114 part, through a defined set of providers under contract with the insurer, including the financing
1115 and delivery of an item paid for as medical care.

1116 (128) "Network provider" means a health care provider who has an agreement with a
1117 managed care organization to provide health care services to an enrollee with an expectation of
1118 receiving payment, other than coinsurance, copayments, or deductibles, directly from the
1119 managed care organization.

1120 (129) "Nonparticipating" means a plan of insurance under which the insured is not
1121 entitled to receive a dividend representing a share of the surplus of the insurer.

- 1122 (130) "Ocean marine insurance" means insurance against loss of or damage to:
1123 (a) ships or hulls of ships;
1124 (b) goods, freight, cargoes, merchandise, effects, disbursements, profits, money,
1125 securities, choses in action, evidences of debt, valuable papers, bottomry, respondentia
1126 interests, or other cargoes in or awaiting transit over the oceans or inland waterways;
1127 (c) earnings such as freight, passage money, commissions, or profits derived from
1128 transporting goods or people upon or across the oceans or inland waterways; or
1129 (d) a vessel owner or operator as a result of liability to employees, passengers, bailors,
1130 owners of other vessels, owners of fixed objects, customs or other authorities, or other persons
1131 in connection with maritime activity.
- 1132 (131) "Order" means an order of the commissioner.
- 1133 (132) "ORSA guidance manual" means the current version of the Own Risk and
1134 Solvency Assessment Guidance Manual developed and adopted by the National Association of
1135 Insurance Commissioners and as amended from time to time.
- 1136 (133) "ORSA summary report" means a confidential high-level summary of an insurer
1137 or insurance group's own risk and solvency assessment.
- 1138 (134) "Outline of coverage" means a summary that explains an accident and health
1139 insurance policy.
- 1140 (135) "Own risk and solvency assessment" means an insurer or insurance group's
1141 confidential internal assessment:
- 1142 (a) (i) of each material and relevant risk associated with the insurer or insurance group;
1143 (ii) of the insurer or insurance group's current business plan to support each risk
1144 described in Subsection (135)(a)(i); and
1145 (iii) of the sufficiency of capital resources to support each risk described in Subsection
1146 (135)(a)(i); and
- 1147 (b) that is appropriate to the nature, scale, and complexity of an insurer or insurance
1148 group.
- 1149 (136) "Participating" means a plan of insurance under which the insured is entitled to

1150 receive a dividend representing a share of the surplus of the insurer.

1151 (137) "Participation," as used in a health benefit plan, means a requirement relating to
1152 the minimum percentage of eligible employees that must be enrolled in relation to the total
1153 number of eligible employees of an employer reduced by each eligible employee who
1154 voluntarily declines coverage under the plan because the employee:

1155 (a) has other group health care insurance coverage; or

1156 (b) receives:

1157 (i) Medicare, under the Health Insurance for the Aged Act, Title XVIII of the Social
1158 Security Amendments of 1965; or

1159 (ii) another government health benefit.

1160 (138) "Person" includes:

1161 (a) an individual;

1162 (b) a partnership;

1163 (c) a corporation;

1164 (d) an incorporated or unincorporated association;

1165 (e) a joint stock company;

1166 (f) a trust;

1167 (g) a limited liability company;

1168 (h) a reciprocal;

1169 (i) a syndicate; or

1170 (j) another similar entity or combination of entities acting in concert.

1171 (139) "Personal lines insurance" means property and casualty insurance coverage sold
1172 for primarily noncommercial purposes to:

1173 (a) an individual; or

1174 (b) a family.

1175 (140) "Plan sponsor" means the same as that term is defined in 29 U.S.C. Sec.
1176 1002(16)(B).

1177 (141) "Plan year" means:

- 1178 (a) the year that is designated as the plan year in:
- 1179 (i) the plan document of a group health plan; or
- 1180 (ii) a summary plan description of a group health plan;
- 1181 (b) if the plan document or summary plan description does not designate a plan year or
- 1182 there is no plan document or summary plan description:
- 1183 (i) the year used to determine deductibles or limits;
- 1184 (ii) the policy year, if the plan does not impose deductibles or limits on a yearly basis;
- 1185 or
- 1186 (iii) the employer's taxable year if:
- 1187 (A) the plan does not impose deductibles or limits on a yearly basis; and
- 1188 (B) (I) the plan is not insured; or
- 1189 (II) the insurance policy is not renewed on an annual basis; or
- 1190 (c) in a case not described in Subsection (141)(a) or (b), the calendar year.
- 1191 (142) (a) "Policy" means a document, including an attached endorsement or application
- 1192 that:
- 1193 (i) purports to be an enforceable contract; and
- 1194 (ii) memorializes in writing some or all of the terms of an insurance contract.
- 1195 (b) "Policy" includes a service contract issued by:
- 1196 (i) a motor club under Chapter 11, Motor Clubs;
- 1197 (ii) a service contract provided under Chapter 6a, Service Contracts; and
- 1198 (iii) a corporation licensed under:
- 1199 (A) Chapter 7, Nonprofit Health Service Insurance Corporations; or
- 1200 (B) Chapter 8, Health Maintenance Organizations and Limited Health Plans.
- 1201 (c) "Policy" does not include:
- 1202 (i) a certificate under a group insurance contract; or
- 1203 (ii) a document that does not purport to have legal effect.
- 1204 (143) "Policyholder" means a person who controls a policy, binder, or oral contract by
- 1205 ownership, premium payment, or otherwise.

1206 (144) "Policy illustration" means a presentation or depiction that includes
1207 nonguaranteed elements of a policy [of] offering life insurance over a period of years.

1208 (145) "Policy summary" means a synopsis describing the elements of a life insurance
1209 policy.

1210 (146) "PPACA" means the Patient Protection and Affordable Care Act, Pub. L. No.
1211 111-148 and the Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, and
1212 related federal regulations and guidance.

1213 (147) "Preexisting condition," with respect to health care insurance:

1214 (a) means a condition that was present before the effective date of coverage, whether or
1215 not medical advice, diagnosis, care, or treatment was recommended or received before that day,
1216 and

1217 (b) does not include a condition indicated by genetic information unless an actual
1218 diagnosis of the condition by a physician has been made.

1219 (148) (a) "Premium" means the monetary consideration for an insurance policy.

1220 (b) "Premium" includes, however designated:

1221 (i) an assessment;

1222 (ii) a membership fee;

1223 (iii) a required contribution; or

1224 (iv) monetary consideration.

1225 (c) (i) "Premium" does not include consideration paid to a third party administrator for
1226 the third party administrator's services.

1227 (ii) "Premium" includes an amount paid by a third party administrator to an insurer for
1228 insurance on the risks administered by the third party administrator.

1229 (149) "Principal officers" for a corporation means the officers designated under
1230 Subsection [31A-5-203\(3\)](#).

1231 (150) "Proceeding" includes an action or special statutory proceeding.

1232 (151) "Professional liability insurance" means insurance against legal liability incident
1233 to the practice of a profession and provision of a professional service.

1234 (152) (a) Except as provided in Subsection (152)(b), "property insurance" means
1235 insurance against loss or damage to real or personal property of every kind and any interest in
1236 that property:

- 1237 (i) from all hazards or causes; and
- 1238 (ii) against loss consequential upon the loss or damage including vehicle
1239 comprehensive and vehicle physical damage coverages.

1240 (b) "Property insurance" does not include:

- 1241 (i) inland marine insurance; and
- 1242 (ii) ocean marine insurance.

1243 (153) "Qualified long-term care insurance contract" or "federally tax qualified
1244 long-term care insurance contract" means:

1245 (a) an individual or group insurance contract that meets the requirements of Section
1246 7702B(b), Internal Revenue Code; or

1247 (b) the portion of a life insurance contract that provides long-term care insurance:

- 1248 (i) (A) by rider; or
- 1249 (B) as a part of the contract; and
- 1250 (ii) that satisfies the requirements of Sections 7702B(b) and (e), Internal Revenue
1251 Code.

1252 (154) "Qualified United States financial institution" means an institution that:

1253 (a) is:

- 1254 (i) organized under the laws of the United States or any state; or
- 1255 (ii) in the case of a United States office of a foreign banking organization, licensed
1256 under the laws of the United States or any state;

1257 (b) is regulated, supervised, and examined by a United States federal or state authority
1258 having regulatory authority over a bank or trust company; and

1259 (c) meets the standards of financial condition and standing that are considered
1260 necessary and appropriate to regulate the quality of a financial institution whose letters of credit
1261 will be acceptable to the commissioner as determined by:

- 1262 (i) the commissioner by rule; or
1263 (ii) the Securities Valuation Office of the National Association of Insurance
1264 Commissioners.
- 1265 (155) (a) "Rate" means:
1266 (i) the cost of a given unit of insurance; or
1267 (ii) for property or casualty insurance, that cost of insurance per exposure unit either
1268 expressed as:
1269 (A) a single number; or
1270 (B) a pure premium rate, adjusted before the application of individual risk variations
1271 based on loss or expense considerations to account for the treatment of:
1272 (I) expenses;
1273 (II) profit; and
1274 (III) individual insurer variation in loss experience.
1275 (b) "Rate" does not include a minimum premium.
- 1276 (156) (a) Except as provided in Subsection (156)(b), "rate service organization" means
1277 a person who assists an insurer in rate making or filing by:
1278 (i) collecting, compiling, and furnishing loss or expense statistics;
1279 (ii) recommending, making, or filing rates or supplementary rate information; or
1280 (iii) advising about rate questions, except as an attorney giving legal advice.
1281 (b) "Rate service organization" does not mean:
1282 (i) an employee of an insurer;
1283 (ii) a single insurer or group of insurers under common control;
1284 (iii) a joint underwriting group; or
1285 (iv) an individual serving as an actuarial or legal consultant.
- 1286 (157) "Rating manual" means any of the following used to determine initial and
1287 renewal policy premiums:
1288 (a) a manual of rates;
1289 (b) a classification;

- 1290 (c) a rate-related underwriting rule; and
- 1291 (d) a rating formula that describes steps, policies, and procedures for determining
- 1292 initial and renewal policy premiums.
- 1293 (158) (a) "Rebate" means a licensee paying, allowing, giving, or offering to pay, allow,
- 1294 or give, directly or indirectly:
- 1295 (i) a refund of premium or portion of premium;
- 1296 (ii) a refund of commission or portion of commission;
- 1297 (iii) a refund of all or a portion of a consultant fee; or
- 1298 (iv) providing services or other benefits not specified in an insurance or annuity
- 1299 contract.
- 1300 (b) "Rebate" does not include:
- 1301 (i) a refund due to termination or changes in coverage;
- 1302 (ii) a refund due to overcharges made in error by the licensee; or
- 1303 (iii) savings or wellness benefits as provided in the contract by the licensee.
- 1304 (159) "Received by the department" means:
- 1305 (a) the date delivered to and stamped received by the department, if delivered in
- 1306 person;
- 1307 (b) the post mark date, if delivered by mail;
- 1308 (c) the delivery service's post mark or pickup date, if delivered by a delivery service;
- 1309 (d) the received date recorded on an item delivered, if delivered by:
- 1310 (i) facsimile;
- 1311 (ii) email; or
- 1312 (iii) another electronic method; or
- 1313 (e) a date specified in:
- 1314 (i) a statute;
- 1315 (ii) a rule; or
- 1316 (iii) an order.
- 1317 (160) "Reciprocal" or "interinsurance exchange" means an unincorporated association

1318 of persons:

1319 (a) operating through an attorney-in-fact common to all of the persons; and

1320 (b) exchanging insurance contracts with one another that provide insurance coverage

1321 on each other.

1322 (161) "Reinsurance" means an insurance transaction where an insurer, for

1323 consideration, transfers any portion of the risk it has assumed to another insurer. In referring to

1324 reinsurance transactions, this title sometimes refers to:

1325 (a) the insurer transferring the risk as the "ceding insurer"; and

1326 (b) the insurer assuming the risk as the:

1327 (i) "assuming insurer"; or

1328 (ii) "assuming reinsurer."

1329 (162) "Reinsurer" means a person licensed in this state as an insurer with the authority

1330 to assume reinsurance.

1331 (163) "Residential dwelling liability insurance" means insurance against liability

1332 resulting from or incident to the ownership, maintenance, or use of a residential dwelling that is

1333 a detached single family residence or multifamily residence up to four units.

1334 (164) (a) "Retrocession" means reinsurance with another insurer of a liability assumed

1335 under a reinsurance contract.

1336 (b) A reinsurer "retrocedes" when the reinsurer reinsures with another insurer part of a

1337 liability assumed under a reinsurance contract.

1338 (165) "Rider" means an endorsement to:

1339 (a) an insurance policy; or

1340 (b) an insurance certificate.

1341 (166) "Secondary medical condition" means a complication related to an exclusion

1342 from coverage in accident and health insurance.

1343 (167) (a) "Security" means a:

1344 (i) note;

1345 (ii) stock;

- 1346 (iii) bond;
- 1347 (iv) debenture;
- 1348 (v) evidence of indebtedness;
- 1349 (vi) certificate of interest or participation in a profit-sharing agreement;
- 1350 (vii) collateral-trust certificate;
- 1351 (viii) preorganization certificate or subscription;
- 1352 (ix) transferable share;
- 1353 (x) investment contract;
- 1354 (xi) voting trust certificate;
- 1355 (xii) certificate of deposit for a security;
- 1356 (xiii) certificate of interest of participation in an oil, gas, or mining title or lease or in
- 1357 payments out of production under such a title or lease;
- 1358 (xiv) commodity contract or commodity option;
- 1359 (xv) certificate of interest or participation in, temporary or interim certificate for,
- 1360 receipt for, guarantee of, or warrant or right to subscribe to or purchase any of the items listed
- 1361 in Subsections (167)(a)(i) through (xiv); or
- 1362 (xvi) another interest or instrument commonly known as a security.
- 1363 (b) "Security" does not include:
- 1364 (i) any of the following under which an insurance company promises to pay money in a
- 1365 specific lump sum or periodically for life or some other specified period:
- 1366 (A) insurance;
- 1367 (B) an endowment policy; or
- 1368 (C) an annuity contract; or
- 1369 (ii) a burial certificate or burial contract.
- 1370 (168) "Securityholder" means a specified person who owns a security of a person,
- 1371 including:
- 1372 (a) common stock;
- 1373 (b) preferred stock;

1374 (c) debt obligations; and
1375 (d) any other security convertible into or evidencing the right of any of the items listed
1376 in this Subsection (168).

1377 (169) (a) "Self-insurance" means an arrangement under which a person provides for
1378 spreading its own risks by a systematic plan.

1379 (b) Except as provided in this Subsection (169), "self-insurance" does not include an
1380 arrangement under which a number of persons spread their risks among themselves.

1381 (c) "Self-insurance" includes:

1382 (i) an arrangement by which a governmental entity undertakes to indemnify an
1383 employee for liability arising out of the employee's employment; and

1384 (ii) an arrangement by which a person with a managed program of self-insurance and
1385 risk management undertakes to indemnify its affiliates, subsidiaries, directors, officers, or
1386 employees for liability or risk that is related to the relationship or employment.

1387 (d) "Self-insurance" does not include an arrangement with an independent contractor.

1388 (170) "Sell" means to exchange a contract of insurance:

1389 (a) by any means;

1390 (b) for money or its equivalent; and

1391 (c) on behalf of an insurance company.

1392 [~~(171) "Short-term care insurance" means an insurance policy or rider advertised,~~
1393 ~~marketed, offered, or designed to provide coverage that is similar to long-term care insurance,~~
1394 ~~but that provides coverage for less than 12 consecutive months for each covered person.]~~

1395 [(172)] (171) "Short-term[~~;-limited-duration~~] limited duration health insurance" means
1396 a health benefit product that:

1397 (a) after taking into account any renewals or extensions, has a total duration of no more
1398 than 36 months; and

1399 (b) has an expiration date specified in the contract that is less than 12 months after the
1400 original effective date of coverage under the health benefit product.

1401 [(173)] (172) "Significant break in coverage" means a period of 63 consecutive days

1402 during each of which an individual does not have creditable coverage.

1403 ~~[(174)]~~ (173) (a) "Small employer" means, in connection with a health benefit plan and
1404 with respect to a calendar year and to a plan year, an employer who:

1405 (i) (A) employed at least one but not more than 50 eligible employees on business days
1406 during the preceding calendar year; or

1407 (B) if the employer did not exist for the entirety of the preceding calendar year,
1408 reasonably expects to employ an average of at least one but not more than 50 eligible
1409 employees on business days during the current calendar year;

1410 (ii) employs at least one employee on the first day of the plan year; and

1411 (iii) for an employer who has common ownership with one or more other employers, is
1412 treated as a single employer under 26 U.S.C. Sec. 414(b), (c), (m), or (o).

1413 (b) "Small employer" does not include a sole proprietor that does not employ at least
1414 one employee.

1415 ~~[(175)]~~ (174) "Special enrollment period," in connection with a health benefit plan, has
1416 the same meaning as provided in federal regulations adopted pursuant to the Health Insurance
1417 Portability and Accountability Act.

1418 ~~[(176)]~~ (175) (a) "Subsidiary" of a person means an affiliate controlled by that person
1419 either directly or indirectly through one or more affiliates or intermediaries.

1420 (b) "Wholly owned subsidiary" of a person is a subsidiary of which all of the voting
1421 shares are owned by that person either alone or with its affiliates, except for the minimum
1422 number of shares the law of the subsidiary's domicile requires to be owned by directors or
1423 others.

1424 ~~[(177)]~~ (176) Subject to Subsection (91)(b), "surety insurance" includes:

1425 (a) a guarantee against loss or damage resulting from the failure of a principal to pay or
1426 perform the principal's obligations to a creditor or other obligee;

1427 (b) bail bond insurance; and

1428 (c) fidelity insurance.

1429 ~~[(178)]~~ (177) (a) "Surplus" means the excess of assets over the sum of paid-in capital

1430 and liabilities.

1431 (b) (i) "Permanent surplus" means the surplus of an insurer or organization that is
1432 designated by the insurer or organization as permanent.

1433 (ii) Sections 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, and 31A-14-205 require
1434 that insurers or organizations doing business in this state maintain specified minimum levels of
1435 permanent surplus.

1436 (iii) Except for assessable mutuals, the minimum permanent surplus requirement is the
1437 same as the minimum required capital requirement that applies to stock insurers.

1438 (c) "Excess surplus" means:

1439 (i) for a life insurer, accident and health insurer, health organization, or property and
1440 casualty insurer as defined in Section 31A-17-601, the lesser of:

1441 (A) that amount of an insurer's or health organization's total adjusted capital that
1442 exceeds the product of:

1443 (I) 2.5; and

1444 (II) the sum of the insurer's or health organization's minimum capital or permanent
1445 surplus required under Section 31A-5-211, 31A-9-209, or 31A-14-205; or

1446 (B) that amount of an insurer's or health organization's total adjusted capital that
1447 exceeds the product of:

1448 (I) 3.0; and

1449 (II) the authorized control level RBC as defined in Subsection 31A-17-601(8)(a); and

1450 (ii) for a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer
1451 that amount of an insurer's paid-in-capital and surplus that exceeds the product of:

1452 (A) 1.5; and

1453 (B) the insurer's total adjusted capital required by Subsection 31A-17-609(1).

1454 [(179)] (178) "Third party administrator" or "administrator" means a person who
1455 collects charges or premiums from, or who, for consideration, adjusts or settles claims of
1456 residents of the state in connection with insurance coverage, annuities, or service insurance
1457 coverage, except:

- 1458 (a) a union on behalf of its members;
- 1459 (b) a person administering a:
 - 1460 (i) pension plan subject to the federal Employee Retirement Income Security Act of
 - 1461 1974;
 - 1462 (ii) governmental plan as defined in Section 414(d), Internal Revenue Code; or
 - 1463 (iii) nonelecting church plan as described in Section 410(d), Internal Revenue Code;
- 1464 (c) an employer on behalf of the employer's employees or the employees of one or
- 1465 more of the subsidiary or affiliated corporations of the employer;
- 1466 (d) an insurer licensed under the following, but only for a line of insurance for which
- 1467 the insurer holds a license in this state:
 - 1468 (i) Chapter 5, Domestic Stock and Mutual Insurance Corporations;
 - 1469 (ii) Chapter 7, Nonprofit Health Service Insurance Corporations;
 - 1470 (iii) Chapter 8, Health Maintenance Organizations and Limited Health Plans;
 - 1471 (iv) Chapter 9, Insurance Fraternal; or
 - 1472 (v) Chapter 14, Foreign Insurers;
- 1473 (e) a person:
 - 1474 (i) licensed or exempt from licensing under:
 - 1475 (A) Chapter 23a, Insurance Marketing - Licensing Producers, Consultants, and
 - 1476 Reinsurance Intermediaries; or
 - 1477 (B) Chapter 26, Insurance Adjusters; and
 - 1478 (ii) whose activities are limited to those authorized under the license the person holds
 - 1479 or for which the person is exempt; or
- 1480 (f) an institution, bank, or financial institution:
 - 1481 (i) that is:
 - 1482 (A) an institution whose deposits and accounts are to any extent insured by a federal
 - 1483 deposit insurance agency, including the Federal Deposit Insurance Corporation or National
 - 1484 Credit Union Administration; or
 - 1485 (B) a bank or other financial institution that is subject to supervision or examination by

1486 a federal or state banking authority; and

1487 (ii) that does not adjust claims without a third party administrator license.

1488 [~~(180)~~] (179) "Title insurance" means the insuring, guaranteeing, or indemnifying of an
1489 owner of real or personal property or the holder of liens or encumbrances on that property, or
1490 others interested in the property against loss or damage suffered by reason of liens or
1491 encumbrances upon, defects in, or the unmarketability of the title to the property, or invalidity
1492 or unenforceability of any liens or encumbrances on the property.

1493 [~~(181)~~] (180) "Total adjusted capital" means the sum of an insurer's or health
1494 organization's statutory capital and surplus as determined in accordance with:

1495 (a) the statutory accounting applicable to the annual financial statements required to be
1496 filed under Section 31A-4-113; and

1497 (b) another item provided by the RBC instructions, as RBC instructions is defined in
1498 Section 31A-17-601.

1499 [~~(182)~~] (181) (a) "Trustee" means "director" when referring to the board of directors of
1500 a corporation.

1501 (b) "Trustee," when used in reference to an employee welfare fund, means an
1502 individual, firm, association, organization, joint stock company, or corporation, whether acting
1503 individually or jointly and whether designated by that name or any other, that is charged with
1504 or has the overall management of an employee welfare fund.

1505 [~~(183)~~] (182) (a) "Unauthorized insurer," "unadmitted insurer," or "nonadmitted
1506 insurer" means an insurer:

1507 (i) not holding a valid certificate of authority to do an insurance business in this state;

1508 or

1509 (ii) transacting business not authorized by a valid certificate.

1510 (b) "Admitted insurer" or "authorized insurer" means an insurer:

1511 (i) holding a valid certificate of authority to do an insurance business in this state; and

1512 (ii) transacting business as authorized by a valid certificate.

1513 [~~(184)~~] (183) "Underwrite" means the authority to accept or reject risk on behalf of the

1514 insurer.

1515 ~~[(185)]~~ (184) "Vehicle liability insurance" means insurance against liability resulting
 1516 from or incident to ownership, maintenance, or use of a land vehicle or aircraft, exclusive of a
 1517 vehicle comprehensive or vehicle physical damage coverage under Subsection (152).

1518 ~~[(186)]~~ (185) "Voting security" means a security with voting rights, and includes a
 1519 security convertible into a security with a voting right associated with the security.

1520 ~~[(187)]~~ (186) "Waiting period" for a health benefit plan means the period that must
 1521 pass before coverage for an individual, who is otherwise eligible to enroll under the terms of
 1522 the health benefit plan, can become effective.

1523 ~~[(188)]~~ (187) "Workers' compensation insurance" means:

1524 (a) insurance for indemnification of an employer against liability for compensation
 1525 based on:

1526 (i) a compensable accidental injury; and

1527 (ii) occupational disease disability;

1528 (b) employer's liability insurance incidental to workers' compensation insurance and
 1529 written in connection with workers' compensation insurance; and

1530 (c) insurance assuring to a person entitled to workers' compensation benefits the
 1531 compensation provided by law.

1532 Section 3. Section **31A-17-404** is amended to read:

1533 **31A-17-404. Credit allowed a domestic ceding insurer against reserves for**
 1534 **reinsurance.**

1535 (1) (a) ~~[(a)]~~ Subject to Subsections (1)(b) and (c), a domestic ceding insurer is allowed
 1536 credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only
 1537 if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), (7), (8), or (9) ~~[subject to~~
 1538 ~~the following:]~~.

1539 ~~[(a)]~~ (b) Credit is allowed under Subsection (3), (4), or (5) only with respect to a
 1540 cession of a kind or class of business that the assuming insurer is licensed or otherwise
 1541 permitted to write or assume:

- 1542 (i) in [its] the assuming insurer's state of domicile; or
- 1543 (ii) in the case of a United States branch of an alien assuming insurer, in the state
- 1544 through which [it] the assuming insurer is entered and licensed to transact insurance or
- 1545 reinsurance.
- 1546 [~~(b)~~] (c) Credit is allowed under Subsection (5) or (6) only if the applicable
- 1547 requirements of Subsection (11) are met.
- 1548 (2) A domestic ceding insurer is allowed credit for reinsurance ceded:
- 1549 (a) only if the reinsurance is payable in a manner consistent with Section [31A-22-1201](#);
- 1550 (b) only to the extent that the accounting:
- 1551 (i) is consistent with the terms of the reinsurance contract; and
- 1552 (ii) clearly reflects:
- 1553 (A) the amount and nature of risk transferred; and
- 1554 (B) liability, including contingent liability, of the ceding insurer;
- 1555 (c) only to the extent the reinsurance contract shifts insurance policy risk from the
- 1556 ceding insurer to the assuming reinsurer in fact and not merely in form; and
- 1557 (d) only if the reinsurance contract contains a provision placing on the reinsurer the
- 1558 credit risk of all dealings with intermediaries regarding the reinsurance contract.
- 1559 (3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 1560 assuming insurer that is licensed to transact insurance or reinsurance in this state.
- 1561 (4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
- 1562 assuming insurer that is accredited by the commissioner as a reinsurer in this state.
- 1563 (b) An insurer is accredited as a reinsurer if the insurer:
- 1564 (i) files with the commissioner evidence of the insurer's submission to this state's
- 1565 jurisdiction;
- 1566 (ii) submits to the commissioner's authority to examine the insurer's books and records;
- 1567 (iii) (A) is licensed to transact insurance or reinsurance in at least one state; or
- 1568 (B) in the case of a United States branch of an alien assuming insurer, is entered
- 1569 through and licensed to transact insurance or reinsurance in at least one state;

1570 (iv) files annually with the commissioner a copy of the insurer's:
1571 (A) annual statement filed with the insurance department of ~~[its]~~ the insurer's state of
1572 domicile; and
1573 (B) most recent audited financial statement; and
1574 (v) (A) (I) has not had ~~[its]~~ the insurer's accreditation denied by the commissioner
1575 within 90 days after the day on which the insurer submits the information required by this
1576 Subsection (4); and
1577 (II) maintains a surplus with regard to policyholders in an amount not less than
1578 \$20,000,000; or
1579 (B) (I) has ~~[its]~~ the insurer's accreditation approved by the commissioner; and
1580 (II) maintains a surplus with regard to policyholders in an amount less than
1581 \$20,000,000.
1582 (c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's
1583 accreditation is revoked by the commissioner after a notice and hearing.
1584 (5) (a) A domestic ceding insurer is allowed a credit if:
1585 (i) the reinsurance is ceded to an assuming insurer that is:
1586 (A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or
1587 (B) in the case of a United States branch of an alien assuming insurer, is entered
1588 through a state meeting the requirements of Subsection (5)(a)(ii);
1589 (ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for
1590 reinsurance substantially similar to those applicable under this section; and
1591 (iii) the assuming insurer or United States branch of an alien assuming insurer:
1592 (A) maintains a surplus with regard to policyholders in an amount not less than
1593 \$20,000,000; and
1594 (B) submits to the authority of the commissioner to examine ~~[its]~~ the insurer's books
1595 and records.
1596 (b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance ceded
1597 and assumed pursuant to a pooling arrangement among insurers in the same holding company

1598 system.

1599 (6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
1600 assuming insurer that maintains a trust fund:

1601 (i) created in accordance with rules made by the commissioner pursuant to Title 63G,
1602 Chapter 3, Utah Administrative Rulemaking Act; and

1603 (ii) in a qualified United States financial institution for the payment of a valid claim of:

1604 (A) a United States ceding insurer of the assuming insurer;

1605 (B) an assign of the United States ceding insurer; and

1606 (C) a successor in interest to the United States ceding insurer.

1607 (b) To enable the commissioner to determine the sufficiency of the trust fund described
1608 in Subsection (6)(a), the assuming insurer shall:

1609 (i) report annually to the commissioner information substantially the same as that
1610 required to be reported on the National Association of Insurance Commissioners Annual
1611 Statement form by a licensed insurer; and

1612 (ii) (A) submit to examination of its books and records by the commissioner; and

1613 (B) pay the cost of an examination.

1614 (c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the
1615 form of the trust and any amendment to the trust is approved by:

1616 (A) the commissioner of the state where the trust is domiciled; or

1617 (B) the commissioner of another state who, pursuant to the terms of the trust
1618 instrument, accepts principal regulatory oversight of the trust.

1619 (ii) The form of the trust and an amendment to the trust shall be filed with the
1620 commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

1621 (iii) The trust instrument shall provide that a contested claim is valid and enforceable
1622 upon the final order of a court of competent jurisdiction in the United States.

1623 (iv) The trust shall vest legal title to [~~its~~] the trust's assets in [~~its~~] one or more of the
1624 trust's trustees for the benefit of:

1625 (A) a United States ceding insurer of the assuming insurer;

- 1626 (B) an assign of the United States ceding insurer; or
1627 (C) a successor in interest to the United States ceding insurer.
1628 (v) The trust and the assuming insurer are subject to examination as determined by the
1629 commissioner.
- 1630 (vi) The trust shall remain in effect for as long as the assuming insurer has an
1631 outstanding obligation due under a reinsurance agreement subject to the trust.
- 1632 (vii) No later than February 28 of each year, the trustee of the trust shall:
1633 (A) report to the commissioner in writing the balance of the trust;
1634 (B) list the trust's investments at the end of the preceding calendar year; and
1635 (C) (I) certify the date of termination of the trust, if so planned; or
1636 (II) certify that the trust will not expire before the following December 31.
- 1637 (d) The following requirements apply to the following categories of assuming insurer:
1638 (i) For a single assuming insurer:
1639 (A) the trust fund shall consist of funds in trust in an amount not less than the assuming
1640 insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and
1641 (B) the assuming insurer shall maintain a trustee surplus of not less than \$20,000,000,
1642 except as provided in Subsection (6)(d)(ii).
- 1643 (ii) (A) At any time after the assuming insurer has permanently discontinued
1644 underwriting new business secured by the trust for at least three full years, the commissioner
1645 with principal regulatory oversight of the trust may authorize a reduction in the required
1646 trustee surplus, but only after a finding, based on an assessment of the risk, that the new
1647 required surplus level is adequate for the protection of United States ceding insurers,
1648 policyholders, and claimants in light of reasonably foreseeable adverse loss development.
- 1649 (B) The risk assessment may involve an actuarial review, including an independent
1650 analysis of reserves and cash flows, and shall consider all material risk factors, including, when
1651 applicable, the lines of business involved, the stability of the incurred loss estimates, and the
1652 effect of the surplus requirements on the assuming insurer's liquidity or solvency.
- 1653 (C) The minimum required trustee surplus may not be reduced to an amount less than

1654 30% of the assuming insurer's liabilities attributable to reinsurance ceded by United States
1655 ceding insurers covered by the trust.

1656 (iii) For a group acting as assuming insurer, including incorporated and individual
1657 unincorporated underwriters:

1658 (A) for reinsurance ceded under a reinsurance agreement with an inception,
1659 amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed
1660 account in an amount not less than the respective underwriters' several liabilities attributable to
1661 business ceded by the one or more United States domiciled ceding insurers to an underwriter of
1662 the group;

1663 (B) for reinsurance ceded under a reinsurance agreement with an inception date on or
1664 before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the
1665 other provisions of this chapter, the trust shall consist of a trusteed account in an amount not
1666 less than the respective underwriters' several insurance and reinsurance liabilities attributable to
1667 business written in the United States;

1668 (C) in addition to a trust described in Subsection (6)(d)(iii)(A) or (B), the group shall
1669 maintain in trust a trusteed surplus of which \$100,000,000 is held jointly for the benefit of the
1670 one or more United States domiciled ceding insurers of a member of the group for all years of
1671 account;

1672 (D) the incorporated members of the group:

1673 (I) may not be engaged in a business other than underwriting as a member of the group;
1674 and

1675 (II) are subject to the same level of regulation and solvency control by the group's
1676 domiciliary regulator as are the unincorporated members; and

1677 (E) within 90 days after the day on which the group's financial statements are due to be
1678 filed with the group's domiciliary regulator, the group shall provide to the commissioner:

1679 (I) an annual certification by the group's domiciliary regulator of the solvency of each
1680 underwriter member; or

1681 (II) if a certification is unavailable, a financial statement, prepared by an independent

1682 public accountant, of each underwriter member of the group.

1683 (iv) For a group of incorporated underwriters under common administration, the group
1684 shall:

1685 (A) have continuously transacted an insurance business outside the United States for at
1686 least three years immediately preceding the day on which the group makes application for
1687 accreditation;

1688 (B) maintain aggregate policyholders' surplus of at least \$10,000,000,000;

1689 (C) maintain a trust fund in an amount not less than the group's several liabilities
1690 attributable to business ceded by the one or more United States domiciled ceding insurers to a
1691 member of the group pursuant to a reinsurance contract issued in the name of the group;

1692 (D) in addition to complying with the other provisions of this Subsection (6)(d)(iv),
1693 maintain a joint trusteed surplus of which \$100,000,000 is held jointly for the benefit of the one
1694 or more United States domiciled ceding insurers of a member of the group as additional
1695 security for these liabilities; and

1696 (E) within 90 days after the day on which the group's financial statements are due to be
1697 filed with the group's domiciliary regulator, make available to the commissioner:

1698 (I) an annual certification of each underwriter member's solvency by the member's
1699 domiciliary regulator; and

1700 (II) a financial statement of each underwriter member of the group prepared by an
1701 independent public accountant.

1702 (7) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an
1703 assuming insurer that secures [its] the assuming insurer's obligations in accordance with this
1704 Subsection (7):

1705 (a) The insurer shall be certified by the commissioner as a reinsurer in this state.

1706 (b) To be eligible for certification, the assuming insurer shall:

1707 (i) be domiciled and licensed to transact insurance or reinsurance in a qualified
1708 jurisdiction, as determined by the commissioner pursuant to Subsection (7)(d);

1709 (ii) maintain minimum capital and surplus, or its equivalent, in an amount to be

1710 determined by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
1711 3, Utah Administrative Rulemaking Act;

1712 (iii) maintain financial strength ratings from two or more rating agencies considered
1713 acceptable by the commissioner pursuant to rules made in accordance with Title 63G, Chapter
1714 3, Utah Administrative Rulemaking Act; and

1715 (iv) agree to:

1716 (A) submit to the jurisdiction of this state;

1717 (B) appoint the commissioner as ~~[its]~~ the assuming insurer's agent for service of
1718 process in this state;

1719 (C) provide security for 100% of the assuming insurer's liabilities attributable to
1720 reinsurance ceded by United States ceding insurers if ~~[it]~~ the assuming insurer resists
1721 enforcement of a final United States judgment;

1722 (D) agree to meet applicable information filing requirements as determined by the
1723 commissioner including an application for certification, a renewal and on an ongoing basis; and

1724 (E) any other requirements for certification considered relevant by the commissioner.

1725 (c) An association, including incorporated and individual unincorporated underwriters,
1726 may be a certified reinsurer~~[- To be eligible for certification, in addition to satisfying~~
1727 ~~requirements of Subsections (7)(a) and (b)],~~ if the association:

1728 (i) satisfies the requirements of Subsections (7)(a) and (b);

1729 ~~[(i)]~~ (ii) ~~[shall satisfy its]~~ satisfies the association's minimum capital and surplus
1730 requirements through the capital and surplus equivalents, net of liabilities, of the association
1731 and ~~[its]~~ the association's members, which shall include a joint central fund that may be applied
1732 to any unsatisfied obligation of the association or any of ~~[its]~~ the association's members in an
1733 amount determined by the commissioner to provide adequate protection;

1734 ~~[(ii)]~~ (iii) ~~[may]~~ does not have incorporated members of the association engaged in any
1735 business other than underwriting as a member of the association;

1736 ~~[(iii)]~~ (iv) ~~[shall be]~~ is subject to the same level of regulation and solvency control of
1737 the incorporated members of the association by the association's domiciliary regulator as are

1738 the unincorporated members; and

1739 ~~[(iv)]~~ (v) within 90 days after ~~[its]~~ the day on which the association's financial
1740 statements are due to be filed with the association's domiciliary regulator ~~[provide: (A)]~~,
1741 provides to the commissioner:

1742 (A) an annual certification by the association's domiciliary regulator of the solvency of
1743 each underwriter member; or

1744 (B) if a certification described in Subsection (7)(c)(v)(A) is unavailable, financial
1745 statements prepared by independent public accountants, of each underwriter member of the
1746 association.

1747 (d) (i) The commissioner shall create and publish a list of qualified jurisdictions under
1748 which an assuming insurer licensed and domiciled in the jurisdiction is eligible to be
1749 considered for certification by the commissioner as a certified reinsurer.

1750 ~~[(i)]~~ (ii) To determine whether the domiciliary jurisdiction of a non-United States
1751 assuming insurer is eligible to be recognized as a qualified jurisdiction, the commissioner:

1752 (A) shall evaluate the appropriateness and effectiveness of the reinsurance supervisory
1753 system of the jurisdiction, both initially and on an ongoing basis;

1754 (B) shall consider the rights, the benefits, and the extent of reciprocal recognition
1755 afforded by the non-United States jurisdiction to reinsurers licensed and domiciled in the
1756 United States;

1757 (C) shall require the qualified jurisdiction to share information and cooperate with the
1758 commissioner with respect to all certified reinsurers domiciled within that jurisdiction; and

1759 (D) may not recognize a jurisdiction as a qualified jurisdiction if the commissioner has
1760 determined that the jurisdiction does not adequately and promptly enforce final United States
1761 judgments and arbitration awards.

1762 ~~[(ii)]~~ (iii) The commissioner may consider additional factors in determining a qualified
1763 jurisdiction.

1764 ~~[(iii)]~~ (iv) A list of qualified jurisdictions shall be published through the National
1765 Association of Insurance Commissioners' Committee Process ~~[and the]~~.

1766 (v) The commissioner shall:

1767 (A) consider ~~[this list]~~ the National Association of Insurance Commissioners' list of
1768 qualified jurisdictions in determining qualified jurisdictions; and

1769 (B) if the commissioner approves a jurisdiction as qualified that does not appear on the
1770 National Association of Insurance ~~[Commissioner's]~~ Commissioners' list of qualified
1771 jurisdictions, provide thoroughly documented justification in accordance with criteria to be
1772 developed by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
1773 Rulemaking Act.

1774 ~~[(iv)]~~ (vi) United States jurisdictions that meet the requirement for accreditation under
1775 the National Association of Insurance Commissioners' financial standards and accreditation
1776 program shall be recognized as qualified jurisdictions.

1777 ~~[(v)]~~ (vii) If a certified reinsurer's domiciliary jurisdiction ceases to be a qualified
1778 jurisdiction, the commissioner may suspend the reinsurer's certification indefinitely, in lieu of
1779 revocation.

1780 (e) The commissioner shall:

1781 (i) assign a rating to each certified reinsurer, giving due consideration to the financial
1782 strength ratings that have been assigned by rating agencies considered acceptable to the
1783 commissioner by rule made in accordance with Title 63G, Chapter 3, Utah Administrative
1784 Rulemaking Act; and

1785 (ii) publish a list of all certified reinsurers and their ratings.

1786 (f) A certified reinsurer shall secure obligations assumed from United States ceding
1787 insurers under this Subsection (7) at a level consistent with ~~[its]~~ the certified reinsurer's rating,
1788 as specified in rules made by the commissioner in accordance with Title 63G, Chapter 3, Utah
1789 Administrative Rulemaking Act.

1790 (i) For a domestic ceding insurer to qualify for full financial statement credit for
1791 reinsurance ceded to a certified reinsurer, the certified reinsurer shall maintain security in a
1792 form acceptable to the commissioner and consistent with Section [31A-17-404.1](#), or in a
1793 multibeneficiary trust in accordance with Subsections (5), (6), and (9), except as otherwise

1794 provided in this Subsection (7).

1795 (ii) If a certified reinsurer maintains a trust to fully secure ~~[its]~~ the certified reinsurer's
1796 obligations subject to Subsections (5), (6), and (9), and chooses to secure ~~[its]~~ the certified
1797 reinsurer's obligations incurred as a certified reinsurer in the form of a multibeneficiary trust,
1798 the certified reinsurer shall maintain separate trust accounts for ~~[its]~~ the certified reinsurer's
1799 obligations incurred under reinsurance agreements issued or renewed as a certified reinsurer
1800 with reduced security as permitted by this Subsection (7) or comparable laws of other United
1801 States jurisdictions and for ~~[its]~~ the certified reinsurer's obligations subject to Subsections (5),
1802 (6), and (9).

1803 (iii) It shall be a condition to the grant of certification under this Subsection (7) that the
1804 certified reinsurer shall have bound itself:

1805 (A) by the language of the trust and agreement with the commissioner with principal
1806 regulatory oversight of the trust account; and

1807 (B) upon termination of the trust account, to fund, out of the remaining surplus of the
1808 trust, any deficiency of any other trust account.

1809 (iv) The minimum trustee surplus requirements provided in Subsections (5), (6), and
1810 (9) are not applicable with respect to a multibeneficiary trust maintained by a certified reinsurer
1811 for the purpose of securing obligations incurred under this Subsection (7), except that the trust
1812 shall maintain a minimum trustee surplus of \$10,000,000.

1813 (v) With respect to obligations incurred by a certified reinsurer under this Subsection
1814 (7), if the security is insufficient, the commissioner:

1815 (A) shall reduce the allowable credit by an amount proportionate to the deficiency; and

1816 (B) may impose further reductions in allowable credit upon finding that there is a
1817 material risk that the certified reinsurer's obligations will not be paid in full when due.

1818 (vi) (A) For purposes of this Subsection (7), a certified reinsurer whose certification
1819 has been terminated for any reason shall be treated as a certified reinsurer required to secure
1820 100% of ~~[its]~~ the certified reinsurer's obligations.

1821 ~~[(A)]~~ (B) As used in this Subsection (7), the term "terminated" refers to revocation,

1822 suspension, voluntary surrender, and inactive status.

1823 ~~(B)~~ (C) If the commissioner continues to assign a higher rating as permitted by other
1824 provisions of this section, the requirement under this Subsection (7)(f)(vi) does not apply to a
1825 certified reinsurer in inactive status or to a reinsurer whose certification has been suspended.

1826 (g) If an applicant for certification has been certified as a reinsurer in a National
1827 Association of Insurance Commissioners' accredited jurisdiction, the commissioner may:

1828 (i) defer to that jurisdiction's certification;

1829 (ii) defer to the rating assigned by that jurisdiction; and

1830 (iii) consider such reinsurer to be a certified reinsurer in this state.

1831 (h) (i) A certified reinsurer that ceases to assume new business in this state may request
1832 to maintain ~~[its]~~ the certified reinsurer's certification in inactive status in order to continue to
1833 qualify for a reduction in security for its in-force business.

1834 (ii) An inactive certified reinsurer shall continue to comply with all applicable
1835 requirements of this Subsection (7).

1836 (iii) The commissioner shall assign a rating to a reinsurer that qualifies under this
1837 Subsection (7)(h), that takes into account, if relevant, the reasons why the reinsurer is not
1838 assuming new business.

1839 (8) (a) As used in this Subsection (8):

1840 (i) "Covered agreement" means an agreement entered into pursuant to Dodd-Frank
1841 Wall Street Reform and Consumer Protection Act, 31 U.S.C. Sections 313 and 314, that:

1842 (A) is currently in effect or in a period of provisional application; and

1843 (B) addresses the elimination, under specified conditions, of collateral requirements as
1844 a condition for entering into any reinsurance agreement with a ceding insurer domiciled in this
1845 state or for allowing the ceding insurer to recognize credit for reinsurance.

1846 (ii) "Reciprocal jurisdiction" means a jurisdiction that is:

1847 (A) a non-United States jurisdiction that is subject to an in-force covered agreement
1848 with the United States, each within its legal authority, or, in the case of a covered agreement
1849 between the United States and European Union, is a member state of the European Union;

1850 (B) a United States jurisdiction that meets the requirements for accreditation under the
1851 National Association of Insurance Commissioners' financial standards and accreditation
1852 program; or

1853 (C) a qualified jurisdiction, as determined by the commissioner in accordance with
1854 Subsection (7)(d), that is not otherwise described in this Subsection (8)(a)(ii) and meets certain
1855 additional requirements, consistent with the terms and conditions of in-force covered
1856 agreements, as specified by the commissioner in rule made in accordance with Title 63G,
1857 Chapter 3, Utah Administrative Rulemaking Act.

1858 (b) (i) Credit [~~shall be~~] is allowed when the reinsurance is ceded to an assuming insurer
1859 meeting each of the conditions set forth in this Subsection (8)(b).

1860 (ii) The assuming insurer must have [~~its~~] the assuming insurer's head office in or be
1861 domiciled in, as applicable, and be licensed in a reciprocal jurisdiction.

1862 (iii) (A) The assuming insurer [~~must~~] shall have and maintain, on an ongoing basis,
1863 minimum capital and surplus, or its equivalent, calculated according to the methodology of
1864 [~~its~~] the assuming insurer's domiciliary jurisdiction, in an amount to be set forth in regulation.

1865 (B) If the assuming insurer is an association, including incorporated and individual
1866 unincorporated underwriters, [~~it must~~] the assuming insurer shall have and maintain, on an
1867 ongoing basis, minimum capital and surplus equivalents (net of liabilities), calculated
1868 according to the methodology applicable in [~~its~~] the assuming insurer's domiciliary jurisdiction,
1869 and a central fund containing a balance in amounts [~~to be~~] set forth in regulation.

1870 (iv) (A) The assuming insurer must have and maintain, on an ongoing basis, a
1871 minimum solvency or capital ratio, as applicable, which will be set forth in regulation.

1872 (B) If the assuming insurer is an association, including incorporated and individual
1873 unincorporated underwriters, [~~it~~] the assuming insurer must have and maintain, on an ongoing
1874 basis, a minimum solvency or capital ratio in the reciprocal jurisdiction where the assuming
1875 insurer has [~~its~~] the assuming insurer's head office or is domiciled, as applicable, and is also
1876 licensed.

1877 (v) The assuming insurer must agree and provide adequate assurance to the

1878 commissioner, in a form specified by the commissioner by rule made in accordance with Title
1879 63G, Chapter 3, Utah Administrative Rulemaking Act, as follows:

1880 (A) the assuming insurer must provide prompt written notice and explanation to the
1881 commissioner if ~~[it]~~ the assuming insurer falls below the minimum requirements set forth in
1882 ~~[Subsections]~~ Subsection (8)(c) or (d), or if any regulatory action is taken against ~~[it]~~ the
1883 assuming insurer for serious noncompliance with applicable law;

1884 (B) the assuming insurer must consent in writing to the jurisdiction of the courts of this
1885 state and to the appointment of the commissioner as agent for service of process, however the
1886 commissioner may require that consent for service of process be provided to the commissioner
1887 and included in each reinsurance agreement and nothing in this provision shall limit, or in any
1888 way alter, the capacity of parties to a reinsurance agreement to agree to alternative dispute
1889 resolution mechanisms, except to the extent such agreements are unenforceable under
1890 applicable insolvency or delinquency laws;

1891 (C) the assuming insurer must consent in writing to pay all final judgments, wherever
1892 enforcement is sought, obtained by a ceding insurer or ~~[its]~~ the ceding insurer's legal successor,
1893 that have been declared enforceable in the jurisdiction where the judgment was obtained;

1894 (D) each reinsurance agreement must include a provision requiring the assuming
1895 insurer to provide security in an amount equal to 100% of the assuming insurer's liabilities
1896 attributable to reinsurance ceded pursuant to that agreement if the assuming insurer resists
1897 enforcement of a final judgment that is enforceable under the law of the jurisdiction in which
1898 ~~[it]~~ the final judgement was obtained or a properly enforceable arbitration award, whether
1899 obtained by the ceding insurer or by ~~[its]~~ the ceding insurer's legal successor on behalf of ~~[its]~~
1900 the ceding insurer's resolution estate; and

1901 (E) the assuming insurer must confirm that ~~[it]~~ the assuming insurer is not presently
1902 participating in any solvent scheme of arrangement which involved this state's ceding insurers,
1903 and agree to notify the ceding insurer and the commissioner and to provide security:

1904 (I) in an amount equal to 100% of the assuming insurer's liabilities to the ceding
1905 insurer, should the assuming insurer enter into such a solvent scheme of arrangement; and

1906 (II) in a form consistent with the provisions of Subsections (7) and (10) and as
1907 specified by the commissioner in regulation.

1908 (vi) The assuming insurer or [~~its~~] the assuming insurer's legal successor must provide,
1909 if requested by the commissioner, on behalf of [~~itself~~] the assuming insurer and any legal
1910 predecessors, certain documentation to the commissioner, as specified by the commissioner by
1911 rule made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

1912 (vii) The assuming insurer must maintain a practice of prompt payment of claims under
1913 reinsurance agreements, pursuant to criteria set forth in rule made in accordance with Title
1914 63G, Chapter 3, Utah Administrative Rulemaking Act.

1915 (viii) The assuming insurer's supervisory authority must confirm to the commissioner
1916 on an annual basis, as of the preceding December 31 or at the annual date otherwise statutorily
1917 reported to the reciprocal jurisdiction, that the assuming insurer complies with the requirements
1918 set forth in Subsections (8)(c) and (d).

1919 (ix) Nothing in this provision precludes an assuming insurer from providing the
1920 commissioner with information on a voluntary basis.

1921 (c) (i) The commissioner shall timely create and publish a list of reciprocal
1922 jurisdictions.

1923 (ii) (A) A list of reciprocal jurisdictions is published through the National Association
1924 of Insurance Commissioners' Committee Process.

1925 (B) The commissioner's list of reciprocal jurisdictions shall include any reciprocal
1926 jurisdiction as defined in this Subsection (8), and shall consider any other reciprocal
1927 jurisdictions in accordance with the criteria developed under rule made in accordance with
1928 Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

1929 (iii) (A) The commissioner may remove a jurisdiction from the list of reciprocal
1930 jurisdictions upon a determination that the jurisdiction no longer meets the requirements of a
1931 reciprocal jurisdiction, in accordance with a process set forth in rule made in accordance with
1932 Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except that the commissioner
1933 [~~shall~~] may not remove from the list a reciprocal jurisdiction.

1934 (B) Upon removal of a reciprocal jurisdiction from this list, credit for reinsurance
1935 ceded to an assuming insurer [~~which has its~~] whose home office or [~~is domiciled~~] domicile is in
1936 that jurisdiction [~~shall be~~] is allowed, if otherwise allowed under this chapter.

1937 (d) (i) The commissioner shall timely create and publish a list of assuming insurers that
1938 have satisfied the conditions set forth in this subsection and to which cessions shall be granted
1939 credit in accordance with this Subsection (8).

1940 (ii) The commissioner may add an assuming insurer to such list if a National
1941 Association of Insurance Commissioners accredited jurisdiction has added such assuming
1942 insurer to a list of such assuming insurers or if, upon initial eligibility, the assuming insurer
1943 submits the information to the commissioner as required under this Subsection (8) and
1944 complies with any additional requirements that the commissioner may impose by rule made in
1945 accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, except to the
1946 extent that they conflict with an applicable covered agreement.

1947 (e) (i) If the commissioner determines that an assuming insurer no longer meets one or
1948 more of the requirements under this Subsection (8), the commissioner may revoke or suspend
1949 the eligibility of the assuming insurer for recognition under this Subsection (8) in accordance
1950 with procedures established in rule made in accordance with Title 63G, Chapter 3, Utah
1951 Administrative Rulemaking Act.

1952 (ii) (A) While an assuming insurer's eligibility is suspended, no reinsurance agreement
1953 issued, amended, or renewed after the [~~effective date of the suspension~~] day on which the
1954 suspension is effective qualifies for credit except to the extent that the assuming insurer's
1955 obligations under the contract are secured in accordance with Subsection (10).

1956 (B) If an assuming insurer's eligibility is revoked, no credit for reinsurance may be
1957 granted after the [~~effective date of the revocation~~] day on which the revocation is effective with
1958 respect to any reinsurance agreements entered into by the assuming insurer, including
1959 reinsurance agreements entered into [~~prior to the date of~~] before the day on which the
1960 revocation is effective, except to the extent that the assuming insurer's obligations under the
1961 contract are secured in a form acceptable to the commissioner and consistent with the

1962 provisions of Subsection (10).

1963 (f) If subject to a legal process of rehabilitation, liquidation, or conservation, as
1964 applicable, the ceding insurer, or [its] the ceding insurer's representative, may seek and, if
1965 determined appropriate by the court in which the proceedings are pending, may obtain an order
1966 requiring that the assuming insurer post security for all outstanding ceded liabilities.

1967 (g) Nothing in this Subsection (8) limits or in any way alters the capacity of parties to a
1968 reinsurance agreement to agree on requirements for security or other terms in that reinsurance
1969 agreement, except as expressly prohibited by this chapter or other applicable law or regulation.

1970 (h) (i) Credit may be taken under this Subsection (8) only for reinsurance agreements
1971 entered into, amended, or renewed on or after the effective date of the statute adding this
1972 Subsection (8), and only with respect to losses incurred and reserves reported on or after the
1973 later of:

1974 (A) the [date] day on which the assuming insurer has met all eligibility requirements
1975 pursuant to Subsection (8)(b); and

1976 ~~[(B) the effective date of the new reinsurance agreement, amendment or renewal.]~~

1977 (B) the day on which the new reinsurance agreement, amendment, or renewal is
1978 effective.

1979 (ii) This Subsection (8) does not alter or impair a ceding insurer's right to take credit
1980 for reinsurance, to the extent that credit is not available under this Subsection (8), as long as the
1981 reinsurance qualifies for credit under any other applicable provision of this chapter.

1982 (iii) Nothing in this Subsection (8) authorizes an assuming insurer to withdraw or
1983 reduce the security provided under any reinsurance agreement except as permitted by the terms
1984 of the agreement.

1985 (iv) Nothing in this Subsection (8) limits, or in any way alters, the capacity of parties to
1986 any reinsurance agreement to renegotiate the agreement.

1987 (9) If reinsurance is ceded to an assuming insurer not meeting the requirements of
1988 Subsection (3), (4), (5), (6), (7), or (8), a domestic ceding insurer is allowed credit only as to
1989 the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable

1990 law or regulation of that jurisdiction.

1991 (10) (a) An asset or a reduction from liability for the reinsurance ceded by a domestic
1992 insurer to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), (6), (7),
1993 or (8) shall be allowed in an amount not exceeding the liabilities carried by the ceding insurer.

1994 (b) The commissioner may adopt by rule made in accordance with Title 63G, Chapter
1995 3, Utah Administrative Rulemaking Act, specific additional requirements relating to or setting
1996 forth:

1997 (i) the valuation of assets or reserve credits;

1998 (ii) the amount and forms of security supporting reinsurance arrangements; and

1999 (iii) the circumstances pursuant to which credit will be reduced or eliminated.

2000 (c) (i) The reduction shall be in the amount of funds held by or on behalf of the ceding
2001 insurer, including funds held in trust for the ceding insurer, under a reinsurance contract with
2002 the assuming insurer as security for the payment of obligations thereunder, if the security is:

2003 (A) held in the United States subject to withdrawal solely by, and under the exclusive
2004 control of, the ceding insurer; or

2005 (B) in the case of a trust, held in a qualified United States financial institution.

2006 (ii) The security described in this Subsection (10)(c) may be in the form of:

2007 (A) cash;

2008 (B) securities listed by the Securities Valuation Office of the National Association of
2009 Insurance Commissioners, including those deemed exempt from filing as defined by the
2010 Purposes and Procedures Manual of the Securities Valuation Office, and qualifying as admitted
2011 assets;

2012 (C) clean, irrevocable, unconditional letters of credit, issued or confirmed by a
2013 qualified United States financial institution effective no later than December 31 of the year for
2014 which the filing is being made, and in the possession of, or in trust for, the ceding insurer on or
2015 before the filing date of its annual statement;

2016 (D) letters of credit meeting applicable standards of issuer acceptability as of the dates
2017 of their issuance or confirmation shall, notwithstanding the issuing or confirming institution's

2018 subsequent failure to meet applicable standards of issuer acceptability, continue to be
2019 acceptable as security until their expiration, extension, renewal, modification or amendment,
2020 whichever first occurs; or

2021 (E) any other form of security acceptable to the commissioner.

2022 (11) Reinsurance credit [~~may not be~~] is not allowed a domestic ceding insurer unless
2023 the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts
2024 by:

2025 (a) (i) being an admitted insurer; and

2026 (ii) submitting to jurisdiction under Section 31A-2-309;

2027 (b) having irrevocably appointed the commissioner as the domestic ceding insurer's
2028 agent for service of process in an action arising out of or in connection with the reinsurance,
2029 which appointment is made under Section 31A-2-309; or

2030 (c) agreeing in the reinsurance contract:

2031 (i) that if the assuming insurer fails to perform [~~its~~] the assuming insurer's obligations
2032 under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding
2033 insurer, shall:

2034 (A) submit to the jurisdiction of a court of competent jurisdiction in a state of the
2035 United States;

2036 (B) comply with all requirements necessary to give the court jurisdiction; and

2037 (C) abide by the final decision of the court or of an appellate court in the event of an
2038 appeal; and

2039 (ii) to designate the commissioner or a specific attorney licensed to practice law in this
2040 state as its attorney upon whom may be served lawful process in an action, suit, or proceeding
2041 instituted by or on behalf of the ceding company.

2042 (12) Submitting to the jurisdiction of Utah courts under Subsection (11) does not
2043 override a duty or right of a party under the reinsurance contract, including a requirement that
2044 the parties arbitrate their disputes.

2045 (13) (a) If an assuming insurer does not meet the requirements of Subsection (3), (4),

2046 (5), or (8), the credit permitted by Subsection (6) or (7) may not be allowed unless the
2047 assuming insurer agrees in the trust instrument to the ~~[following conditions:]~~ conditions
2048 described in Subsections (13)(b) through (e).

2049 ~~[(a)]~~ (b) (i) Notwithstanding any other provision in the trust instrument, if an event
2050 described in Subsection (13)~~[(a)]~~(b)(ii) occurs the trustee shall comply with:

- 2051 (A) an order of the commissioner with regulatory oversight over the trust; or
2052 (B) an order of a court of competent jurisdiction directing the trustee to transfer to the
2053 commissioner with regulatory oversight all of the assets of the trust fund.

2054 (ii) This Subsection (13)~~[(a)]~~(b) applies if:

2055 (A) the trust fund is inadequate because the trust contains an amount less than the
2056 amount required by Subsection (6)(d); or

2057 (B) the grantor of the trust is:

2058 (I) declared insolvent; or

2059 (II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the
2060 laws of its state or country of domicile.

2061 ~~[(b)]~~ (c) The assets of a trust fund described in Subsection ~~[(13)(a)]~~ (13)(b) shall be
2062 distributed by and a claim shall be filed with and valued by the commissioner with regulatory
2063 oversight in accordance with the laws of the state in which the trust is domiciled that are
2064 applicable to the liquidation of a domestic insurance company.

2065 ~~[(c)]~~ (d) If the commissioner with regulatory oversight determines that the assets of the
2066 trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more
2067 United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall
2068 be returned by the commissioner with regulatory oversight to the trustee for distribution in
2069 accordance with the trust instrument.

2070 ~~[(d)]~~ (e) A grantor shall waive any right otherwise available to ~~[it]~~ the grantor under
2071 United States law that is inconsistent with this Subsection (13).

2072 (14) (a) If an accredited or certified reinsurer ceases to meet the requirements for
2073 accreditation or certification, the commissioner may suspend or revoke the reinsurer's

2074 accreditation or certification.

2075 ~~[(a)]~~ (b) The commissioner shall give the reinsurer notice and opportunity for hearing.

2076 ~~[(b)]~~ (c) The suspension or revocation may not take effect until after the

2077 ~~[commissioner's]~~ day on which the commissioner issues an order after a hearing, unless:

2078 (i) the reinsurer waives ~~[its]~~ the reinsurer's right to hearing;

2079 (ii) the commissioner's order is based on:

2080 (A) regulatory action by the reinsurer's domiciliary jurisdiction; or

2081 (B) the voluntary surrender or termination of the reinsurer's eligibility to transact
2082 insurance or reinsurance business in its domiciliary jurisdiction or primary certifying state
2083 under Subsection (7)(g); or

2084 (iii) the commissioner's finding that an emergency requires immediate action and a
2085 court of competent jurisdiction has not stayed the commissioner's action.

2086 ~~[(c)]~~ (d) While a reinsurer's accreditation or certification is suspended, no reinsurance
2087 contract issued or renewed after the effective date of the suspension qualifies for credit except
2088 to the extent that the reinsurer's obligations under the contract are secured in accordance with
2089 Section 31A-17-404.1.

2090 ~~[(d)]~~ (e) If a reinsurer's accreditation or certification is revoked, no credit for
2091 reinsurance may be granted after the effective date of the revocation except to the extent that
2092 the reinsurer's obligations under the contract are secured in accordance with Subsection (7)(f)
2093 or Section 31A-17-404.1.

2094 (15) (a) A ceding insurer shall take steps to manage ~~[its]~~ the ceding insurer's
2095 reinsurance recoverables proportionate to ~~[its]~~ the ceding insurer's own book of business.

2096 (b) (i) A domestic ceding insurer shall notify the commissioner within 30 days after the
2097 day on which reinsurance recoverables from any single assuming insurer, or group of affiliated
2098 assuming insurers:

2099 (A) exceeds 50% of the domestic ceding insurer's last reported surplus to
2100 policyholders; or

2101 (B) after it is determined that reinsurance recoverables from any single assuming

2102 insurer, or group of affiliated assuming insurers, is likely to exceed 50% of the domestic ceding
2103 insurer's last reported surplus to policyholders.

2104 (ii) The notification required by Subsection (15)(b)(i) shall demonstrate that the
2105 exposure is safely managed by the domestic ceding insurer.

2106 (c) A ceding insurer shall take steps to diversify [its] the ceding insurer's reinsurance
2107 program.

2108 (d) (i) A domestic ceding insurer shall notify the commissioner within 30 days after
2109 [~~ceding or being likely to cede~~] the day on which the ceding insurer cedes or is likely to cede
2110 more than 20% of the ceding insurer's gross written premium in the prior calendar year to any:

2111 (A) single assuming insurer; or

2112 (B) group of affiliated assuming insurers.

2113 (ii) The notification shall demonstrate that the exposure is safely managed by the
2114 domestic ceding insurer.

2115 (16) A ceding insurer licensed under Chapter 5, Domestic Stock and Mutual Insurance
2116 Corporations, Chapter 7, Nonprofit Health Service Insurance Corporations, Chapter 8, Health
2117 Maintenance Organizations and Limited Health Plans, Chapter 9, Insurance Fraternal, or
2118 Chapter 14, Foreign Insurers is not allowed credit if the reinsurance is ceded to an assuming
2119 domestic or foreign captive insurer, unless the assuming domestic or foreign captive insurer
2120 complies with:

2121 (a) Chapter 4, Insurers in General;

2122 (b) Chapter 16, Insurance Holding Companies;

2123 (c) Chapter 16a, Risk Management and Own Risk and Solvency Assessment Act;

2124 (d) Chapter 17, Determination of Financial Condition; and

2125 (e) Chapter 18, Investments.

2126 Section 4. Section **31A-21-101** is amended to read:

2127 **31A-21-101. Scope of Chapters 21 and 22.**

2128 (1) Except as provided in Subsections (2) through (6), this chapter and Chapter 22,
2129 Contracts in Specific Lines, apply to all insurance policies, applications, and certificates:

- 2130 (a) delivered or issued for delivery in this state;
- 2131 (b) on property ordinarily located in this state;
- 2132 (c) on persons residing in this state when the policy is issued; or
- 2133 (d) on business operations in this state.
- 2134 (2) This chapter and Chapter 22, Contracts in Specific Lines, do not apply to:
- 2135 (a) an exemption provided in Section 31A-1-103;
- 2136 (b) an insurance policy procured under Sections 31A-15-103 and 31A-15-104;
- 2137 (c) an insurance policy on business operations in this state:
- 2138 (i) if:
- 2139 (A) the contract is negotiated primarily outside this state; and
- 2140 (B) the operations in this state are incidental or subordinate to operations outside this
- 2141 state; and
- 2142 (ii) except that insurance required by a Utah statute shall conform to the statutory
- 2143 requirements; or
- 2144 (d) other exemptions provided in this title.
- 2145 (3) (a) Sections 31A-21-102, 31A-21-103, 31A-21-104, Subsections 31A-21-107(1)
- 2146 and (3), and Sections 31A-21-306, 31A-21-308, 31A-21-312, and 31A-21-314 apply to ocean
- 2147 marine and inland marine insurance.
- 2148 (b) Section 31A-21-201 applies to inland marine insurance that is written according to
- 2149 manual rules or rating plans.
- 2150 (c) Inland marine insurance that includes accident and health insurance is subject to
- 2151 Chapter 22, Contracts in Specific Lines.
- 2152 (4) A group insurance policy or a blanket insurance policy is subject to this chapter and
- 2153 Chapter 22, Contracts in Specific Lines, except:
- 2154 (a) a group [~~or blanket~~] insurance policy outside the scope of this title under
- 2155 Subsection 31A-1-103(3)(h);
- 2156 (b) a blanket insurance policy outside the scope of this title under Subsection
- 2157 31A-1-103(3)(h); and

2158 [~~(b)~~] (c) other exemptions provided under Subsection (5).

2159 (5) The commissioner may by rule exempt any class of insurance contract or class of
2160 insurer from any or all of the provisions of this chapter and Chapter 22, Contracts in Specific
2161 Lines, if the interests of the Utah insureds, creditors, or the public would not be harmed by the
2162 exemption.

2163 (6) Workers' compensation insurance is subject to this chapter and Chapter 22,
2164 Contracts in Specific Lines.

2165 (7) Unless clearly inapplicable, any provision of this chapter or Chapter 22, Contracts
2166 in Specific Lines, applicable to either a policy or a contract is applicable to both.

2167 Section 5. Section **31A-21-201** is amended to read:

2168 **31A-21-201. Filing of forms.**

2169 (1) (a) Except as exempted under Subsections **31A-21-101**(2) through (6), a form may
2170 not be used, sold, or offered for sale until the form is filed with the commissioner.

2171 (b) A form is considered filed with the commissioner when the commissioner receives:

2172 (i) the form;

2173 (ii) the applicable filing fee as prescribed under Section **31A-3-103**; and

2174 (iii) the applicable transmittal forms as required by the commissioner.

2175 (2) In filing a form for use in this state the insurer is responsible for assuring that the
2176 form is in compliance with this title and rules adopted by the commissioner.

2177 (3) (a) The commissioner may prohibit the use of a form at any time upon a finding
2178 that:

2179 (i) the form:

2180 (A) is inequitable;

2181 (B) is unfairly discriminatory;

2182 (C) is misleading;

2183 (D) is deceptive;

2184 (E) is obscure;

2185 (F) is unfair;

2186 (G) encourages misrepresentation; or
2187 (H) is not in the public interest;
2188 (ii) the form provides benefits or contains another provision that endangers the solidity
2189 of the insurer;
2190 (iii) except for a life or accident and health insurance policy form, the form is an
2191 insurance policy or application for an insurance policy, that fails to conspicuously~~[, as defined~~
2192 ~~by rule,]~~ provide:
2193 (A) the exact name of the insurer; and
2194 (B) the state of domicile of the insurer filing the insurance policy or application for the
2195 insurance policy;
2196 (iv) except an application required by Section 31A-22-635, the form is a life or
2197 accident and health insurance policy form that fails to conspicuously~~[, as defined by rule,]~~
2198 provide:
2199 (A) the exact name of the insurer;
2200 (B) the state of domicile of the insurer filing the insurance policy or application for the
2201 insurance policy; and
2202 (C) for a life insurance policy only, the address of the administrative office of the
2203 insurer filing the form;
2204 (v) the form violates a statute or a rule adopted by the commissioner; or
2205 (vi) the form is otherwise contrary to law.
2206 (b) (i) When the commissioner prohibits the use of a form under Subsection (3)(a), the
2207 commissioner may order that, on or before a date not less than 15 days after the day on which
2208 the commissioner issues the order, the use of the form be discontinued.
2209 (ii) Once use of a form is prohibited, the form may not be used until appropriate
2210 changes are filed with and reviewed by the commissioner.
2211 (iii) When the commissioner prohibits the use of a form under Subsection (3)(a), the
2212 commissioner may require the insurer to disclose contract deficiencies to the existing
2213 policyholders.

2214 (c) If the commissioner prohibits use of a form under this Subsection (3), the
2215 prohibition shall:
2216 (i) be in writing;
2217 (ii) constitute an order; and
2218 (iii) state the reasons for the prohibition.

2219 (4) (a) If, after a hearing, the commissioner determines that it is in the public interest,
2220 the commissioner may require by rule or order that a form be subject to the commissioner's
2221 approval before ~~[its use]~~ an insurer uses the form.

2222 (b) The rule or order described in Subsection (4)(a) shall prescribe the filing
2223 procedures for a form if the procedures are different from the procedures stated in this section.

2224 (c) The type of form that under Subsection (4)(a) the commissioner may require
2225 approval of before use includes:

- 2226 (i) a form for a particular class of insurance;
- 2227 (ii) a form for a specific line of insurance;
- 2228 (iii) a specific type of form; or
- 2229 (iv) a form for a specific market segment.

2230 (5) (a) An insurer shall maintain a complete and accurate record of the following for
2231 the time period described in Subsection (5)(b):

- 2232 (i) a form:
 - 2233 (A) filed under this section for use; or
 - 2234 (B) that is in use; and
- 2235 (ii) a document filed under this section with a form described in Subsection (5)(a)(i).

2236 (b) The insurer shall maintain a record required under Subsection (5)(a) for the balance
2237 of the current year, plus five years from:

- 2238 (i) the last day on which the form is used; or
- 2239 (ii) the last day an insurance policy that is issued using the form is in effect.

2240 Section 6. Section **31A-21-402** is amended to read:

2241 **31A-21-402. Definitions.**

2242 As used in this part:

2243 (1) (a) "Direct response solicitation" means any offer [~~by~~] an insurer makes to persons
2244 in this state, either directly or through a third party, to effect life or accident and health
2245 insurance coverage which enables the individual to apply or enroll for the insurance on the
2246 basis of the offer.

2247 (b) "Direct response solicitation" does not include:

2248 (i) solicitations for insurance through an employee benefit plan exempt from state
2249 regulation under preemptive federal law[~~, nor does it include~~]; or

2250 (ii) solicitations through [~~the~~] an individual's creditor with respect to credit life or
2251 credit accident and health insurance.

2252 (2) "Mass marketed life or accident and health insurance" means the insurance under
2253 any individual, franchise, group, or blanket insurance policy [~~of~~] offering life or accident and
2254 health insurance [~~which~~];

2255 (a) that is offered by means of direct response solicitation through:

2256 (i) a sponsoring organization; or [~~through~~]

2257 (ii) the mails or other mass communications media; and

2258 (b) under which the person insured pays all or substantially all of the cost of [~~his~~] the
2259 person's insurance.

2260 Section 7. Section **31A-21-404** is amended to read:

2261 **31A-21-404. Out-of-state insurers.**

2262 [~~Any~~] Notwithstanding Subsection 31A-1-103(3)(h), an insurer extending mass
2263 marketed life or accident and health insurance under a group insurance policy issued outside of
2264 this state to residents of this state or a blanket insurance policy issued outside of this state to
2265 residents of this state shall, with respect to the mass marketed life or accident and health
2266 insurance policy:

2267 (1) comply with:

2268 (a) Sections 31A-23a-402, 31A-23a-402.5, and 31A-23a-403; and

2269 (b) Chapter 26, Part 3, Claim Practices; and

- 2270 (2) upon the commissioner's request, deliver to the commissioner a copy of:
- 2271 (a) any mass marketed life or accident and health insurance policy~~[, certificates issued~~
2272 ~~under these policies, and];~~
- 2273 (b) a certificate issued under a mass marketed life or accident and health insurance
2274 policy;
- 2275 (c) an application for a mass marketed life or accident and health insurance policy;
- 2276 (d) an enrollment form for a mass marketed life or accident and health insurance
2277 policy; and
- 2278 (e) advertising material used in this state in connection with ~~[the]~~ a mass marketed life
2279 or accident and health insurance policy.

2280 Section 8. Section **31A-22-409** is amended to read:

2281 **31A-22-409. Standard Nonforfeiture Law for Individual Deferred Annuities.**

2282 (1) This section is known as the "Standard Nonforfeiture Law for Individual Deferred
2283 Annuities."

2284 (2) This section does not apply to:

- 2285 (a) reinsurance;
- 2286 (b) a group annuity purchased under a retirement plan or plan of deferred
2287 compensation:
- 2288 (i) established or maintained by:
- 2289 (A) an employer, including a partnership or sole proprietorship;
- 2290 (B) an employee organization; or
- 2291 (C) both an employer and an employee organization; and
- 2292 (ii) other than a plan providing individual retirement accounts or individual retirement
2293 annuities under Section 408, Internal Revenue Code;
- 2294 (c) a premium deposit fund;
- 2295 (d) a variable annuity;
- 2296 (e) an investment annuity;
- 2297 (f) an immediate annuity;

2298 (g) a deferred annuity contract after annuity payments have commenced;
2299 (h) a reversionary annuity; or
2300 (i) a contract that is delivered outside this state through an agent or other representative
2301 of the company issuing the contract.

2302 (3) (a) If a policy is issued after this section takes effect as set forth in Subsection (15),
2303 a contract of annuity, except as stated in Subsection (2), may not be delivered or issued for
2304 delivery in this state unless the contract of annuity contains in substance:

2305 (i) the provisions described in Subsection (3)(b); or
2306 (ii) provisions corresponding to the provisions described in Subsection (3)(b) that in
2307 the opinion of the commissioner are at least as favorable to the contractholder, governing
2308 cessation of payment of consideration under the contract.

2309 (b) Subsection (3)(a)(i) requires the following provisions:

2310 (i) the company shall grant a paid-up annuity benefit on a plan stipulated in the contract
2311 of such a value as specified in Subsections (7), (8), (9), (10), and (12):

2312 (A) upon cessation of payment of consideration under a contract; or
2313 (B) upon a written request of the contract owner;

2314 (ii) if a contract provides for a lump-sum settlement at maturity, or at any other time,
2315 upon surrender of the contract at or before the commencement of any annuity payments, the
2316 company shall pay in lieu of any paid-up annuity benefit a cash surrender benefit of such
2317 amount as is specified in Subsections (7), (8), (10), and (12);

2318 (iii) a statement of the mortality table, if any, and interest rates used in calculating any
2319 of the following that are guaranteed under the contract:

2320 (A) minimum paid-up annuity benefit;
2321 (B) cash surrender benefit; or
2322 (C) death benefit;

2323 (iv) sufficient information to determine the amounts of the benefits described in
2324 Subsection (3)(b)(iii);

2325 (v) a statement that any paid-up annuity, cash surrender, or death benefits that may be

2326 available under the contract are not less than the minimum benefits required by a statute of the
2327 state in which the contract is delivered; and

2328 (vi) an explanation of the manner in which a benefit described in Subsection (3)(b)(v)
2329 is altered by the existence of any:

2330 (A) additional amounts credited by the company to the contract;

2331 (B) indebtedness to the company on the contract; or

2332 (C) prior withdrawals from or partial surrender of the contract.

2333 (c) Notwithstanding the requirements of this Subsection (3), a deferred annuity contract
2334 may provide that if no consideration is received under a contract for a period of two full years
2335 and the portion of the paid-up annuity benefit at maturity on the plan stipulated in the contract
2336 arising from consideration paid before the period would be less than \$20 monthly:

2337 (i) the company may at the company's option terminate the contract by payment in cash
2338 of the then present value of such portion of the paid-up annuity benefit, calculated on the basis
2339 of the mortality table specified in the contract, if any, and the interest rate specified in the
2340 contract for determining the paid-up annuity benefit; and

2341 (ii) the payment described in Subsection (3)(c)(i), relieves the company of any further
2342 obligation under the contract.

2343 (d) A company may reserve the right to defer the payment of cash surrender benefit for
2344 a period not to exceed six months after demand for the payment of the cash surrender benefit
2345 with surrender of the contract.

2346 (4) For a policy issued before June 1, 2006, the minimum values as specified in
2347 Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits
2348 available under an annuity contract shall be based upon minimum nonforfeiture amounts as
2349 established in this Subsection (4).

2350 (a) (i) With respect to a contract providing for flexible considerations, the minimum
2351 nonforfeiture amount at any time at or before the commencement of any annuity payments shall
2352 be equal to an accumulation up to such time, at a rate of interest of 3% per annum of
2353 percentages of the net considerations paid [~~prior to~~] before such time:

2354 (A) decreased by the sum of:
2355 (I) any prior withdrawals from or partial surrenders of the contract accumulated at a
2356 rate of interest of 3% per annum; and
2357 (II) the amount of any indebtedness to the company on the contract, including interest
2358 due and accrued; and
2359 (B) increased by any existing additional amounts credited by the company to the
2360 contract.
2361 (ii) For purposes of this Subsection (4)(a), the net consideration for a given contract
2362 year used to define the minimum nonforfeiture amount shall be:
2363 (A) an amount not less than zero; and
2364 (B) equal to the corresponding gross considerations credited to the contract during that
2365 contract year less:
2366 (I) an annual contract charge of \$30; and
2367 (II) a collection charge of \$1.25 per consideration credited to the contract during that
2368 contract year.
2369 (iii) The percentages of net considerations shall be:
2370 (A) 65% of the net consideration for the first contract year; and
2371 (B) 87-1/2% of the net considerations for the second and later contract years.
2372 (iv) Notwithstanding Subsection (4)(a)(iii), the percentage shall be 65% of the portion
2373 of the total net consideration for any renewal contract year that exceeds by not more than two
2374 times the sum of those portions of the net considerations in all prior contract years for which
2375 the percentage was 65%.
2376 (b) (i) Except as provided in Subsections (4)(b)(ii) and (iii), with respect to a contract
2377 providing for fixed scheduled consideration, minimum nonforfeiture amounts shall be:
2378 (A) calculated on the assumption that considerations are paid annually in advance; and
2379 (B) defined as for contracts with flexible considerations that are paid annually.
2380 (ii) The portion of the net consideration for the first contract year to be accumulated
2381 shall be equal to an amount that is the sum of:

2382 (A) 65% of the net consideration for the first contract year; and
2383 (B) 22-1/2% of the excess of the net consideration for the first contract year over the
2384 lesser of the net considerations for:
2385 (I) the second contract year; and
2386 (II) the third contract year.
2387 (iii) The annual contract charge shall be the lesser of \$30 or 10% of the gross annual
2388 consideration.
2389 (c) With respect to a contract providing for a single consideration payment, minimum
2390 nonforfeiture amounts shall be defined as for contracts with flexible considerations except that:
2391 (i) the percentage of net consideration used to determine the minimum nonforfeiture
2392 amount shall be equal to 90%; and
2393 (ii) the net consideration shall be the gross consideration less a contract charge of \$75.
2394 (5) (a) For a policy issued on or after June 1, 2006, the minimum values as specified in
2395 Subsections (7), (8), (9), (10), and (12) of any paid-up annuity, cash surrender, or death benefits
2396 available under an annuity contract shall be based upon minimum nonforfeiture amounts as
2397 established in this Subsection (5).
2398 ~~[(a)]~~ (b) The minimum nonforfeiture amount at any time at or before the
2399 commencement of any annuity payments shall be equal to an accumulation up to such time, at
2400 rates of interest as indicated in Subsection (5)~~[(b)]~~(c), of 87-1/2% of the gross considerations
2401 paid before such time decreased by the sum of:
2402 (i) any prior withdrawals from or partial surrenders of the contract accumulated at rates
2403 of interest as indicated in Subsection (5)~~[(b)]~~(c);
2404 (ii) an annual contract charge of \$50, accumulated at rates of interest as indicated in
2405 Subsection (5)~~[(b)]~~(c);
2406 (iii) any premium tax paid by the company for the contract, accumulated at rates of
2407 interest as indicated in Subsection (5)~~[(b)]~~(c); and
2408 (iv) the amount of any indebtedness to the company on the contract, including interest
2409 due and accrued.

2410 ~~(b)~~ (c) (i) The interest rate used in determining minimum nonforfeiture amounts shall
2411 be an annual rate of interest determined as the lesser of:

2412 (A) 3% per annum; ~~and~~ or

2413 (B) the five-year Constant Maturity Treasury Rate reported by the Federal Reserve,
2414 rounded to the nearest 1/20th of 1%, as of a date or average over a period no longer than 15
2415 months ~~prior to~~ before the contract issue date or redetermination date under Subsection
2416 (5)~~(b)~~(c)(iii):

2417 (I) reduced by 125 basis points; and

2418 (II) where the resulting interest rate is not less than 100 basis points, 1% for a policy
2419 issued on or after June 1, 2006, and before June 1, 2021, or where the resulting interest rate is
2420 not less than 15 basis points, 0.15% for a policy issued on or after June 1, 2021.

2421 (ii) The interest rate shall apply for an initial period and may be redetermined for
2422 additional periods.

2423 (iii) (A) If the interest rate will be reset, the contract shall state:

2424 (I) the initial period;

2425 (II) the redetermination date;

2426 (III) the redetermination basis; and

2427 (IV) the redetermination period.

2428 (B) The basis is the date or average over a specified period that produces the value of
2429 the five-year Constant Maturity Treasury Rate to be used at each redetermination date.

2430 ~~(e)~~ (d) (i) During the period or term that a contract provides substantive participation
2431 in an equity indexed benefit, the reduction described in Subsection (5)~~(b)~~(c)(i)(B)(I) may be
2432 increased by up to an additional 100 basis points to reflect the value of the equity index benefit.

2433 (ii) The present value of the additional reduction at the contract issue date and at each
2434 redetermination date may not exceed the market value of the benefit.

2435 (iii) (A) The commissioner may require a demonstration that the present value of the
2436 additional reduction does not exceed the market value of the benefit.

2437 (B) If the demonstration required under Subsection (5)~~(e)~~(d)(iii)(A) is not made to the

2438 satisfaction of the commissioner, the commissioner may disallow or limit the additional
2439 reduction.

2440 (6) Notwithstanding Subsection (4), for a policy issued on or after June 1, 2004 and
2441 before June 1, 2006, at the election of a company, on a contract form-by-contract form basis,
2442 the minimum values as specified in Subsections (7), (8), (9), (10), and (12) of any paid-up
2443 annuity, cash surrender, or death benefits available under an annuity contract may be based
2444 upon minimum nonforfeiture amounts as established in Subsection (5).

2445 (7) (a) A paid-up annuity benefit available under a contract shall be such that the
2446 contract's present value on the date annuity payments are to commence is at least equal to the
2447 minimum nonforfeiture amount on that date.

2448 (b) The present value described in Subsection (7)(a) shall be computed using the
2449 mortality table, if any, and the interest rate specified in the contract for determining the
2450 minimum paid-up annuity benefits guaranteed in the contract.

2451 (8) (a) For a contract that provides cash surrender benefits, the cash surrender benefits
2452 available before maturity may not be less than the present value as of the date of surrender of
2453 that portion of the cash surrender value that would be provided under the contract at maturity
2454 arising from considerations paid before the time of cash surrender:

2455 (i) decreased by the amount appropriate to reflect any prior withdrawals from or partial
2456 surrender of the contract;

2457 (ii) decreased by the amount of any indebtedness to the company on the contract,
2458 including interest due and accrued; and

2459 (iii) increased by any existing additional amounts credited by the company to the
2460 contract.

2461 (b) For purposes of this Subsection (8), the present value is to be calculated on the
2462 basis of an interest rate not more than 1% higher than the interest rate specified in the contract
2463 for accumulating the net considerations to determine the maturity value.

2464 (c) In no event shall a cash surrender benefit be less than the minimum nonforfeiture
2465 amount at that time.

2466 (d) The death benefit under a contract described in Subsection (8)(a) shall be at least
2467 equal to the cash surrender benefit.

2468 (9) (a) For a contract that does not provide cash surrender benefits, the present value of
2469 any paid-up annuity benefit available as a nonforfeiture option at any time [~~prior to~~] before
2470 maturity may not be less than the present value of that portion of the maturity value of the
2471 paid-up annuity benefit provided under the contract arising from considerations paid before the
2472 time the contract is surrendered in exchange for, or changed to, a deferred paid-up annuity
2473 increased by any existing additional amounts credited by the company to the contract.

2474 (b) For purposes of Subsection (9)(a), the present value for the period [~~prior to~~] before
2475 the maturity date is to be calculated on the basis of the interest rate specified in the contract for
2476 accumulating the net considerations to determine maturity value.

2477 (c) For a contract that does not provide a death benefit before commencement of any
2478 annuity payments, the present values shall be calculated on the basis of the interest rate and the
2479 mortality table specified in the contract for determining the maturity value of the paid-up
2480 annuity benefit.

2481 (d) In no event shall the present value of a paid-up annuity benefit be less than the
2482 minimum nonforfeiture amount at that time.

2483 (10) (a) For the purpose of determining the benefits calculated under Subsections (8)
2484 and (9), the maturity date shall be considered to be:

2485 (i) in the case of an annuity contract issued on or before May 5, 2002, under which an
2486 election may be made to have an annuity payment commence at an optional maturity date, the
2487 latest date for which an election is permitted by the contract, except that it may not be
2488 considered to be later than the later of:

2489 (A) the anniversary of the contract next following the day on which the annuitant
2490 becomes 70 years [~~of age~~] old; or

2491 (B) the tenth anniversary of the contract; or

2492 (ii) in the case of an annuity contract issued on or after May 6, 2002, the latest date
2493 permitted by the contract, except that [~~it~~] the maturity date may not be considered to be later

2494 than the later of:

2495 (A) the anniversary of the contract next following the day on which the annuitant
2496 becomes 70 years ~~[of age]~~ old; or

2497 (B) the tenth anniversary of the contract.

2498 (b) In the case of an annuity contract issued on or after May 6, 2002:

2499 (i) for a contract that provides cash surrender benefits, the cash surrender value on or
2500 past the maturity date shall be equal to the amount used to determine the annuity benefit
2501 payments; and

2502 (ii) a surrender charge may not be imposed on or past maturity.

2503 (11) A contract that does not provide cash surrender benefits or does not provide death
2504 benefits at least equal to the minimum nonforfeiture amount before the commencement of any
2505 annuity payments shall include a statement in a prominent place in the contract that these
2506 benefits are not provided.

2507 (12) A paid-up annuity, cash surrender, or death benefit available at any time, other than
2508 on the contract anniversary under a contract with fixed scheduled considerations, shall be
2509 calculated with allowance for the lapse of time and the payment of any scheduled
2510 considerations beyond the beginning of the contract year in which cessation of payment of
2511 considerations under the contract occurs.

2512 (13) (a) For a contract that provides, within the same contract by rider or supplemental
2513 contract provisions, both annuity benefits and life insurance benefits that are in excess of the
2514 greater of cash surrender benefits or a return of the gross considerations with interest, the
2515 minimum nonforfeiture benefits shall:

2516 (i) be equal to the sum of:

2517 (A) the minimum nonforfeiture benefits for the annuity portion; and

2518 (B) the minimum nonforfeiture benefits, if any, for the life insurance portion; and

2519 (ii) computed as if each portion were a separate contract.

2520 (b) (i) Notwithstanding Subsections (7), (8), (9), (10), and (12), additional benefits
2521 payable, as described in Subsection (13)(b)(ii), and consideration for the additional benefits

2522 payable, shall be disregarded in ascertaining, if required by this section:

2523 (A) the minimum nonforfeiture amounts;

2524 (B) paid-up annuity;

2525 (C) cash surrender; and

2526 (D) death benefits.

2527 (ii) For purposes of this Subsection (13), an additional benefit is a benefit payable:

2528 (A) in the event of total and permanent disability;

2529 (B) as reversionary annuity or deferred reversionary annuity benefits; or

2530 (C) as other policy benefits additional to life insurance, endowment, and annuity

2531 benefits.

2532 (iii) The inclusion of the additional benefits described in this Subsection (13) may not
2533 be required in any paid-up benefits, unless the additional benefits separately would require:

2534 (A) minimum nonforfeiture amounts;

2535 (B) paid-up annuity;

2536 (C) cash surrender; and

2537 (D) death benefits.

2538 (14) In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act,
2539 the commissioner may adopt rules necessary to implement this section, including:

2540 (a) ensuring that any additional reduction under Subsection (5)~~(c)~~(d) is consistent
2541 with the requirements imposed by Subsection (5)~~(c)~~(d); and

2542 (b) providing for adjustments in addition to the adjustments allowed under Subsection
2543 (5)~~(c)~~(d) to the calculation of minimum nonforfeiture amounts for:

2544 (i) a contract that provides substantive participation in an equity index benefit; and

2545 (ii) a contract for which the commissioner determines adjustments are justified.

2546 (15) (a) After this section takes effect, a company may file with the commissioner a
2547 written notice of ~~its~~ the company's election to comply with this section after a specified date
2548 before July 1, 1988.

2549 (b) This section applies to annuity contracts of a company issued on or after the date

2550 the company specifies in the notice.

2551 (c) If a company makes no election under Subsection (15)(a), the operative date of this
2552 section for such company is July 1, 1988.

2553 Section 9. Section 31A-22-501 is amended to read:

2554 **31A-22-501. Eligible groups.**

2555 A group insurance policy offering life insurance or a blanket insurance policy [~~of~~
2556 offering life insurance may not be delivered in Utah unless the insured group:

2557 (1) falls within at least one of the classifications under Sections 31A-22-501.1 through
2558 31A-22-509; and

2559 (2) is formed and maintained in good faith for purposes other than obtaining insurance.

2560 Section 10. Section 31A-22-504 is amended to read:

2561 **31A-22-504. Trustee groups.**

2562 (1) [~~Group~~] A group insurance policy offering life insurance [~~policies~~] may be issued
2563 to:

2564 (a) policyholders who are the trustees of a fund established by two or more employers,
2565 by one or more labor unions, or similar employee organizations, or by one or more employers
2566 and one or more labor unions or similar employee organizations, to insure employees of the
2567 employers or members of the unions or the organizations for the benefit of persons other than
2568 the employers, the unions, or the organizations; or

2569 (b) notwithstanding Subsection 31A-22-501(2)[;];

2570 (i) a Taft Hartley trust created in accordance with Section 302(c)(5) of the Federal
2571 Labor Management Relations Act[;]; or

2572 (ii) a trustee under a trust established for the purpose of facilitating the continuation of
2573 a policy when an individual's coverage would otherwise end, if the participating group through
2574 which the original coverage was offered would be eligible under this section, Section
2575 31A-22-502, or Section 31A-22-503.

2576 (2) [~~These policies are~~] A group insurance policy offering life insurance is subject to
2577 the following requirements:

2578 (a) ~~[The]~~ the persons eligible for insurance are all of the employees of the employers or
2579 all of the members of the unions or organizations, or all of any classes of employees or
2580 members~~[-The]~~;

2581 (b) the policy may include retired or former employees or members, elected and
2582 appointed officials of a public agency if the employees of the agency are insured, and
2583 individual proprietors or partners who are employers~~[-The]~~;

2584 (c) the policy may include the trustees or ~~[their]~~ the trustees' employees, or both, if
2585 their duties are principally connected with the trusteeship~~[-]~~;

2586 ~~[(b)-The]~~ (d) the premiums for the policy are paid by the policyholders from funds
2587 contributed by the employers, unions, or similar employee organizations, or from funds
2588 contributed by the insured persons, or any combination of these~~[-Except]~~; and

2589 (e) except as provided under Section 31A-22-512, a policy on which no part of the
2590 premium is contributed by the insured persons specifically for ~~[their]~~ the insured persons'
2591 insurance is required to insure all eligible persons.

2592 Section 11. Section 31A-22-505 is amended to read:

2593 **31A-22-505. Association groups.**

2594 ~~[(1) A policy is subject to the requirements of this section if the policy is issued as
2595 policyholder to an association or to the trustees of a fund established, created, or maintained for
2596 the benefit of members of one or more associations:]~~

2597 ~~[(a) with a minimum membership of 100 persons;]~~

2598 ~~[(b) with a constitution and bylaws;]~~

2599 ~~[(c) having a shared substantial common purpose that:]~~

2600 ~~[(i) is the same profession, trade, occupation, or similar; or]~~

2601 ~~[(ii) is by some common economic or representation of interest or genuine
2602 organizational relationship unrelated to the provision of benefits; and]~~

2603 ~~[(d) that has been in active existence for at least two years.]~~

2604 (1) An insurer may issue a group insurance policy offering life insurance to an
2605 association group if:

- 2606 (a) the commissioner authorizes the association group;
- 2607 (b) the benefits of the group insurance policy are reasonable in relation to the
- 2608 premiums charged for the policy; and
- 2609 (c) the association group:
 - 2610 (i) purchases insurance on a group basis on behalf of the association group's members;
 - 2611 (ii) is formed and maintained for a shared substantially common purpose that:
 - 2612 (A) is not related to obtaining insurance; and
 - 2613 (B) is the same profession, trade, or occupation or has some common economic,
 - 2614 representation of interest, or genuine organizational relationship;
 - 2615 (iii) has at least 100 members;
 - 2616 (iv) has been actively in existence for at least five years;
 - 2617 (v) has a constitution and bylaws that require:
 - 2618 (A) the association to hold regular meetings not less than annually to further the
 - 2619 purpose of the association's members; and
 - 2620 (B) members of the association to have voting privileges and representation on any
 - 2621 governing board or committee;
 - 2622 (vi) does not condition membership in the association group on any health
 - 2623 status-related factor;
 - 2624 (vii) makes insurance offered through the association group available exclusively to a
 - 2625 member of the association; and
 - 2626 (viii) only offers insurance through the association group in connection with a member
 - 2627 of the association group.
 - 2628 (2) [~~The policy~~] A group insurance policy offering life insurance that an insurer issues
 - 2629 to an association group may insure members and employees of the association, employees of
 - 2630 the members, one or more of the preceding entities, or all of any classes of these named entities
 - 2631 for the benefit of persons other than the employees' employer, or any officials, representatives,
 - 2632 trustees, or agents of the employer or association.
 - 2633 (3) (a) The [~~premiums~~] following shall [be paid by] pay the premium under a group

2634 insurance policy offering life insurance that an insurer issues to an association group:
 2635 (i) the policyholder from funds contributed by the [associations] association;
 2636 (ii) employer members, from funds contributed by the covered persons; or
 2637 (iii) from any combination of Subsections (3)(a)(i) and (ii).
 2638 (b) Except as provided under Section 31A-22-512, a policy on which no part of the
 2639 premium is contributed by the covered persons, specifically for their insurance, is required to
 2640 insure all eligible persons.
 2641 (4) (a) An association group that meets the requirements described under Subsection
 2642 (1) shall disclose the following to each insured member:
 2643 (i) each cost related to joining and maintaining membership in the association;
 2644 (ii) that membership fees or dues are in addition to the policy premium;
 2645 (iii) that the association group holds the master group insurance policy;
 2646 (iv) that the association group and insurer determine the amount of the premium
 2647 charged and the terms and conditions of coverage under the group insurance policy; and
 2648 (v) that the association group policyholder and insurer may change the premium and
 2649 terms and conditions of coverage under the insurance policy:
 2650 (A) through agreement; and
 2651 (B) without the consent of the individual certificate holder.
 2652 (b) If an insurer collects membership fees or dues on behalf of an association, the
 2653 insurer shall disclose to each member of the association that the insurer is billing and collecting
 2654 membership fees and dues on behalf of the association.
 2655 Section 12. Section 31A-22-517 is amended to read:
 2656 **31A-22-517. Conversion on termination of eligibility.**
 2657 (1) [A] Except as provided in Subsection (6), a person is entitled to be issued by an
 2658 insurer, without evidence of insurability, an individual policy [of] offering life insurance
 2659 without accident and health or other supplementary benefits, if:
 2660 (a) any portion of insurance on a person covered by a policy ceases because of:
 2661 (i) termination of employment; or

2662 (ii) termination of membership in the classes eligible for coverage;

2663 (b) an application for the individual policy is made; and

2664 (c) the first premium is paid to the insurer within 31 days after the day on which the
2665 termination described in Subsection (1)(a) occurs.

2666 (2) The individual policy described in Subsection (1) shall, at the option of the person
2667 entitled to the policy, be on any form then customarily provided by the insurer at the age and
2668 for the amount applied for, except that the group policy may exclude the option to elect:

2669 (a) term insurance; or

2670 (b) flexible premium insurance.

2671 (3) (a) The individual policy described in Subsection (1) shall be for an amount equal
2672 to or, at the election of the person entitled, less than the life insurance that ceases because of
2673 the termination described in Subsection (1)(a), less the amount of any group life insurance for
2674 which the person is eligible within 30 days after the day on which the termination described in
2675 Subsection (1)(a) occurs.

2676 (b) Any amount of insurance that matures on or before the termination, as an
2677 endowment payable to the person insured, is not included in the amount that is considered to
2678 cease because of the termination whether the endowment payment is in:

2679 (i) one sum;

2680 (ii) installments; or

2681 (iii) the form of an annuity.

2682 (4) The premium on the individual policy described in Subsection (1) shall be at the
2683 insurer's customary rate at the time of termination, which is applicable to:

2684 (a) the form and amount of the individual policy;

2685 (b) the class of risk to which the person belonged when terminated from the group
2686 policy; and

2687 (c) the age attained on the effective date of the individual policy.

2688 (5) Subject to the conditions of this section, the conversion privilege described in this
2689 section is available:

2690 (a) to a surviving dependent, if any, at the death of the employee or member, with
 2691 respect to the survivor's coverage under the group policy that terminates by reason of the death;
 2692 and

2693 (b) to the dependent of the employee or member upon termination of coverage of the
 2694 dependent, while the employee or member remains insured, because the dependent ceases to be
 2695 a qualified dependent under the group policy.

2696 (6) This section does not apply to an insured whose coverage will continue being the
 2697 policy of group life insurance issued to a group as authorized under Subsection
 2698 31A-22-504(1)(b)(ii).

2699 Section 13. Section 31A-22-522 is amended to read:

2700 **31A-22-522. Required provision for notice of termination.**

2701 (1) ~~[A policy for]~~ A group insurance policy offering life insurance coverage or a
 2702 blanket insurance policy offering life insurance coverage ~~[issued or renewed after July 1,~~
 2703 ~~2001,]~~ shall include a provision that obligates the policyholder to notify each employee or
 2704 group member:

2705 (a) in writing;

2706 (b) 30 days before the ~~[date]~~ day on which the coverage ~~[is terminated]~~ terminates; and

2707 (c) (i) that the group insurance policy offering life insurance coverage or blanket
 2708 insurance policy offering life insurance coverage is being terminated; and

2709 (ii) the rights the employee or group member has to convert coverage upon
 2710 termination.

2711 (2) For a ~~[policy for]~~ group insurance policy offering life insurance coverage or a
 2712 blanket insurance policy offering life insurance coverage described in Subsection (1), an
 2713 insurer shall:

2714 (a) include a statement of a policyholder's obligations under Subsection (1) in the
 2715 insurer's monthly notice to the policyholder of premium payments due; and

2716 (b) provide a sample notice to the policyholder at least once a year.

2717 Section 14. Section 31A-22-600 is amended to read:

2718 **31A-22-600. Scope of Part 6.**

2719 (1) Except where a provision's application is otherwise specifically limited, this part
2720 applies to all:

2721 (a) accident and health insurance contracts, including credit accident and health;

2722 (b) franchise;

2723 (c) group contracts; and

2724 (d) [a] life insurance and annuity [~~policy, but only if~~] policies that directly or through a
2725 rider provide:

2726 [~~(i) it includes supplemental benefits and riders including accelerated benefits; and]~~

2727 (i) accident and health insurance benefits; or

2728 (ii) accelerated benefits where the receipt of benefits is contingent on morbidity
2729 requirements.

2730 (2) Nothing in this part applies to or affects:

2731 (a) workers' compensation insurance;

2732 (b) reinsurance; or

2733 (c) accident and health insurance when it is part of or supplemental to liability, steam
2734 boiler, elevator, automobile, or other insurance covering loss of or damage to property,
2735 provided the loss, damage, or expense arises out of a hazard directly related to the other
2736 insurance.

2737 (3) Except as provided in Subsection (1), this part does not apply to or affect a life
2738 insurance or annuity policy including a life insurance policy:

2739 (a) with a rider or supplemental benefit that accelerates the death benefit contingent
2740 upon a mortality risk specifically for one or more of the qualifying events of:

2741 (i) terminal illness;

2742 (ii) medical conditions requiring extraordinary medical intervention; or

2743 (iii) permanent institutional confinement; and

2744 (b) that provides the option of a lump-sum payment for those benefits.

2745 Section 15. Section **31A-22-602** is amended to read:

2746 **31A-22-602. Premium rates.**

2747 (1) [~~This~~] Except as provided in Subsection 31A-22-701(4), this section does not apply
2748 to group accident and health insurance.

2749 (2) The benefits in an accident and health insurance policy shall be reasonable in
2750 relation to the premiums charged.

2751 (3) The commissioner shall prohibit the use of [~~an accident and health insurance~~] a
2752 policy offering accident and health insurance form or rates if the form or rates do not satisfy
2753 Subsection (2).

2754 Section 16. Section **31A-22-607** is amended to read:

2755 **31A-22-607. Grace period.**

2756 (1) (a) An individual or franchise accident and health insurance policy shall contain
2757 one or more clauses providing for a grace period for premium payment only of:

2758 (i) at least 15 days for a weekly or monthly premium policy; and

2759 (ii) 30 days for a policy that is not a weekly or monthly premium policy, for each
2760 premium after the first premium payment.

2761 (b) An insurer may elect to include a grace period that is longer than 15 days for a
2762 weekly or monthly policy.

2763 (c) An individual or franchise accident and health insurance policy is not in force
2764 during a grace period.

2765 (d) If an insurer receives payment before the day on which a grace period expires, the
2766 individual or franchise accident and health insurance policy continues in force with no gap in
2767 coverage.

2768 (e) If an insurer does not receive payment before the day on which a grace period
2769 expires, the individual or franchise accident and health insurance policy [~~is terminated~~]
2770 terminates as of the last date for which the premium is paid in full.

2771 (f) A grace period is not required if the policyholder has requested that the individual
2772 or franchise accident and health insurance policy be discontinued.

2773 (2) (a) A group insurance policy offering accident and health insurance or a blanket

2774 insurance policy offering accident and health insurance [~~policy~~] shall provide for a grace period
2775 of at least 30 days, unless the policyholder gives written notice of discontinuance before the
2776 [~~date of discontinuance~~] day on which the policy discontinues, in accordance with the policy
2777 terms.

2778 (b) A group insurance policy offering accident and health insurance or a blanket
2779 insurance policy offering accident and health insurance [~~policy~~] is in force during a grace
2780 period.

2781 (c) If an insurer does not receive payment before the day on which a grace period
2782 expires, the group insurance policy offering accident and health insurance or blanket insurance
2783 policy offering accident and health insurance [~~policy is terminated~~] terminates as of the last day
2784 [~~of~~] on which the grace period is in effect.

2785 (d) A group insurance policy offering accident and health insurance or a blanket
2786 insurance policy offering accident and health insurance [~~policy~~] may provide for payment of a
2787 pro rata premium for the period the [~~group or blanket accident and health insurance~~] policy is
2788 in effect during a grace period under this Subsection (2).

2789 (3) If an insurer has not guaranteed the insured a right to renew an accident and health
2790 insurance policy, a grace period beyond the expiration or anniversary date may, if provided in
2791 the accident and health insurance policy, be cut off by compliance with the notice provision
2792 under Subsection [~~31A-21-303(4)(b)~~] (4).

2793 (4) (a) An insurer shall send a written renewal notice to the policyholder or, if the
2794 insurer issued the policy to an employer group, the producer:

2795 (i) no sooner than 90 days before, and no later than 14 days before, the day on which an
2796 accident and health insurance policy renews; or

2797 (ii) if the renewal notice includes a change in premium, at least 45 days before the day
2798 on which an accident and health insurance policy renews.

2799 (b) The renewal notice described in Subsection (4)(a) shall clearly state:

2800 (i) the renewal amount;

2801 (ii) how the policyholder may pay the renewal premium, including the day on which

2802 the renewal premium is due; and

2803 (iii) that failure of the policyholder to pay the renewal premium extinguishes the
2804 policyholder's right to renew.

2805 (5) The extinguishment of a policyholder's right to renew for nonpayment of premium
2806 is effective no sooner than 10 days after the day on which the policyholder receives written
2807 notice that the policyholder has failed to pay the premium when due.

2808 Section 17. Section **31A-22-608** is amended to read:

2809 **31A-22-608. Reinstatement of individual or franchise accident and health**
2810 **insurance policies.**

2811 (1) Every individual or franchise accident and health insurance policy shall contain a
2812 provision which reads substantially as follows:

2813 "REINSTATEMENT: If any renewal premium is not paid within the time granted the
2814 insured for payment, a subsequent acceptance of premium by the insurer or by any agent duly
2815 authorized by the insurer to accept the premium, without also requiring an application for
2816 reinstatement, shall reinstate the policy. However, if the insurer or agent requires an
2817 application for reinstatement and issues a conditional receipt for the premium tendered, the
2818 policy shall be reinstated upon approval of this application from the insurer or, lacking this
2819 approval, upon the 45th day following the date of the conditional receipt, unless the insurer has
2820 previously notified the insured in writing of its disapproval of the application. The reinstated
2821 policy shall cover only loss resulting from such accidental injury as may be sustained after the
2822 date of reinstatement and loss due to such sickness as may begin more than 10 days after that
2823 date. In all other respects the insured and insurer have the same rights under the reinstated
2824 policy as they had under the policy immediately before the due date of the defaulted premium,
2825 subject to any provisions endorsed on or attached to this policy in connection with the
2826 reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a
2827 period for which premium has not been previously paid, but not to any period more than 60
2828 days prior to the date of reinstatement."

2829 (2) The last sentence of the provision [~~set forth~~] described in Subsection (1) may be

2830 omitted from any policy that the insured has the right to continue in force subject to [its] the
2831 policy's terms by the timely payment of premiums until at least age 50, or in the case of a
2832 policy issued after age 44, for at least five years from ~~[its date of issue]~~ the day on which the
2833 insurer issues the policy.

2834 Section 18. Section **31A-22-612** is amended to read:

2835 **31A-22-612. Conversion privileges for insured former spouse.**

2836 (1) An accident and health insurance policy, ~~[which]~~ that in addition to covering the
2837 insured also provides coverage to the spouse of the insured, may not contain a provision for
2838 termination of coverage of a spouse covered under the policy, except by entry of a valid decree
2839 of divorce, legal separation, or annulment between the parties.

2840 (2) Every policy ~~[which]~~ that contains ~~[this]~~ the type of provision described in
2841 Subsection (1) shall provide that:

2842 (a) upon the entry of the divorce decree the spouse is entitled to have issued an
2843 individual policy ~~[of]~~ offering accident and health insurance without evidence of insurability,
2844 upon application to the company and payment of the appropriate premium~~[- The];~~ and

2845 (b) the individual policy described in Subsection (2)(a) shall:

2846 (i) provide the coverage ~~[being issued which]~~ that is most nearly similar to the
2847 terminated coverage~~[- Probationary or waiting periods in the policy are considered];~~ and

2848 (ii) consider a probationary or waiting period satisfied to the extent the coverage was in
2849 force under the prior policy.

2850 (3) (a) When ~~[the]~~ an insurer receives actual notice that the coverage of a spouse is to
2851 be terminated because of a divorce, legal separation, or annulment, the insurer shall promptly
2852 provide the spouse written notification of the right to obtain individual coverage as provided in
2853 Subsection (2), the premium amounts required, and the manner, place, and time in which
2854 premiums may be paid.

2855 (b) The premium is determined in accordance with the insurer's table of premium rates
2856 applicable to the age and class of risk of the persons to be covered and to the type and amount
2857 of coverage provided.

2858 (c) If ~~the~~ a spouse applies and tenders the first monthly premium to the insurer within
2859 30 days after ~~receiving~~ the day on which the spouse receives the notice provided by this
2860 Subsection (3), the spouse shall receive individual coverage that commences immediately upon
2861 termination of coverage under the insured's policy.

2862 (4) This section does not apply to:

2863 (a) a blanket insurance policy offering accident and health insurance ~~[policies offered~~
2864 ~~on a group blanket basis]~~; or

2865 (b) a health benefit plan.

2866 Section 19. Section **31A-22-618.6** is amended to read:

2867 **31A-22-618.6. Discontinuance, nonrenewal, or changes to group health benefit**
2868 **plans.**

2869 (1) Except as otherwise provided in this section, a group health benefit plan for a plan
2870 sponsor is renewable and continues in force:

2871 (a) with respect to all eligible employees and dependents; and

2872 (b) at the option of the plan sponsor.

2873 (2) A health benefit plan for a plan sponsor may be discontinued or nonrenewed:

2874 (a) for noncompliance with the insurer's employer contribution requirements;

2875 (b) if there is no longer any enrollee under the group health plan who lives, resides, or
2876 works in:

2877 (i) the service area of the insurer; or

2878 (ii) the area for which the insurer is authorized to do business;

2879 (c) for coverage made available in the small or large employer market only through an
2880 association, if:

2881 (i) the employer's membership in the association ceases; and

2882 (ii) the coverage is terminated uniformly without regard to any health status-related
2883 factor relating to any covered individual; or

2884 (d) for noncompliance with the insurer's minimum employee participation
2885 requirements, except as provided in Subsection (3).

2886 (3) If a small employer no longer employs at least one eligible employee, a carrier may
2887 not discontinue or not renew the health benefit plan until the first renewal date following the
2888 beginning of a new plan year, even if the carrier knows at the beginning of the plan year that
2889 the employer no longer has at least one eligible employee.

2890 (4) (a) A small employer that, after purchasing a health benefit plan in the small group
2891 market, employs on average more than 50 eligible employees on each business day in a
2892 calendar year may continue to renew the health benefit plan purchased in the small group
2893 market.

2894 (b) A large employer that, after purchasing a health benefit plan in the large group
2895 market, employs on average fewer than 51 eligible employees on each business day in a
2896 calendar year may continue to renew the health benefit plan purchased in the large group
2897 market.

2898 (5) A health benefit plan for a plan sponsor may be discontinued if:

2899 (a) a condition described in Subsection (2) exists;

2900 (b) the plan sponsor fails to pay premiums or contributions in accordance with the
2901 terms of the contract;

2902 (c) the plan sponsor:

2903 (i) performs an act or practice that constitutes fraud; or

2904 (ii) makes an intentional misrepresentation of material fact under the terms of the
2905 coverage;

2906 (d) the insurer:

2907 (i) elects to discontinue offering a particular health benefit plan [~~product~~] delivered or
2908 issued for delivery in this state; [~~and~~]

2909 (ii) [~~(A)~~] provides notice of the discontinuation in writing to each plan sponsor,
2910 employee, [~~or~~] and dependent of [~~a plan sponsor or~~] an employee, at least 90 days before the
2911 [~~date~~] day on which the coverage [~~will be discontinued~~] discontinues;

2912 [~~(B)~~] (iii) provides notice of the discontinuation in writing to the commissioner, and at
2913 least three working days before the [~~date~~] day on which the notice is sent to [~~the~~] each affected

2914 plan ~~[sponsors, employees, and dependents of the plan sponsors or employees]~~ sponsor,
2915 employee, and dependent of an employee;

2916 ~~[(C)]~~ (iv) offers to each plan sponsor, on a guaranteed issue basis, the option to
2917 purchase all other health benefit plans currently being offered by the insurer in the market or, in
2918 the case of a large employer, any other health benefit plans currently being offered in that
2919 market; and

2920 ~~[(D)]~~ (v) in exercising the option to discontinue that health benefit plan and in offering
2921 the option of coverage in this section, acts uniformly without regard to the claims experience of
2922 a plan sponsor, any health status-related factor relating to any covered participant or
2923 beneficiary, or any health status-related factor relating to any new participant or beneficiary
2924 who may become eligible for the coverage; or

2925 (e) the insurer:

2926 (i) elects to discontinue all of the insurer's health benefit plans in:

2927 (A) the small employer market;

2928 (B) the large employer market; or

2929 (C) both the small employer and large employer markets; ~~[and]~~

2930 (ii) ~~[(A)]~~ provides notice of the discontinuation in writing to each plan sponsor,
2931 employee, ~~[or]~~ and dependent of ~~[a plan sponsor or]~~ an employee at least 180 days before the
2932 ~~[date]~~ day on which the coverage ~~[will be discontinued]~~ discontinues;

2933 ~~[(B)]~~ (iii) provides notice of the discontinuation in writing to the commissioner in each
2934 state in which an affected insured individual is known to reside and, at least 30 working days
2935 before the ~~[date]~~ day on which the notice is sent to ~~[the]~~ each affected plan ~~[sponsors,~~
2936 ~~employees, and the dependents of the plan sponsors or employees]~~ sponsor, employee, and
2937 dependent of an employee;

2938 ~~[(C)]~~ (iv) discontinues and nonrenews all plans issued or delivered for issuance in the
2939 market described in Subsection (5)(e)(i); and

2940 ~~[(D)]~~ (v) provides a plan of orderly withdrawal as required by Section [31A-4-115](#).

2941 (6) (a) Except as provided in Subsection (6)(d), an eligible employee may be

2942 discontinued if after issuance of coverage the eligible employee:

2943 (i) engages in an act or practice in connection with the coverage that constitutes fraud;

2944 or

2945 (ii) makes an intentional misrepresentation of material fact in connection with the

2946 coverage.

2947 (b) An eligible employee [~~that~~] whose coverage is discontinued under Subsection

2948 (6)(a) may reenroll:

2949 (i) 12 months after the [~~date of discontinuance~~] day on which the employee's coverage

2950 discontinues; and

2951 (ii) if the plan sponsor's coverage is in effect at the time the eligible employee applies

2952 to reenroll.

2953 (c) At the time the eligible employee's coverage [~~is discontinued~~] discontinues under

2954 Subsection (6)(a), the insurer shall notify the eligible employee of the right to reenroll [~~when~~

2955 ~~coverage is discontinued~~] as described in Subsection (6)(b).

2956 (d) An eligible [~~employee~~] employee's coverage may not be discontinued under this

2957 Subsection (6) because of a fraud or misrepresentation that relates to health status.

2958 (7) For purposes of this section, a reference to "plan sponsor" includes a reference to

2959 the employer:

2960 (a) with respect to coverage provided to an employer member of the association; and

2961 (b) if the health benefit plan is made available by an insurer in the employer market

2962 only through:

2963 (i) an association;

2964 (ii) a trust; or

2965 (iii) a discretionary group.

2966 (8) An insurer may modify a health benefit plan for a plan sponsor only:

2967 (a) at the time of coverage renewal; and

2968 (b) if the modification is effective uniformly among all plans with that product.

2969 Section 20. Section **31A-22-618.7** is amended to read:

2970 **31A-22-618.7. Discontinuance, nonrenewal, and modification for individual**
2971 **health benefit plans.**

2972 (1) (a) Except as otherwise provided in this section, a health benefit plan offered on an
2973 individual basis is renewable and continues in force:

2974 (i) with respect to all enrollees or dependents; and

2975 (ii) at the option of the enrollee.

2976 (b) Subsection (1)(a) applies regardless of:

2977 (i) whether the contract is issued through:

2978 (A) a trust;

2979 (B) an association;

2980 (C) a discretionary group; or

2981 (D) other similar grouping; or

2982 (ii) the situs of delivery of the policy or contract.

2983 (2) An individual health benefit plan may be discontinued or nonrenewed:

2984 (a) if:

2985 (i) there is no longer an enrollee under the individual health benefit plan who lives,
2986 resides, or works in:

2987 (A) the service area of the insurer; or

2988 (B) the area for which the insurer is authorized to do business; and

2989 (ii) coverage is terminated uniformly without regard to any health status-related factor
2990 relating to any covered enrollee; or

2991 (b) for coverage made available through an association, if:

2992 (i) the enrollee's membership in the association ceases; and

2993 (ii) the coverage is terminated uniformly without regard to any health status-related
2994 factor relating to any covered enrollee.

2995 (3) An individual health benefit plan may be discontinued if:

2996 (a) a condition described in Subsection (2) exists;

2997 (b) the enrollee fails to pay premiums or contributions in accordance with the terms of

2998 the health benefit plan, including any timeliness requirements;

2999 (c) the enrollee:

3000 (i) performs an act or practice in connection with the coverage that constitutes fraud; or

3001 (ii) makes an intentional misrepresentation of material fact under the terms of the

3002 coverage;

3003 (d) the insurer:

3004 (i) elects to discontinue offering a particular health benefit plan product delivered or

3005 issued for delivery in this state; and

3006 (ii) (A) provides notice of the discontinuation in writing to each enrollee provided

3007 coverage at least 90 days before the ~~[date]~~ day on which the coverage ~~[will be discontinued]~~

3008 discontinues;

3009 (B) provides notice of the discontinuation in writing to the commissioner and, at least

3010 three working days before the ~~[date]~~ day on which the notice is sent, to ~~[the affected enrollees]~~

3011 each affected enrollee;

3012 (C) offers to each covered enrollee on a guaranteed issue basis the option to purchase

3013 all other individual health benefit plans currently being offered by the insurer for individuals in

3014 that market; and

3015 (D) acts uniformly without regard to any health status-related factor of covered

3016 enrollees or dependents of covered enrollees who may become eligible for coverage; or

3017 (e) the insurer:

3018 (i) elects to discontinue all of the insurer's health benefit plans in the individual market;

3019 and

3020 (ii) (A) provides notice of the discontinuation in writing to each enrollee provided

3021 coverage at least 180 days before the ~~[date]~~ day on which the coverage ~~[will be discontinued]~~

3022 discontinues;

3023 (B) provides notice of the discontinuation in writing to the commissioner in each state

3024 in which an affected enrollee is known to reside and, at least 30 working days before the ~~[date]~~

3025 day on which the insurer sends the notice ~~[is sent, to the affected enrollees]~~, to each affected

3026 enrollee;

3027 (C) discontinues and nonrenews all health benefit plans the insurer issues or delivers
3028 for issuance in the individual market; and

3029 (D) acts uniformly without regard to any health status-related factor of covered
3030 enrollees or dependents of covered enrollees who may become eligible for coverage.

3031 (4) An insurer may modify an individual health benefit plan only:

3032 (a) at the time of coverage renewal; and

3033 (b) if the modification is effective uniformly among all health benefit plans.

3034 Section 21. Section **31A-22-618.8** is amended to read:

3035 **31A-22-618.8. Discontinuance and nonrenewal limitations for health benefit**
3036 **plans.**

3037 (1) Subject to Section **31A-4-115**, an insurer that elects to discontinue offering a health
3038 benefit plan under Subsections **31A-22-618.6(5)(e)** and **31A-22-618.7(3)(e)** is prohibited from
3039 writing new business:

3040 (a) in the market in this state for which the insurer discontinues or does not renew; and

3041 (b) for a period of five years beginning on the [~~date of discontinuation of~~] day on
3042 which the last coverage that is discontinued.

3043 (2) If an insurer is doing business in one established geographic service area of the
3044 state, Sections **31A-22-618.6** and **31A-22-618.7** apply only to the insurer's operations in that
3045 service area.

3046 (3) The commissioner may, by rule or order, define the scope of service area.

3047 Section 22. Section **31A-22-627** is amended to read:

3048 **31A-22-627. Coverage of emergency medical services.**

3049 (1) A health insurance policy or managed care organization contract:

3050 (a) shall provide[~~, at a minimum,~~] coverage of emergency services [~~as required in 29~~
3051 ~~C.F.R. Sec. 2590.715-2719A~~]; and

3052 (b) may not:

3053 (i) require any form of preauthorization for treatment of an emergency medical

3054 condition until after the insured's condition has been stabilized; [~~or~~]

3055 (ii) deny a claim for any covered evaluation, covered diagnostic test, or other covered
3056 treatment considered medically necessary to stabilize the emergency medical condition of an
3057 insured[-]; or

3058 (iii) impose any cost-sharing requirement for out-of-network that exceeds the
3059 cost-sharing requirement imposed for in-network.

3060 (2) (a) A health insurance policy or managed care organization contract may require
3061 authorization for the continued treatment of an emergency medical condition after the insured's
3062 condition has been stabilized.

3063 (b) If [~~such~~] authorization described in Subsection (2)(a) is required, an insurer who
3064 does not accept or reject a request for authorization may not deny a claim for any evaluation,
3065 diagnostic testing, or other treatment considered medically necessary that occurred between the
3066 time the request was received and the time the insurer rejected the request for authorization.

3067 (3) For purposes of this section:

3068 (a) "Emergency medical condition" means a medical condition manifesting itself by
3069 acute symptoms of sufficient severity, including severe pain, such that a prudent layperson,
3070 who possesses an average knowledge of medicine and health, would reasonably expect the
3071 absence of immediate medical attention through a hospital emergency department to result in:

3072 (i) placing the insured's health, or with respect to a pregnant woman, the health of the
3073 woman or her unborn child, in serious jeopardy;

3074 (ii) serious impairment to bodily functions; or

3075 (iii) serious dysfunction of any bodily organ or part.

3076 (b) "Hospital emergency department" means that area of a hospital in which emergency
3077 services are provided on a 24-hour-a-day basis.

3078 (c) "Stabilize" means the same as that term is defined in 42 U.S.C. Sec. 1395dd(e)(3).

3079 (4) Nothing in this section may be construed as:

3080 (a) altering the level or type of benefits that are provided under the terms of a contract
3081 or policy; or

3082 (b) restricting a policy or contract from providing enhanced benefits for certain
3083 emergency medical conditions that are identified in the policy or contract.

3084 (5) Notwithstanding Section 31A-2-308, if the commissioner finds an insurer has
3085 violated this section, the commissioner may:

3086 (a) work with the insurer to improve the insurer's compliance with this section; or

3087 (b) impose the following fines:

3088 (i) not more than \$5,000; or

3089 (ii) twice the amount of any profit gained from violations of this section.

3090 Section 23. Section 31A-22-654 is amended to read:

3091 **31A-22-654. Study of coverage for in vitro fertilization and genetic testing --**

3092 **Reporting -- Coverage requirements.**

3093 (1) As used in this section:

3094 (a) "Qualified condition" means the same as that term is defined in Section 49-20-420.

3095 (b) "Qualified insurer" means an insurer that provides a health benefit plan [~~described~~]

3096 as defined in Section [31A-22-600] 31A-1-301 to more than 25,000 enrollees in the state as of

3097 December 31 of the preceding reporting year.

3098 (c) "Qualified enrollee" means an enrollee of a qualified insurer who:

3099 (i) has been diagnosed by a physician as having a genetic trait associated with a

3100 qualified condition; and

3101 (ii) intends to get pregnant with a partner who is diagnosed by a physician as having a

3102 genetic trait associated with the same qualified condition as the enrollee.

3103 (2) (a) A qualified insurer shall submit the information described in this Subsection (2)

3104 to the department [~~with the qualified insurer's rate filings required under Section 31A-2-201.1~~]

3105 for a plan year beginning:

3106 (i) on or after January 1, 2022, but before December 31, 2022; and

3107 (ii) on or after January 1, 2025, but before December 31, 2025.

3108 (b) A qualified insurer shall study whether providing the coverage for the services

3109 described in Subsections (3)(a) and (b) for qualified enrollees will result in cost savings for the

3110 qualified insurer.

3111 (c) (i) If a qualified insurer determines that providing the coverage described in
3112 Subsection (3) for qualified enrollees will result in cost savings for the qualified insurer, the
3113 qualified insurer shall submit a summary of the results of the study described in Subsection
3114 (2)(b), and:

3115 (A) describe how the qualified insurer intends to provide the coverage described in
3116 Subsection (3); or

3117 (B) submit an explanation of why the insurer will not provide the coverage described in
3118 Subsection (3).

3119 (ii) If a qualified insurer determines that providing the coverage described in
3120 Subsection (3) will not result in cost savings to the qualified insurer, the qualified insurer shall
3121 submit a summary of the results of the study described in Subsection (2)(b).

3122 (d) A qualified insurer shall provide the information required under this Subsection (2)
3123 to the department no later than:

3124 (i) January 1, 2022, for a plan year beginning on or after January 1, 2022, but before
3125 December 31, 2022; and

3126 (ii) January 1, 2025, for a plan year beginning on or after January 1, 2025, but before
3127 December 31, 2025.

3128 (3) A qualified insurer shall consider coverage for:

3129 (a) in vitro fertilization services for a qualified enrollee; and

3130 (b) genetic testing of a qualified enrollee who received in vitro fertilization services
3131 under Subsection (3)(a).

3132 (4) The department shall report the information received under Subsection (2) to the
3133 Health and Human Services Interim Committee on or before:

3134 (a) for information submitted under Subsection (2)(a)(i), November 1, 2022; and

3135 (b) for information submitted under Subsection (2)(a)(ii), November 1, 2025.

3136 Section 24. Section **31A-22-701** is amended to read:

3137 **31A-22-701. Groups eligible for group or blanket insurance.**

3138 ~~[(1) As used in this section, "association group" means a lawfully formed association~~
3139 ~~of individuals or business entities that:]~~

3140 ~~[(a) purchases insurance on a group basis on behalf of members; and]~~

3141 ~~[(b) is formed and maintained in good faith for purposes other than obtaining~~
3142 ~~insurance;]~~

3143 ~~[(2)]~~ (1) A group ~~[accident and health]~~ insurance policy offering accident and health
3144 insurance may be issued to:

3145 (a) a group:

3146 (i) to which a group life insurance policy may be issued under Section [31A-22-502](#),
3147 [31A-22-503](#), [31A-22-504](#), [31A-22-505](#), [31A-22-506](#), or [31A-22-507](#); and

3148 (ii) that is formed and maintained in good faith for a purpose other than obtaining
3149 insurance;

3150 ~~[(b) an association group authorized by the commissioner that:]~~

3151 ~~[(i) has been actively in existence for at least five years;]~~

3152 ~~[(ii) has a constitution and bylaws;]~~

3153 ~~[(iii) has a shared or common purpose that is not primarily a business or customer~~
3154 ~~relationship;]~~

3155 ~~[(iv) is formed and maintained in good faith for purposes other than obtaining~~
3156 ~~insurance;]~~

3157 ~~[(v) does not condition membership in the association group on any health~~
3158 ~~status-related factor relating to an individual, including an employee of an employer or a~~
3159 ~~dependent of an employee;]~~

3160 ~~[(vi) makes accident and health insurance coverage offered through the association~~
3161 ~~group available to all members regardless of any health status-related factor relating to the~~
3162 ~~members or individuals eligible for coverage through a member;]~~

3163 ~~[(vii) does not make accident and health insurance coverage offered through the~~
3164 ~~association group available other than in connection with a member of the association group;~~
3165 ~~and]~~

- 3166 ~~[(viii) is actuarially sound; or]~~
3167 ~~[(e)]~~ (b) a group specifically authorized by the commissioner, upon a finding that:
3168 (i) authorization is not contrary to the public interest;
3169 (ii) the group is actuarially sound;
3170 (iii) formation of the proposed group may result in economies of scale in acquisition,
3171 administrative, marketing, and brokerage costs;
3172 (iv) the insurance policy, insurance certificate, or other indicia of coverage that will be
3173 offered to the proposed group is substantially equivalent to insurance policies that are
3174 otherwise available to similar groups;
3175 (v) the group would not present hazards of adverse selection;
3176 (vi) the premiums for the insurance policy and any contributions by or on behalf of the
3177 insured persons are reasonable in relation to the benefits provided; and
3178 (vii) the group is formed and maintained in good faith for a purpose other than
3179 obtaining insurance~~[-]; or~~
3180 (c) a postsecondary educational institution covering students, upon a finding that:
3181 (i) the policy provides standards for financial soundness;
3182 (ii) the policy protects the students covered;
3183 (iii) the policy provides for the establishment of a financially viable alternative to
3184 traditional health care plans;
3185 (iv) authorization is not contrary to the public interest;
3186 (v) the policy would not present hazards of adverse selection; and
3187 (vi) the premiums for the policy and any contributions by or on behalf of the insured
3188 persons are reasonable in relation to the benefits provided.
3189 ~~[(3)]~~ (2) A blanket insurance policy offering accident and health insurance ~~[policy]~~:
3190 (a) covers a defined class of persons;
3191 (b) may not be offered or underwritten on an individual basis;
3192 (c) shall cover only a group that is:
3193 (i) actuarially sound; and

3194 (ii) formed and maintained in good faith for a purpose other than obtaining insurance;

3195 and

3196 (d) may be issued only to:

3197 (i) a common carrier or an operator, owner, or lessee of a means of transportation, as
3198 policyholder, covering persons who may become passengers as defined by reference to the
3199 person's travel status;

3200 (ii) an employer, as policyholder, covering any group of employees, dependents, or
3201 guests, as defined by reference to specified hazards incident to any activities of the
3202 policyholder;

3203 (iii) an institution of learning, including a school district, a school jurisdictional unit, or
3204 the head, principal, or governing board of a school jurisdictional unit, as policyholder, covering
3205 students, teachers, or employees;

3206 (iv) a religious, charitable, recreational, educational, or civic organization, or branch of
3207 one of those organizations, as policyholder, covering a group of members or participants as
3208 defined by reference to specified hazards incident to the activities sponsored or supervised by
3209 the policyholder;

3210 (v) a sports team, camp, or sponsor of a sports team or camp, as policyholder, covering
3211 members, campers, employees, officials, or supervisors;

3212 (vi) a volunteer fire department, first aid, civil defense, or other similar volunteer
3213 organization, as policyholder, covering a group of members or participants as defined by
3214 reference to specified hazards incident to activities sponsored, supervised, or participated in by
3215 the policyholder;

3216 (vii) a newspaper or other publisher, as policyholder, covering its carriers;

3217 (viii) a labor union, as a policyholder, covering a group of members or participants as
3218 defined by reference to specified hazards incident to the activities or operations sponsored or
3219 supervised by the policyholder;

3220 (ix) an association that has a constitution and bylaws covering a group of members or
3221 participants as defined by reference to specified hazards incident to the activities or operations

3222 sponsored or supervised by the policyholder; or

3223 (x) any other class of risks that, in the judgment of the commissioner, may be properly
3224 eligible for a blanket insurance policy offering accident and health insurance.

3225 [~~(4)~~] (3) The judgment of the commissioner may be exercised on the basis of:

3226 (a) individual risks;

3227 (b) a class of risks; or

3228 (c) both Subsections [~~(4)~~](3)(a) and (b).

3229 (4) A group insurance policy offering accident and health insurance issued to a group
3230 authorized under Subsection 31A-22-504(b)(ii) is subject to the provisions of Section
3231 31A-22-602.

3232 Section 25. Section 31A-22-716 is amended to read:

3233 **31A-22-716. Required provision for notice of termination.**

3234 (1) [~~A policy for~~] A group insurance policy offering accident and health insurance or a
3235 blanket insurance policy offering accident and health [coverage issued or renewed after July 1,
3236 ~~1990,] insurance shall include a provision that obligates the policyholder:~~

3237 (a) to give [~~30 days prior~~] written notice of termination to each employee or group
3238 member 30 days before the day on which the policy terminates; and

3239 (b) to notify each employee or group member of the employee's or group member's
3240 rights to continue coverage upon termination.

3241 (2) (a) An insurer's monthly notice to the policyholder of premium payments due shall
3242 include a statement of the policyholder's obligations as set forth in Subsection (1).

3243 (b) Insurers shall provide a sample notice to the policyholder at least once a year.

3244 Section 26. Section 31A-22-717 is amended to read:

3245 **31A-22-717. Provisions pertaining to service members and their families affected**
3246 **by mobilization into the armed forces.**

3247 For [~~any~~] a group insurance policy offering accident and health insurance or a blanket
3248 insurance policy offering accident and health [coverage] insurance, an insurer:

3249 (1) may not refuse to reinstate an insured or [~~his~~] the insured's family whose coverage

3250 lapsed due to the insured's mobilization into the United States armed forces provided
3251 application is made within 180 days [~~of release~~] after the day on which the insured is released
3252 from active duty;

3253 (2) shall reinstate an insured in full upon payment of the first premium without the
3254 requirement of a waiting period or exclusion for preexisting conditions or any other
3255 underwriting requirements that were covered previously; and

3256 (3) may not increase the insured's premium in excess of what [it] the premium would
3257 have been increased to in the normal course of time had the insured not been mobilized into the
3258 United States armed forces.

3259 Section 27. Section **31A-22-1404** is amended to read:

3260 **31A-22-1404. Rulemaking authority.**

3261 The commissioner may adopt rules that may permit or include:

3262 (1) the increase of benefits over time;

3263 (2) standards for full and fair disclosure of the manner, content, and required
3264 disclosures for the sale of long-term care insurance policies;

3265 (3) terms of renewability;

3266 (4) initial and subsequent conditions of eligibility;

3267 (5) nonduplication of coverage provisions;

3268 (6) coverage of dependents;

3269 (7) termination of coverage;

3270 (8) continuation or conversion;

3271 (9) probationary periods;

3272 (10) limitations, exceptions, and reductions of coverage;

3273 (11) preexisting conditions;

3274 (12) elimination and waiting periods;

3275 (13) requirements for replacement;

3276 (14) recurrent conditions;

3277 (15) definition of terms;

- 3278 (16) loss ratio requirements;
- 3279 (17) post claim underwriting;
- 3280 (18) waiver of premium;
- 3281 (19) independent review of benefit determinations;
- 3282 [~~(19)~~] (20) inflation protection benefits; and
- 3283 [~~(20)~~] (21) premium rate filing and review.

3284 Section 28. Section **31A-22-2002** is amended to read:

3285 **31A-22-2002. Definitions.**

3286 As used in this part:

3287 (1) "Applicant" means:

3288 (a) when referring to an individual limited long-term care insurance policy, the person
3289 who seeks to contract for benefits; and

3290 (b) when referring to a group limited long-term care insurance policy, the proposed
3291 certificate holder.

3292 (2) "Elimination period" means the length of time between meeting the eligibility for
3293 benefit payment and receiving benefit payments from an insurer.

3294 (3) "Group limited long-term care insurance" means a limited long-term care insurance
3295 policy that is delivered or issued for delivery:

3296 (a) in this state; and

3297 (b) to an eligible group, as described under Subsection [31A-22-701\(2\)](#).

3298 (4) (a) "Limited long-term care insurance" means an insurance[~~;~~~~(i)~~] policy,
3299 endorsement, or rider that is advertised, marketed, offered, or designed to provide coverage:

3300 [~~(A)~~] (i) for less than 12 consecutive months for each covered person;

3301 [~~(B)~~] (ii) on an expense-incurred, indemnity, prepaid or other basis; and

3302 [~~(C)~~] (iii) for one or more necessary or medically necessary diagnostic, preventative,
3303 therapeutic, rehabilitative, maintenance, or personal care services that is provided in a setting
3304 other than an acute care unit of a hospital[~~;~~~~or~~].

3305 [~~(i)~~] (b) "Limited long-term care insurance" includes a policy or rider described in

3306 Subsection (4)(a) that provides for payment of benefits based on cognitive impairment or the
3307 loss of functional capacity.

3308 ~~(b)~~ (c) "Limited long-term care insurance" does not include an insurance policy that
3309 is offered primarily to provide:

- 3310 (i) basic Medicare supplement coverage;
- 3311 (ii) basic hospital expense coverage;
- 3312 (iii) basic medical-surgical expense coverage;
- 3313 (iv) hospital confinement indemnity coverage;
- 3314 (v) major medical expense coverage;
- 3315 (vi) disability income or related asset-protection coverage;
- 3316 (vii) accidental only coverage;
- 3317 (viii) specified disease or specified accident coverage; or
- 3318 (ix) limited benefit health coverage.

3319 (5) "Preexisting condition" means a condition for which medical advice or treatment is
3320 recommended:

- 3321 (a) by, or received from, a provider of health care services; and
- 3322 (b) within six months before the day on which the coverage of an insured person
3323 becomes effective.

3324 (6) "Waiting period" means the time an insured waits before some or all of the
3325 insured's coverage becomes effective.

3326 Section 29. Section **31A-23a-113** is amended to read:

3327 **31A-23a-113. License lapse and voluntary surrender.**

3328 (1) (a) A license issued under this chapter, including a line of authority, shall lapse if
3329 the licensee fails to:

- 3330 (i) pay when due a fee under Section [31A-3-103](#);
- 3331 (ii) complete continuing education requirements under Section [31A-23a-202](#) before
3332 submitting the license renewal application;
- 3333 (iii) submit a completed renewal application as required by Section [31A-23a-104](#);

3334 (iv) submit additional documentation required to complete the licensing process as
3335 related to a specific license type or line of authority; or

3336 (v) maintain an active license in a licensee's home state if the licensee is a nonresident
3337 licensee.

3338 (b) A license that lapses shall expire effective at midnight on the day on which the
3339 license expires.

3340 ~~(b)~~ (c) (i) A licensee whose license lapses may request reinstatement of the license
3341 and line of authority no more than one year after the day on which the license lapses.

3342 (ii) A licensee whose license lapses due to the following may request an action
3343 described in Subsection (1)~~(b)~~(c)(iii):

3344 (A) military service;

3345 (B) voluntary service for a period of time designated by the person for whom the
3346 licensee provides voluntary service; or

3347 (C) some other extenuating circumstances, ~~such as~~ including long-term medical
3348 disability.

3349 (iii) A licensee described in Subsection (1)~~(b)~~(c)(ii) may request:

3350 (A) reinstatement of the license and line of authority no later than one year after the
3351 day on which the license lapses; and

3352 (B) waiver of any of the following imposed for failure to comply with renewal
3353 procedures:

3354 (I) an examination requirement;

3355 (II) reinstatement fees set under Section [31A-3-103](#);

3356 (III) continuing education requirements; or

3357 (IV) other sanction imposed for failure to comply with renewal procedures.

3358 (2) If a license or line of authority issued under this chapter is voluntarily surrendered,
3359 the license or line of authority may be reinstated:

3360 (a) during the license period in which the license or line of authority is voluntarily
3361 surrendered; and

3362 (b) no later than one year after the day on which the license or line of authority is
3363 voluntarily surrendered.

3364 Section 30. Section **31A-23a-201** is amended to read:

3365 **31A-23a-201. Exceptions to producer licensing.**

3366 (1) The commissioner may not require a license as an insurance producer of:

3367 (a) an officer, director, or employee of an insurer or of an insurance producer if:

3368 (i) the officer, director, or employee does not receive any commission on a policy
3369 written or sold to insure risks residing, located, or to be performed in this state; and

3370 (ii) (A) the officer's, director's, or employee's activities are:

3371 (I) executive, administrative, managerial, clerical, or a combination of these activities;

3372 and

3373 (II) only indirectly related to the sale, solicitation, or negotiation of insurance;

3374 (B) the officer's, director's, or employee's function relates to:

3375 (I) underwriting;

3376 (II) loss control;

3377 (III) inspection; or

3378 (IV) the processing, adjusting, investigating or settling of a claim on a contract of
3379 insurance; or

3380 (C) (I) the officer, director, or employee is acting in the capacity of a special agent or
3381 agency supervisor assisting an insurance producer;

3382 (II) the officer's, director's, or employee's activities are limited to providing technical
3383 advice and assistance to a licensed insurance producer; and

3384 (III) the officer's, director's, or employee's activities do not include the sale, solicitation,
3385 or negotiation of insurance;

3386 (b) a person who:

3387 (i) is paid no commission for the services described in Subsection (1)(b)(ii); and

3388 (ii) secures and furnishes information for the purpose of:

3389 (A) group life insurance;

- 3390 (B) group property and casualty insurance;
- 3391 (C) group annuities;
- 3392 (D) a group insurance policy offering accident and health insurance or a blanket
- 3393 insurance policy offering accident and health insurance;
- 3394 (E) enrolling individuals under plans;
- 3395 (F) issuing certificates under plans; or
- 3396 (G) otherwise assisting in administering plans;
- 3397 (c) a person who:
- 3398 (i) is paid no commission for the services described in Subsection (1)(c)(ii); and
- 3399 (ii) performs administrative services related to mass marketed property and casualty
- 3400 insurance;
- 3401 (d) (i) any of the following if the conditions of Subsection (1)(d)(ii) are met:
- 3402 (A) an employer or association; or
- 3403 (B) an officer, director, employee, or trustee of an employee trust plan;
- 3404 (ii) a person listed in Subsection (1)(d)(i):
- 3405 (A) to the extent that the employer, officer, employee, director, or trustee is engaged in
- 3406 the administration or operation of a program of employee benefits for:
- 3407 (I) the employer's or association's own employees; or
- 3408 (II) the employees of a subsidiary or affiliate of an employer or association;
- 3409 (B) the program involves the use of insurance issued by an insurer; and
- 3410 (C) the employer, association, officer, director, employee, or trustee is not in any
- 3411 manner compensated, directly or indirectly, by the company issuing the contract;
- 3412 (e) an employee of an insurer or organization employed by an insurer who:
- 3413 (i) is engaging in:
- 3414 (A) the inspection, rating, or classification of risks; or
- 3415 (B) the supervision of the training of insurance producers; and
- 3416 (ii) is not individually engaged in the sale, solicitation, or negotiation of insurance;
- 3417 (f) a person whose activities in this state are limited to advertising:

- 3418 (i) without the intent to solicit insurance in this state;
- 3419 (ii) through communications in mass media including:
- 3420 (A) a printed publication; or
- 3421 (B) a form of electronic mass media;
- 3422 (iii) that is distributed to residents outside of the state; and
- 3423 (iv) if the person does not sell, solicit, or negotiate insurance that would insure risks
- 3424 residing, located, or to be performed in this state;
- 3425 (g) a person who:
- 3426 (i) is not a resident of this state;
- 3427 (ii) sells, solicits, or negotiates a contract of insurance:
- 3428 (A) for commercial property and casualty risks to an insured with risks located in more
- 3429 than one state insured under that contract; and
- 3430 (B) insures risks located in a state in which the person is licensed as provided in
- 3431 Subsection (1)(g)(iii); and
- 3432 (iii) is licensed as an insurance producer to sell, solicit, or negotiate that insurance in
- 3433 the state where the insured maintains its principal place of business; or
- 3434 (h) if the employee does not sell, solicit, or receive a commission for a contract of
- 3435 insurance, a salaried full-time employee who counsels or advises the employee's employer
- 3436 relating to the insurance interests of:
- 3437 (i) the employer; or
- 3438 (ii) a subsidiary or business affiliate of the employer.
- 3439 (2) The commissioner may by rule exempt a class of persons from the license
- 3440 requirement of Subsection [31A-23a-103\(1\)](#) if:
- 3441 (a) the functions performed by the class of persons does not require:
- 3442 (i) special competence;
- 3443 (ii) special trustworthiness; or
- 3444 (iii) regulatory surveillance made possible by licensing; or
- 3445 (b) other existing safeguards make regulation unnecessary.

3446 Section 31. Section **31A-23a-402.5** is amended to read:

3447 **31A-23a-402.5. Inducements.**

3448 (1) (a) Except as provided in Subsection (2), a producer, consultant, or other licensee
3449 under this title, or an officer or employee of a licensee, may not induce a person to enter into,
3450 continue, or terminate an insurance contract by offering a benefit that is not:

3451 (i) specified in the insurance contract; or

3452 (ii) directly related to the insurance contract.

3453 (b) An insurer may not make or knowingly allow an agreement of insurance that is not
3454 clearly expressed in the insurance contract to be issued or renewed.

3455 (c) A licensee under this title may not absorb the tax under Section [31A-3-301](#).

3456 (2) This section does not apply to a title insurer, an individual title insurance producer,
3457 or agency title insurance producer, or an officer or employee of a title insurer, an individual
3458 title insurance producer, or an agency title insurance producer.

3459 (3) Items not prohibited by Subsection (1) include an insurer:

3460 (a) reducing premiums because of expense savings;

3461 (b) providing to a policyholder or insured one or more incentives, as defined by the
3462 commissioner by rule, made in accordance with Title 63G, Chapter 3, Utah Administrative
3463 Rulemaking Act, to participate in a program or activity designed to reduce claims or claim
3464 expenses, including:

3465 (i) a premium discount offered to a small or large employer group based on a wellness
3466 program if:

3467 (A) the premium discount for the employer group does not exceed 20% of the group
3468 premium; and

3469 (B) the premium discount based on the wellness program is offered uniformly by the
3470 insurer to all employer groups in the large or small group market;

3471 (ii) a premium discount offered to employees of a small or large employer group in an
3472 amount that does not exceed federal limits on wellness program incentives;

3473 (iii) a combination of premium discounts offered to the employer group and the

3474 employees of an employer group, based on a wellness program, if:
3475 (A) the premium discounts for the employer group comply with Subsection (3)(b)(i);
3476 and
3477 (B) the premium discounts for the employees of an employer group comply with
3478 Subsection (3)(b)(ii); or
3479 (iv) rewards or incentives for employees of an employer group, if the rewards or
3480 incentives are for a savings reward program described in Section 31A-22-647; or
3481 (c) receiving premiums under an installment payment plan.
3482 (4) Items not prohibited by Subsection (1) include a producer, consultant, or other
3483 licensee, or an officer or employee of a licensee, either directly or through a third party:
3484 (a) engaging in a usual kind of social courtesy if receipt of the social courtesy is not
3485 conditioned on a quote or the purchase of a particular insurance product;
3486 (b) extending credit on a premium to the insured:
3487 (i) without interest, for no more than 90 days [~~from the effective date of~~] after the day
3488 on which the insurance contract becomes effective;
3489 (ii) for interest that is not less than the legal rate under Section 15-1-1, on the unpaid
3490 balance after the time period described in Subsection (4)(b)(i); and
3491 (iii) except that an installment or payroll deduction payment of premiums on an
3492 insurance contract issued under an insurer's mass marketing program is not considered an
3493 extension of credit for purposes of this Subsection (4)(b);
3494 (c) preparing or conducting a survey that:
3495 (i) is directly related to an accident and health insurance policy purchased from the
3496 licensee; or
3497 (ii) is used by the licensee to assess the benefit needs and preferences of insureds,
3498 employers, or employees directly related to an insurance product sold by the licensee;
3499 (d) providing limited human resource services that are directly related to an insurance
3500 product sold by the licensee, including:
3501 (i) answering questions directly related to:

- 3502 (A) an employee benefit offering or administration, if the insurance product purchased
3503 from the licensee is accident and health insurance or health insurance; and
- 3504 (B) employment practices liability, if the insurance product offered by or purchased
3505 from the licensee is property or casualty insurance; and
- 3506 (ii) providing limited human resource compliance training and education directly
3507 pertaining to an insurance product purchased from the licensee;
- 3508 (e) providing the following types of information or guidance:
- 3509 (i) providing guidance directly related to compliance with federal and state laws for an
3510 insurance product purchased from the licensee;
- 3511 (ii) providing a workshop or seminar addressing an insurance issue that is directly
3512 related to an insurance product purchased from the licensee; or
- 3513 (iii) providing information regarding:
- 3514 (A) employee benefit issues;
- 3515 (B) directly related insurance regulatory and legislative updates; or
- 3516 (C) similar education about an insurance product sold by the licensee and how the
3517 insurance product interacts with tax law;
- 3518 (f) preparing or providing a form that is directly related to an insurance product
3519 purchased from, or offered by, the licensee;
- 3520 (g) preparing or providing documents directly related to a premium only cafeteria plan
3521 within the meaning of Section 125, Internal Revenue Code, or a flexible spending account, but
3522 not providing ongoing administration of a flexible spending account;
- 3523 (h) providing enrollment and billing assistance, including:
- 3524 (i) providing benefit statements or new hire insurance benefits packages; and
- 3525 (ii) providing technology services such as an electronic enrollment platform or
3526 application system;
- 3527 (i) communicating coverages in writing and in consultation with the insured and
3528 employees;
- 3529 (j) providing employee communication materials and notifications directly related to an

- 3530 insurance product purchased from a licensee;
- 3531 (k) providing claims management and resolution to the extent permitted under the
- 3532 licensee's license;
- 3533 (l) providing underwriting or actuarial analysis or services;
- 3534 (m) negotiating with an insurer regarding the placement and pricing of an insurance
- 3535 product;
- 3536 (n) recommending placement and coverage options;
- 3537 (o) providing a health fair or providing assistance or advice on establishing or
- 3538 operating a wellness program, but not providing any payment for or direct operation of the
- 3539 wellness program;
- 3540 (p) providing COBRA and Utah mini-COBRA administration, consultations, and other
- 3541 services directly related to an insurance product purchased from the licensee;
- 3542 (q) assisting with a summary plan description, including providing a summary plan
- 3543 description wraparound;
- 3544 (r) providing information necessary for the preparation of documents directly related to
- 3545 the Employee Retirement Income Security Act of 1974, 29 U.S.C. Sec. 1001, et seq., as
- 3546 amended;
- 3547 (s) providing information or services directly related to the Health Insurance Portability
- 3548 and Accountability Act of 1996, Pub. L. 104-191, 110 Stat. 1936, as amended, such as services
- 3549 directly related to health care access, portability, and renewability when offered in connection
- 3550 with accident and health insurance sold by a licensee;
- 3551 (t) sending proof of coverage to a third party with a legitimate interest in coverage;
- 3552 (u) providing information in a form approved by the commissioner and directly related
- 3553 to determining whether an insurance product sold by the licensee meets the requirements of a
- 3554 third party contract that requires or references insurance coverage;
- 3555 (v) facilitating risk management services directly related to property and casualty
- 3556 insurance products sold or offered for sale by the licensee, including:
- 3557 (i) risk management;

- 3558 (ii) claims and loss control services;
- 3559 (iii) risk assessment consulting, including analysis of:
- 3560 (A) employer's job descriptions; or
- 3561 (B) employer's safety procedures or manuals; and
- 3562 (iv) providing information and training on best practices;
- 3563 (w) otherwise providing services that are legitimately part of servicing an insurance
- 3564 product purchased from a licensee; and
- 3565 (x) providing other directly related services approved by the department.
- 3566 (5) An inducement prohibited under Subsection (1) includes a producer, consultant, or
- 3567 other licensee, or an officer or employee of a licensee:
- 3568 (a) (i) except as permitted under Section [31A-22-647](#), providing a rebate, reward, or
- 3569 incentive;
- 3570 (ii) paying the salary of an employee of a person who purchases an insurance product
- 3571 from the licensee; or
- 3572 (iii) if the licensee is an insurer, or a third party administrator who contracts with an
- 3573 insurer, paying the salary for an onsite staff member to perform an act prohibited under
- 3574 Subsection (5)(b)(xii); or
- 3575 (b) except as provided in Subsection (10), engaging in one or more of the following,
- 3576 unless a fee is paid in accordance with Subsection (8):
- 3577 (i) performing background checks of prospective employees;
- 3578 (ii) providing legal services by a person licensed to practice law;
- 3579 (iii) performing drug testing that is directly related to an insurance product purchased
- 3580 from the licensee;
- 3581 (iv) preparing employer or employee handbooks, except that a licensee may:
- 3582 (A) provide information for a medical benefit section of an employee handbook;
- 3583 (B) provide information for the section of an employee handbook directly related to an
- 3584 employment practices liability insurance product purchased from the licensee; or
- 3585 (C) prepare or print an employee benefit enrollment guide;

- 3586 (v) providing job descriptions, postings, and applications for a person;
- 3587 (vi) providing payroll services;
- 3588 (vii) providing performance reviews or performance review training;
- 3589 (viii) providing union advice;
- 3590 (ix) providing accounting services;
- 3591 (x) providing data analysis information technology programs, except as provided in
- 3592 Subsection (4)(h)(ii);
- 3593 (xi) providing administration of health reimbursement accounts or health savings
- 3594 accounts; or
- 3595 (xii) if the licensee is an insurer, or a third party administrator who contracts with an
- 3596 insurer, the insurer issuing an insurance policy that lists in the insurance policy one or more of
- 3597 the following prohibited benefits:
- 3598 (A) performing background checks of prospective employees;
- 3599 (B) providing legal services by a person licensed to practice law;
- 3600 (C) performing drug testing that is directly related to an insurance product purchased
- 3601 from the insurer;
- 3602 (D) preparing employer or employee handbooks;
- 3603 (E) providing job descriptions postings, and applications;
- 3604 (F) providing payroll services;
- 3605 (G) providing performance reviews or performance review training;
- 3606 (H) providing union advice;
- 3607 (I) providing accounting services;
- 3608 (J) providing discrimination testing; or
- 3609 (K) providing data analysis information technology programs.
- 3610 (6) A producer, consultant, or other licensee or an officer or employee of a licensee
- 3611 shall itemize and bill separately from any other insurance product or service offered or
- 3612 provided under Subsection (5)(b).
- 3613 (7) (a) A de minimis gift or meal not to exceed a fair market value of \$100 for each

3614 individual receiving the gift or meal is presumed to be a social courtesy not conditioned on a
3615 quote or purchase of a particular insurance product for purposes of Subsection (4)(a).

3616 (b) Notwithstanding Subsection (4)(a), a de minimis gift or meal not to exceed \$10
3617 may be conditioned on receipt of a quote of a particular insurance product.

3618 (8) If as provided under Subsection (5)(b) a producer, consultant, or other licensee is
3619 paid a fee to provide an item listed in Subsection (5)(b), [~~the licensee shall comply with~~
3620 ~~Subsection 31A-23a-501(2) in charging the fee, except that~~] the fee paid for the item shall
3621 equal or exceed the fair market value of the item.

3622 (9) For purposes of this section, "fair market value" means what a knowledgeable,
3623 willing, and unpressured buyer would pay for a product or service to a knowledgeable, willing,
3624 and unpressured seller in the open market without any connection to other goods, services,
3625 including insurance services, or contracts, including insurance contracts, sold by the producer,
3626 consultant, or other licensee, or an officer or employee of the licensee.

3627 (10) Notwithstanding any other provision of this section, a producer, consultant, or
3628 other licensee, or an officer or employee of a licensee, may offer, make available, or provide
3629 goods or services, whether or not the goods or services are directly related to an insurance
3630 contract, for free or for less than fair market value if:

3631 (a) the goods or services are available on the same terms to the general public;

3632 (b) receipt of the goods or services is not contingent upon the immediate or future
3633 purchase, continuation, or termination of an insurance product or receipt of a quote for an
3634 insurance product; and

3635 (c) the producer, consultant, or other licensee, or an officer or an employee of a
3636 licensee, does not retroactively charge for the goods or services based on an event subsequent
3637 to receipt of the goods or services.

3638 (11) (a) A producer, consultant, or other licensee, or an officer or employee of a
3639 licensee, that provides or offers goods or services that are not described in Subsection (3) or (4)
3640 for free or less than fair market value shall conspicuously disclose to the recipient before the
3641 purchase of insurance, receipt of a quote for insurance, or designation of an agent of record,

3642 that receipt of the goods or services is not contingent on the purchase, continuation, or
 3643 termination of an insurance product or receiving a quote for an insurance product.

3644 (b) A producer, consultant, or other licensee, or an officer or employee of the licensee,
 3645 may comply with this Subsection (11) by an oral or written disclosure.

3646 Section 32. Section **31A-23a-406** is amended to read:

3647 **31A-23a-406. Title insurance producer's business.**

3648 (1) An individual title insurance producer or agency title insurance producer may do
 3649 escrow involving real property transactions if all of the following exist:

3650 (a) the individual title insurance producer or agency title insurance producer is licensed
 3651 with:

3652 (i) the title line of authority; and

3653 (ii) the escrow subline of authority;

3654 (b) the individual title insurance producer or agency title insurance producer is
 3655 appointed by a title insurer authorized to do business in the state;

3656 (c) except as provided in Subsection (3), the individual title insurance producer or
 3657 agency title insurance producer issues one or more of the following as part of the transaction:

3658 (i) an owner's policy [~~of~~] offering title insurance;

3659 (ii) a lender's policy [~~of~~] offering title insurance; or

3660 (iii) if the transaction does not involve a transfer of ownership, an endorsement to an
 3661 owner's or a lender's policy [~~of~~] offering title insurance;

3662 (d) money deposited with the individual title insurance producer or agency title
 3663 insurance producer in connection with any escrow[~~-(i)-~~] is deposited:

3664 [~~(A)~~] (i) in a federally insured [~~financial~~] depository institution, as defined in Section
 3665 7-1-103, that:

3666 (A) has an office in this state, if the individual title insurance producer or agency title
 3667 insurance producer depositing the money is a resident licensee; and

3668 (B) is authorized by the depository institution's primary regulator to engage in trust
 3669 business, as defined in Section 7-5-1, in this state; and

3670 ~~[(B)]~~ (ii) in a trust account that is separate from all other trust account money that is
3671 not related to real estate transactions;

3672 ~~[(ii)]~~ (e) money deposited with the individual title insurance producer or agency title
3673 insurance producer in connection with any escrow is the property of the one or more persons
3674 entitled to the money under the provisions of the escrow; and

3675 ~~[(iii)]~~ (f) money deposited with the individual title insurance producer or agency title
3676 insurance producer in connection with an escrow is segregated escrow by escrow in the records
3677 of the individual title insurance producer or agency title insurance producer;

3678 ~~[(e)]~~ (g) earnings on money held in escrow may be paid out of the escrow account to
3679 any person in accordance with the conditions of the escrow;

3680 ~~[(f)]~~ (h) the escrow does not require the individual title insurance producer or agency
3681 title insurance producer to hold:

3682 (i) construction money; or

3683 (ii) money held for exchange under Section 1031, Internal Revenue Code; and

3684 ~~[(g)]~~ (i) the individual title insurance producer or agency title insurance producer shall
3685 maintain a physical office in Utah staffed by a person with an escrow subline of authority who
3686 processes the escrow.

3687 (2) Notwithstanding Subsection (1), an individual title insurance producer or agency
3688 title insurance producer may engage in the escrow business if:

3689 (a) the escrow involves:

3690 (i) a mobile home;

3691 (ii) a grazing right;

3692 (iii) a water right; or

3693 (iv) other personal property authorized by the commissioner; and

3694 (b) the individual title insurance producer or agency title insurance producer complies
3695 with this section except for Subsection (1)(c).

3696 (3) (a) Subsection (1)(c) does not apply if the transaction is for the transfer of real
3697 property from the School and Institutional Trust Lands Administration.

3698 (b) This subsection does not prohibit an individual title insurance producer or agency
3699 title insurance producer from issuing a policy described in Subsection (1)(c) as part of a
3700 transaction described in Subsection (3)(a).

3701 (4) Money held in escrow:

3702 (a) is not subject to any debts of the individual title insurance producer or agency title
3703 insurance producer;

3704 (b) may only be used to fulfill the terms of the individual escrow under which the
3705 money is accepted; and

3706 (c) may not be used until the conditions of the escrow are met.

3707 (5) Assets or property other than escrow money received by an individual title
3708 insurance producer or agency title insurance producer in accordance with an escrow shall be
3709 maintained in a manner that will:

3710 (a) reasonably preserve and protect the asset or property from loss, theft, or damages;
3711 and

3712 (b) otherwise comply with the general duties and responsibilities of a fiduciary or
3713 bailee.

3714 (6) (a) A check from the trust account described in Subsection (1)(d) may not be
3715 drawn, executed, or dated, or money otherwise disbursed unless the segregated escrow account
3716 from which money is to be disbursed contains a sufficient credit balance consisting of collected
3717 and cleared money at the time the check is drawn, executed, or dated, or money is otherwise
3718 disbursed.

3719 (b) As used in this Subsection (6), money is considered to be "collected and cleared,"
3720 and may be disbursed as follows:

3721 (i) cash may be disbursed on the same day the cash is deposited;

3722 (ii) a wire transfer may be disbursed on the same day the wire transfer is deposited; and

3723 (iii) the proceeds of one or more of the following financial instruments may be
3724 disbursed on the same day the financial instruments are deposited if received from a single
3725 party to the real estate transaction and if the aggregate of the financial instruments for the real

3726 estate transaction is less than \$10,000:

3727 (A) a cashier's check, certified check, or official check that is drawn on an existing
3728 account at a federally insured financial institution;

3729 (B) a check drawn on the trust account of a principal broker or associate broker
3730 licensed under Title 61, Chapter 2f, Real Estate Licensing and Practices Act, if the individual
3731 title insurance producer or agency title insurance producer has reasonable and prudent grounds
3732 to believe sufficient money will be available from the trust account on which the check is
3733 drawn at the time of disbursement of proceeds from the individual title insurance producer or
3734 agency title insurance producer's escrow account;

3735 (C) a personal check not to exceed \$500 per closing; or

3736 (D) a check drawn on the escrow account of another individual title insurance producer
3737 or agency title insurance producer, if the individual title insurance producer or agency title
3738 insurance producer in the escrow transaction has reasonable and prudent grounds to believe
3739 that sufficient money will be available for withdrawal from the account upon which the check
3740 is drawn at the time of disbursement of money from the escrow account of the individual title
3741 insurance producer or agency title insurance producer in the escrow transaction.

3742 (c) A check or deposit not described in Subsection (6)(b) may be disbursed:

3743 (i) within the time limits provided under the Expedited Funds Availability Act, 12
3744 U.S.C. Sec. 4001 et seq., as amended, and related regulations of the Federal Reserve System; or

3745 (ii) upon notification from the financial institution to which the money has been
3746 deposited that final settlement has occurred on the deposited financial instrument.

3747 (7) An individual title insurance producer or agency title insurance producer shall
3748 maintain a record of a receipt or disbursement of escrow money.

3749 (8) An individual title insurance producer or agency title insurance producer shall
3750 comply with:

3751 (a) Section [31A-23a-409](#);

3752 (b) Title 46, Chapter 1, Notaries Public Reform Act; and

3753 (c) any rules adopted by the Title and Escrow Commission, subject to Section

3754 31A-2-404, that govern escrows.

3755 (9) If an individual title insurance producer or agency title insurance producer conducts
3756 a search for real estate located in the state, the individual title insurance producer or agency
3757 title insurance producer shall conduct a reasonable search of the public records.

3758 Section 33. Section 31A-23a-409 is amended to read:

3759 **31A-23a-409. Trust obligation for money collected.**

3760 (1) (a) Subject to Subsection (7), a licensee is a trustee for money that is paid to,
3761 received by, or collected by a licensee for forwarding to insurers or to insureds.

3762 (b) (i) Except as provided in Subsection (1)(b)(ii), a licensee may not commingle trust
3763 funds with:

3764 (A) the licensee's own money; or

3765 (B) money held in any other capacity.

3766 (ii) This Subsection (1)(b) does not apply to:

3767 (A) amounts necessary to pay bank charges; and

3768 (B) money paid by insureds and belonging in part to the licensee as a fee or
3769 commission.

3770 (c) Except as provided under Subsection (4), a licensee owes to insureds and insurers
3771 the fiduciary duties of a trustee with respect to money to be forwarded to insurers or insureds
3772 through the licensee.

3773 (d) (i) Unless money is sent to the appropriate payee by the close of the next business
3774 day after their receipt, the licensee shall deposit them in an account authorized under
3775 Subsection (2).

3776 (ii) Money deposited under this Subsection (1)(d) shall remain in an account
3777 authorized under Subsection (2) until sent to the appropriate payee.

3778 (2) Money required to be deposited under Subsection (1) shall be deposited:

3779 (a) in a federally insured trust account in a depository institution, as defined in Section
3780 7-1-103, which:

3781 (i) has an office in this state, if the licensee depositing the money is a resident licensee;

3782 (ii) has federal deposit insurance; and
3783 (iii) is authorized by its primary regulator to engage in the trust business, as defined by
3784 Section 7-5-1, in this state; or

3785 (b) in some other account, ~~approved by~~ that:

3786 (i) the commissioner approves by rule or order~~[-providing]; and~~

3787 (ii) provides safety comparable to ~~[federally insured trust accounts]~~ an account
3788 described in Subsection (2)(a).

3789 (3) It is not a violation of Subsection (2)(a) if the amounts in the accounts exceed the
3790 amount of the federal insurance on the accounts.

3791 (4) A trust account into which money is deposited may be interest bearing. The
3792 interest accrued on the account may be paid to the licensee, so long as the licensee otherwise
3793 complies with this section and with the contract with the insurer.

3794 (5) A depository institution or other organization holding trust funds under this section
3795 may not offset or impound trust account funds against debts and obligations incurred by the
3796 licensee.

3797 (6) A licensee who, not being lawfully entitled to do so, diverts or appropriates any
3798 portion of the money held under Subsection (1) to the licensee's own use, is guilty of theft
3799 under Title 76, Chapter 6, Part 4, Theft. Section 76-6-412 applies in determining the
3800 classification of the offense. Sanctions under Section 31A-2-308 also apply.

3801 (7) A nonresident licensee:

3802 (a) shall comply with Subsection (1)(a) by complying with the trust account
3803 requirements of the nonresident licensee's home state; and

3804 (b) is not required to comply with the other provisions of this section.

3805 Section 34. Section 31A-23a-501 is amended to read:

3806 **31A-23a-501. Licensee compensation.**

3807 (1) As used in this section:

3808 (a) "Commission compensation" includes funds paid to or credited for the benefit of a
3809 licensee from:

3810 (i) commission amounts deducted from insurance premiums on insurance sold by or
3811 placed through the licensee;

3812 (ii) commission amounts received from an insurer or another licensee as a result of the
3813 sale or placement of insurance; or

3814 (iii) overrides, bonuses, contingent bonuses, or contingent commissions received from
3815 an insurer or another licensee as a result of the sale or placement of insurance.

3816 (b) (i) "Compensation from an insurer or third party administrator" means
3817 commissions, fees, awards, overrides, bonuses, contingent commissions, loans, stock options,
3818 gifts, prizes, or any other form of valuable consideration:

3819 (A) whether or not payable pursuant to a written agreement; and

3820 (B) received from:

3821 (I) an insurer; or

3822 (II) a third party to the transaction for the sale or placement of insurance.

3823 (ii) "Compensation from an insurer or third party administrator" does not mean
3824 compensation from a customer that is:

3825 (A) a fee or pass-through costs as provided in Subsection (1)(e); or

3826 (B) a fee or amount collected by or paid to the producer that does not exceed an
3827 amount established by the commissioner by administrative rule.

3828 (c) (i) "Customer" means:

3829 (A) the person signing the application or submission for insurance; or

3830 (B) the authorized representative of the insured actually negotiating the placement of
3831 insurance with the producer.

3832 (ii) "Customer" does not mean a person who is a participant or beneficiary of:

3833 (A) an employee benefit plan; or

3834 (B) a group or blanket insurance policy or group annuity contract sold, solicited, or
3835 negotiated by the producer or affiliate.

3836 (d) (i) "Noncommission compensation" includes all funds paid to or credited for the
3837 benefit of a licensee other than commission compensation.

3838 (ii) "Noncommission compensation" does not include charges for pass-through costs
3839 incurred by the licensee in connection with obtaining, placing, or servicing an insurance policy.

3840 (e) "Pass-through costs" include:

3841 (i) costs for copying documents to be submitted to the insurer; and

3842 (ii) bank costs for processing cash or credit card payments.

3843 (2) (a) ~~[A] Except as provided in Subsection (3), a licensee may receive from an~~
3844 ~~insured or from a person purchasing an insurance policy, noncommission compensation [if the~~
3845 ~~noncommission compensation is stated on a separate, written disclosure].~~

3846 ~~[(a) The disclosure required by this Subsection (2) shall:]~~

3847 ~~[(i) include the signature of the insured or prospective insured acknowledging the~~
3848 ~~noncommission compensation;]~~

3849 ~~[(ii) clearly specify:]~~

3850 ~~[(A) the amount of any known noncommission compensation; and]~~

3851 ~~[(B) the type and amount, if known, of any potential and contingent noncommission~~
3852 ~~compensation; and]~~

3853 ~~[(iii) be provided to the insured or prospective insured before the performance of the~~
3854 ~~service.]~~

3855 (b) Noncommission compensation shall be:

3856 (i) limited to actual or reasonable expenses incurred for services; and

3857 (ii) uniformly applied to all insureds or prospective insureds in a class or classes of
3858 business or for a specific service or services.

3859 ~~[(c) A copy of the signed disclosure required by this Subsection (2) shall be maintained~~
3860 ~~by any licensee who collects or receives the noncommission compensation or any portion of~~
3861 ~~the noncommission compensation.]~~

3862 (c) The following additional noncommission compensation is authorized:

3863 (i) compensation a surety bond's principal debtor pays, under procedures approved by a
3864 rule or order of the commissioner, to a producer of a compensation corporate surety for an
3865 extra service;

3866 (ii) compensation an insurance producer receives for services performed for an insured
3867 in connection with a claim adjustment, if the producer:

3868 (A) does not receive and is not promised compensation for aiding in the claim
3869 adjustment before the claim occurs; and

3870 (B) is also licensed as a public adjuster in accordance with Section [31A-26-203](#);

3871 (iii) compensation a consultant receives as a consulting fee, if the consultant complies
3872 with the requirements under Section [31A-23a-401](#); and

3873 (iv) a compensation arrangement that the commissioner approves after finding that the
3874 arrangement:

3875 (A) does not violate Section [31A-23a-401](#); and

3876 (B) is not harmful to the public.

3877 (d) All accounting records relating to noncommission compensation shall be
3878 maintained [~~by the person described in Subsection (2)(c)] in a manner that facilitates an audit.~~

3879 (3) (a) A [~~licensee~~] surplus lines producer may receive noncommission compensation
3880 when acting as a producer for the insured in [~~connection with the actual sale or placement of~~
3881 ~~insurance~~] a surplus lines transaction, if:

3882 (i) the producer and the insured have agreed on the producer's noncommission
3883 compensation; and

3884 (ii) the producer has disclosed to the insured the existence and source of any other
3885 compensation that accrues to the producer as a result of the transaction.

3886 (b) The disclosure required by this Subsection (3) shall:

3887 (i) include the signature of the insured or prospective insured acknowledging the
3888 noncommission compensation;

3889 (ii) clearly specify:

3890 (A) the amount of any known noncommission compensation;

3891 (B) the type and amount, if known, of any potential and contingent noncommission
3892 compensation; and

3893 (C) the existence and source of any other compensation; and

3894 (iii) be provided to the insured or prospective insured before the performance of the
3895 service.

3896 [~~(c) The following additional noncommission compensation is authorized:~~]

3897 [~~(i) compensation received by a producer of a compensated corporate surety who under
3898 procedures approved by a rule or order of the commissioner is paid by surety bond principal
3899 debtors for extra services;~~]

3900 [~~(ii) compensation received by an insurance producer who is also licensed as a public
3901 adjuster under Section 31A-26-203, for services performed for an insured in connection with a
3902 claim adjustment, so long as the producer does not receive or is not promised compensation for
3903 aiding in the claim adjustment prior to the occurrence of the claim;~~]

3904 [~~(iii) compensation received by a consultant as a consulting fee, provided the
3905 consultant complies with the requirements of Section 31A-23a-401; or]~~

3906 [~~(iv) other compensation arrangements approved by the commissioner after a finding
3907 that they do not violate Section 31A-23a-401 and are not harmful to the public.]~~

3908 [~~(d) Subject to Section 31A-23a-402.5, a producer for the insured may receive
3909 compensation from an insured through an insurer, for the negotiation and sale of a health
3910 benefit plan, if there is a separate written agreement between the insured and the licensee for
3911 the compensation. An insurer who passes through the compensation from the insured to the
3912 licensee under this Subsection (3)(d) is not providing direct or indirect compensation or
3913 commission compensation to the licensee.]~~

3914 (4) (a) For purposes of this Subsection (4):

3915 (i) "Large customer" means an employer who, with respect to a calendar year and to a
3916 plan year:

3917 (A) employed an average of at least 100 eligible employees on each business day
3918 during the preceding calendar year; and

3919 (B) employs at least two employees on the first day of the plan year.

3920 (ii) "Producer" includes:

3921 (A) a producer;

3922 (B) an affiliate of a producer; or

3923 (C) a consultant.

3924 (b) A producer may not accept or receive any compensation from an insurer or third
3925 party administrator for the initial placement of a health benefit plan, other than a hospital
3926 confinement indemnity policy, unless prior to a large customer's initial purchase of the health
3927 benefit plan the producer discloses in writing to the large customer that the producer will
3928 receive compensation from the insurer or third party administrator for the placement of
3929 insurance, including the amount or type of compensation known to the producer at the time of
3930 the disclosure.

3931 (c) A producer shall:

3932 (i) obtain the large customer's signed acknowledgment that the disclosure under
3933 Subsection (4)(b) was made to the large customer; or

3934 (ii) (A) sign a statement that the disclosure required by Subsection (4)(b) was made to
3935 the large customer; and

3936 (B) keep the signed statement on file in the producer's office while the health benefit
3937 plan placed with the large customer is in force.

3938 (d) A licensee who collects or receives any part of the compensation from an insurer or
3939 third party administrator in a manner that facilitates an audit shall, while the health benefit plan
3940 placed with the large customer is in force, maintain a copy of:

3941 (i) the signed acknowledgment described in Subsection (4)(c)(i); or

3942 (ii) the signed statement described in Subsection (4)(c)(ii).

3943 (e) Subsection (4)(c) does not apply to:

3944 (i) a person licensed as a producer who acts only as an intermediary between an insurer
3945 and the customer's producer, including a managing general agent; or

3946 (ii) the placement of insurance in a secondary or residual market.

3947 (f) (i) A producer shall provide to a large customer listed in this Subsection (4)(f) an
3948 annual accounting, as defined by rule made by the department in accordance with Title 63G,
3949 Chapter 3, Utah Administrative Rulemaking Act, of all amounts the producer receives in

3950 commission compensation from an insurer or third party administrator as a result of the sale or
3951 placement of a health benefit plan to a large customer that is:

3952 (A) the state;

3953 (B) a political subdivision or instrumentality of the state or a combination thereof
3954 primarily engaged in educational activities or the administration or servicing of educational
3955 activities, including the State Board of Education and its instrumentalities, an institution of
3956 higher education and its branches, a school district and its instrumentalities, a vocational and
3957 technical school, and an entity arising out of a consolidation agreement between entities
3958 described under this Subsection (4)(f)(i)(B);

3959 (C) a county, city, town, local district under Title 17B, Limited Purpose Local
3960 Government Entities - Local Districts, special service district under Title 17D, Chapter 1,
3961 Special Service District Act, an entity created by an interlocal cooperation agreement under
3962 Title 11, Chapter 13, Interlocal Cooperation Act, or any other governmental entity designated
3963 in statute as a political subdivision of the state; or

3964 (D) a quasi-public corporation, that has the same meaning as defined in Section
3965 [63E-1-102](#).

3966 (ii) The department shall pattern the annual accounting required by this Subsection
3967 (4)(f) on the insurance related information on Internal Revenue Service Form 5500 and its
3968 relevant attachments.

3969 (g) At the request of the department, a producer shall provide the department a copy of:

3970 (i) a disclosure required by this Subsection (4); or

3971 (ii) an Internal Revenue Service Form 5500 and its relevant attachments.

3972 (5) This section does not alter the right of any licensee to recover from an insured the
3973 amount of any premium due for insurance effected by or through that licensee or to charge a
3974 reasonable rate of interest upon past-due accounts.

3975 (6) This section does not apply to bail bond producers or bail enforcement agents as
3976 defined in Section [31A-35-102](#).

3977 (7) A licensee may not receive noncommission compensation from an insurer, insured,

3978 or enrollee for providing a service or engaging in an act that is required to be provided or
3979 performed in order to receive commission compensation, except for the surplus lines
3980 transactions that do not receive commissions.

3981 Section 35. Section **31A-26-102** is amended to read:

3982 **31A-26-102. Definitions.**

3983 As used in this chapter, unless expressly provided otherwise:

3984 (1) "Company adjuster" means a person employed by an insurer~~[-or an entity under~~
3985 ~~common control or ownership with the insurer,]~~ who negotiates or settles claims on behalf of
3986 the [~~employer]~~ insurer or an affiliated insurer.

3987 (2) "Designated home state" means the state or territory of the United States or the
3988 District of Columbia:

3989 (a) in which an insurance adjuster does not maintain the adjuster's principal:

3990 (i) place of residence; or

3991 (ii) place of business;

3992 (b) if the resident state, territory, or District of Columbia of the adjuster does not
3993 license adjusters for the line of authority sought, the adjuster has qualified for the license as if
3994 the person were a resident in the state, territory, or District of Columbia described in
3995 Subsection (2)(a), including an applicable:

3996 (i) examination requirement;

3997 (ii) fingerprint background check requirement; and

3998 (iii) continuing education requirement; and

3999 (c) that the adjuster has designated [~~the state, territory, or District of Columbia]~~ as the
4000 insurance adjuster's designated home state.

4001 (3) "Home state" means:

4002 (a) a state or territory of the United States or the District of Columbia in which an
4003 insurance adjuster:

4004 (i) maintains the adjuster's principal:

4005 (A) place of residence; or

4006 (B) place of business; and
4007 (ii) is licensed to act as a resident adjuster; or
4008 (b) if the resident state, territory, or the District of Columbia described in Subsection
4009 (3)(a) does not license adjusters for the line of authority sought, a state, territory, or the District
4010 of Columbia:
4011 (i) in which the adjuster is licensed;
4012 (ii) in which the adjuster is in good standing; and
4013 (iii) that the adjuster has designated as the adjuster's designated home state.
4014 (4) "Independent adjuster" means an insurance adjuster required to be licensed under
4015 Section 31A-26-201, who engages in insurance adjusting as a representative of one or more
4016 insurers.
4017 (5) "Insurance adjusting" or "adjusting" means directing or conducting the
4018 investigation, negotiation, or settlement of a claim under an insurance policy, on behalf of an
4019 insurer, policyholder, or a claimant under an insurance policy.
4020 (6) (a) "Organization" means a person other than a natural person~~[-and]~~.
4021 (b) "Organization" includes a sole proprietorship by which a natural person does
4022 business under an assumed name.
4023 (7) "Portable electronics insurance" ~~[is as]~~ means the same as that term is defined in
4024 Section 31A-22-1802.
4025 (8) "Public adjuster" means a person required to be licensed under Section
4026 31A-26-201, who engages in insurance adjusting as a representative of insureds and claimants
4027 under insurance policies.
4028 Section 36. Section 31A-28-103 is amended to read:
4029 **31A-28-103. Coverage and limitations.**
4030 (1) This part provides coverage for a policy or contract specified in Subsections (6) and
4031 (7) to a person who is:
4032 (a) except for a nonresident certificate holder under a group policy or contract, a
4033 beneficiary, assignee, or payee of a person covered by Subsection (1)(b), including a health

4034 care provider rendering services covered under an accident and health insurance policy or
4035 certificate, regardless of where that person resides; or

4036 (b) an owner of or a certificate holder or enrollee under a policy or contract, other than
4037 an unallocated annuity contract or structured settlement annuity, if the owner, enrollee, or
4038 certificate holder is:

4039 (i) a resident of Utah; or

4040 (ii) not a resident of Utah, but only if:

4041 (A) the member insurer that issued the policy or contract is domiciled in this state;

4042 (B) the state in which the person resides has an association similar to the association
4043 created by this part; and

4044 (C) the person is not eligible for coverage by an association in any other state because
4045 the insurer was not licensed in the other states at the time specified in the other states' guaranty
4046 association's laws.

4047 (2) For an unallocated annuity contract specified in Subsections (6) and (7):

4048 (a) Subsection (1) does not apply; and

4049 (b) except as provided in Subsections (4) and (5), this part provides coverage for the
4050 unallocated annuity contract specified in Subsection (2) to a person who is:

4051 (i) the owner of the unallocated annuity contract if the contract is issued to or in
4052 connection with a specific benefit plan whose plan sponsor has its principal place of business
4053 in this state; or

4054 (ii) an owner of an unallocated annuity contract issued to or in connection with a
4055 government lottery if the owner is a resident.

4056 (3) For a structured settlement annuity specified in Subsections (6) and (7):

4057 (a) Subsection (1) does not apply; and

4058 (b) except as provided in Subsections (4) and (5), this part provides coverage for the
4059 structured settlement annuity specified in Subsections (6) and (7) to a person who is a payee
4060 under a structured settlement annuity, or beneficiary of a payee if the payee is deceased, if the
4061 payee:

- 4062 (i) is a resident, regardless of where the contract owner resides;
- 4063 (ii) is not a resident, but only if one or more of the contract owners of the structured
4064 settlement annuity is a resident, and the payee, beneficiary, or contract owner is not eligible for
4065 coverage by the association of the state in which the payee or contract owner resides; or
- 4066 (iii) is not a resident, but only if:
- 4067 (A) no contract owner of the structured settlement annuity is a resident;
- 4068 (B) the insurer that issued the structured settlement annuity is domiciled in this state;
- 4069 (C) the state in which the contract owner resides has an association similar to the
4070 association created by this part; and
- 4071 (D) the payee, beneficiary, or the contract owner is not eligible for coverage by the
4072 association of the state in which the payee or contract owner resides.
- 4073 (4) This part may not provide coverage for a policy or contract specified in Subsections
4074 (6) and (7) to a person who:
- 4075 (a) is a payee or beneficiary of a contract owner resident of this state, if the payee or
4076 beneficiary is afforded any coverage by the association of another state;
- 4077 (b) is covered under Subsection (2), if any coverage is provided to the person by the
4078 association of another state; or
- 4079 (c) acquires rights to receive payments through a structured settlement factoring
4080 transaction, regardless of whether the transaction occurred before or after 26 U.S.C. Sec.
4081 5891(c)(3)(A) became effective.
- 4082 (5) (a) This part provides coverage for a policy or contract specified in Subsections (6)
4083 and (7) to a person who is a resident of this state and, in special circumstances, to a
4084 nonresident.
- 4085 (b) To avoid duplicate coverage, if a person who would otherwise receive coverage
4086 under this part is provided coverage under the laws of any other state, the person may not be
4087 provided coverage under this part.
- 4088 (c) In determining the application of this Subsection (5) when a person could be
4089 covered by the association of more than one state, whether as an owner, payee, enrollee,

4090 beneficiary, or assignee, this part shall be construed in conjunction with other state laws to
4091 result in coverage by only one association.

4092 (6) (a) Except as limited by this part, this part provides coverage to a person specified
4093 in Subsections (1) through (5) for:

4094 (i) a direct nongroup life insurance, direct accident and health insurance, or direct
4095 annuity policy or contract;

4096 (ii) a supplemental contract to a policy or contract described in Subsection (6)(a)(i);

4097 (iii) a certificate under a direct group policy or contract; and

4098 (iv) an unallocated annuity contract issued by a member insurer.

4099 (b) For purposes of Subsection (6)(a), an annuity contract and a certificate under a
4100 group annuity contract includes:

4101 (i) a guaranteed investment contract;

4102 (ii) a deposit administration contract;

4103 (iii) an unallocated funding agreement;

4104 (iv) an allocated funding agreement;

4105 (v) a structured settlement annuity;

4106 (vi) an annuity issued to or in connection with a government lottery; and

4107 (vii) an immediate or deferred annuity contract.

4108 (7) This part does not provide coverage for:

4109 (a) a portion of a policy or contract:

4110 (i) not guaranteed by the member insurer; or

4111 (ii) under which the risk is borne by the policy or contract owner;

4112 (b) a policy or contract of reinsurance, unless:

4113 (i) an assumption certificate is issued before the coverage date;

4114 (ii) the assumption certificate required by Subsection (7)(b)(i) is in effect pursuant to
4115 the reinsurance policy or contract; and

4116 (iii) the reinsurance contract is approved by the appropriate regulatory authorities;

4117 (c) except as provided in Subsection (11)(e), a portion of a policy or contract to the

4118 extent that the rate of interest on which the policy or contract is based, or the interest rate,
4119 crediting rate, or similar factor determined by use of an index or other external reference stated
4120 in the policy or contract employed in calculating returns or changes in value exceeds:

4121 (i) a rate of interest determined by subtracting two percentage points from Moody's
4122 Corporate Bond Yield Average averaged:

4123 (A) over the period of four years before the coverage date with respect to the policy or
4124 contract; or

4125 (B) for the corresponding lesser period if the policy or contract was issued less than
4126 four years before the association became obligated; or

4127 (ii) a rate of interest determined by subtracting three percentage points from Moody's
4128 Corporate Bond Yield Average as most recently available as determined on or after the earlier
4129 of:

4130 (A) the day on which the member insurer becomes an impaired insurer; or

4131 (B) the day on which the member insurer becomes an insolvent insurer;

4132 (d) a portion of a policy or contract issued to a plan or program of an employer,
4133 association, or other person to provide life, accident and health, or annuity benefits to its
4134 employees, members, or others, to the extent that the plan or program is self-funded or
4135 uninsured, including benefits payable by an employer, association, or other person under:

4136 (i) a multiple employer welfare arrangement, as that term is defined in 29 U.S.C. Sec.
4137 1002;

4138 (ii) a minimum premium group insurance plan;

4139 (iii) a stop-loss group insurance plan; or

4140 (iv) an administrative services only contract;

4141 (e) a portion of a policy or contract to the extent that it provides:

4142 (i) a dividend;

4143 (ii) an experience rating credit;

4144 (iii) voting rights; or

4145 (iv) payment of a fee or allowance to any person, including the policy or contract

4146 owner, in connection with the service to or administration of the policy or contract;

4147 (f) an unallocated annuity contract issued to or in connection with a benefit plan

4148 protected under the federal Pension Benefit Guaranty Corporation, regardless of whether the

4149 federal Pension Benefit Guaranty Corporation has yet become liable to make any payment with

4150 respect to the benefit plan;

4151 (g) a portion of an unallocated annuity contract that is not issued to or in connection

4152 with:

4153 (i) a specific benefit plan of:

4154 (A) employees;

4155 (B) a union; or

4156 (C) an association of natural persons; or

4157 (ii) a government lottery;

4158 (h) a portion of a policy or contract to the extent that the assessment required by

4159 Section [31A-28-109](#) that applies to the policy or contract is preempted by federal or state law;

4160 (i) an obligation that does not arise under the express written terms of the policy or

4161 contract issued by a member insurer to the enrollee, certificate holder, contract owner, or policy

4162 owner, including:

4163 (i) a claim based on marketing materials;

4164 (ii) a claim based on a side letter, rider, or other document that is issued by the member

4165 insurer without meeting applicable policy or contract form filing or approval requirements;

4166 (iii) a misrepresentation regarding a policy or contract benefit;

4167 (iv) an extra-contractual claim;

4168 (v) a claim for penalties; or

4169 (vi) a claim for consequential or incidental damages;

4170 (j) a contract that establishes the member insurer's obligations to provide a book value

4171 accounting guaranty for defined contribution benefit plan participants by reference to a

4172 portfolio of assets that is owned by a person that is:

4173 (i) (A) the benefit plan; or

4174 (B) the benefit plan's trustee; and
4175 (ii) not an affiliate of the member insurer;
4176 (k) a portion of a policy or contract to the extent it provides for interest or other
4177 changes in value:
4178 (i) to be determined by the use of an index or other external reference stated in the
4179 policy or contract; and
4180 (ii) as of the date the member insurer becomes an impaired or insolvent insurer,
4181 whichever occurs earlier:
4182 (A) that have not been credited to the policy or contract; or
4183 (B) as to which the policy or contract owner's rights are subject to forfeiture;
4184 (l) a policy or contract [~~providing~~] offering hospital, medical, prescription drug, or
4185 other health care benefit pursuant to:
4186 (i) Part C or D of Title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.; [~~or~~]
4187 (ii) Title XIX of the Social Security Act, 42 U.S.C. Sec. 1396 et seq.; or
4188 (iii) Title XXI of the Social Security Act, 42 U.S.C. Sec. 1397aa et seq.; or
4189 (m) a structured settlement annuity benefit to which a payee or beneficiary has
4190 transferred the payee or beneficiary's rights in a structured settlement factoring transaction,
4191 regardless of whether the transaction occurred before or after 26 U.S.C. Sec. 5891(c)(3)(A)
4192 became effective.
4193 (8) The benefits for which the association may become liable may not exceed the lesser
4194 of:
4195 (a) the contractual obligations for which the member insurer is liable or would have
4196 been liable if it were not an impaired or insolvent insurer;
4197 (b) with respect to one life, regardless of the number of policies or contracts:
4198 (i) for a life insurance policy:
4199 (A) if the insured died before the coverage date, \$500,000 of the death benefit;
4200 (B) if the insurer received a valid request for cash surrender before the coverage date
4201 but has not paid the cash surrender value before the coverage date, \$200,000 of cash surrender

4202 benefits; or
4203 (C) if neither Subsection (8)(b)(i)(A) nor (B) applies, the covered portion of each
4204 benefit provided under the policy;
4205 (ii) for an annuity contract, the covered portion of each benefit provided under the
4206 contract; and
4207 (iii) for an accident and health insurance policy or contract:
4208 (A) classified as a health benefit plan, \$500,000; or
4209 (B) not classified as a health benefit plan, the covered portion of each benefit provided
4210 under the policy;
4211 (c) for an individual participating in a governmental retirement plan established under
4212 Section 401, 403(b), or 457, Internal Revenue Code, covered by an unallocated annuity
4213 contract, or a beneficiary of that individual if the individual is deceased, \$250,000 in present
4214 value of annuity benefits, in the aggregate, including:
4215 (i) net cash surrender; and
4216 (ii) net cash withdrawal values; or
4217 (d) for a payee of a structured settlement annuity or a beneficiary of the payee if the
4218 payee is deceased, the limits set forth in Subsection (8)(b).
4219 (9) Notwithstanding Subsection (8), the association may not be obligated to cover more
4220 than:
4221 (a) an aggregate of \$500,000 in benefits for any one life under:
4222 (i) Subsection (8)(b)(i)(A);
4223 (ii) Subsection (8)(b)(i)(B);
4224 (iii) Subsection (8)(b)(ii); and
4225 (iv) Subsection (8)(b)(iii)(B);
4226 (b) \$5,000,000 in benefits for one owner of multiple nongroup policies of life
4227 insurance:
4228 (i) whether the policy or contract owner is an individual, firm, corporation, or other
4229 person;

4230 (ii) whether the persons insured are officers, managers, employees, or other persons;

4231 and

4232 (iii) regardless of the number of policies and contracts held by the owner; and

4233 (c) \$5,000,000 in benefits, regardless of the number of contracts held by the contract

4234 owner or plan sponsor, for:

4235 (i) one contract owner provided coverage under Subsection (2)(b)(ii); or

4236 (ii) one plan sponsor whose plans own, directly or in trust, one or more unallocated

4237 annuity contracts not included in Subsection (8)(b)(ii).

4238 (10) (a) Notwithstanding Subsection (9)(c) and except as provided in Subsection

4239 (10)(b), the association shall provide coverage if one or more unallocated annuity contracts are:

4240 (i) covered contracts under this part;

4241 (ii) owned by a trust or other entity for the benefit of two or more plan sponsors; and

4242 (iii) the largest interest in the trust or entity owning the contract or contracts is held by

4243 a plan sponsor whose principal place of business is in the state.

4244 (b) The association may not be obligated to cover more than \$5,000,000 in benefits

4245 with respect to the unallocated contracts described in Subsection (10)(a).

4246 (11) (a) The limitations set forth in Subsections (8) and (9) are limitations on the

4247 benefits for which the association is obligated before taking into account:

4248 (i) the association's subrogation and assignment rights; or

4249 (ii) the extent to which those benefits could be provided out of the assets of the

4250 impaired or insolvent insurer attributable to covered policies.

4251 (b) The costs of the association's obligations under this part may be met by the use of

4252 assets:

4253 (i) attributable to covered policies, as described in Subsection [31A-28-114\(3\)\(c\)](#); or

4254 (ii) reimbursed to the association pursuant to the association's subrogation and

4255 assignment rights.

4256 (c) Benefits provided by a long-term care rider to a life insurance policy or annuity

4257 contract shall be considered the same type of benefits as the base life insurance policy or

4258 annuity contract to which the long-term care rider relates.

4259 (d) In performing [its] the association's obligations to provide coverage under Section
 4260 31A-28-108, the association may not be required to guarantee, assume, reinsure, reissue,
 4261 perform, or cause to be guaranteed, assumed, reinsured, reissued, or performed a contractual
 4262 obligation of the insolvent or impaired insurer under a covered policy or contract that does not
 4263 materially affect the economic values or economic benefits of the covered policy or contract.

4264 (e) The exclusion from coverage described in Subsection (7)(c) does not apply to any
 4265 portion of a policy or contract, including a rider, that [~~provides~~] offers long-term care or any
 4266 other accident and health insurance benefit.

4267 Section 37. Section 31A-35-404 is amended to read:

4268 **31A-35-404. Minimum financial requirements for bail bond agency license.**

4269 (1) (a) A bail bond agency that pledges the assets of a letter of credit from a Utah
 4270 depository institution in connection with a judicial proceeding shall maintain an irrevocable
 4271 letter of credit with a minimum face value of \$300,000 assigned to the state from a Utah
 4272 depository institution.

4273 (b) Notwithstanding Subsection (1)(a), a bail bond agency described in Subsection
 4274 (1)(a) that is licensed under this chapter [~~as of~~] on or before December 31, 1999, shall maintain
 4275 an irrevocable letter of credit with a minimum face value of \$250,000 assigned to the state
 4276 from a Utah depository institution.

4277 (2) (a) A bail bond agency that pledges personal or real property, or both, as security
 4278 for a bail bond in connection with a judicial proceeding shall maintain[~~:(i)-(A)] a verified
 4279 financial statement for the current year:~~

4280 [~~(i)~~] (i) reviewed by a certified public accountant; and

4281 [~~(ii)~~] (ii) showing a minimum net worth of [~~at least~~];

4282 (A) \$300,000, at least \$100,000 of which is in liquid assets; or

4283 (B) if the bail bond agency is licensed under this chapter on or before December 31,
 4284 1999, \$250,000, at least \$50,000 of which is in liquid assets.

4285 [~~(B) notwithstanding Subsection (2)(a)(i), if the bail bond agency is licensed under this~~

- 4286 ~~chapter as of December 31, 1999, a current financial statement:]~~
- 4287 ~~[(F) reviewed by a certified public accountant; and]~~
- 4288 ~~[(H) showing a net worth of at least \$250,000, at least \$50,000 of which is in liquid~~
- 4289 ~~assets;]~~
- 4290 ~~[(ii) a copy of the applicant's federal and state income tax returns for the preceding two~~
- 4291 ~~years, but only for an original application; and]~~
- 4292 ~~[(iii) for each parcel of real property owned by the applicant and included in net worth~~
- 4293 ~~calculations:]~~
- 4294 ~~[(A) a title letter or report, or a current abstract of title from the office of the county~~
- 4295 ~~recorder; and]~~
- 4296 ~~[(B) (i) a certified appraisal made not more than six months prior to licensure for each~~
- 4297 ~~parcel and a title report that is current as of the date of licensure, if the bail bond agency is in its~~
- 4298 ~~first year of licensure and has pledged real property owned by the applicant; or]~~
- 4299 ~~[(H) a certified appraisal report or a current tax notice and a title letter or report, or a~~
- 4300 ~~current abstract of title from the county recorder if the bail bond agency is in its second or~~
- 4301 ~~subsequent year of licensure and has pledged real property owned by the applicant.]~~
- 4302 (b) For purposes of this Subsection (2), only real or personal property located in Utah
- 4303 may be included in the net worth of the bail bond agency.
- 4304 (3) A bail bond agency shall maintain a qualifying power of attorney issued by a surety
- 4305 insurer if:
- 4306 (a) the bail bond agency is the agent of the surety insurer; and
- 4307 (b) the surety insurer:
- 4308 (i) sells bail bonds;
- 4309 (ii) is in good standing in its state of domicile; and
- 4310 (iii) is granted a certificate to write bail bonds in Utah.
- 4311 (4) The commissioner may revoke the license of a bail bond agency that fails to
- 4312 maintain the minimum financial requirements required under this section.
- 4313 (5) The commissioner may set by rule the limits on the aggregate amounts of bail

4314 bonds issued by a bail bond agency.

4315 Section 38. Section **31A-35-406** is amended to read:

4316 **31A-35-406. Initial licensing, license renewal, and license reinstatement.**

4317 (1) An applicant for an initial bail bond agency license shall:

4318 (a) complete and submit to the department an application;

4319 (b) submit to the department, as applicable, a copy of the applicant's:

4320 (i) irrevocable letter of credit, as required under Subsection [31A-35-404\(1\)](#);

4321 (ii) verified financial statement, as required under Subsection [31A-35-404\(2\)](#); or

4322 (iii) qualifying power of attorney, as required under Subsection [31A-35-404\(3\)](#); and

4323 (c) pay the department the applicable renewal fee established in accordance with

4324 Section [31A-3-103](#).

4325 ~~[(H)]~~ (2) (a) A license under this chapter expires annually effective at midnight on
4326 August 14.

4327 (b) To renew [its] a bail bond agency license issued under this chapter, on or before
4328 July 15, [a] the bail bond agency shall:

4329 (i) complete and submit to the department a renewal application [to the department;]
4330 that includes certification that:

4331 ~~[(ii) require that a principal of the agency attends at least one board meeting each year;~~
4332 ~~and]~~

4333 (A) a principal of the agency attended or participated by telephone in at least one entire
4334 board meeting during the 12-month period before July 15; and

4335 (B) as of May 1, the agency complies with aggregate bond limits established by rule
4336 made in accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act;

4337 (ii) submit to the department, as applicable, a copy of the applicant's:

4338 (A) irrevocable letter of credit, as required under Subsection [31A-35-404\(1\)](#);

4339 (B) verified financial statement, as required under Subsection [31A-35-404\(2\)](#); or

4340 (C) qualifying power of attorney, as required under Subsection [31A-35-404\(3\)](#); and

4341 (iii) pay the department the applicable renewal fee established in accordance with

4342 Section [31A-3-103](#).

4343 ~~[(b)]~~ (c) A bail bond agency shall renew ~~[its]~~ the bail bond agency's license under this
4344 chapter annually as established by department rule, regardless of when the license is issued.

4345 ~~[(2)]~~ (3) (a) A bail bond agency may apply for reinstatement of an expired bail bond
4346 agency license within one year ~~[following the expiration of the license under Subsection (1)~~
4347 ~~by:]~~ after the day on which the license expires by complying with the renewal requirements
4348 described in Subsection (2).

4349 ~~[(a) submitting the renewal application required by Subsection (1); and]~~

4350 ~~[(b) paying a license reinstatement fee established in accordance with Section~~
4351 ~~[31A-3-103](#).]~~

4352 ~~[(3)]~~ (b) If a bail bond agency license has been expired for more than one year, the
4353 person applying for reinstatement of the bail bond agency license shall~~[:]~~ comply with the
4354 initial licensing requirements described in Subsection (1).

4355 ~~[(a) submit a new application form to the commissioner; and]~~

4356 ~~[(b) pay the application fee established in accordance with Section [31A-3-103](#).]~~

4357 (4) If a bail bond agency license is suspended, the applicant may not submit an
4358 application for a bail bond agency license until after ~~[the end of]~~ the day on which the period of
4359 suspension ends.

4360 (5) ~~[(A)]~~ The department shall deposit a fee collected under this section ~~[shall be~~
4361 ~~deposited]~~ in the restricted account created in Section [31A-35-407](#).

4362 Section 39. Section [31A-37-102](#) is amended to read:

4363 **[31A-37-102. Definitions.](#)**

4364 As used in this chapter:

4365 (1) (a) "Affiliated company" means a business entity that because of common
4366 ownership, control, operation, or management is in the same corporate or limited liability
4367 company system as:

4368 (i) a parent;

4369 (ii) an industrial insured; or

- 4370 (iii) a member organization.
- 4371 (b) ~~[Notwithstanding Subsection (1)(a), the commissioner may issue]~~ "Affiliated
- 4372 company" does not include a business entity for which the commissioner issues an order
- 4373 finding that ~~[a]~~ the business entity is not an affiliated company.
- 4374 (2) "Alien captive insurance company" means an insurer:
- 4375 (a) formed to write insurance business for a parent or affiliate of the insurer; and
- 4376 (b) licensed pursuant to the laws of an alien or foreign jurisdiction that imposes
- 4377 statutory or regulatory standards:
- 4378 (i) on a business entity transacting the business of insurance in the alien or foreign
- 4379 jurisdiction; and
- 4380 (ii) in a form acceptable to the commissioner.
- 4381 (3) "Applicant captive insurance company" means an entity that has submitted an
- 4382 application for a certificate of authority for a captive insurance company, unless the application
- 4383 has been denied or withdrawn.
- 4384 (4) "Association" means a legal association of two or more persons that has been in
- 4385 continuous existence for at least one year if:
- 4386 (a) the association or its member organizations:
- 4387 (i) own, control, or hold with power to vote all of the outstanding voting securities of
- 4388 an association captive insurance company incorporated as a stock insurer; or
- 4389 (ii) have complete voting control over an association captive insurance company
- 4390 incorporated as a mutual insurer;
- 4391 (b) the association's member organizations collectively constitute all of the subscribers
- 4392 of an association captive insurance company formed as a reciprocal insurer; or
- 4393 (c) the association or ~~[its]~~ the association's member organizations have complete voting
- 4394 control over an association captive insurance company formed as a limited liability company.
- 4395 (5) "Association captive insurance company" means a business entity that insures risks
- 4396 of:
- 4397 (a) a member organization of the association;

4398 (b) an affiliate of a member organization of the association; and

4399 (c) the association.

4400 (6) "Branch business" means an insurance business transacted by a branch captive
4401 insurance company in this state.

4402 (7) "Branch captive insurance company" means an alien captive insurance company
4403 that has a certificate of authority from the commissioner to transact the business of insurance in
4404 this state through a captive insurance company that is domiciled outside of this state.

4405 (8) "Branch operation" means a business operation of a branch captive insurance
4406 company in this state.

4407 (9) (a) "Captive insurance company" means the same as that term is defined in Section
4408 [31A-1-301](#).

4409 (b) "Captive insurance company" includes any of the following formed or holding a
4410 certificate of authority under this chapter:

4411 [~~(a)~~] (i) a branch captive insurance company;

4412 [~~(b)~~] (ii) a pure captive insurance company;

4413 [~~(c)~~] (iii) an association captive insurance company;

4414 [~~(d)~~] (iv) a sponsored captive insurance company;

4415 [~~(e)~~] (v) an industrial insured captive insurance company, including an industrial
4416 insured captive insurance company formed as a risk retention group captive in this state
4417 pursuant to the provisions of the Federal Liability Risk Retention Act of 1986;

4418 [~~(f)~~] (vi) a special purpose captive insurance company; or

4419 [~~(g)~~] (vii) a special purpose financial captive insurance company.

4420 (10) "Commissioner" means Utah's Insurance Commissioner or the commissioner's
4421 designee.

4422 (11) "Common ownership and control" means that two or more captive insurance
4423 companies are owned or controlled by the same person or group of persons as follows:

4424 (a) in the case of a captive insurance company that is a stock corporation, the direct or
4425 indirect ownership of 80% or more of the outstanding voting stock of the stock corporation;

4426 (b) in the case of a captive insurance company that is a mutual corporation, the direct
4427 or indirect ownership of 80% or more of the surplus and the voting power of the mutual
4428 corporation;

4429 (c) in the case of a captive insurance company that is a limited liability company, the
4430 direct or indirect ownership by the same member or members of 80% or more of the
4431 membership interests in the limited liability company; or

4432 (d) in the case of a sponsored captive insurance company, a protected cell is a separate
4433 captive insurance company owned and controlled by the protected cell's participant, only if:

4434 (i) the participant is the only participant with respect to the protected cell; and

4435 (ii) the participant is the sponsor or is affiliated with the sponsor of the sponsored
4436 captive insurance company through common ownership and control.

4437 (12) "Consolidated debt to total capital ratio" means the ratio of Subsection (12)(a) to
4438 (b).

4439 (a) This Subsection (12)(a) is an amount equal to the sum of all debts and hybrid
4440 capital instruments including:

4441 (i) all borrowings from depository institutions;

4442 (ii) all senior debt;

4443 (iii) all subordinated debts;

4444 (iv) all trust preferred shares; and

4445 (v) all other hybrid capital instruments that are not included in the determination of
4446 consolidated GAAP net worth issued and outstanding.

4447 (b) This Subsection (12)(b) is an amount equal to the sum of:

4448 (i) total capital consisting of all debts and hybrid capital instruments as described in
4449 Subsection (12)(a); and

4450 (ii) shareholders' equity determined in accordance with generally accepted accounting
4451 principles for reporting to the United States Securities and Exchange Commission.

4452 (13) "Consolidated GAAP net worth" means the consolidated shareholders' or
4453 members' equity determined in accordance with generally accepted accounting principles for

4454 reporting to the United States Securities and Exchange Commission.

4455 (14) "Controlled unaffiliated business" means a business entity:

4456 (a) (i) in the case of a pure captive insurance company, that is not in the corporate or
4457 limited liability company system of a parent or the parent's affiliate; or

4458 (ii) in the case of an industrial insured captive insurance company, that is not in the
4459 corporate or limited liability company system of an industrial insured or an affiliated company
4460 of the industrial insured;

4461 (b) (i) in the case of a pure captive insurance company, that has a contractual
4462 relationship with a parent or affiliate; or

4463 (ii) in the case of an industrial insured captive insurance company, that has a
4464 contractual relationship with an industrial insured or an affiliated company of the industrial
4465 insured; and

4466 (c) whose risks that are or will be insured by a pure captive insurance company, an
4467 industrial insured captive insurance company, or both, are managed in accordance with
4468 Subsection 31A-37-106(1)(j) by:

4469 (i) (A) a pure captive insurance company; or

4470 (B) an industrial insured captive insurance company; or

4471 (ii) a parent or affiliate of:

4472 (A) a pure captive insurance company; or

4473 (B) an industrial insured captive insurance company.

4474 (15) "Criminal act" means an act for which a person receives a verdict or finding of
4475 guilt after a criminal trial or a plea of guilty or nolo contendere to a criminal charge.

4476 [~~(15)~~] (16) "Establisher" means a person who establishes a business entity or a trust.

4477 [~~(16)~~] (17) "Governing body" means the persons who hold the ultimate authority to
4478 direct and manage the affairs of an entity.

4479 [~~(17)~~] (18) "Industrial insured" means an insured:

4480 (a) that produces insurance:

4481 (i) by the services of a full-time employee acting as a risk manager or insurance

4482 manager; or

4483 (ii) using the services of a regularly and continuously qualified insurance consultant;

4484 (b) whose aggregate annual premiums for insurance on all risks total at least \$25,000;

4485 and

4486 (c) that has at least 25 full-time employees.

4487 [~~(18)~~] (19) "Industrial insured captive insurance company" means a business entity

4488 that:

4489 (a) insures risks of the industrial insureds that comprise the industrial insured group;

4490 and

4491 (b) may insure the risks of:

4492 (i) an affiliated company of an industrial insured; or

4493 (ii) a controlled unaffiliated business of:

4494 (A) an industrial insured; or

4495 (B) an affiliated company of an industrial insured.

4496 [~~(19)~~] (20) "Industrial insured group" means:

4497 (a) a group of industrial insureds that collectively:

4498 (i) own, control, or hold with power to vote all of the outstanding voting securities of

4499 an industrial insured captive insurance company incorporated or organized as a limited liability

4500 company as a stock insurer; or

4501 (ii) have complete voting control over an industrial insured captive insurance company

4502 incorporated or organized as a limited liability company as a mutual insurer;

4503 (b) a group that is:

4504 (i) created under the Product Liability Risk Retention Act of 1981, 15 U.S.C. Sec. 3901

4505 et seq., as amended, as a corporation or other limited liability association; and

4506 (ii) taxable under this title as a:

4507 (A) stock corporation; or

4508 (B) mutual insurer; or

4509 (c) a group that has complete voting control over an industrial captive insurance

4510 company formed as a limited liability company.

4511 ~~[(20)]~~ (21) "Member organization" means a person that belongs to an association.

4512 ~~[(21)]~~ (22) "Parent" means a person that directly or indirectly owns, controls, or holds
4513 with power to vote more than 50% of the outstanding securities of an organization.

4514 ~~[(22)]~~ (23) "Participant" means an entity that is insured by a sponsored captive
4515 insurance company:

4516 (a) if the losses of the participant are limited through a participant contract to the assets
4517 of a protected cell; and

4518 (b) (i) the entity is permitted to be a participant under Section 31A-37-403; or

4519 (ii) the entity is an affiliate of an entity permitted to be a participant under Section
4520 31A-37-403.

4521 ~~[(23)]~~ (24) "Participant contract" means a contract by which a sponsored captive
4522 insurance company:

4523 (a) insures the risks of a participant; and

4524 (b) limits the losses of the participant to the assets of a protected cell.

4525 ~~[(24)]~~ (25) "Protected cell" means a separate account established and maintained by a
4526 sponsored captive insurance company for one participant.

4527 ~~[(25)]~~ (26) "Pure captive insurance company" means a business entity that insures risks
4528 of a parent or affiliate of the business entity.

4529 ~~[(26)]~~ (27) "Special purpose financial captive insurance company" ~~[is-as]~~ means the
4530 same as that term is defined in Section 31A-37a-102.

4531 ~~[(27)]~~ (28) "Sponsor" means an entity that:

4532 (a) meets the requirements of Section 31A-37-402; and

4533 (b) is approved by the commissioner to:

4534 (i) provide all or part of the capital and surplus required by applicable law in an amount
4535 of not less than \$350,000, which amount the commissioner may increase by order if the
4536 commissioner considers it necessary; and

4537 (ii) organize and operate a sponsored captive insurance company.

4538 [~~(28)~~] (29) "Sponsored captive insurance company" means a captive insurance
4539 company:

4540 (a) in which the minimum capital and surplus required by applicable law is provided by
4541 one or more sponsors;

4542 (b) that is formed or holding a certificate of authority under this chapter;

4543 (c) that insures the risks of a separate participant through the contract; and

4544 (d) that segregates each participant's liability through one or more protected cells.

4545 [~~(29)~~] (30) "Treasury rates" means the United States Treasury strip asked yield as
4546 published in the Wall Street Journal as of a balance sheet date.

4547 Section 40. Section **31A-37-202** is amended to read:

4548 **31A-37-202. Permissive areas of insurance.**

4549 (1) Except as provided in Subsections (2) and (3), a captive insurance company may
4550 not directly insure a risk other than the risk of the captive insurance company's parent or
4551 affiliated company.

4552 (2) In addition to the risks described in Subsection (1), an association captive insurance
4553 company may insure the risk of:

4554 (a) a member organization of the association captive insurance company's association;
4555 or

4556 (b) an affiliate of a member organization of the association captive insurance
4557 company's association.

4558 (3) The following may insure a risk of a controlled unaffiliated business:

4559 (a) an industrial insured captive insurance company;

4560 (b) a protected cell;

4561 (c) a pure captive insurance company; or

4562 (d) a sponsored captive insurance company.

4563 (4) To the extent allowed by a captive insurance company's organizational charter, a
4564 captive insurance company may provide any type of insurance described in this title, except:

4565 (a) workers' compensation insurance;

- 4566 (b) personal motor vehicle insurance;
- 4567 (c) homeowners' insurance; and
- 4568 (d) any component of the types of insurance described in Subsections (4)(a) through
- 4569 (c).

4570 (5) A captive insurance company may not provide coverage for:

- 4571 (a) a wager or gaming risk;
- 4572 (b) loss of an election; or
- 4573 (c) the penal consequences of a crime~~[-or]~~;
- 4574 ~~[(d) punitive damages.]~~

4575 (6) Unless the punitive damages award arises out of a criminal act of an insured, a
 4576 captive insurance company may provide coverage for punitive damages awarded, including
 4577 through adjudication or compromise, against the captive insurance company's:

- 4578 (a) parent;
- 4579 (b) affiliated company; or
- 4580 (c) controlled unaffiliated business.

4581 ~~[(6)]~~ (7) Notwithstanding Subsection (4), if approved by the commissioner, a captive
 4582 insurance company may insure as a reimbursement a limited layer or deductible of workers'
 4583 compensation coverage.

4584 Section 41. Section **31A-37-204** is amended to read:

4585 **31A-37-204. Paid-in capital -- Other capital.**

4586 (1) (a) The commissioner may not issue a certificate of authority to a company
 4587 described in Subsection (1)(c) unless the company possesses and thereafter maintains
 4588 unimpaired paid-in capital and unimpaired paid-in surplus of:

- 4589 (i) in the case of a pure captive insurance company, not less than \$250,000;
- 4590 (ii) in the case of an association captive insurance company, not less than \$750,000;
- 4591 (iii) in the case of an industrial insured captive insurance company incorporated as a
 4592 stock insurer, not less than \$700,000;
- 4593 (iv) in the case of a sponsored captive insurance company, not less than ~~[\$1,000,000]~~

4594 \$500,000, of which a minimum of [~~\$350,000~~] \$200,000 is provided by the sponsor; or
4595 (v) in the case of a special purpose captive insurance company, an amount determined
4596 by the commissioner after giving due consideration to the company's business plan, feasibility
4597 study, and pro-formas, including the nature of the risks to be insured.

4598 (b) The paid-in capital and surplus required under this Subsection (1) may be in the
4599 form of:

4600 (i) (A) cash; or
4601 (B) cash equivalent;
4602 (ii) an irrevocable letter of credit:
4603 (A) issued by:
4604 (I) a bank chartered by this state; or
4605 (II) a member bank of the Federal Reserve System; and
4606 (B) approved by the commissioner;
4607 (iii) marketable securities as determined by Subsection (5); or
4608 (iv) some other thing of value approved by the commissioner, for a period not to
4609 exceed 45 days, to facilitate the formation of a captive insurance company in this state pursuant
4610 to an approved plan of liquidation and reorganization of another captive insurance company or
4611 alien captive insurance company in another jurisdiction.

4612 (c) This Subsection (1) applies to:
4613 (i) a pure captive insurance company;
4614 (ii) a sponsored captive insurance company;
4615 (iii) a special purpose captive insurance company;
4616 (iv) an association captive insurance company; or
4617 (v) an industrial insured captive insurance company.

4618 (2) (a) The commissioner may, under Section [31A-37-106](#), prescribe additional capital
4619 based on the type, volume, and nature of insurance business transacted.

4620 (b) The capital prescribed by the commissioner under this Subsection (2) may be in the
4621 form of:

- 4622 (i) cash;
- 4623 (ii) an irrevocable letter of credit issued by:
 - 4624 (A) a bank chartered by this state; or
 - 4625 (B) a member bank of the Federal Reserve System; or
- 4626 (iii) marketable securities as determined by Subsection (5).
- 4627 (3) (a) Except as provided in Subsection (3)(c), a branch captive insurance company, as
- 4628 security for the payment of liabilities attributable to branch operations, shall, through its branch
- 4629 operations, establish and maintain a trust fund:
 - 4630 (i) funded by an irrevocable letter of credit or other acceptable asset; and
 - 4631 (ii) in the United States for the benefit of:
 - 4632 (A) United States policyholders; and
 - 4633 (B) United States ceding insurers under:
 - 4634 (I) insurance policies issued; or
 - 4635 (II) reinsurance contracts issued or assumed.
 - 4636 (b) The amount of the security required under this Subsection (3) shall be no less than:
 - 4637 (i) the capital and surplus required by this chapter; and
 - 4638 (ii) the reserves on the insurance policies or reinsurance contracts, including:
 - 4639 (A) reserves for losses;
 - 4640 (B) allocated loss adjustment expenses;
 - 4641 (C) incurred but not reported losses; and
 - 4642 (D) unearned premiums with regard to business written through branch operations.
 - 4643 (c) Notwithstanding the other provisions of this Subsection (3):
 - 4644 (i) the commissioner may permit a branch captive insurance company that is required
 - 4645 to post security for loss reserves on branch business by its reinsurer to reduce the funds in the
 - 4646 trust account required by this section by the same amount as the security posted if the security
 - 4647 remains posted with the reinsurer; and
 - 4648 (ii) a branch captive insurance company that is the result of the licensure of an alien
 - 4649 captive insurance company that is not formed in an alien jurisdiction is not subject to the

4650 requirements of this Subsection (3).

4651 (4) (a) A captive insurance company may not pay the following without the prior
4652 approval of the commissioner:

4653 (i) a dividend out of capital or surplus in excess of the limits under Section
4654 16-10a-640; or

4655 (ii) a distribution with respect to capital or surplus in excess of the limits under Section
4656 16-10a-640.

4657 (b) The commissioner shall condition approval of an ongoing plan for the payment of
4658 dividends or other distributions on the retention, at the time of each payment, of capital or
4659 surplus in excess of:

4660 (i) amounts specified by the commissioner under Section 31A-37-106; or

4661 (ii) determined in accordance with formulas approved by the commissioner under
4662 Section 31A-37-106.

4663 (5) For purposes of this section, marketable securities means:

4664 (a) a bond or other evidence of indebtedness of a governmental unit in the United
4665 States or Canada or any instrumentality of the United States or Canada; or

4666 (b) securities:

4667 (i) traded on one or more of the following exchanges in the United States:

4668 (A) New York;

4669 (B) American; or

4670 (C) NASDAQ;

4671 (ii) when no particular security, or a substantially related security, applied toward the
4672 required minimum capital and surplus requirement of Subsection (1) represents more than 50%
4673 of the minimum capital and surplus requirement; and

4674 (iii) when no group of up to four particular securities, consolidating substantially
4675 related securities, applied toward the required minimum capital and surplus requirement of
4676 Subsection (1) represents more than 90% of the minimum capital and surplus requirement.

4677 (6) Notwithstanding Subsection (5), to protect the solvency and liquidity of a captive

4678 insurance company, the commissioner may reject the application of specific assets or amounts
4679 of specific assets to satisfying the requirement of Subsection (1).

4680 Section 42. Section **31A-37-303** is amended to read:

4681 **31A-37-303. Reinsurance.**

4682 (1) (a) A captive insurance company may cede risks to any insurance company
4683 approved by the commissioner.

4684 (b) [A] Except as provided in Subsection (1)(c), a captive insurance company may
4685 provide reinsurance[~~, as authorized in this title,~~] on risks ceded by any other insurer with prior
4686 approval of the commissioner.

4687 (c) A captive insurance company may not provide reinsurance on a punitive damages
4688 risk ceded by an insurer, unless the punitive damages risk is the risk of the captive insurance
4689 company's:

4690 (i) parent;

4691 (ii) affiliated company; or

4692 (iii) controlled unaffiliated business.

4693 (2) (a) A captive insurance company may take credit for reserves on risks or portions of
4694 risks ceded to reinsurers if the captive insurance company complies with:

4695 (i) Section 31A-17-404, 31A-17-404.1, 31A-17-404.3, or 31A-17-404.4; or [if the
4696 captive insurance company complies with]

4697 (ii) other requirements as the commissioner may establish by rule made in accordance
4698 with Title 63G, Chapter 3, Utah Administrative Rulemaking Act.

4699 (b) Unless the reinsurer is in compliance with Section 31A-17-404, 31A-17-404.1,
4700 31A-17-404.3, or 31A-17-404.4 or a rule adopted under Subsection (2)(a)(ii), a captive
4701 insurance company may not take credit for:

4702 (i) reserves on risks ceded to a reinsurer; or

4703 (ii) portions of risks ceded to a reinsurer.

4704 Section 43. Section **31A-37-701** is amended to read:

4705 **31A-37-701. Certificate of dormancy.**

4706 (1) In accordance with the provisions of this section, a captive insurance company,
4707 other than a risk retention group, may apply, without fee, to the commissioner for a certificate
4708 of dormancy.

4709 (2) (a) A captive insurance company, other than a risk retention group, is eligible for a
4710 certificate of dormancy if the captive insurance company:

4711 (i) has ceased transacting the business of insurance, including the issuance of insurance
4712 policies; and

4713 (ii) has no remaining insurance liabilities or obligations associated with insurance
4714 business transactions or insurance policies.

4715 (b) For purposes of Subsection (2)(a)(ii), the commissioner may disregard liabilities or
4716 obligations for which the captive insurance company has withheld sufficient funds or that are
4717 otherwise sufficiently secured.

4718 (3) Except as provided in Subsection ~~[(5)]~~ (4), a captive insurance company that holds
4719 a certificate of dormancy is subject to all requirements of this chapter.

4720 (4) A captive insurance company that holds a certificate of dormancy:

4721 (a) shall possess and maintain unimpaired paid-in capital and unimpaired paid-in
4722 surplus of:

4723 (i) in the case of a pure captive insurance company or a special purpose captive
4724 insurance company, not less than \$25,000;

4725 (ii) in the case of an association captive insurance company, not less than \$75,000; or

4726 (iii) in the case of a sponsored captive insurance company, not less than ~~[\$100,000]~~
4727 \$50,000, of which the sponsor provides at least ~~[\$35,000 is provided by the sponsor]~~ \$20,000;

4728 and

4729 (b) is not required to:

4730 (i) subject to Subsection (5), submit an annual audit or statement of actuarial opinion;

4731 (ii) maintain an active agreement with an independent auditor or actuary; or

4732 (iii) hold an annual meeting of the captive insurance company in the state.

4733 (5) The commissioner may require a captive insurance company that holds a certificate

4734 of dormancy to submit an annual audit if the commissioner determines that there are concerns
4735 regarding the captive insurance company's solvency or liquidity.

4736 (6) To maintain a certificate of dormancy and in lieu of a certificate of authority
4737 renewal fee, no later than July 1 of each year, a captive insurance company shall pay an annual
4738 dormancy renewal fee that is equal to 50% of the captive insurance's company's certificate of
4739 authority renewal fee.

4740 (7) A captive insurance company may consecutively renew a certificate of dormancy
4741 no more than five times.

4742 Section 44. Section **31A-45-501** is amended to read:

4743 **31A-45-501. Access to health care providers.**

4744 (1) As used in this section:

4745 (a) "Class of health care provider" means a health care provider or a health care facility
4746 regulated by the state within the same professional, trade, occupational, or certification
4747 category established under Title 58, Occupations and Professions, or within the same facility
4748 licensure category established under Title 26, Chapter 21, Health Care Facility Licensing and
4749 Inspection Act.

4750 (b) "Covered health care services" or "covered services" means health care services for
4751 which an enrollee is entitled to receive under the terms of a [~~health maintenance~~] managed care
4752 organization contract.

4753 (c) "Credentialed staff member" means a health care provider with active staff
4754 privileges at an independent hospital or federally qualified health center.

4755 (d) "Federally qualified health center" means as defined in the Social Security Act, 42
4756 U.S.C. Sec. 1395x.

4757 (e) "Independent hospital" means a general acute hospital or a critical access hospital
4758 that:

4759 (i) is either:

4760 (A) located 20 miles or more from any other general acute hospital or critical access
4761 hospital; or

- 4762 (B) licensed as of January 1, 2004;
- 4763 (ii) is licensed pursuant to Title 26, Chapter 21, Health Care Facility Licensing and
4764 Inspection Act; [~~and~~]
- 4765 (iii) is controlled by a board of directors of which 51% or more reside in the county
4766 where the hospital is located; and[:]
- 4767 (iv) (A) the hospital's board of directors is ultimately responsible for the policy and
4768 financial decisions of the hospital; or
- 4769 (B) the hospital is licensed for 60 or fewer beds and is not owned, in whole or in part,
4770 by an entity that owns or controls a health maintenance organization if the hospital is a
4771 contracting facility of the organization.
- 4772 (f) "Noncontracting provider" means an independent hospital, federally qualified health
4773 center, or credentialed staff member that has not contracted with a managed care organization
4774 to provide health care services to enrollees of the managed care organization.
- 4775 (2) Except for a managed care organization that is under the common ownership or
4776 control of an entity with a hospital located within 10 paved road miles of an independent
4777 hospital, a managed care organization shall pay for covered health care services rendered to an
4778 enrollee by an independent hospital, a credentialed staff member at an independent hospital, or
4779 a credentialed staff member at his local practice location if:
- 4780 (a) the enrollee:
- 4781 (i) lives or resides within 30 paved road miles of the independent hospital; or
4782 (ii) if Subsection (2)(a)(i) does not apply, lives or resides in closer proximity to the
4783 independent hospital than a contracting hospital;
- 4784 (b) the independent hospital is located prior to December 31, 2000 in a county with a
4785 population density of less than 100 people per square mile, or the independent hospital is
4786 located in a county with a population density of less than 30 people per square mile; and
- 4787 (c) the enrollee has complied with the prior authorization and utilization review
4788 requirements otherwise required by the managed care organization contract.
- 4789 (3) A managed care organization shall pay for covered health care services rendered to

4790 an enrollee at a federally qualified health center if:

4791 (a) the enrollee:

4792 (i) lives or resides within 30 paved road miles of the federally qualified health center;

4793 or

4794 (ii) if Subsection (3)(a)(i) does not apply, lives or resides in closer proximity to the
4795 federally qualified health center than a contracting provider;

4796 (b) the federally qualified health center is located in a county with a population density
4797 of less than 30 people per square mile; and

4798 (c) the enrollee has complied with the prior authorization and utilization review
4799 requirements otherwise required by the managed care organization contract.

4800 (4) (a) A managed care organization shall reimburse a noncontracting provider or the
4801 enrollee for covered services rendered pursuant to Subsection (2) a like dollar amount as [it]
4802 the managed care organization pays to contracting providers under a noncapitated arrangement
4803 for comparable services.

4804 (b) A managed care organization shall reimburse a federally qualified health center or
4805 the enrollee for covered services rendered pursuant to Subsection (3) a like amount as paid by
4806 the managed care organization under a noncapitated arrangement for comparable services to a
4807 contracting provider in the same class of health care providers as the provider who rendered the
4808 service.

4809 (5) (a) A noncontracting independent hospital may not balance bill a patient when the
4810 [~~health maintenance~~] managed care organization reimburses a noncontracting independent
4811 hospital or an enrollee in accordance with Subsection (4)(a).

4812 (b) A noncontracting federally qualified health center may not balance bill a patient
4813 when the federally qualified health center or the enrollee receives reimbursement in accordance
4814 with Subsection (4)(b).

4815 (6) A noncontracting provider may only refer an enrollee to another noncontracting
4816 provider so as to obligate the enrollee's managed care organization to pay for the resulting
4817 services if:

4818 (a) the noncontracting provider making the referral or the enrollee has received prior
4819 authorization from the organization for the referral; or

4820 (b) the practice location of the noncontracting provider to whom the referral is made:

4821 (i) is located in a county with a population density of less than 25 people per square
4822 mile; and

4823 (ii) is within 30 paved road miles of:

4824 (A) the place where the enrollee lives or resides; or

4825 (B) the independent hospital or federally qualified health center at which the enrollee
4826 may receive covered services pursuant to Subsection (2) or (3).

4827 (7) Notwithstanding this section, a managed care organization may contract directly
4828 with an independent hospital, federally qualified health center, or credentialed staff member.

4829 (8) (a) A managed care organization that violates any provision of this section is
4830 subject to sanctions as determined by the commissioner in accordance with Section [31A-2-308](#).

4831 (b) Violations of this section include:

4832 (i) failing to provide the notice required by Subsection (8)(d) by placing the notice in
4833 any managed care organization's provider list that is supplied to enrollees, including any
4834 website maintained by the managed care organization;

4835 (ii) failing to provide notice of an enrollee's rights under this section when:

4836 (A) an enrollee makes personal contact with the managed care organization by
4837 telephone, electronic transaction, or in person; and

4838 (B) the enrollee inquires about the enrollee's rights to access an independent hospital or
4839 federally qualified health center; and

4840 (iii) refusing to reprocess or reconsider a claim, initially denied by the managed care
4841 organization, when the provisions of this section apply to the claim.

4842 (c) The commissioner shall, pursuant to Chapter 2, Part 2, Duties and Powers of
4843 Commissioner:

4844 (i) adopt rules as necessary to implement this section;

4845 (ii) identify in rule:

4846 (A) the counties with a population density of less than 100 people per square mile;

4847 (B) independent hospitals as defined in Subsection (1)(e); and

4848 (C) federally qualified health centers as defined in Subsection (1)(d).

4849 (d) (i) A managed care organization shall:

4850 (A) use the information developed by the commissioner under Subsection (8)(c) to
4851 identify the rural counties, independent hospitals, and federally qualified health centers that are
4852 located in the managed care organization's service area; and

4853 (B) include the providers identified under Subsection (8)(d)(i)(A) in the notice required
4854 in Subsection (8)(d)(ii).

4855 (ii) The managed care organization shall provide the following notice, in bold type, to
4856 enrollees as specified under Subsection (8)(b)(i), and shall keep the notice current:

4857 "You may be entitled to coverage for health care services from the following
4858 noncontracted providers if you live or reside within 30 paved road miles of the listed providers,
4859 or if you live or reside in closer proximity to the listed providers than to your contracted
4860 providers:

4861 This list may change periodically, please check on our website or call for verification.
4862 Please be advised that if you choose a noncontracted provider you will be responsible for any
4863 charges not covered by your health insurance plan.

4864 If you have questions concerning your rights to see a provider on this list you may
4865 contact your managed care organization at _____. If the managed care organization does
4866 not resolve your problem, you may contact the Office of Consumer Health Assistance in the
4867 Insurance Department, toll free."

4868 (e) A person whose interests are affected by an alleged violation of this section may
4869 contact the Office of Consumer Health Assistance and request assistance, or file a complaint as
4870 provided in Section [31A-2-216](#).